University Hospitals Bristol
NHS Foundation Trust

October 2018 Published Papers

Including:

Quality and Performance Report

Quality and Outcomes Chair's Report

People Committee Chair's Report

Finance Committee Chair's Report

Respecting everyone
Embracing change
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Our hospitals.

Conference Room, Trust HQ, Marlborough St, Bristol, BS13NU

Meeting of the Trust Board on Wednesday 31 October 2018 in the Conference Room, Trust Headquarters

Report Title	**Quality and Performance Report**
Report Author	**James Rabbitts, Head of Performance Reporting** **Anne Reader, Head of Quality (Patient Safety)** **Matt Joint, Director of People**
Executive Lead	**Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer** **Quality – Carolyn Mills, Chief Nurse/William Oldfield, Medical Director**
Agenda Item No:	**9**

1. Report Summary

To review the Trust's performance on Quality, Workforce and Access standards.

2. Key points to note
(Including decisions taken)

Please refer to the Executive Summary in the report.

3. Risks

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

Members are asked to:

- This report is for **ASSURANCE**
- The Trust Board is asked to **NOTE** the report

5. History of the paper

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)
		26 October 2018		**People Committee 26 October 2018**

University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

October 2018

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 88.9 % for August, so the national standard of 85% was achieved. The national standard is on track to be achieved for the quarter.
- The measure for percentage of A&E patients seen in less than 4 hours was 85.0% for September. This did not achieve the 95% national standard and is below the improvement trajectory target of 90.84%. However, with the addition of Walk-In Centre data (as part of NHS England's "Trust Footprint" publication), UHBristol's A&E performance for Quarter 2 was 91.5%. This delivered the year-to-date recovery trajectory.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.52% as at end of September. This did not achieve the national 92% standard. The improvement trajectory target for this measure has been set at 88.50% so this was achieved. The Trust was 1017 patients away from the national compliance of 92%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of September was 98.1%, with 153 patients waiting 6+ weeks. This is lower than the national 99% standard. The maximum allowed breaches to achieve 99% was 81. The Trust recovery trajectory is set to achieve 99% in February.

Headline Indicators

There were seven Clostridium Difficile cases in September. An initial review has not identified areas of concern, and seven cases is within normal variation limits for this measure. This gives 20 cases over the first six months of the year; so the Trust is still on track to have fewer than 44 cases for the whole year. There was one MRSA cases in September, which makes four cases for the year to date.

Patient Falls, as a proportion of beddays, reduced in September to 4.9 falls per 1000 beddays. This is slightly above the target of 4.8. The learning from these incidents will be shared at the Falls group and cascaded through to the Divisions. Pressure Ulcer incidence was at 0.28 per 1000 beddays, which remains below the 0.4 target. There were no new Grade 3 or Grade 4 pressure ulcers in September. Patient experience scores (monthly surveys and Friends & Family Test) remain consistently above their minimum target levels, indicating the continued provision of a positive patient experience at UH Bristol.

Last Minute Cancelled Operations (LMCs) were at 1.4% of elective activity and equated to 89 cases. There were four breaches of the 28 day standard (LMCs from last month had to be re-admitted within 28 days).

The Trust's Summary Hospital Mortality Indicator (SHMI) is 102.7 for latest 12 month period, April 2017 to March 2018. However , the Trust is still in the "As Expected" category and statistically there are insufficient data points to determine any trend. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.

Workforce

Agency usage increased by 3.3 full time equivalents (FTEs) to 107.9 (1.2%), with the largest increase seen in Surgery. Bank usage reduced by 21.2 FTE to 444.2 (5.1%), with the largest increase seen in Surgery.

Turnover reduced to 13.5% from 13.9% last month, with marginal increases in only two divisions – Specialised Services and Trust Services. Overall vacancies increased to 5.6% compared to 5.4% in the previous month. There were reductions in two staff groups (Medical Staff and Nursing Staff).

Sickness absence reduced from 3.9% to 3.8%, with reductions in four divisions. The largest divisional reduction was seen in Women's and Children's. Facilities and Estates saw the largest increase. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, this reduced by 10.2% compared with last month. Other Musculoskeletal Problems are the second highest cause of sickness and this reason reduced by 6.3% compared with last month.

September 2018 compliance for Core Skills (mandatory/statutory) training remained at 89% overall across the eleven core skills programmes.

1.2 OVERVIEW – Single Oversight Framework

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%						
	"Trust Footprint"	92.05%			91.48%								
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
Cancer 62-day GP **Standard: 85%**	Actual (Monthly)	84.08%	82.41%	85.96%	85.66%	88.93%							
	Actual (Quarterly)	84.2%											
	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	88.19%	89.06%	88.55%	88.91%	88.73%	88.52%						
	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	96.80%	97.64%	97.83%	97.88%	97.13%	98.13%						
	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%

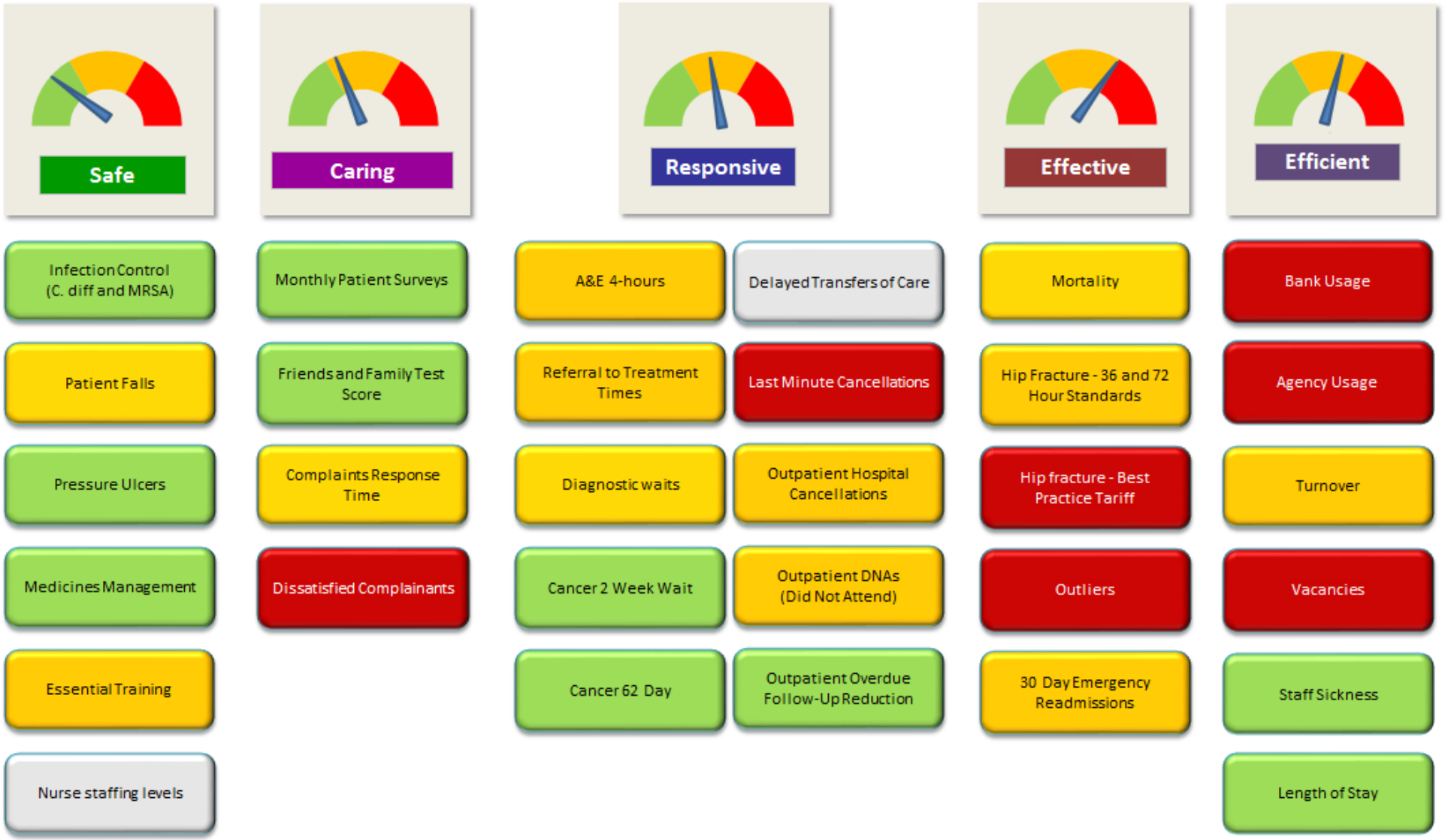
GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E "Trust Footprint":
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres and Minor Injury Units in their region. For UHBristol this was the Bristol, North Somerset, Somerset and South Gloucestershire (BNSSSG) region. The result of this apportionment was 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.

* With addition of WIC data (as part of NHS England's "Trust Footprint" publications), UHBristol's A&E performance for Quarter 2 achieved the trajectory.

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	• Achieved the 62 day GP national standard in June, July and August and forecasting achievement in quarter 2. • Emergency Department 4 Hour performance with Walk-In Centre activity was 91.5% for Quarter 2. This delivered the year-to-date recovery trajectory. • Referral To Treatment (RTT) Performance trajectory was maintained. September achieved 88.52% against a trajectory of 88.50%. • The number of Outpatient Follow-Ups that are overdue by more than 12 months has fallen significantly. It reduced from 4,900 in September 2017 to 383 in September 2018. • Legacy On-hold referrals signed off by NHS Improvement's Intensive Support Team for block closure. This has been approved at Quality and Outcomes Committee, Service Delivery Group and Risk Management Group. Now requires final sign-off at Senior Leadership Team. • The number of patients On Hold was around 85,000 when the review began. As at end of September this is now at 24,000. Work is now underway to agree the sustainable volume. • New escalation and predictor model within adult ED, to better predict potential surges in arrivals, now live.	• Delivery of GP Cancer 62 Day national standard of 85% in each month and quarter. • Ensuring all processes are in place to report against the amended national rules for cancer performance (from October 2018) • Recommendations from the Surgical Acute Assembly and Acute Care Assembly to be taken forward, through Urgent Care Steering Group. • Agree the bed requirement with divisions and commissioners for winter; agree any additional bed requirement and assess potential impact of any demand management schemes. • Deliver A&E 4 hour performance trajectory of 90.06% and RTT trajectory of 88.5% in October. • Deliver the 99% Diagnostic standard by end of February. Maintain performance at 98% between October and February. • Monitoring of patients with a current on-hold status to continue at the weekly performance meeting. • Work with our commissioners to continue the review of the local patient access policy. The Trust has shared its proposal with commissioners and have committed to reviewing and reporting back by December.
	Opportunities	**Risks and Threats**
ACCESS	• Opportunity to improve cancer performance with new national rules for allocation of performance between providers • Funding awarded to support performance improvement across the local area, with a dedicated role at each local provider to troubleshoot pathway issues internally and regionally • A business case for additional medical and nursing staffing in Children's ED has been developed and is with the division for sign off • Development of a new Referral To Treatment report showing the dating of patients in relation to breach date; to be managed through weekly performance meeting. • Cataract Services will be piloting 260 patients per month being offered choice of admission date from pre-op. In February, the service will begin a trial, booking direct to Surgery from outpatient appointment. • Observation of staff working practices in the Trust's Patient Administration System commenced in September with a plan to have an in-depth demonstration of proposed functionality by System C (Medway PAS supplier) planned for 20th November. Outcome of this review will be shared with Quality and Outcomes Committee.	• Rising demand in Dermatology continues to cause pressures in service delivery (11% increase in 2018/19 referrals). Local commissioners are sighted on this increase as a whole system approach is needed to resolve. • ED attendances are increasing: 5% rise at BRI and 8% rise at BCH (Apr-Sep 2017 vs Apr- Sep 2018) • Diagnostic 6 week wait standard did not achieve 99% for end of October, as originally planned for in the Recovery Action Plan (October achieved 98.1%). Recent deterioration in adult Endoscopy and continued capacity issues in Echocardiography are the main areas of concern. • The Trust continues to report 52 week breaches in Paediatric Services. A service assessment of the Paediatric Services is to be carried out by the Deputy Chief Operating Officer in November. The CCG has requested a revised plan of how the Trust will achieve ZERO 52 week breaches by End of March 2019 and require this plan to be shared at November's Access Performance Meeting. • Without an agreed patient access policy to support the high level of cancellation/patient choice achieving no long waiting patients would be difficult to achieve. Work is being undertaken, see "Priorities" section. • Seasonal variation in performance during winter months.

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

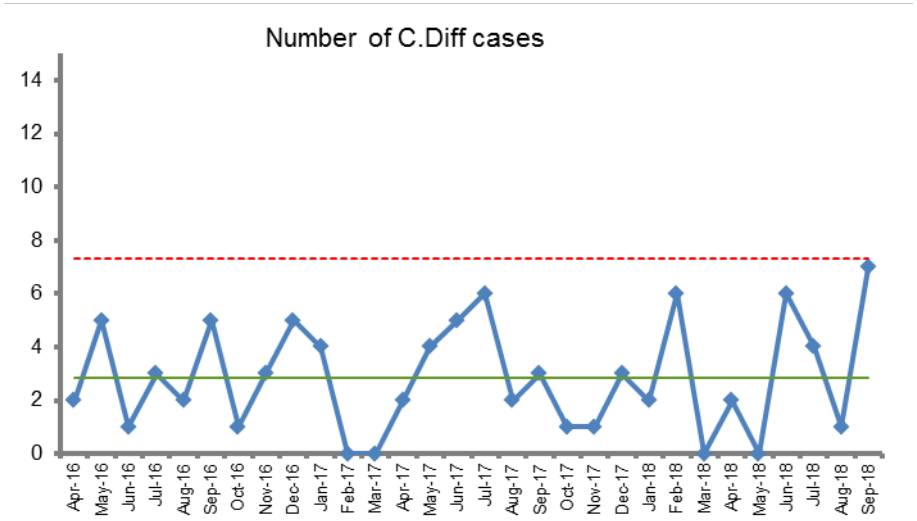
	Successes	Priorities
QUALITY	• No medication incidents in August resulted in moderate or greater harm. The harm to no harm ratio in August 2018 was 0.09, below the target of 0.14. Figures for the previous 12 months indicate sustained improvement in minimising harm from medication incidents. • Nutrition screening of patients has improved from the last two quarters in 2017/18 and been sustained above 90% for the first two quarters in 2018/19.	• Antibiotic prescribing compliance was 75.1% in September, a further reduction from 77.4% in February. There has been a change in data collection with a larger proportion of the sample being from admission areas where there a succession of "take" teams involved in the patients admission. This change has been instigated with the aim of identifying and acting upon issues with antibiotic prescribing earlier in the patient's pathway. The main issue is with documenting the antibiotic review date and feedback if given to individual prescribers. Training in antibiotic prescribing is already given to all doctors on induction but there is a new project planned to implement antibiotic champions. Electronic Prescribing and Medicines Administration is due to commence in the Division of Medicine on 5th November, starting with the Acute Medical Admissions Unit which will support improved compliance. • Asking the dementia case finding question within 72 hours of admission for patients aged 75 or older who are admitted as emergencies is just below the 80% amber threshold. The dementia team are focussing on working with admission areas to improve compliance. • Hospital Standardised Mortality Ratio (HSMR) is 116 in June 2018. We are prioritising investigations to understand what is driving the recent HSMR data as there are no clinical concerns arising from the Learning from Deaths process. Crude mortality is not increasing and is below national peer. Initial investigations suggest there has been a decrease in coding depth (average number of diagnosis codes per episode) and in palliative care coding. Investigations continue.
	Opportunities	**Risks and Threats**
QUALITY	• Prescribing of thrombo-prophylaxsis has reduced slightly 89.6%. The new VTE lead, a haematology consultant is scoping some quality improvement work to take forward with front line staff to improvement systems for VTE prevention. • The new National Early Warning Score (NEWS2) was implemented in adult in-patient areas on 17th October 2018. This tool, validated by the Royal College of Physicians, builds on the previous NEWS tool supporting the early detection of physiological deterioration in patients who may look less sick than their physiology suggests. In particular, NEWS2 reduces variation in triggering escalation for patients with Type 2 respiratory failure by providing an alternative standardised score which did not exist in the old NEWS system.	

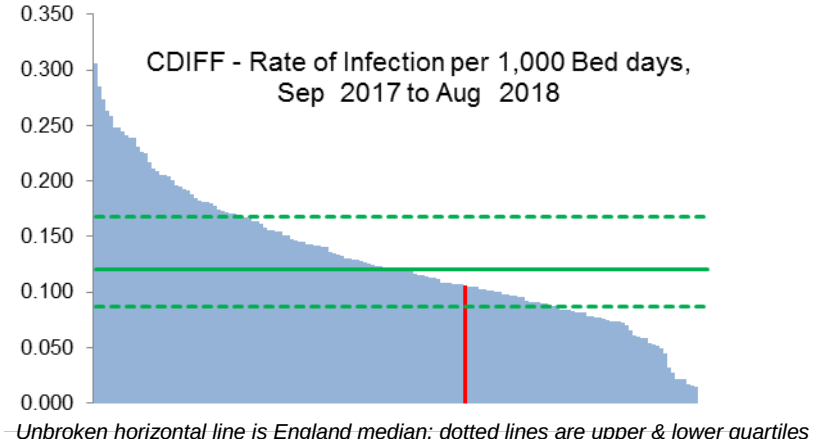
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

Overview

	Successes	Priorities
WORKFORCE	• Sustained achievement of the number of leavers undertaking exit questionnaires. A review of the first year's data from the new exit process has been reported. • Additional training sessions held plus targeted on-site training to support an increase in compliance of the Moving & Handling essential training programme. • After a successful trial, an assessment centre recruitment approach has been adopted for ancillary staff, mirroring the benefits realised through this approach which has been in place for some time for Nursing Assistant roles. • Seasonal Influenza Programme commenced in October. Over 46% of front line staff have already taken up the flu vaccination out of a target of 75%.	• To improve the quality of exit data reporting for Divisions, in order to better understand why staff are leaving the Trust, particularly in areas of concern. • Action plan in place to support the Trust moving to *Smoke Free* by January 2019. • To complete a review of the impact of the Supporting Attendance Policy introduced in March, as agreed with Staffside. • Preparation for the British Safety Council audit.
	Opportunities	**Risks and Threats**
WORKFORCE	• The staff survey is now electronic for majority of staff groups, supporting an increased engagement in completing the survey. • Positioning the Trust as an employer of choice, final year student radiographers who have their last clinical placement at UHB are being targeted, mirroring the approach being taken with final year UWE students • Continue partnership with NHS Improvement to review Workplace Wellbeing programme structure and governance, to drive development of data analysis and performance measures. • Review of the H&S Committee reporting structure to ensure the delivery of quality information.	• Improvement action planning and predictive analysis focused this month on *Moving and Handling* in order to formalise strategies to improve compliance. • Discussions are being held with BNSSG partners to agree collaborative approaches to increase bank fill and minimise the use of high cost, non-framework agency use. • Ensure the flu campaign stays on track to deliver the CQUIN target with a £190k value attached to it. • The impact of BREXIT on the retention of EU workers across all staff groups.

Infections – Clostridium Difficile (C.Diff)	
Standards:	Number of Trust Apportioned C.Diff cases to be below the national trajectory of 44 cases for 2018/19. Review of these cases with commissioners' alternate months to identify if there was a "lapse in care".
Performance:	There were seven trust apportioned C.Diff cases in September 2018, giving 20 cases year-to-date. This is below the year-to-date trajectory of 22 cases
Commentary:	There were seven cases of C. Difficile identified in September 2018. All cases have had an initial review and there is not a link or reason that can be explained regarding the higher number of cases for September.
Ownership:	Chief Nurse





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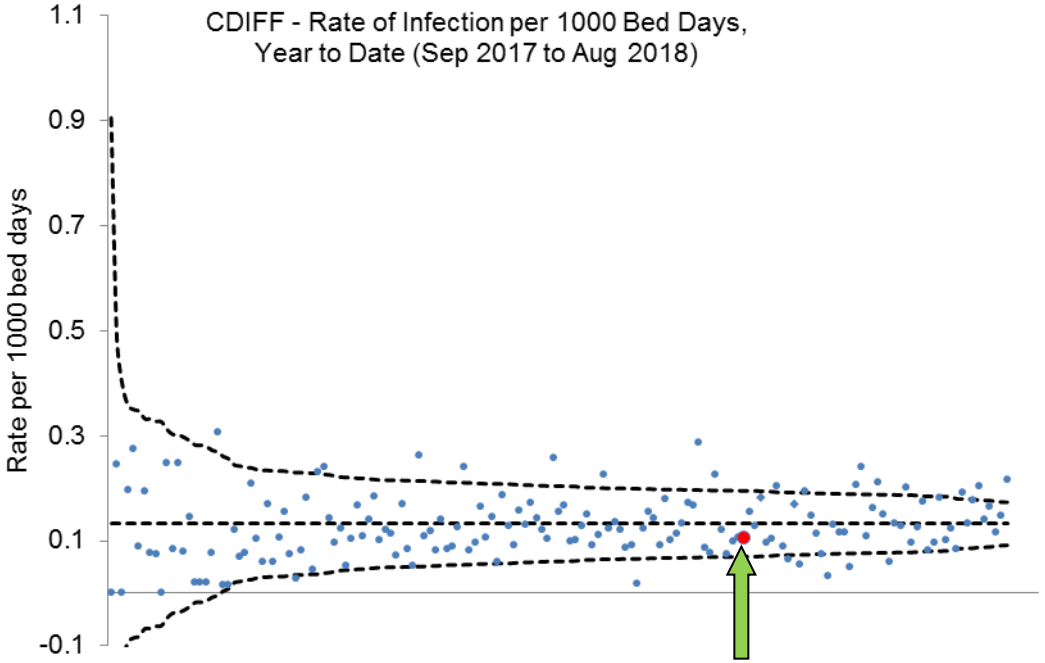
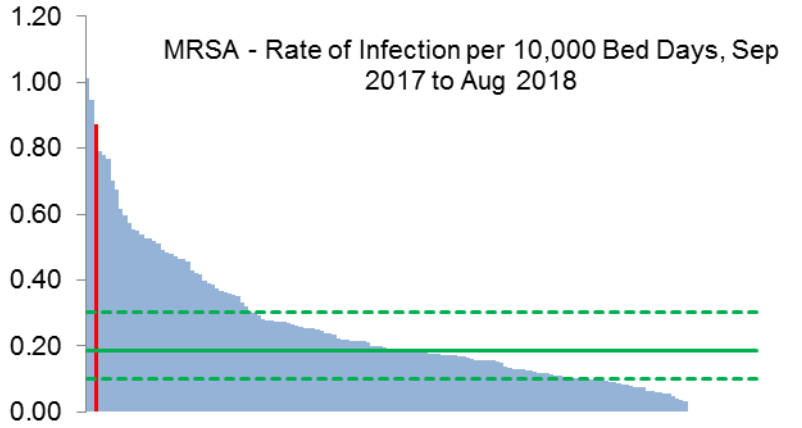


CDIFF Cases	Sep-18	2018/2019
Medicine	1	2
Specialised Services	3	9
Surgery	2	4
Women's and Children's	1	5
Grand Total	7	20

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There was one trust apportioned MRSA cases in September, making four cases year-to-date.
Commentary:	There was one case attributed to the Trust during September 2018. The patient was previously colonised with MRSA and screening was completed in the emergency department and repeated on admission in line with guidance. The patient was also appropriately commenced on antibiotics. Ongoing training and reporting mechanisms are continuously being reviewed to ensure any learning is identified and shared accordingly.
Ownership:	Chief Nurse

MRSA	Sep-18	2018/2019
Medicine	0	2
Specialised Services	0	0
Surgery	1	2
Women's and Children's	0	0
Grand Total	1	4



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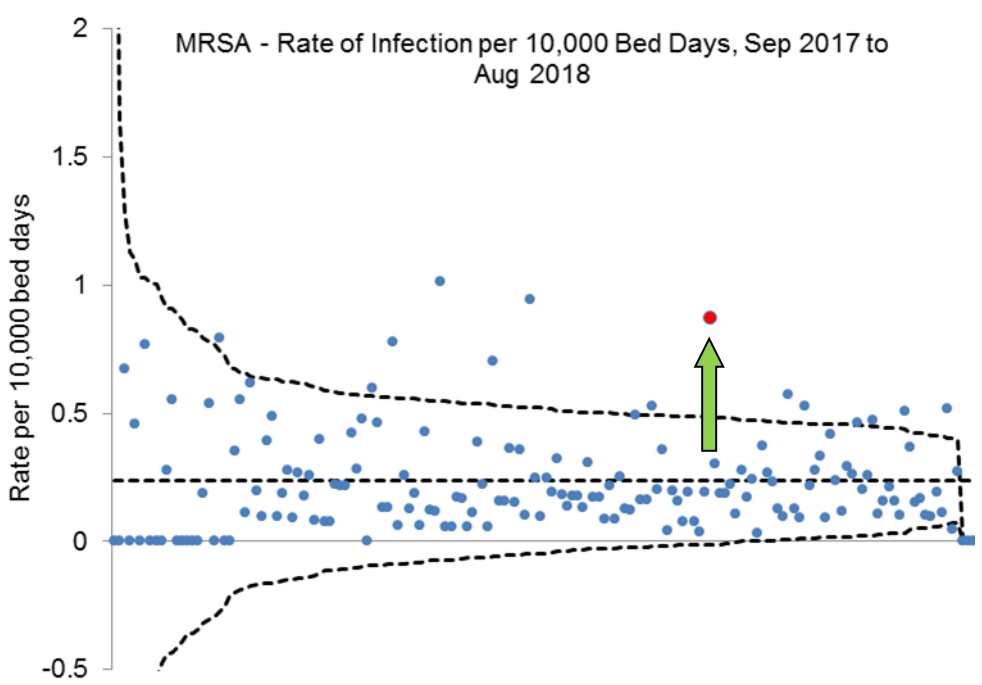
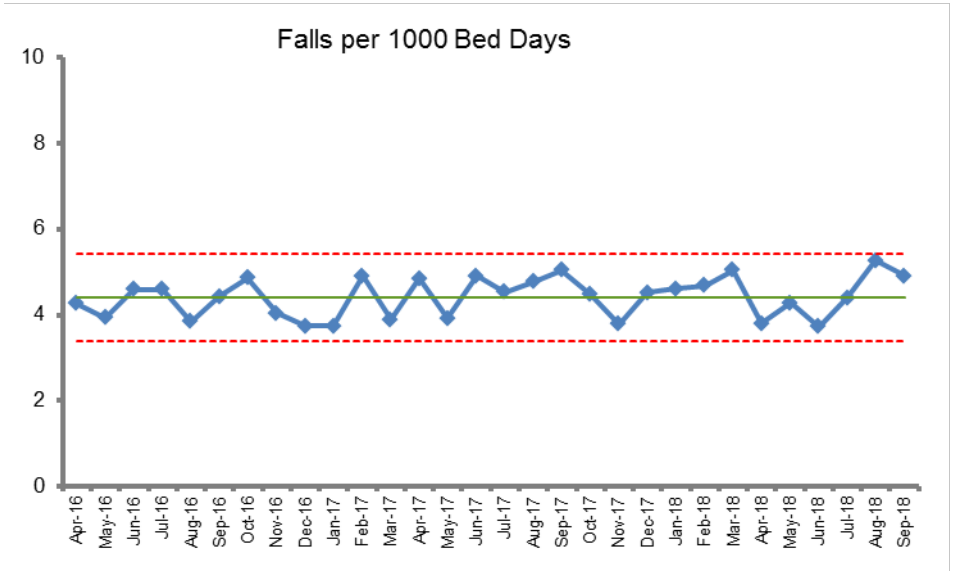
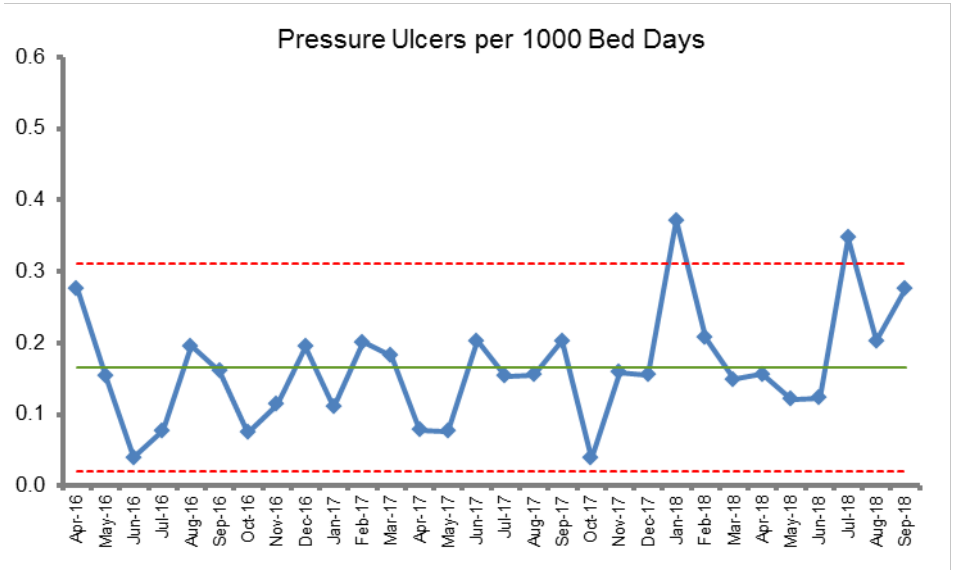


2.1 PERFORMANCE – Safe Domain

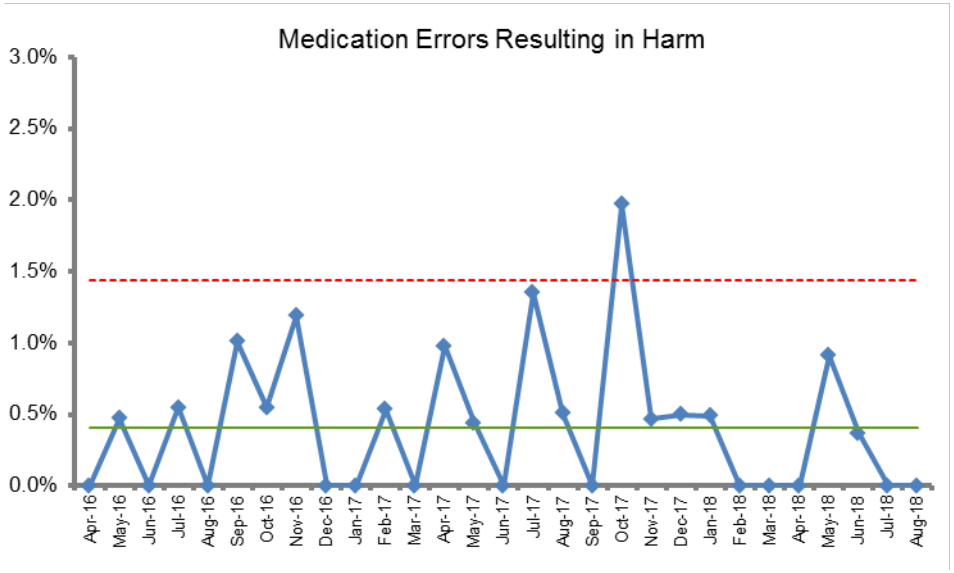
Patient Falls and Pressure Ulcers	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above) Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Falls rate for September was 4.90 per 1,000 beddays. This was 124 Falls with 2 resulting in harm. Pressure Ulcers rate for September was 0.277 per 1,000 beddays. There were 7 Pressure Ulcers in September, with zero at Grades 3 or 4.
Commentary:	The falls data for September has shown a reduction in the number of falls and falls with harm this month. The learning from these incidents will be shared at the Falls group and cascaded through the Divisions with any recommendations/actions incorporated into the work plan. The work plan for 2018/19 includes initiatives to improve falls prevention such as developing a vision checklist for in-patients at risk of falling on admission and the 'End PJ Paralysis' initiative to help prevent deconditioning of elderly people in hospital . The number of pressure ulcers per 1,000 beddays has reduced in September to 0.277 with seven new category 2 pressure ulcers, and remains below the green threshold. Pressure ulcer prevention and reduction work continues across the Trust the work plan for 2018/19 focuses on a number of practice and training related objectives such as developing and implementing a SWARM checklist for category 1 pressure ulcer validation and further strategies for offloading pressure on heels.
Ownership:	Chief Nurse

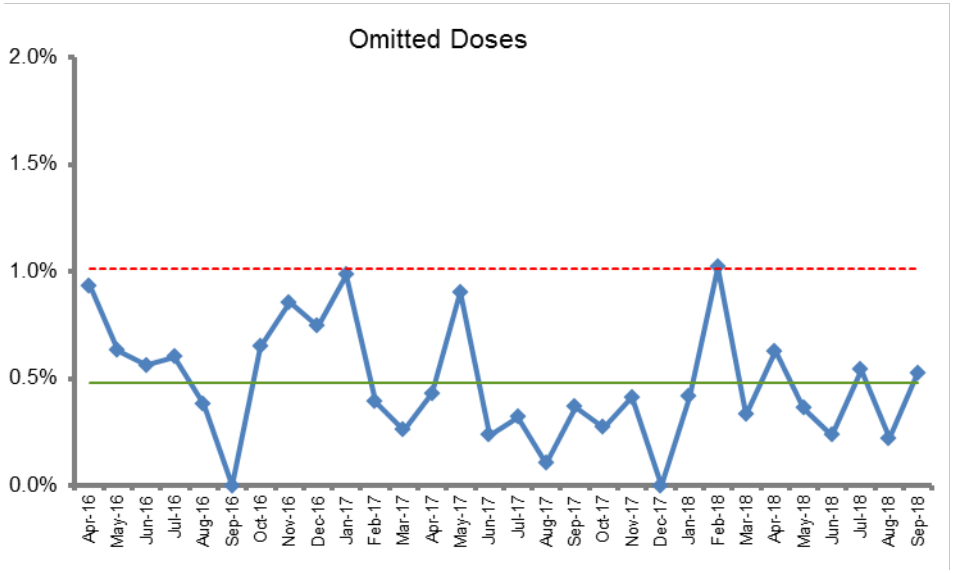




2.1 PERFORMANCE – Safe Domain

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:	0% of medication errors in August resulted in harm (0 errors out of 292 cases reviewed). Omitted doses were at 0.53% in September (3 cases out of 569 reviewed).
Commentary:	No medication incidents in August resulted in moderate or greater harm. 8.6% of all reported medication incidents resulted in any harm (25 out of 292). The harm: no harm ratio in August 2018 was 0.09, below the target of 0.14. The number of non-purposeful omitted doses of critical medicines for September 2018 was 0.53% (3 occurrences identified in 569 reviews). Omitted doses of critical medicines for September 2018 on wards where Electronic Prescribing and Medicines Administration (EPMA) has been implemented was 0%. The above measures are currently in two parts with the majority of wards subject to previous data sampling of paper drug charts. Electronic Prescribing and Medicines Administration (EPMA) has been implemented in adult cardiology wards and the Bristol Haematology and Oncology Centre. The omitted doses data is retrieved directly from Medway and represents full data on omitted doses of critical medicines in all patients prescribed medicines on the EPMA system.
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 September Essential Training overall compliance remained static at 89% compared with the previous month (excluding Child Protection Level 3).
Commentary:	September 2018 compliance for Core Skills (mandatory/statutory) training remained static at 89% overall across the eleven core skills programmes. There were 5 reductions – Fire Safety reducing to 85% from 86%, Information Governance reducing to 83% from 85%, NHS Conflict Resolution Training reducing to 93% from 95%, Resuscitation reducing to 86% from 87% and Safeguarding Adults reducing to 89% from 90%. There were also no increases. Compliance for all other Essential Training reduced to 93% compared with 94% in the previous month.
Ownership:	Director of People

Essential Training	Sep-18	KPI
Equality, Diversity and Human Rights	93%	90%
Fire Safety	85%	90%
Health, Safety and Welfare (formerly Health & Safety)	94%	90%
Infection Prevention and Control	93%	90%
Information Governance	83%	90%
Moving and Handling (formerly Manual Handling)	83%	95%
NHS Conflict Resolution Training	93%	90%
Preventing Radicalisation	91%	90%
Resuscitation	86%	90%
Safeguarding Adults	89%	90%
Safeguarding Children	89%	90%

Essential Training	Sep-18	KPI
UHBristol NHS Foundation Trust	89%	90%
Diagnostics & Therapies	90%	90%
Facilities & Estates	89%	90%
Medicine	88%	90%
Specialised Services	90%	90%
Surgery	88%	90%
Trust Services	91%	90%
Women's & Children's	89%	90%

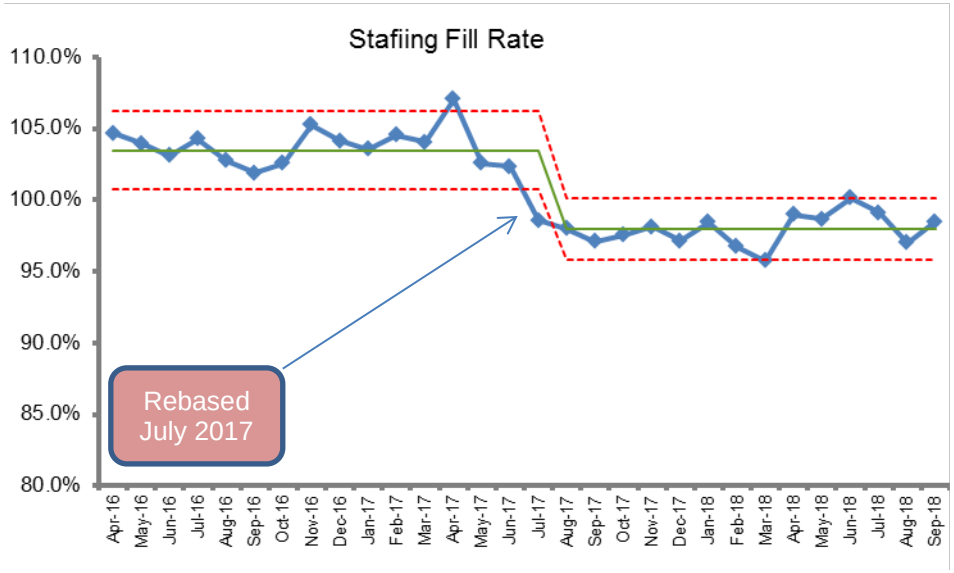
2.1 PERFORMANCE – Safe Domain

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:	September's overall staffing level was at 98.5% (227,034 hours worked against 230,529 planned). Registered Nursing (RN) level was at 94.5% and Nursing Assistant (NA) level was at 108.6 %
Commentary:	Overall for the month of September 2018, the trust had 94% cover for RN's on days and 96% RN cover for nights. The unregistered level of 100% for days and 121% for nights reflects the activity seen in September 2018. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night.
Ownership:	Chief Nurse

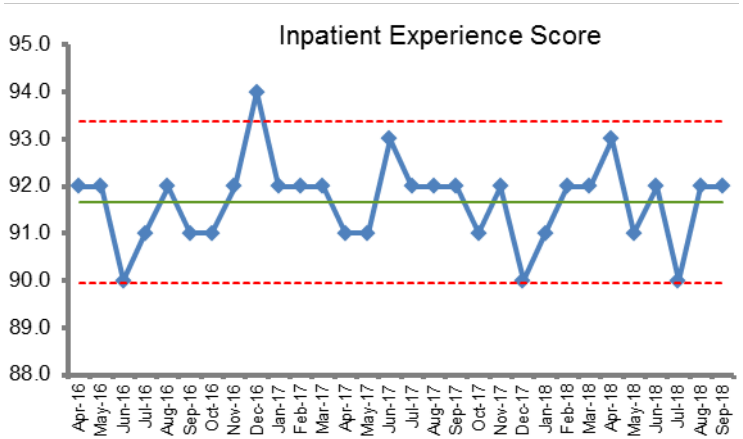
SEPTEMBER 2018 DATA

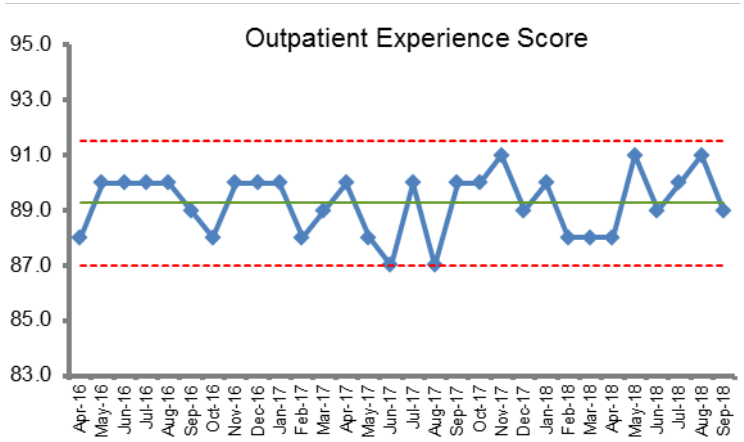
	Day	Night	TOTAL
Registered Nurses	93.6%	95.5%	94.5%
Nursing Assistants	99.7%	121.1%	108.6%
TOTAL	**95.5%**	**102.3%**	**98.5%**

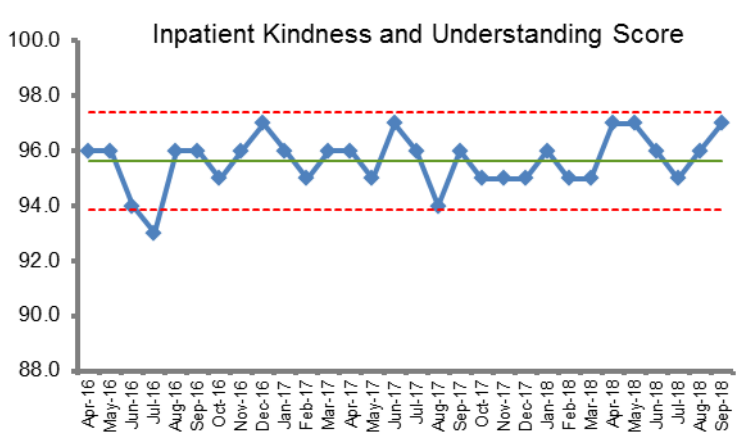
Medicine	108.3%
Specialised Services	102.3%
Surgery	102.6%
Women's and Children's	87.8%
TOTAL	**98.5%**



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 September 2018, the inpatient score was 92/100, for outpatients it was 89. For the kindness and understanding question it was 97.
Commentary:	The headline measures from these surveys remained above their minimum target levels, indicating the continued provision of a positive patient experience at UH Bristol. The SPC chart demonstrates a reliable system is in place to sustain an overall positive experience for patients.
Ownership:	Chief Nurse

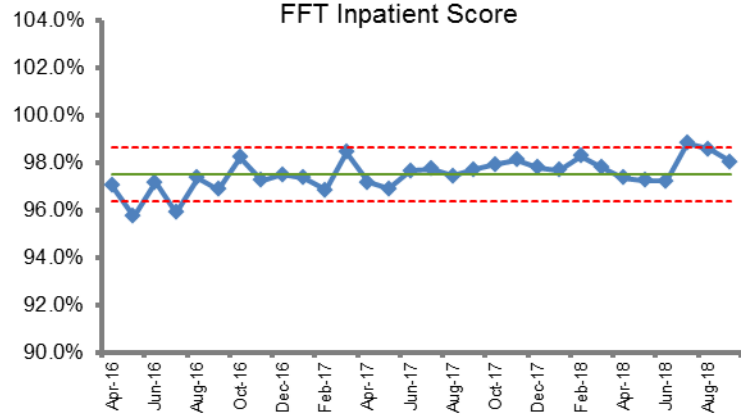


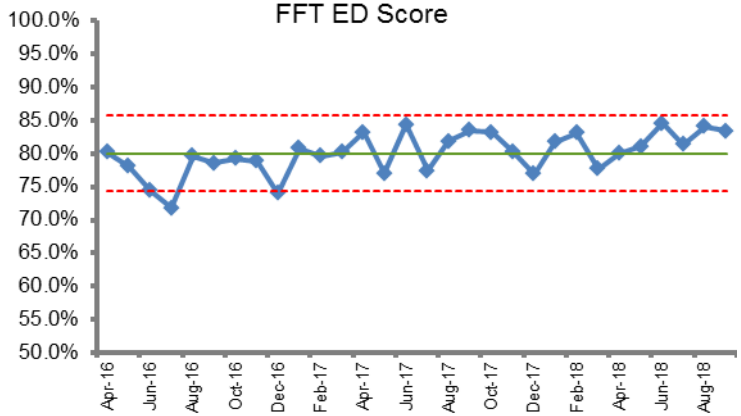


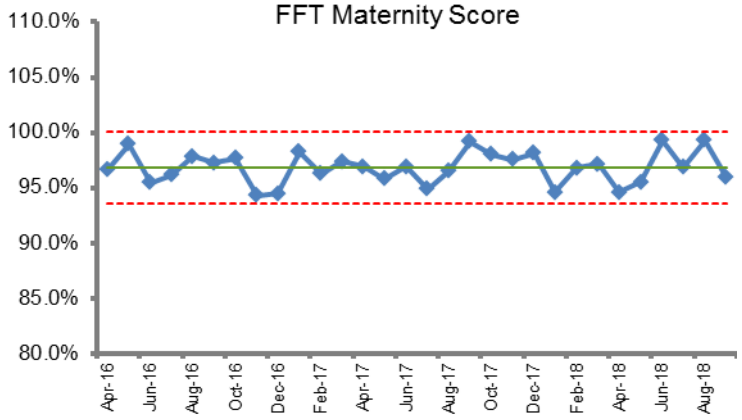


2.2 PERFORMANCE – Caring Domain

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 60%.
Performance:	September's FFT score for Inpatient services was 98.1% (1661 out of 1694 surveyed). The ED score was 83.4% (1204 out of 1443 surveyed). The maternity score was 95.9% (304 out of 317 surveyed).
Commentary:	The Trust's scores on the Friends and Family Test were above their target levels in September 2018 for inpatients, emergency departments and maternity services. Response rates for maternity services increased in September to 23.1% following some planned focussed work in this area previously reported to the board.
Ownership:	Chief Nurse



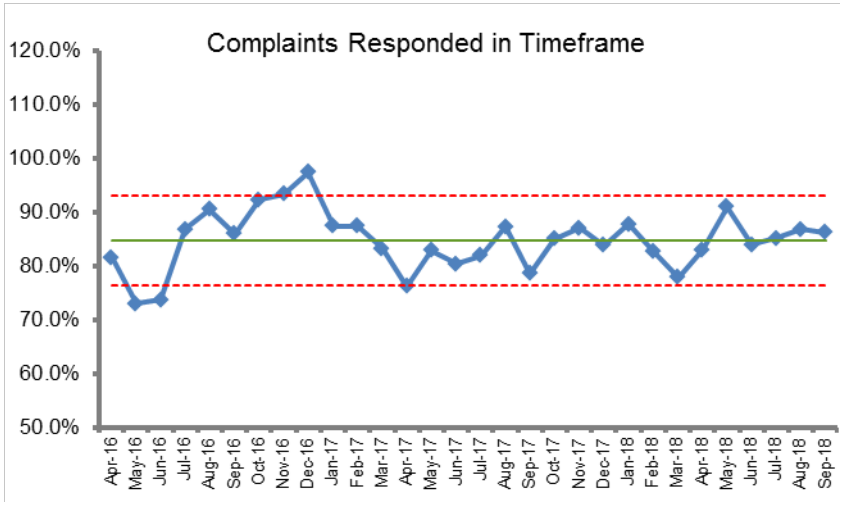


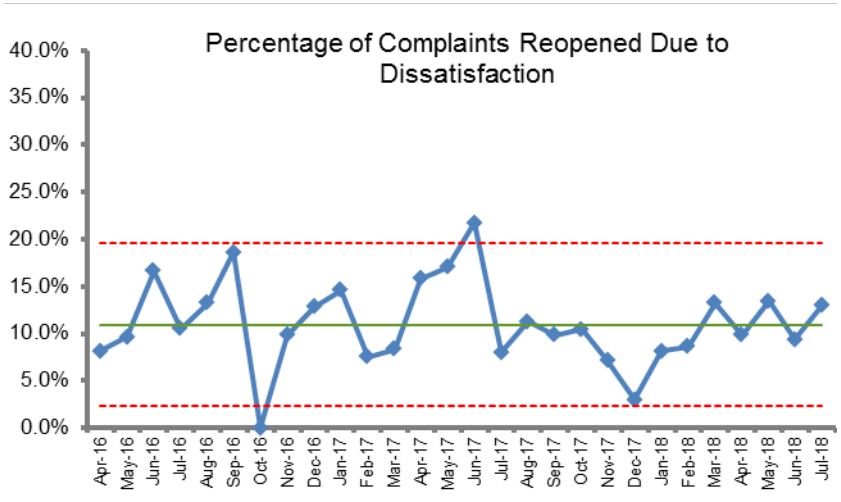


	Response Rate		Score	
	Sep-18	2018/2019	Sep-18	2018/2019
Inpatients				
Medicine	26.9%	35.3%	96.7%	97.1%
Surgery	27.1%	34.9%	99.1%	98.4%
Specialised Services	34.5%	35.1%	97.6%	97.5%
Women's and Children's	32.2%	36.4%	97.8%	98.0%
TOTAL	**29.1%**	**35.3%**	**98.1%**	**97.9%**
Emergency Department				
Bristol Royal Infirmary	10.0%	11.5%	63.2%	66.2%
Children's Hospital	20.6%	21.1%	85.4%	85.9%
Eye Hospital	26.1%	24.1%	97.0%	93.6%
TOTAL	**17.0%**	**17.4%**	**83.4%**	**82.4%**
Maternity				
TOTAL	**23.1%**	**15.2%**	**95.9%**	**96.5%**

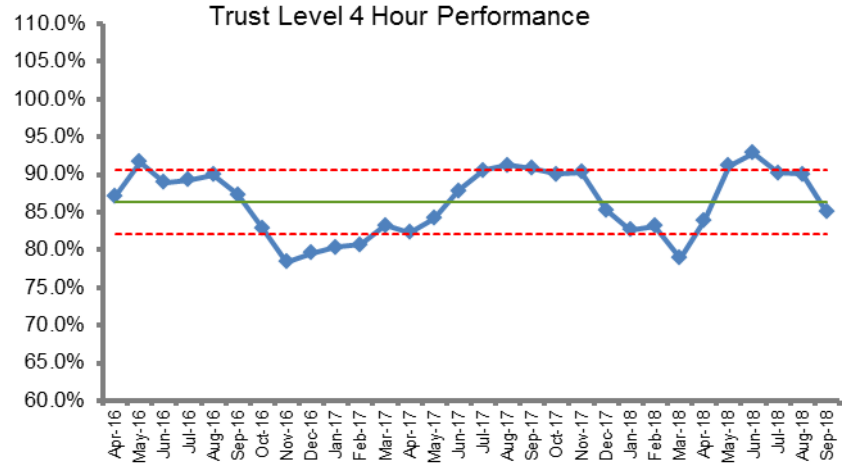
2.2 PERFORMANCE – Caring Domain

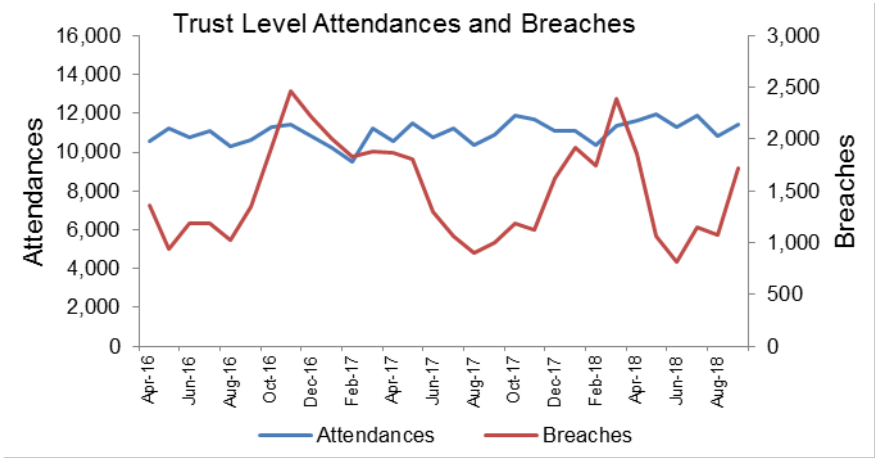
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe. Of all formal complaints responded to, less than 5% should be re-opened because complainant is dissatisfied.
Performance:	In September, 63 out of 73 formal complaints were responded to with timeframe (86.3%) Of the 54 formal complaints responded to in July, 7 resulted in the complainant being dissatisfied with the response (13.0%)
Commentary:	The rate of dissatisfied complaints in July was 13%. This represents seven cases from the 54 responses sent out during that month. A monthly review of all dissatisfied cases is now being carried out by the Head of Quality (Patient Experience and Clinical Effectiveness) and a Divisional Head of Nursing; learning from this review is shared with all Divisions via the Clinical Quality Group. The Trust's performance in responding to complaints via formal resolution within a timescale agreed with the complainant was 86.3% in September. This represents 10 breaches from the 75 responses sent out in September. Since August, Clinical Quality Group has been receiving a monthly report providing details of all breaches and causes to identify learning.
Ownership:	Chief Nurse

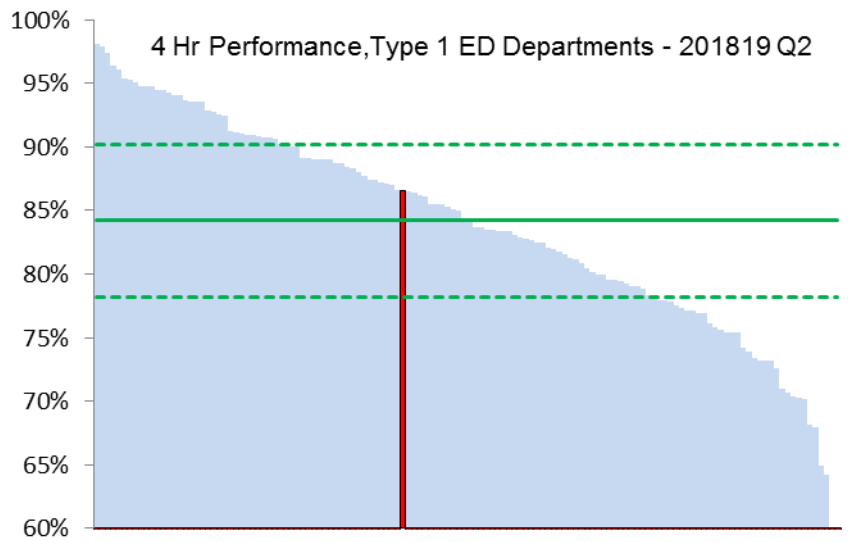




Emergency Department 4 Hour Wait	
Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. The Trust's improvement trajectory is 90.53% for July
Performance:	Trust level performance for September was 85.00% (11442 attendances and 1716 patients waiting over 4 hours).
Commentary:	Performance at the Children's Hospital was 94.2% in September. This is alongside an 8% rise in attendances (Apr-Sep 2018 vs Apr-Sep 2017). The Bristol Royal Infirmary achieved 75.4% in September. Quarter 2 finished at 88.44% and with the addition of local Walk In Centre data, the Trust achieved 91.48% for the quarter, which meant the Trust delivered on the year-to-date improvement trajectory agreed with NHS Improvement.
Ownership:	Chief Operating Officer



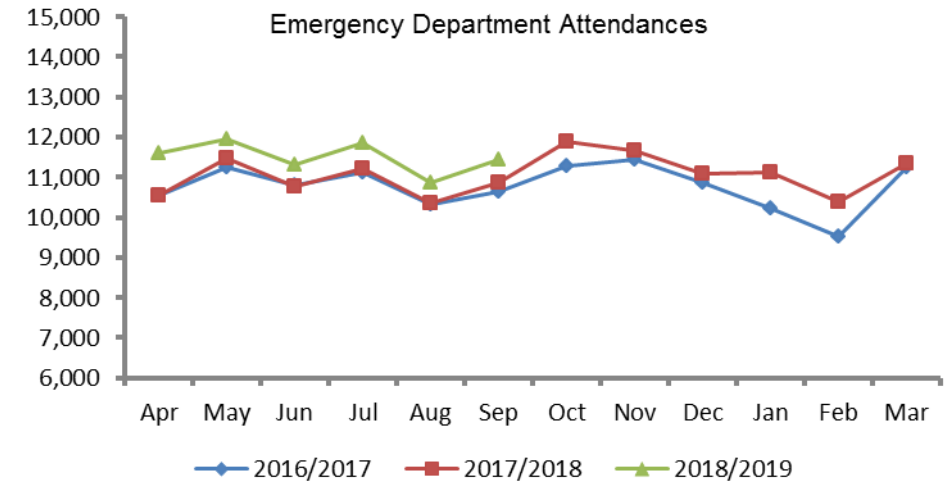


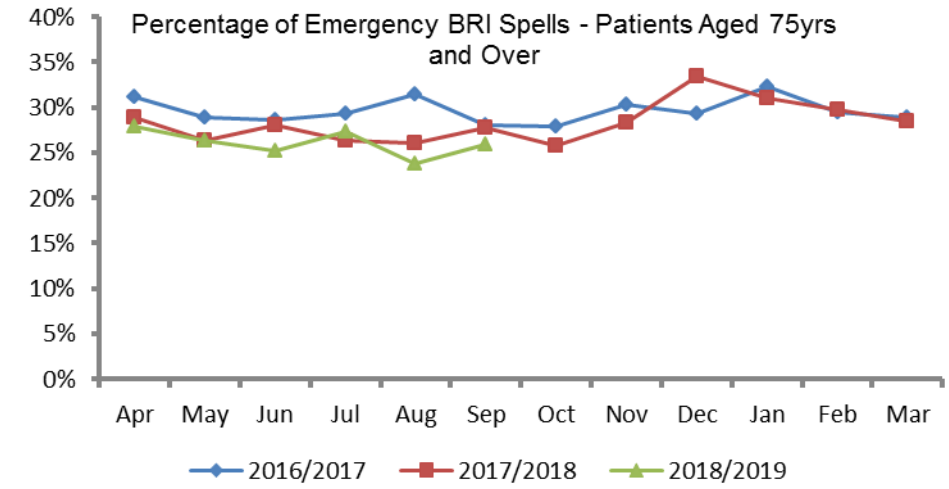


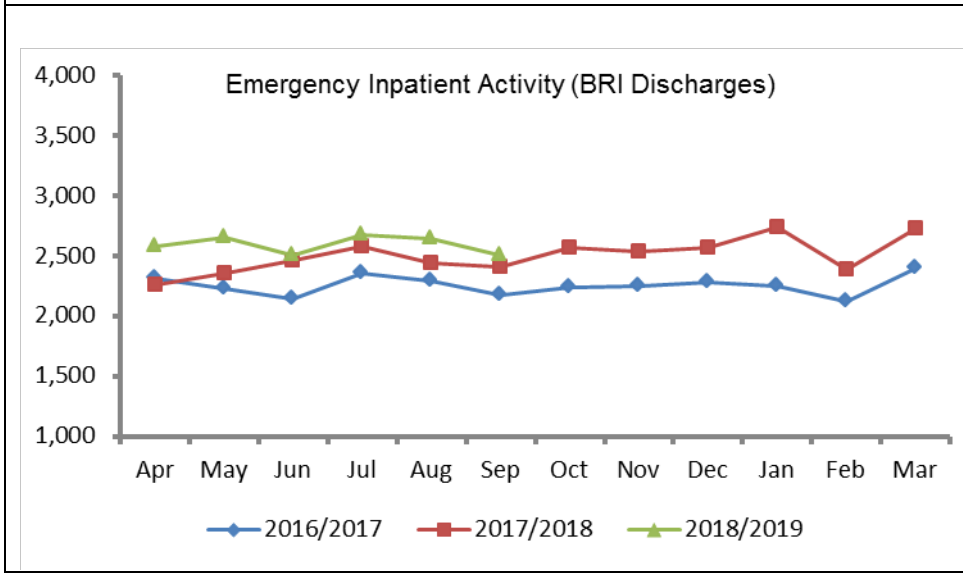
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

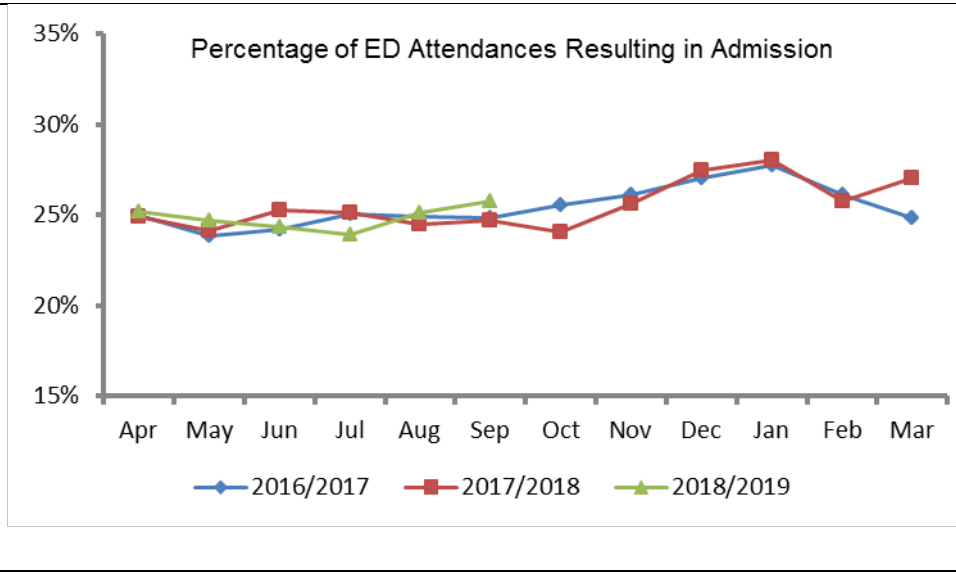
	Attendances		Under 4 Hours		Performance	
	Sep-18	2018/2019	Sep-18	2018/2019	Sep-18	2018/2019
BRI	5937	35894	4479	29445	75.44%	82.03%
Trust	11442	69018	9726	61339	85.00%	88.87%

2.3 PERFORMANCE – Responsive Domain



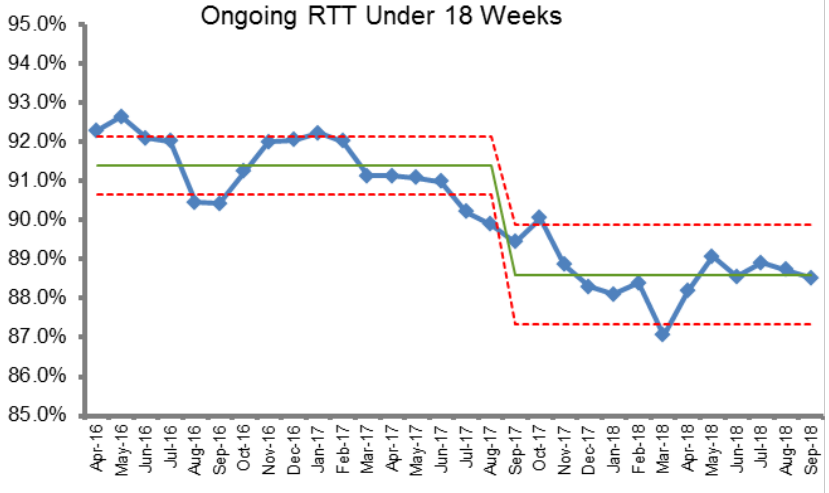


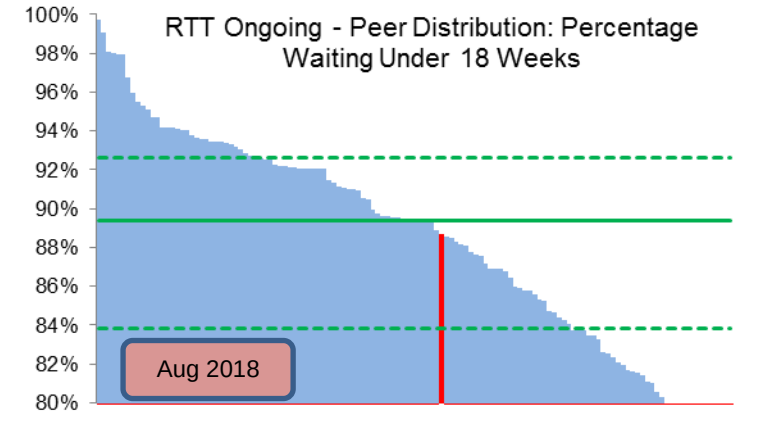




2.3 PERFORMANCE – Responsive Domain

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 88.5% for end of July. In addition, no-one should be waiting 52 weeks or over.
Performance:	At end of September, 88.52% of patients were waiting under 18 week (25,863 out of 29,217 patients). 10 patients were waiting 52+ weeks
Commentary:	The 92% national standard was not met at the end of September; however, this was above the recovery trajectory target of 88.50%. October is on track to deliver the 88.5% recovery trajectory. There were 10 patients waiting 52+ weeks at end of September, these are being reviewed to ensure they are dated.
Ownership:	Chief Operating Officer





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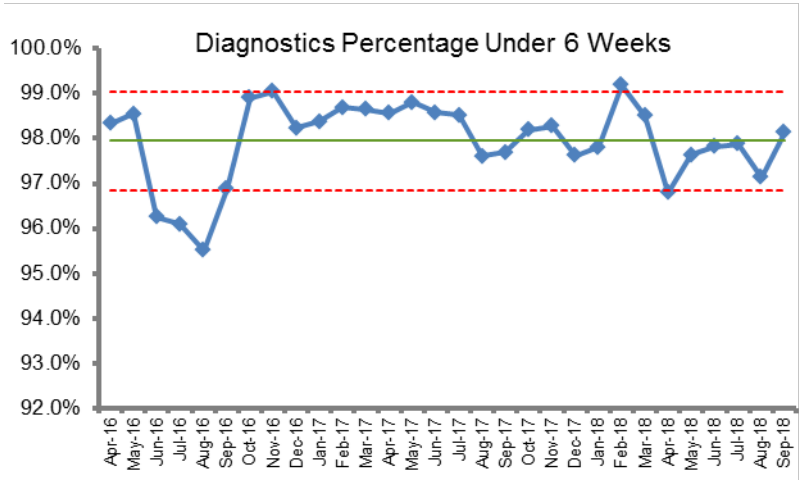
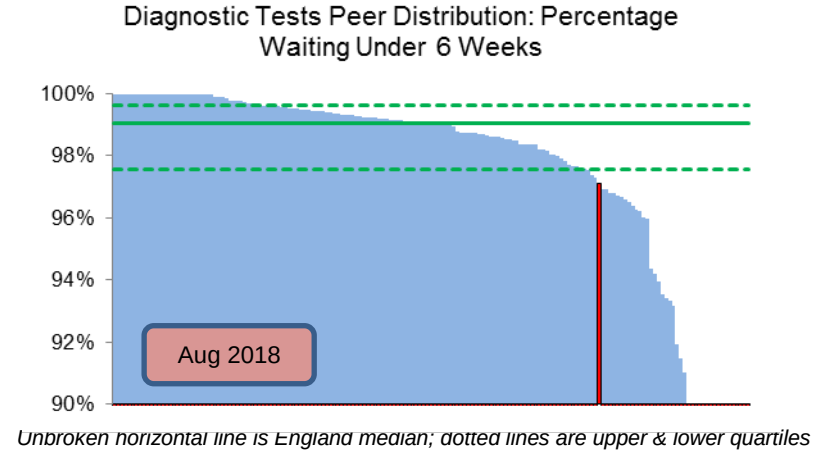
Ongoing Pathways at Sep-18

	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,060	323	84.3%
Cardiothoracic Surgery	311	53	83.0%
Dermatology	2,610	198	92.4%
ENT	2,235	95	95.7%
Gastroenterology	862	13	98.5%
General Medicine	7	1	85.7%
Geriatric Medicine	83	2	97.6%
Gynaecology	1,273	131	89.7%
Neurology	305	62	79.7%
Ophthalmology	4,320	425	90.2%
Oral Surgery	2,718	407	85.0%
Other (Clinical Genetics)	1,013	201	80.2%
Other (Dental)	1,803	122	93.2%
Other (General Surgery)	1,509	256	83.0%
Other (Haem/Onc)	188	1	99.5%
Other (Medicine)	606	29	95.2%
Other (Other)	331	2	99.4%
Other (Paediatric)	5,142	885	82.8%
Other (Pain Relief)	110	0	100.0%
Other (Thoracic Surgery)	89	8	91.0%
Plastic Surgery	0	0	-
Rheumatology	499	32	93.6%
Thoracic Medicine	317	10	96.8%
Trauma & Orthopaedics	825	98	88.1%
TOTAL	**29,217**	**3,354**	**88.5%**

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's improvement trajectory was set at no more than 140 breaches at end of July, which would equate to performance of approximately 98% (depending on total list size).
Performance:	At end of September, 98.1% of patients were waiting under 6 weeks (8,032 out of 8,185 patients). There were 153 breaches of the 6-week standard.
Commentary:	The Trust did not achieve the 99% national standard at end of September and was 72 patients above the maximum number needed to achieve 99% The areas carrying the largest volume of breaches are Adult Endoscopy (65 breaches), Paediatric MRI (12 breaches) and Echocardiography (62 breaches). The recovery trajectory is set to maintain 98% and achieve 99% at end of February.
Ownership:	Chief Operating Officer





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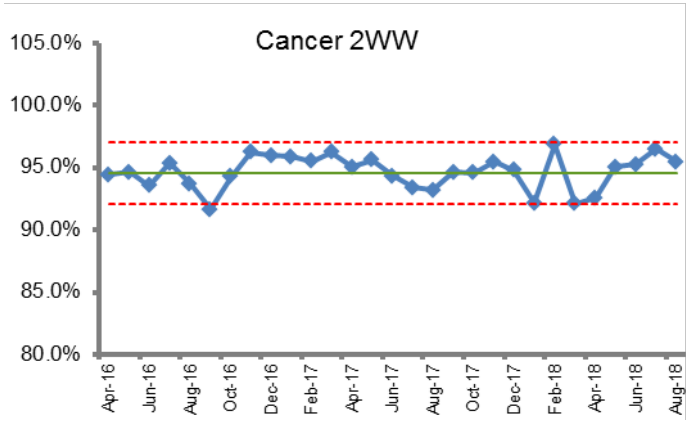
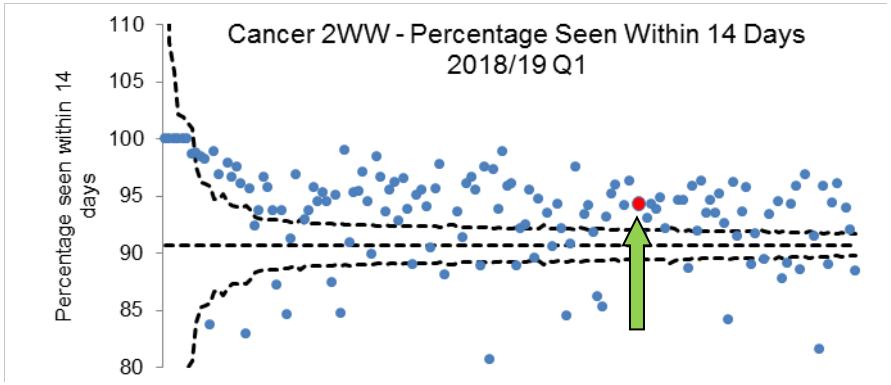
Diagnostic Tests Waiting List at Sep-18

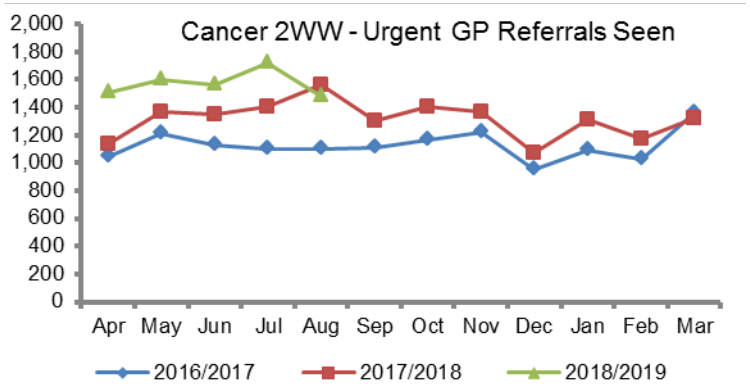
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	765	1	766	99.9%
Colonoscopy	182	47	229	79.5%
CT	989	0	989	100.0%
Cystoscopy	1	0	1	100.0%
DEXA Scan	240	0	240	100.0%
Echocardiography	917	62	979	93.7%
Flexi Sigmoidoscopy	52	6	58	89.7%
Gastroscopy	174	13	187	93.0%
MRI	1,802	14	1,816	99.2%
Neurophysiology	140	4	144	97.2%
Sleep Studies	70	2	72	97.2%
Ultrasound	2,700	4	2,704	99.9%
Grand Total	**8,032**	**153**	**8,185**	**98.1%**

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 August, 95.5% of patients were seen within 2 weeks (1409 out of 1476 patients). Quarter 1 overall achieved 94.3%. Quarter 2 is on track to achieve 93%.
Commentary:	The standard was achieved in quarter 1 2018/19 and is on track to be achieved in quarter 2.
Ownership:	Chief Operating Officer



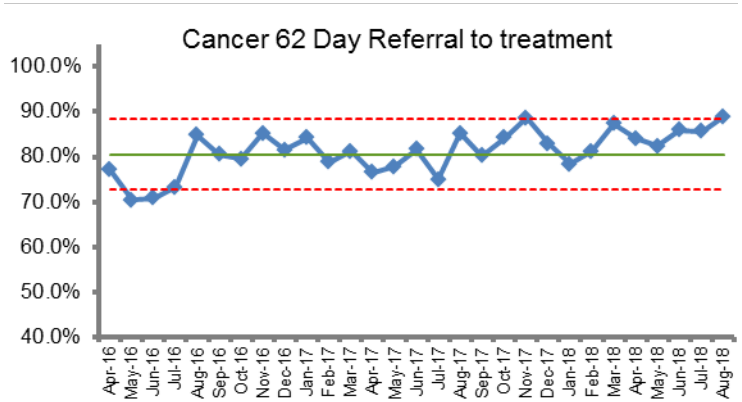


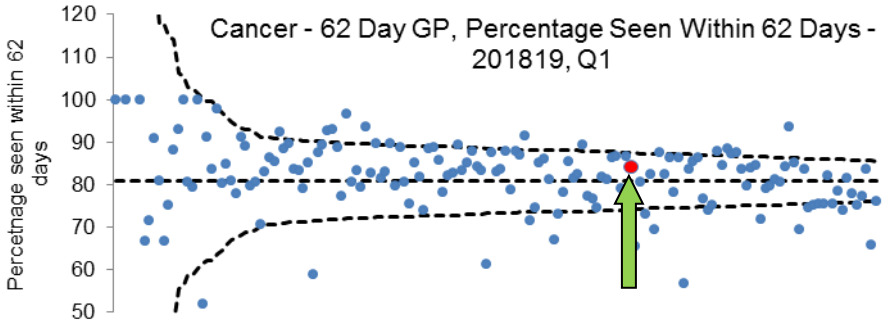


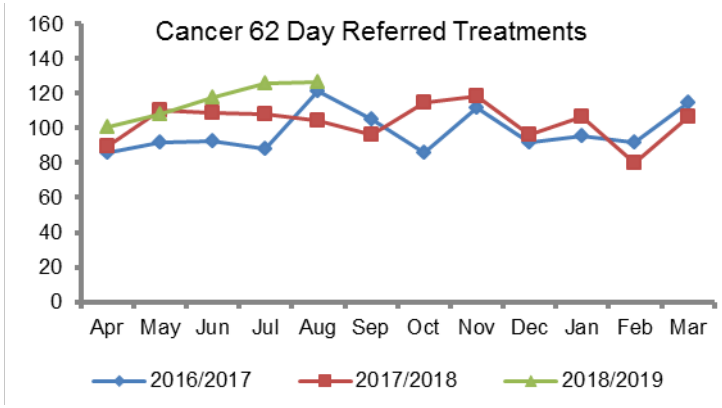
	Cancer 2WW - Aug-18		
Cancer Site	Under 2 Weeks	Total Pathways	Percentage
Other suspected cancer	2	3	66.7%
Suspected children's cancer	23	24	95.8%
Suspected gynaecological cancers	96	104	92.3%
Suspected haematological malignancies excluding ac	11	11	100.0%
Suspected head and neck cancers	355	363	97.8%
Suspected lower gastrointestinal cancers	127	139	91.4%
Suspected lung cancer	30	30	100.0%
Suspected skin cancers	644	678	95.0%
Suspected upper gastrointestinal cancers	121	124	97.6%
Grand Total	1,409	1,476	95.5%

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 is 83% for May and 82.5% for Quarter 1.
Performance:	For August, 88.9% of patients were seen within 62 days (112.5 out of 126.5 patients). Quarter 1 finished at 84.2% and Quarter 2 is at 87.3% (Jul and Aug).
Commentary:	The national standard was achieved in June, July and August and is on track to be achieved in Quarter 2.
Ownership:	Chief Operating Officer

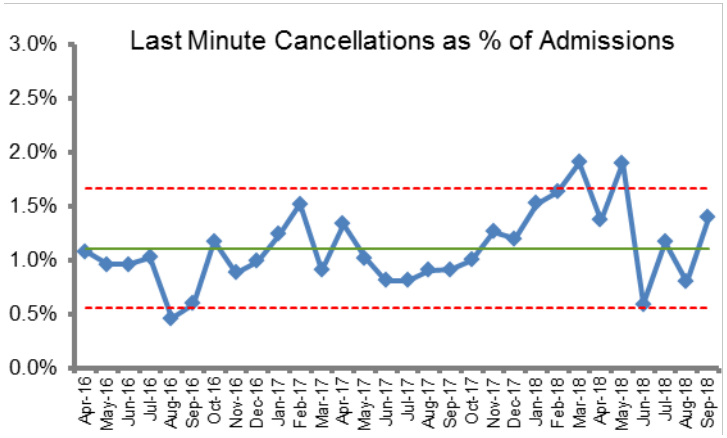


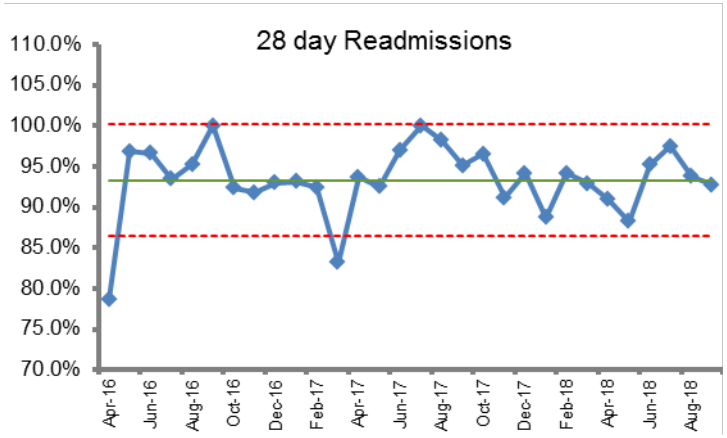


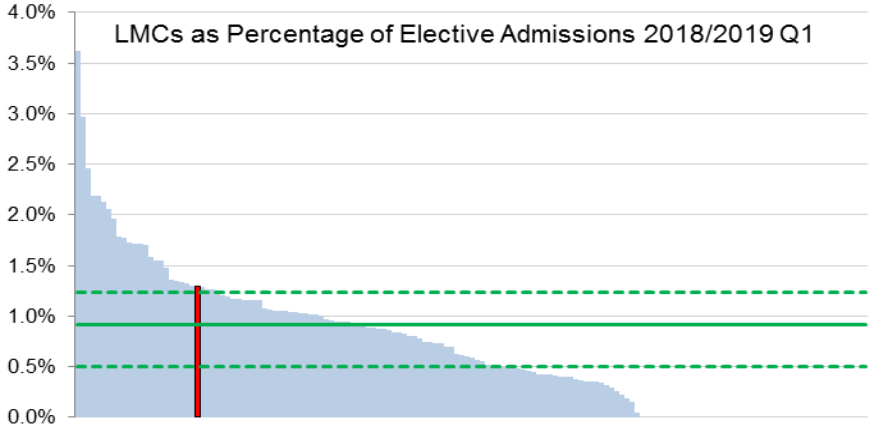


	Cancer 62 Day - Aug-18		
Cancer Site	First Treatment - Within Target	First Treatment - Total	First Treatment - Performance
Breast	4.5	4.5	100.0%
Gynaecological	7.5	7.5	100.0%
Haematological	3.0	3.5	85.7%
Head and Neck	7.0	7.5	93.3%
Lower Gastrointestinal	2.5	4.5	55.6%
Other	1.5	1.5	100.0%
Sarcoma	3.0	3.0	100.0%
Skin	54.0	56.0	96.4%
Upper Gastrointestinal	13.5	16.5	81.8%
Urological	0.5	2.5	20.0%
Grand Total	112.5	126.5	88.9%

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 September there were 89 last minute cancellations, which was 1.4% of elective admissions. Of the 54 cancelled in August, 51 (94.4%) had been re-admitted within 28 days.
Commentary:	September saw an increase in the number of last minute cancellations, compared to August. There were 19 in Cardiac Services, 11 in Dental Services, 10 in ENT/Thoracic, 24 in General Surgery, 7 in Ophthalmology, 3 in Trauma & Orthopaedics and 14 in Paediatrics. The most common reason was "Other Emergency Patient Prioritised" (23 cancellations). Four of August's last minute cancellation patients were not re-admitted within 28 days, so the 95% was narrowly missed.
Ownership:	Chief Operating Officer







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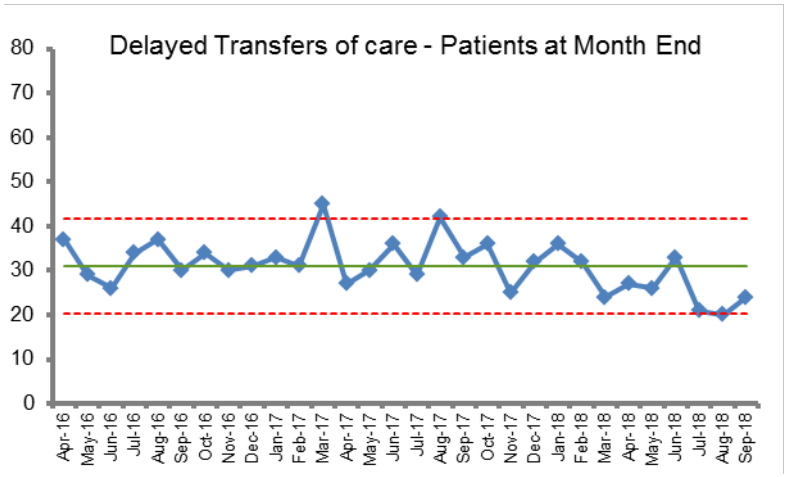
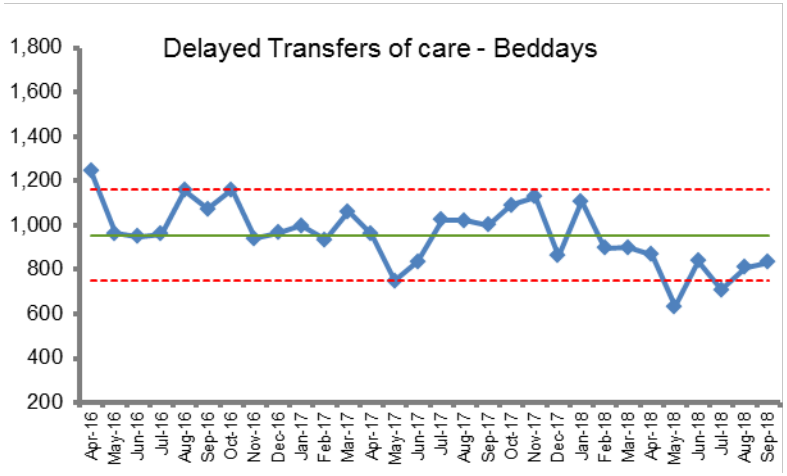
Cancellation Reason	Total
Other Emergency Patient Prioritised	23
No Beds Available	14
Booking Error	8
No HDU Beds	7
No Theatre Staff	6
Equipment Failure	6
Other Non Emergency Patient Prioritised	4
Surgeon Taken Ill	3
Equipment Unavailable	2
AM list over-ran	2
Other clinically complicated Patient in theatre	2
No CICU Staff	2
No ITU Beds	2
Surgeon Unavailable	1
No CICU Beds	1
Anaesthetist Unavailable	1
Op Brought Forward	1
Patient to be treated at another Trust	1
List did not start on time	1
List Overbooked	1
PAS-only Error	1
Grand Total	**89**

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 September there were 24 Delayed Transfer of Care patients as at month-end, and 833 beddays consumed by DToC patients.
Commentary:	There were 8 DToCs at South Bristol Hospital and 16 in the Bristol Royal Infirmary. Most beddays were on ward A605 (115 beddays), A528 (75 beddays) and C808 (71 beddays)
Ownership:	Chief Operating Officer





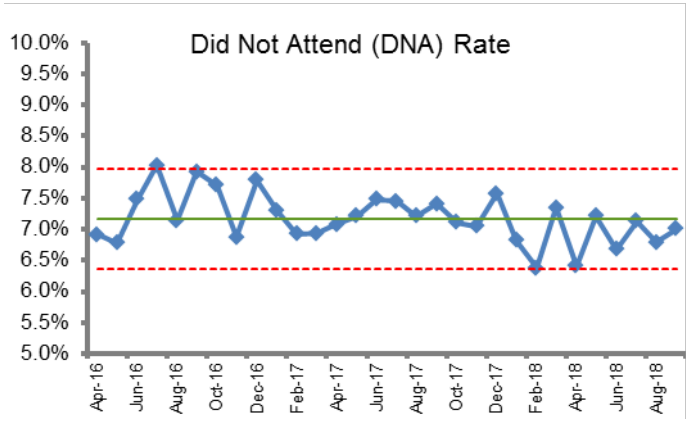
Month	Sep-18					
National DTOC Code	National DTOC Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	0	8	0	19
		NHS	1	37	0	10
		Social Care	2	133	2	95
C	Further non acute NHS Care	NHS	2	34	0	0
Di	Care Home Placement	NHS	0	1	0	0
		Social Care	0	20	3	41
Dii	Care Home Placement	NHS	1	45	1	36
		Social Care	1	27	0	8
E	Care package in own home	NHS	2	31	0	0
		Social Care	2	76	1	60
F	Community equipment / adaptions	NHS	0	0	0	7
		Social Care	3	51	0	12
G	Patient or family choice	NHS	2	48	1	33
H	Disputes	Social Care	0	2	0	0
Grand Total			16	513	8	321

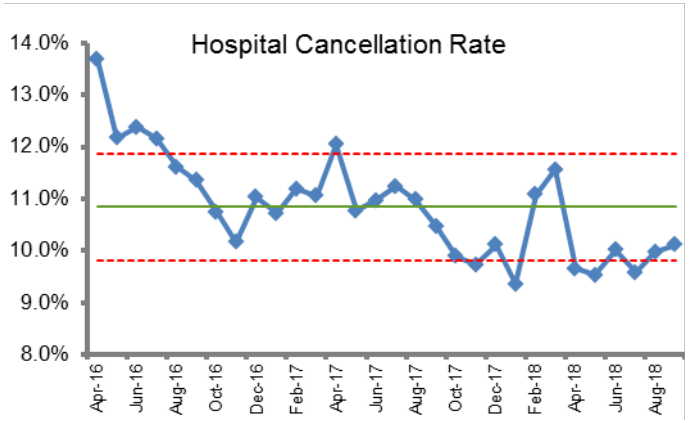
Length of Stay of Inpatients at month-end

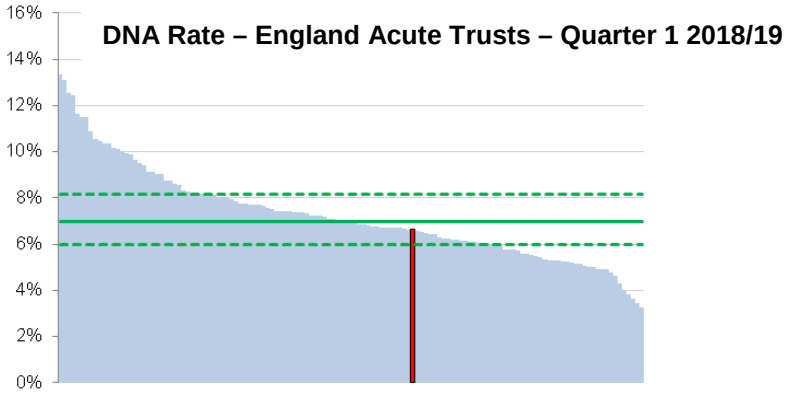
Sep-18	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	49	27	23	19
Bristol Haematology & Oncology Centre	26	12	9	2
Bristol Royal Infirmary	202	123	81	48
South Bristol Hospital	57	52	47	37
St Michael's Hospital	25	17	15	10
TRUST TOTAL	362	233	176	117
Bristol Royal Infirmary Divisional Breakdown:				
Medicine	117	81	57	35
Specialised Services	34	17	10	2
Surgery, Head & Neck	51	25	14	11

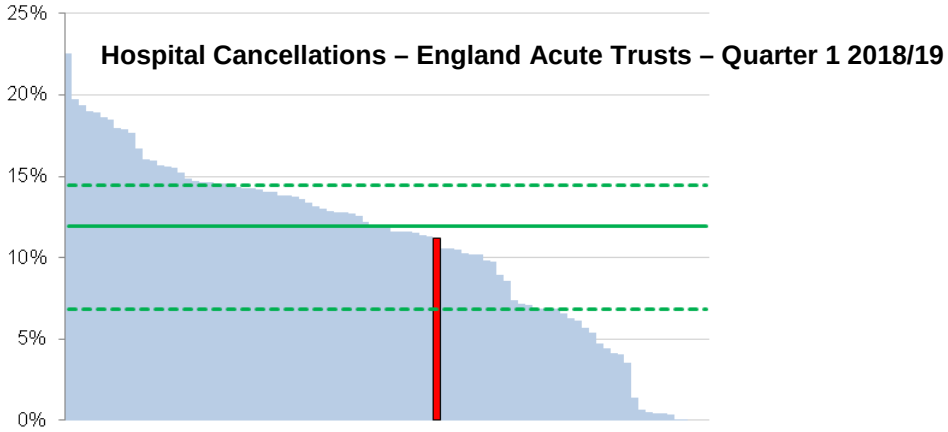
2.3 PERFORMANCE – Responsive Domain

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. The target for DNAs is to be below 5%, with an amber tolerance of between 5% and 10%. 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 September there were 8861 hospital-cancelled appointments, which was 10.1% of all appointments made. There were 4391 appointments that were DNA'ed, which was 7.0% of all planned attendances.
Commentary:	Speciality level DNA targets have been agreed at monthly Outpatient Steering Group (OSG) and will be monitored from Quarter 3.
Ownership:	Chief Operating Officer







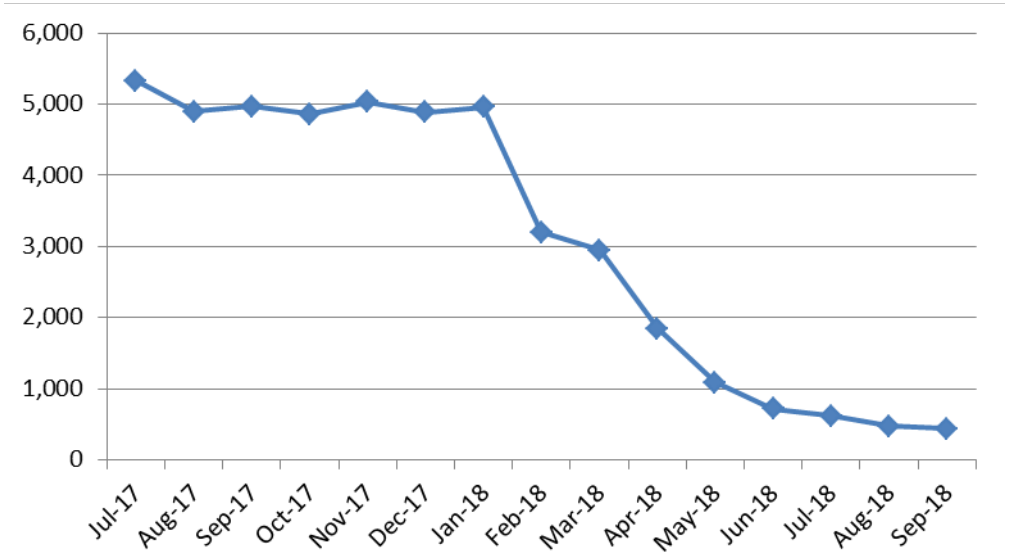


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

2.3 PERFORMANCE – Responsive Domain

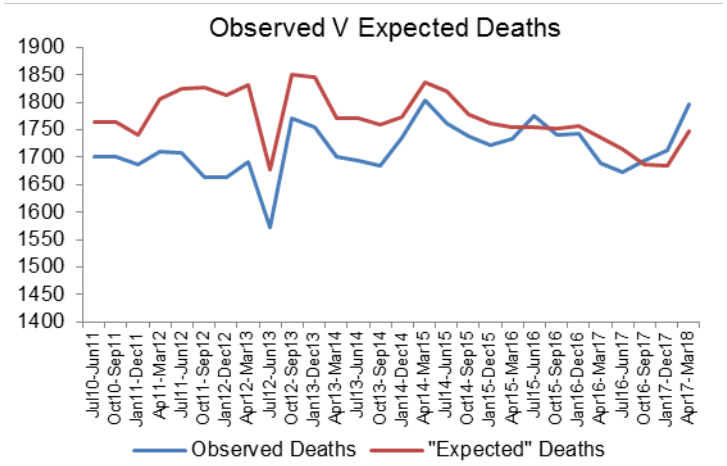
Outpatient – Overdue Follow-Ups	
Standards:	This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can b reported. The current aim is to have no-one more than 12 months overdue
Performance:	As at end of September, number overdue by 12+ months has fallen to 436.
Commentary:	Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting. Focus will shift to the 6-12 months overdue patients from November.
Ownership:	Chief Operating Officer

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicine	1,113	1,045	1,111	1,252	1,336	1,276	1,345	1,245	1,105	461	133	23	5	7	3
Specialised Services	563	432	442	295	353	387	400	367	383	188	206	214	208	95	58
Surgery	1,200	1,058	1,015	934	947	922	887	717	573	444	221	92	17	3	0
Women's and Children's	2,451	2,364	2,400	2,381	2,398	2,299	2,330	868	888	756	526	387	387	371	375
TRUST TOTAL	**5,327**	**4,899**	**4,968**	**4,862**	**5,034**	**4,884**	**4,962**	**3,197**	**2,949**	**1,849**	**1,086**	**716**	**617**	**476**	436

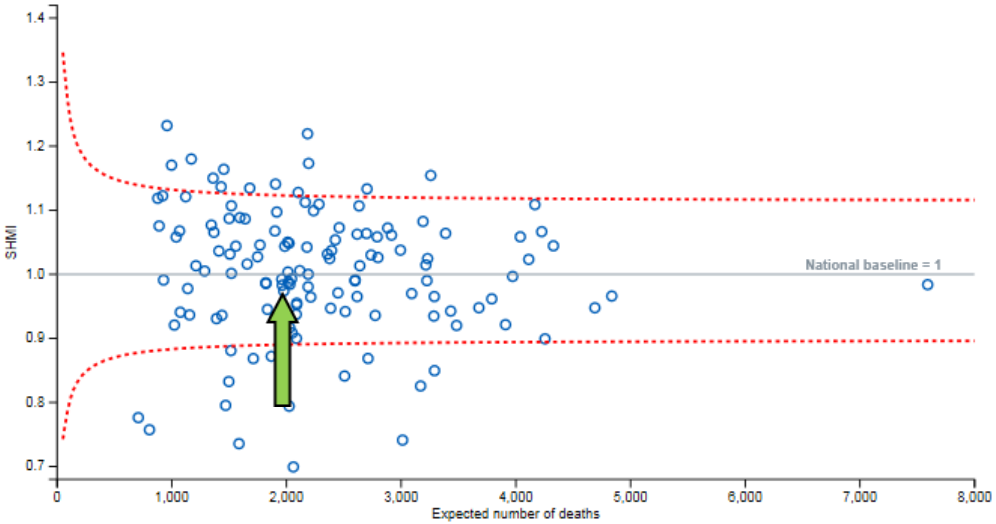


Mortality - Summary Hospital Mortality Indicator (SHMI)	
Standards:	This is the national measure published by NHS Digital .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Summary Hospital Mortality Indicator (SHMI) covers deaths in-hospital and deaths within 30 days of discharge. It is published quarterly as covers a rolling 12 –month period. Data is published 6 months in arrears.
Performance:	Latest SHMI data is for 12 month period April 2017 to March-2018. The SHMI was 102.7 (1796 deaths and 1748 "expected"). Data is updated quarterly by NHS Digital.
Commentary:	Although the Trust SHMI is 102.7 but is still in the "SHMI As Expected" category and statistically there are insufficient data points to determine any trend. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

Timeframe	Banding	Observed Deaths	"Expected" Deaths	SHMI
Jul15-Jun16	As Expected	1775	1754.3478	101.18
Oct15-Sep16	As Expected	1741	1752.0551	99.37
Jan16-Dec16	As Expected	1743	1758.3667	99.13
Apr16-Mar17	As Expected	1690	1736.8023	97.31
Jul16-Jun17	As Expected	1674	1714.451	97.64
Oct16-Sep17	As Expected	1693	1686.2059	100.40
Jan17-Dec17	As Expected	1712	1683.682	101.68
Apr17-Mar18	As Expected	1796	1748.1723	102.74

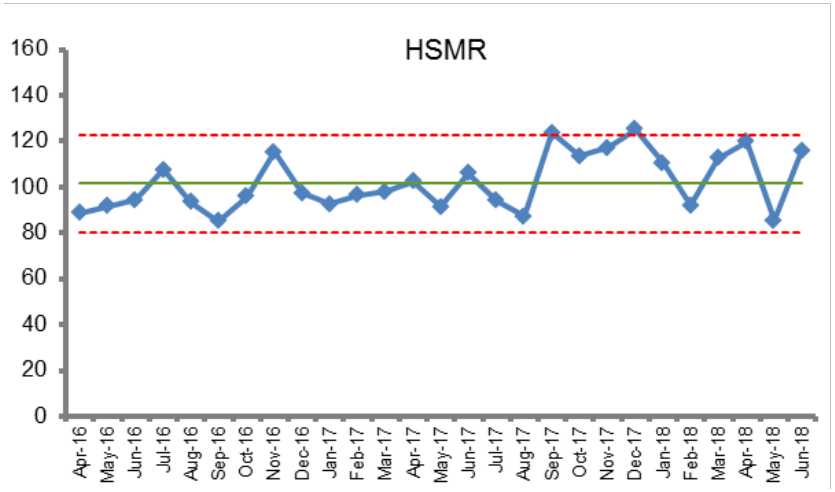


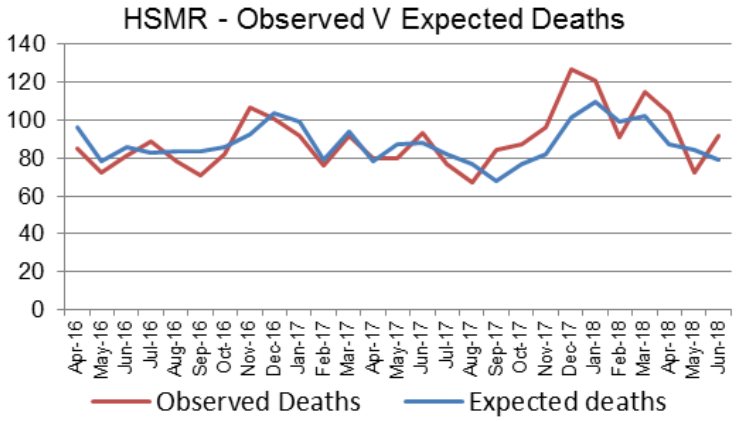
April 2017 to March 2018



2.4 PERFORMANCE – Effective Domain

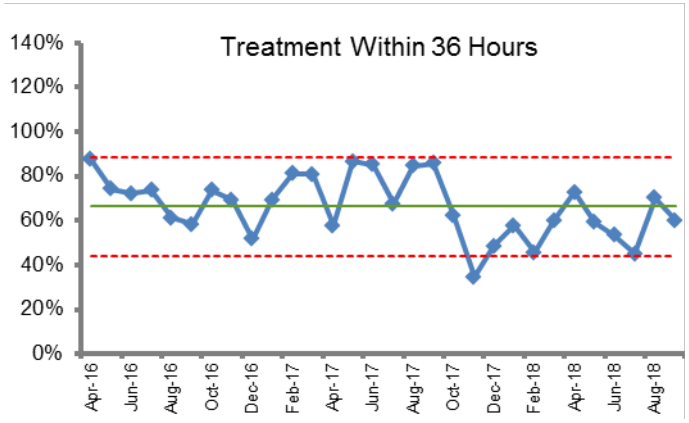
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for June 2018. The HSMR was 116 (92 deaths and 79 "expected")
Commentary:	HSMR for June 2018 is 116. The reason for the increase compared to the national peer is under investigation by the Quality Intelligence Group. Crude mortality is not increasing and is below national peer. Coding depth (average number of diagnosis codes per episode) is in line with the national peer until February 2018 when UH Bristol tailed off but national peer continued to increase at same rate. For non-elective procedures UH Bristol is coding less than national peer from October 2016. Palliative care coding has reduced between June and November 2017. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director. Our Learning from Deaths process does not indicate concerns about clinical care.
Ownership:	Medical Director

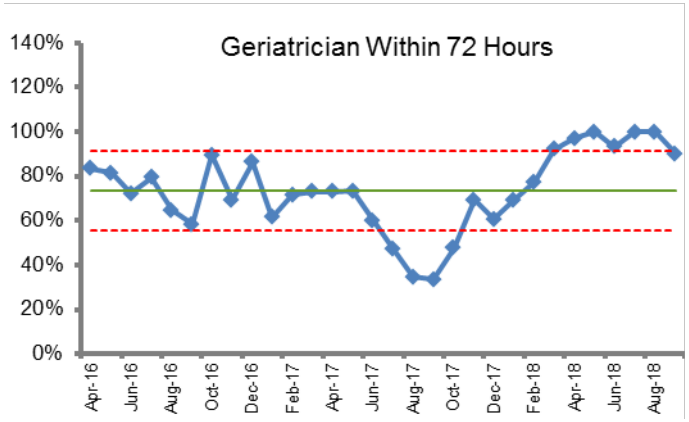


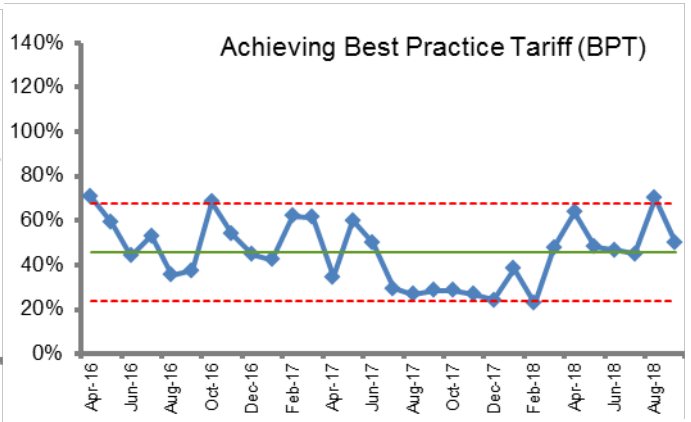


2.4 PERFORMANCE – Effective Domain

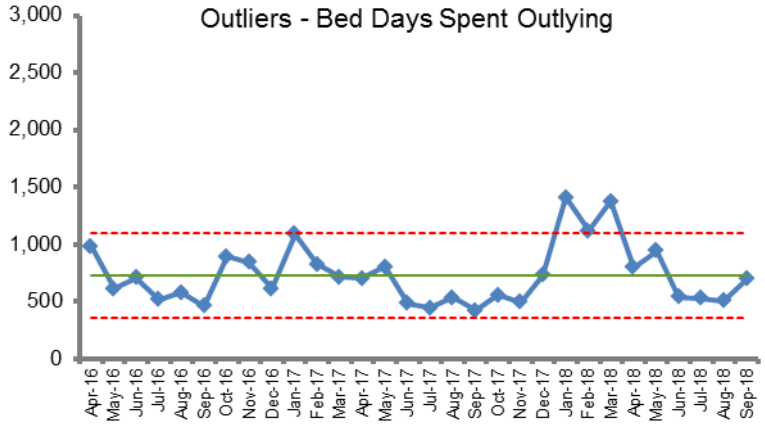
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	In September, there were 23 patients discharged following an admission for fractured neck of femur, of which 20 were eligible for Best Practice Tariff (BPT). For the 36 hour target, 60% were seen with target. For the 72 hour target, 90% were seen within target 10 patients (50%) achieved all elements of the Best Practice Tariff.
Commentary:	Eight of these patients were not operated on in theatre within the required 36 hours. Two patients were not reviewed by an Orthogeriatrician within 72 hours and one patient was also not reviewed by a Physiotherapist on the day of or the day after surgery (one patient did not receive two elements of BPT). Therefore ten patients did not qualify for BPT. Further details are provided below: Reasons why eight patients were not treated in theatre within 36 hours are: • One patient experienced a delay as they needed an MRI scan prior to surgery • Five patients were not operated on within the 36 hour timeframe due to other urgent trauma cases being prioritised • Two patients were not medically fit to have their surgery within the required timeframe The two patients that were not reviewed by an Orthogeriatrican within 72 hours were due to being admitted on a bank holiday. The one patient that was not reviewed by a Physiotherapist was because the patient died intra-operatively.
Ownership:	Medical Director

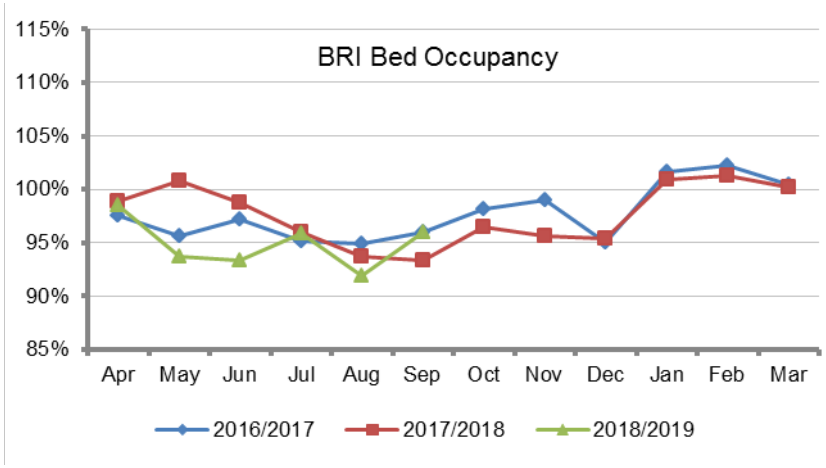


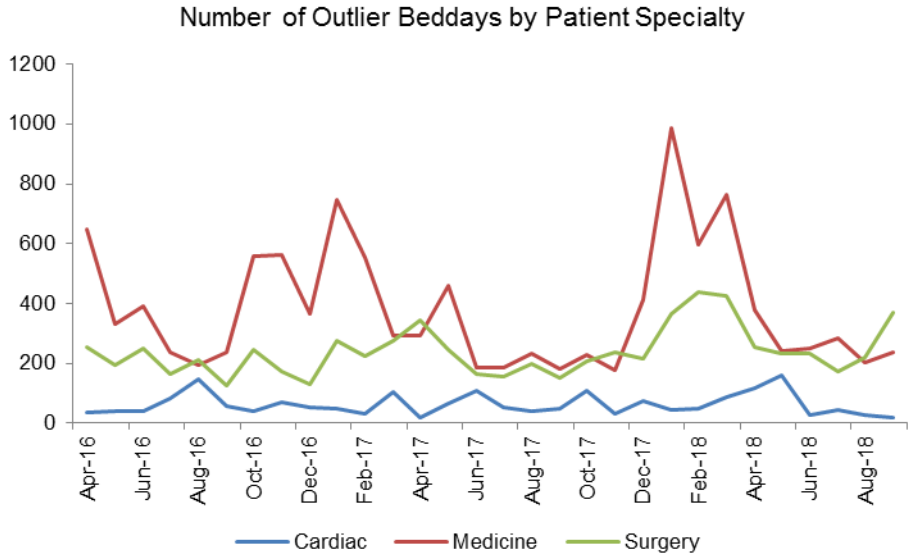




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In September there were 697 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary:	The September target of no more than 563 beddays was not achieved. Of all the outlying beddays 235 were Medicine patients, 51 were Specialised Services patients and 371 were Surgery patients. There were 266 beddays spent outlying overnight on escalation wards, including 171 beddays on Queen's Day Unit (A414)
Ownership:	Chief Operating Officer

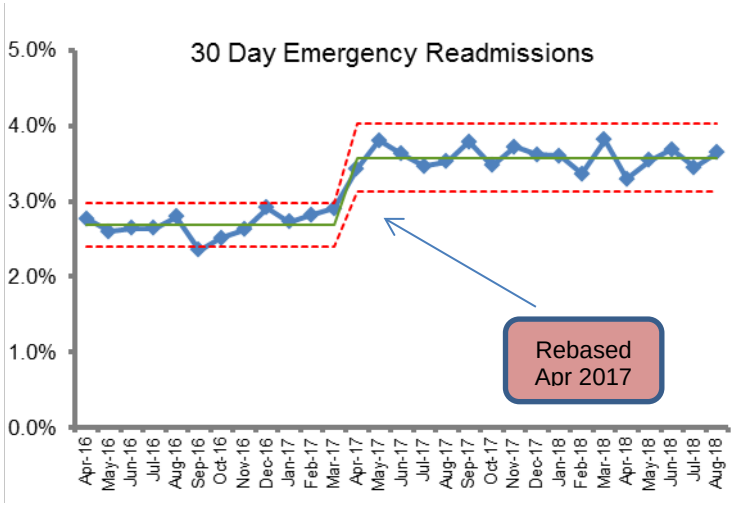






2.4 PERFORMANCE – Effective Domain

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 August, there were 12618 discharges, of which 460 (3.65%) had an emergency re-admission within 30 days.
Commentary:	8.8% of Medicine division discharges were re-admitted within 30 days as an emergency, 5.0% from Surgery and 1.3% from Specialised Services.
Ownership:	Chief Operating Officer

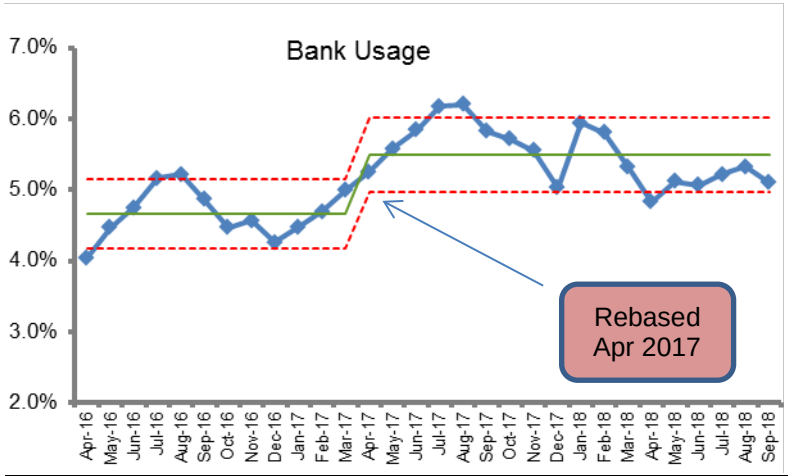


Discharges in August 2018

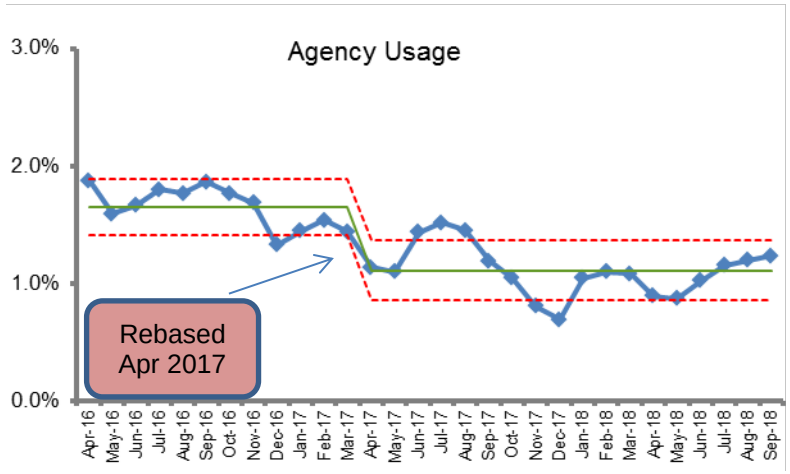
	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	0	31	0.00%
Medicine	208	2,370	8.78%
Specialised Services	36	2,875	1.25%
Surgery	174	3,511	4.96%
Women's and Children's	42	3,822	1.10%
TRUST TOTAL	**460**	**12,618**	**3.65%**

2.5 PERFORMANCE – Efficient Domain

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 September, total staffing was at 8719 FTE. Of this, 5.1% was Bank (444 FTE) and 1.2% was Agency (107.9 FTE)
Commentary:	**Agency usage** increased by 3.3 FTE, with the largest increase seen in Surgery with 21.7 FTE compared to 15.9 FTE in the previous month. The largest reduction was seen in Trust Services, decreasing to 2.5 FTE from 5.5 FTE the previous month. The largest staff group increase was within Nursing & Midwifery increasing to 89.4 FTE from 77.9 FTE in the previous month. **Bank usage** reduced by 21.2 FTE, with the largest increase seen in Surgery; 94.9 FTE compared to 90.6 FTE in the previous month. The largest reduction was seen in Medicine, decreasing to 125.0 FTE from 138.7 FTE the previous month. All staff groups reduced their bank usage, the largest reduction seen within Admin & Clerical staff 90.9 FTE compared to 101.4 FTE in the previous month.
Ownership:	Director of People



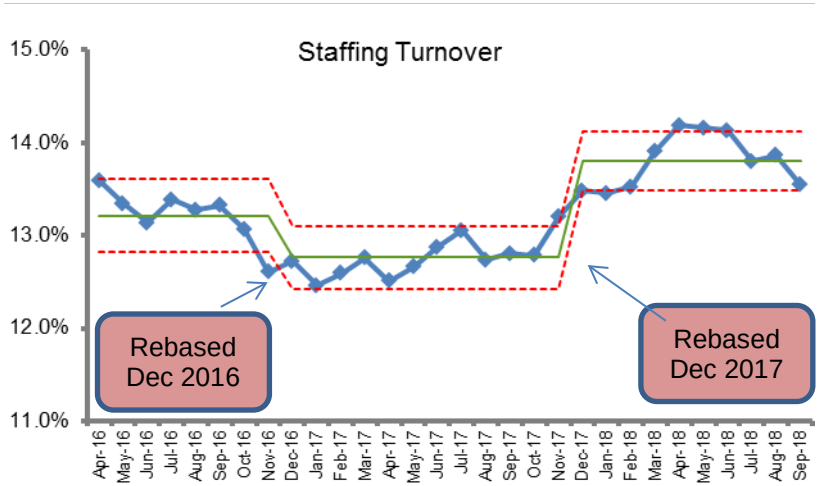
Bank	Sep FTE	Sep Actual %	Sep KPI
UHBristol	**444.2**	**5.1%**	**4.2%**
Diagnostics & Therapies	12.4	1.2%	1.6%
Facilities and Estates	51.3	6.9%	6.8%
Medicine	125.0	9.6%	11.2%
Specialised Services	64.9	6.3%	5.5%
Surgery	94.9	5.2%	1.9%
Trust Services	33.5	4.1%	3.1%
Women's & Children's	62.2	3.1%	1.7%



Agency	Sep FTE	Sep Actual %	Sep KPI
UHBristol	**107.9**	**1.2%**	**0.8%**
Diagnostics & Therapies	6.4	0.6%	1.4%
Facilities and Estates	1.7	0.2%	0.7%
Medicine	32.4	2.5%	1.5%
Specialised Services	17.8	1.7%	0.9%
Surgery	21.7	1.2%	0.55%
Trust Services	2.5	0.3%	0.5%
Women's & Children's	25.5	1.3%	0.5%

2.5 PERFORMANCE – Efficient Domain

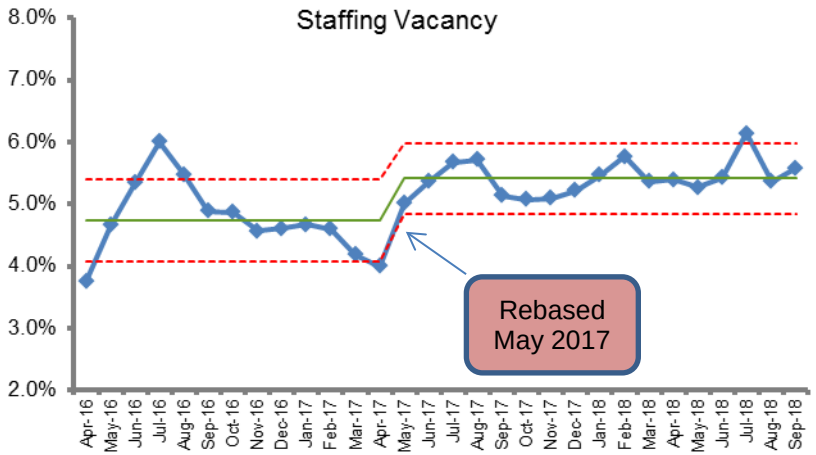
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In September, there had been 957 leavers over the previous 12 months with 7061 FTE staff in post on average over that period; giving a Turnover of 957 / 7061 = 13.5%
Commentary:	Turnover reduced to 13.5% from 13.9% last month, with marginal increases in only two divisions – Specialised Services and Trust Services. The largest divisional reduction was seen within Medicine reducing to 14.3% from 15.1% the previous month. The largest divisional increases were seen within both Specialised Services and Trust Services with both increasing by only 0.03%, 15.01% from 14.98% and 15.33% from 15.30% respectively. The biggest reduction in staff group was seen within Add Prof Scientific and Technic (1.2 percentage points). The largest increase in staff group was seen within Allied Health Professionals (0.9 percentage points).
Ownership:	Director of People



Turnover	Sep-18	KPI
UH Bristol NHS Foundation Trust	**13.5%**	**13.1%**
Diagnostics & Therapies	10.4%	11.8%
Facilities & Estates	18.0%	16.7%
Medicine	14.3%	14.2%
Specialised Services	15.0%	14.2%
Surgery	13.0%	12.3%
Trust Services	15.3%	14.5%
Women's & Children's	12.0%	11.1%

2.5 PERFORMANCE – Efficient Domain

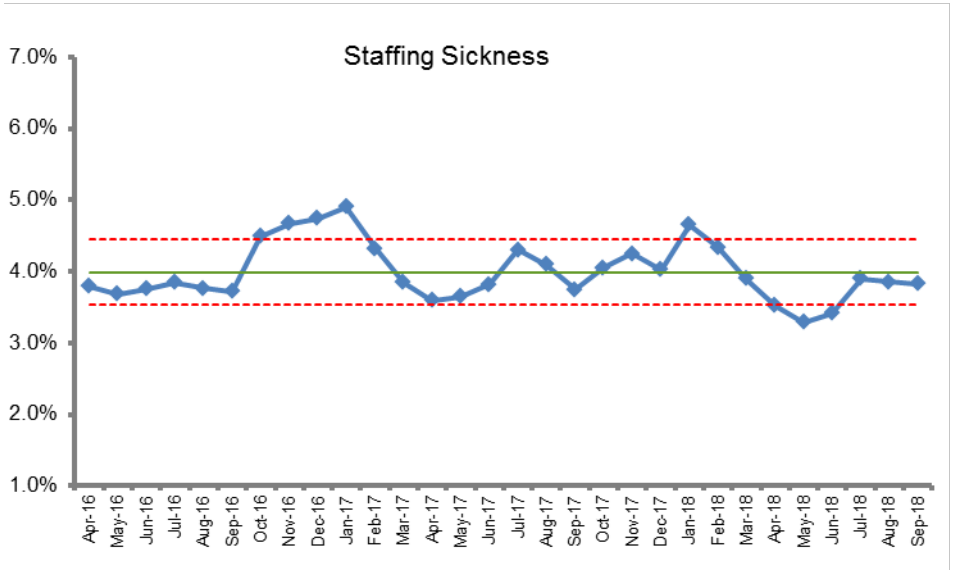
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In September, funded establishment was 8650, with 483 as vacancies (5.6%).
Commentary:	Overall vacancies increased to 5.6% compared to 5.4% in the previous month. There were reductions in two staff groups (Medical Staff and Nursing Staff). Women's and Children's had the largest Divisional reduction to 24.9 FTE from 61.0 FTE the previous month. The largest staff group vacancy position reduction was seen within Nursing staff reducing to 222.6 FTE from 243.3 FTE the previous month. The biggest Divisional reduction in this staff group was seen within Women's and Children's where Nursing vacancies reduced to 41.3 FTE from 70.6 FTE the previous month. The Medical staff group increased their over established position, increasing to -13.9 FTE from -12.9 FTE the previous month.
Ownership:	Director of People



Vacancy	Sep-18	KPI
UH Bristol	**5.6%**	**5.0%**
Diagnostics & Therapies	6.3%	5.0%
Medicine	6.9%	5.0%
Specialised Services	6.0%	5.0%
Surgery	6.3%	5.0%
Women's & Children's	1.3%	5.0%
Trust Services	5.2%	5.0%
Facilities & Estates	11.4%	5.0%

2.5 PERFORMANCE – Efficient Domain

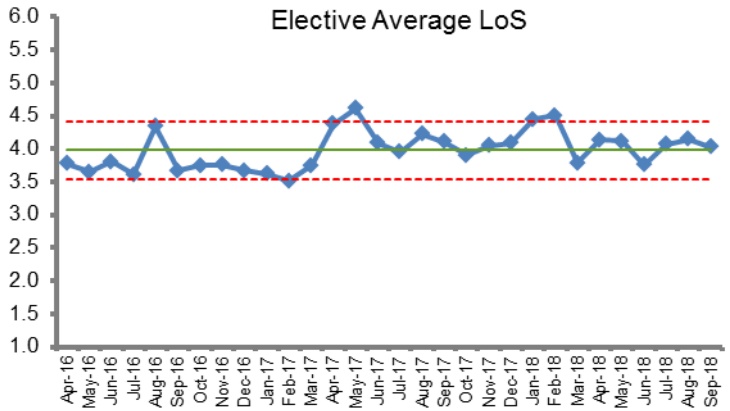
Staff Sickness	
Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In September, total available FTE days were 245164 of which 9374 (3.8%) were lost to staff sickness
Commentary:	Sickness absence reduced from 3.9% to 3.8%, with reductions in four divisions. The largest divisional reduction was seen in Women's and Children's reducing to 3.4% from 3.7% the previous month, Facilities and Estates saw the largest increase to 7.5% from 6.8% the previous month. The largest staff group increase was seen in Estates and Ancillary, rising to 8.1% from 7.1% the previous month. The largest staff group reduction was seen within Add Prof Scientific and Technic reducing to 2.4% from 3.0% the previous month. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, this reduced by 10.2% compared with last month. Other Musculoskeletal Problems are the second highest cause of sickness and this reason reduced by 6.3% compared with last month. The third highest reason, Gastrointestinal problems reduced by 1.4% compared to the previous month.
Ownership:	Director of People

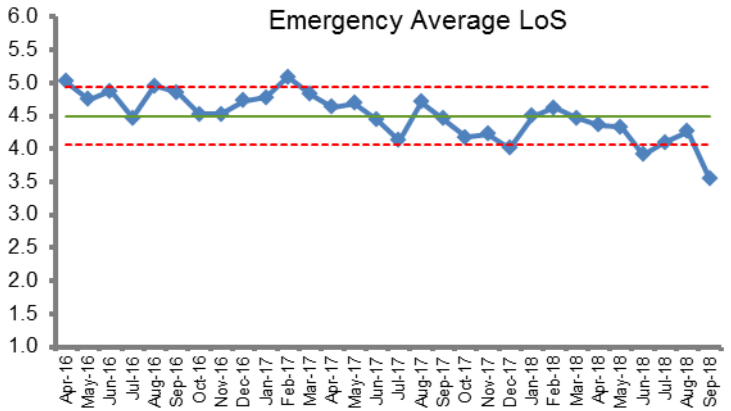


Sickness	Sep-18	Sep KPI
UH Bristol NHS Foundation Trust	**3.8%**	**3.9%**
Diagnostic & Therapies	2.5%	3.0%
Facilities & Estates	7.5%	6.4%
Medicine	4.5%	5.0%
Specialised Services	3.0%	3.5%
Surgery	3.83%	3.6%
Trust Services (exc Facilities & Estates)	3.2%	2.7%
Women's & Children's	3.4%	3.6%

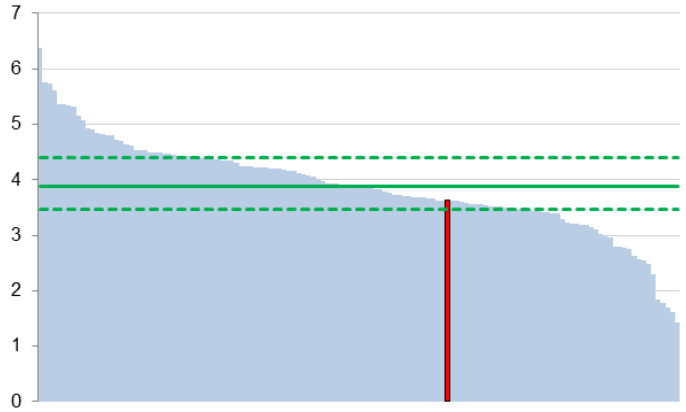
2.5 PERFORMANCE – Efficient Domain

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 September there were 6455 discharges that consumed 22,725 beddays, giving an overall average length of stay of 3.52 days.
Ownership:	Chief Operating Officer



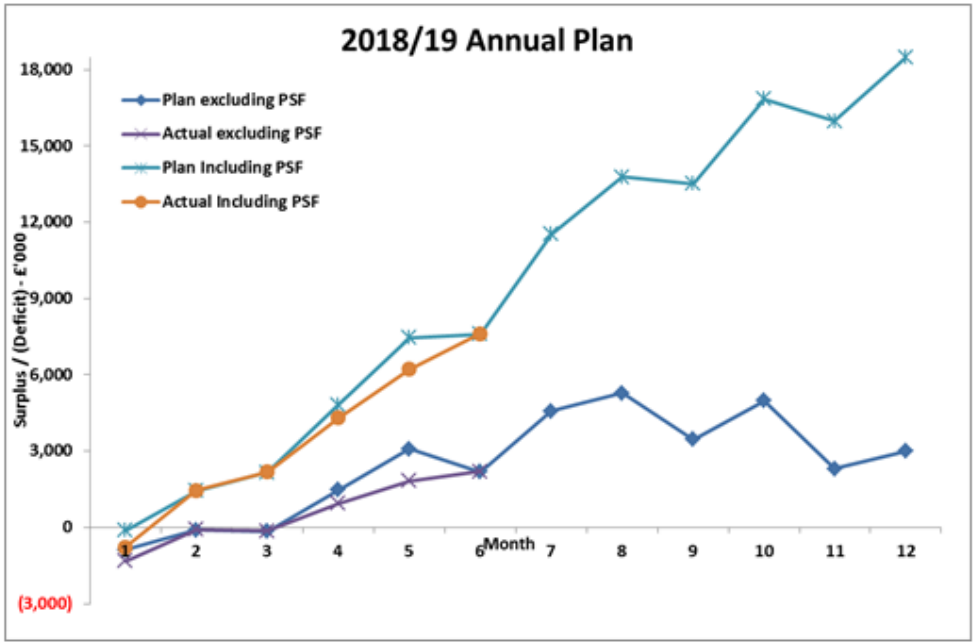


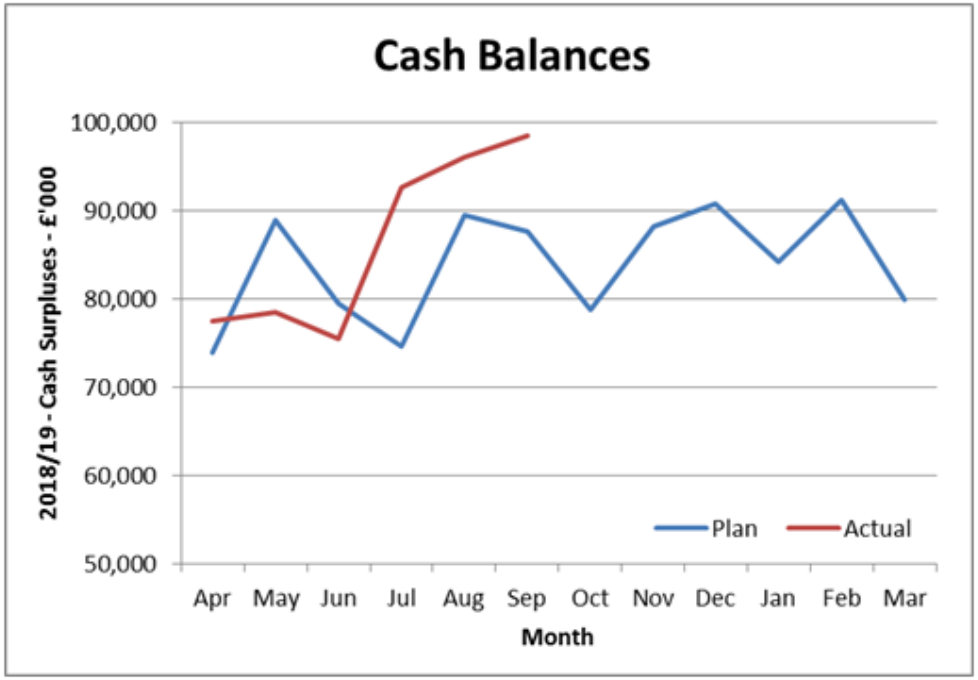
Average Length of Stay – England Acute Trusts – 2018/19 Quarter 1



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

2.6 FINANCIAL PERFORMANCE



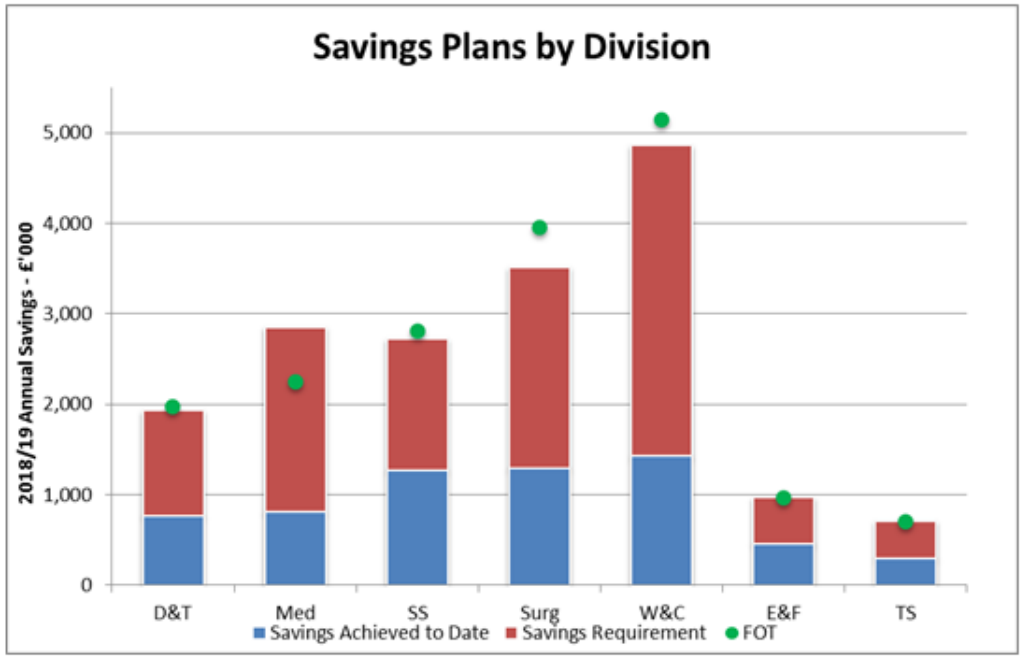


Actual Spend - £'000						
Agency	In Month				Plan for Year	Straight Line Projection
	QTR 1	Jul	Aug	Sept		
Nursing & Midwifery	1,406	549	618	684	**3,257**	**6,514**
Medical						**0**
Consultants	56	71	61	53	**184**	**482**
Other Medical	106	71	24	17	**276**	**436**
Other	189	126	188	129	**1,701**	**1,264**
Total	**1,757**	**817**	**891**	**883**	**5,418**	**8,696**

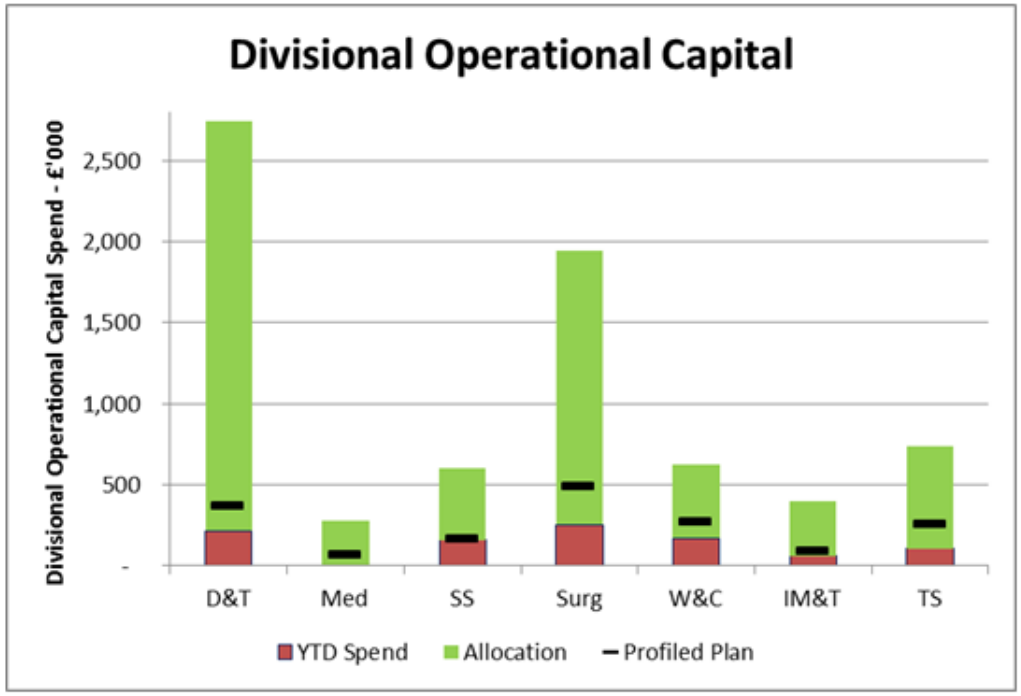
YTD Variance to Budget Surplus/(Deficit) - £'000				
Division	QTR 1	Jul	Aug	Sept
Diagnostics & Therapies	156	161	160	97
Medicine	(449)	(844)	(1,285)	(1,510)
Specialised Services	335	275	204	210
Surgery	(651)	(995)	(1,436)	(1,634)
Women's & Children's	(78)	(121)	(617)	(966)
Estates & facilities	(18)	16	28	20
Trust Services	(18)	(18)	(36)	(32)
Other Corporate Service	152	246	162	187
Total	**(571)**	**(1,280)**	**(2,820)**	**(3,628)**

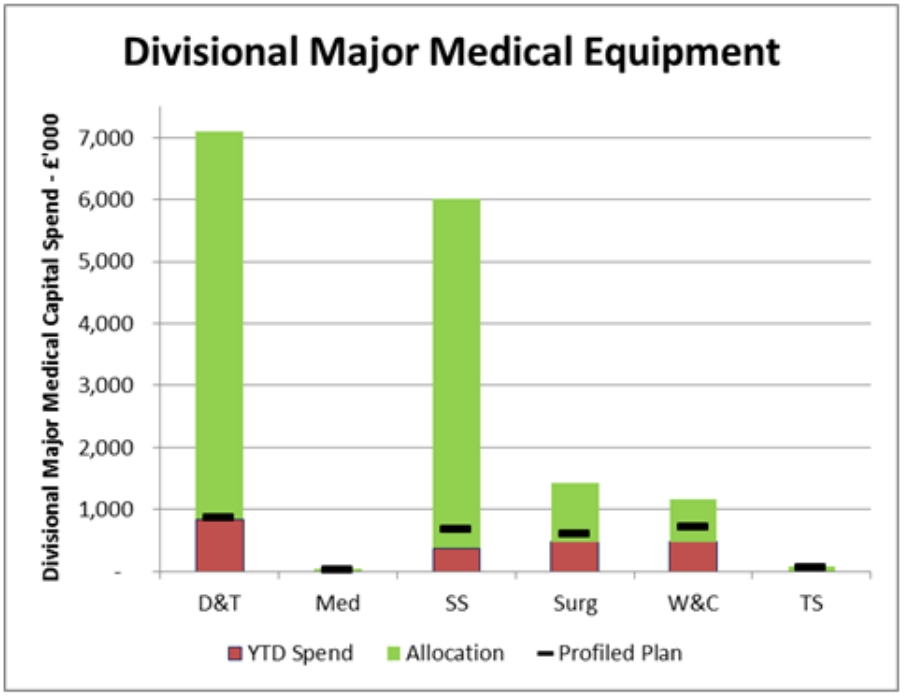
Variance to Budget Surplus/(Deficit) - £'000					
Subjective Heading	In Month				YTD
	QTR 1	Jul	Aug	Sept	Total
Nursing & Midwifery Pay	(1,015)	(338)	(288)	(465)	**(2,106)**
Medical & Dental Pay	(1,033)	(340)	(395)	(449)	**(2,217)**
Other Pay	328	260	80	197	**865**
Non Pay	(1,087)	(475)	(464)	(157)	**(2,183)**
Income from Operations	(27)	75	17	80	**145**
Income from Activities	2,263	109	(490)	(14)	**1,868**
Total	**(571)**	**(709)**	**(1,540)**	**(808)**	**(3,628)**

2.6 FINANCIAL PERFORMANCE



2018/19 Capital Programme			Year To Date		
Operational Plan	Subjective Heading	Revised Plan / FOT	Internal Plan	Actual spend	Variance (over) /under
£'000		£'000	£'000	£'000	£'000
	Sources of Funding				
1,600	PDC	4,094			
3,189	Loan				
3,000	Donations - Cash	2,972	952	644	(308)
	Donations - Direct	28	28	28	0
	Cash:				0
24,338	Depreciation	24,338	11,893	11,651	(242)
14,962	Cash balances	(1,446)	(2,918)	(2,549)	369
47,089	**Total Funding**	**29,986**	**9,955**	**9,774**	**(181)**
	Application/Expenditure				
(11,618)	Strategic Schemes	(7,754)	(417)	(1,664)	(1,247)
(17,620)	Medical Equipment	(18,545)	(2,924)	(2,214)	710
(16,415)	Operational Capital	(15,017)	(2,922)	(2,416)	506
(7,468)	Information Technology	(8,093)	(2,958)	(2,848)	110
(2,367)	Estates Replacement	(3,299)	(734)	(632)	102
(55,488)	**Gross Expenditure**	**(52,708)**	**(9,955)**	**(9,774)**	**181**
8,399	In-Year Slippage	22,722			
(47,089)	**Net Expenditure**	**(29,986)**	**(9,955)**	**(9,774)**	**181**

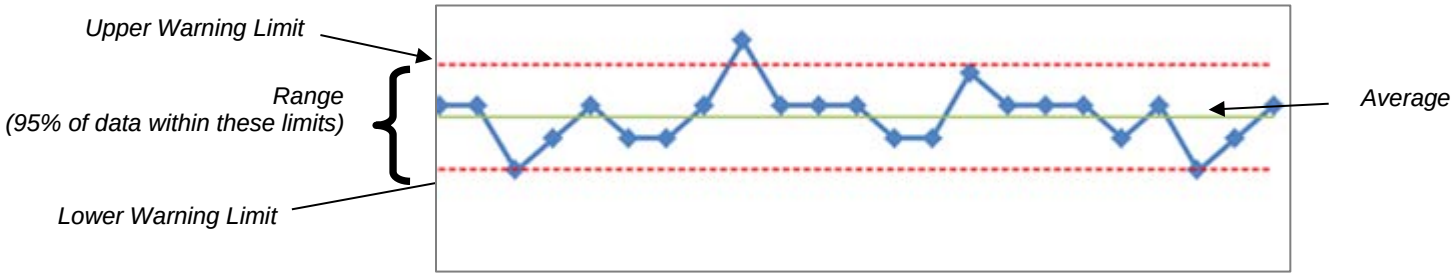




A1 APPENDIX 1 – Explanation of SPC Charts

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

An example chart is shown below:



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

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

A2

APPENDIX 2 External Views of the Trust

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

Care Quality Commission

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

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

NHS Choices

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

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

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

APPENDIX 3 – Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			17/18	18/19 YTD	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	4	4	0	1	1	1	0	0	1	0	2	0	0	1	2	1	3	1
	DA02	MSSA Trust Apportioned Cases	25	18	5	4	1	2	3	3	3	5	4	2	3	1	10	8	12	6
	DA03	CDiff Trust Apportioned Cases	35	20	1	1	3	2	6	0	2	0	6	4	1	7	5	8	8	12
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	7	2	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	12	12	0	1	3	2	6	0	0	0	1	3	1	7	4	8	1	11
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.6%	97.4%	96.4%	97.6%	97.3%	98.4%	98.2%	96.9%	96.8%	97.8%	97.4%	97.7%	97.2%	98%	97.1%	97.8%	97.3%	97.6%
	DB02	Antibiotic Compliance	86.4%	81.2%	85.1%	89.1%	85.4%	85.2%	89.6%	85.3%	82.8%	81.3%	83%	84.6%	77.4%	75.1%	86.4%	86.6%	82.5%	79.6%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	96%	95%	98%	94%	95%	95%	96%	95%	95%	95%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	96%	97%	98%	97%	97%	98%	97%	97%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	96%	97%	96%	93%	96%	96%	96%	95%	96%	96%	95%	95%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	57	37	2	4	4	6	2	7	3	10	4	4	8	8	10	15	17	20
	S02a	Number of Confirmed Serious Incidents	53	17	2	3	4	6	2	6	3	10	4	-	-	-	9	14	17	-
	S02b	Number of Serious Incidents Still Open	-	20	-	-	-	-	-	-	-	-	-	4	8	8	-	-	-	20
	S03	Serious Incidents Reported Within 48 Hours	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	94.7%	97.3%	100%	50%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	80%	100%	100%	95%
	S04	Serious Incident Investigations Completed Within Timescale	96.2%	96.6%	100%	100%	100%	83.3%	100%	100%	100%	75%	100%	100%	100%	100%	100%	93.3%	92.9%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	19	9	1	1	3	3	1	1	2	2	1	2	2	0	5	5	5	4
Never Events	S01	Total Never Events	8	1	2	0	0	1	0	1	0	0	0	0	1	0	2	2	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	15656	8799	1311	1332	1193	1347	1379	1480	1428	1311	1445	1566	1539	1510	3836	4206	4184	4615
	S06b	Patient Safety Incidents Per 1000 Beddays	50.86	58.38	50.19	52.96	46.38	50.04	57.11	55.29	55.84	52.85	59.13	60.39	62.35	59.72	49.82	54.04	55.92	60.81
	S07	Number of Patient Safety Incidents - Severe Harm	92	46	4	9	9	10	7	7	6	13	10	5	3	9	22	24	29	17
Patient Falls	AB01	Falls Per 1,000 Beddays	4.59	4.39	4.48	3.78	4.51	4.61	4.68	5.04	3.79	4.27	3.72	4.4	5.27	4.9	4.26	4.78	3.93	4.85
	AB06a	Total Number of Patient Falls Resulting in Harm	25	15	2	2	5	2	0	2	2	4	1	1	5	2	9	4	7	8
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.162	0.206	0.038	0.159	0.156	0.372	0.207	0.149	0.156	0.121	0.123	0.347	0.203	0.277	0.117	0.244	0.134	0.277
	DE02	Pressure Ulcers - Grade 2	45	27	1	4	4	10	5	4	2	3	3	8	4	7	9	19	8	19
	DE04A	Pressure Ulcers - Grade 3 or 4	5	4	0	0	0	0	0	0	2	0	0	1	1	0	0	0	2	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.4%	98.4%	98.4%	98.2%	98%	98%	98.3%	98.3%	98.1%	98.4%	98.5%	98.3%	98.7%	98.4%	98.2%	98.2%	98.3%	98.5%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	93.3%	97.1%	94%	92.3%	91.4%	94.4%	97.1%	93.8%	96.1%	91.1%	95%	93.4%	89.6%	94.5%	94.1%	93.8%	92.9%
	N04	Number of Hospital Associated VTEs	50	17	6	1	3	8	3	7	3	4	3	4	0	3	10	18	10	7
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	2	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	4	10	0	0	1	0	1	2	1	1	2	3	0	3	1	3	4	6
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	92.1%	-	91%	95.2%	88.8%	95%	91%	93.7%	-	-	-	-	-	-	91.3%	93%	-	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	89.9%	91.2%	-	-	88.9%	-	-	86.3%	-	-	92%	-	-	90.4%	88.9%	86.3%	92%	90.4%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.8%	99.8%	99.2%	99.8%	100%	99.8%	99.7%	99.9%	99.7%	99.7%	99.9%	99.8%	99.8%	99.6%	99.8%	99.7%	99.8%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual 17/18	Annual 18/19 YTD	Monthly Totals Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Quarterly Totals 17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2
Medicines	WA01	Medication Incidents Resulting in Harm	0.55%	0.23%	1.97%	0.47%	0.5%	0.49%	0%	0%	0%	0.91%	0.37%	0%	0%	-	0.97%	0.15%	0.42%	0%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.4%	0.41%	0.27%	0.41%	0%	0.42%	1.02%	0.33%	0.63%	0.36%	0.24%	0.54%	0.22%	0.53%	0.24%	0.57%	0.43%	0.4%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	-	97.5%	98.8%	98.3%	98.8%	98.2%	98.2%	-	-	-	-	-	-	98.2%	98.4%	-	-
	AK04	Safety Thermometer - No New Harms	98.8%	-	98.9%	99.1%	99%	99.9%	98.4%	98.5%	-	-	-	-	-	-	99%	98.9%	-	-
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	96%	-	90%	93%	97%	95%	91%	100%	-	-	-	-	-	-	94%	95%	-	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	9.5%	9.1%	9.4%	9.1%	8.7%	8.2%	9%	10.2%	8.8%	8.9%	10.3%	9.5%	9.4%	9.2%	8.6%	9.3%	9.7%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.4%	21.5%	24.2%	24%	20.8%	20.5%	20.9%	21.9%	20.3%	22.4%	21.7%	21.4%	21.4%	21.4%	23%	21.1%	21.5%	21.4%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11138	5402	1024	1010	863	867	814	945	834	963	875	902	912	916	2897	2626	2672	2730
Staffing Levels	RP01	Staffing Fill Rate - Combined	98.9%	98.7%	97.5%	98.1%	97.2%	98.5%	96.8%	95.7%	99%	98.7%	100.1%	99.1%	97%	98.5%	97.6%	97%	99.2%	98.2%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	100.6	-	-	-	101.7	-	-	102.7	-	-	-	-	-	-	101.7	102.7	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	106.4	107	113.5	117.1	125.3	110.5	91.9	112.6	119.7	85.5	116	-	-	-	119.2	105.2	107	-
Readmissions	C01	Emergency Readmissions Percentage	3.62%	3.55%	3.48%	3.75%	3.62%	3.62%	3.39%	3.84%	3.31%	3.55%	3.78%	3.45%	3.65%	-	3.62%	3.62%	3.55%	3.55%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	51.1%	98.4%	20%	33.3%	46.7%	64.7%	87%	83.3%	87.1%	100%	100%	100%	100%	100%	35.5%	79.7%	95.7%	100%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	77.4%	66.7%	50%	-	100%	-	100%	50%	75%	-	33.3%	100%	-	-	75%	75%	57.1%	100%
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	93.3%	100%	66.7%	-	75%	-	100%	-	100%	-	-	100%	-	-	71.4%	100%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	83.4%	93.7%	91.7%	76%	68%	86%	88%	88%	80%	89.2%	92.8%	98%	100%	96%	75.8%	87.3%	89.3%	98%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	85.5%	84.2%	94.1%	86.2%	91.7%	90%	74.2%	94.1%	75%	91.3%	76.9%	80%	94.3%	82.8%	90%	83.8%	81.1%	86.9%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	93.1%	96.8%	88.9%	84%	90.9%	100%	82.1%	100%	100%	95.1%	92.9%	100%	100%	96%	87.7%	91.2%	94.9%	98.8%
Maternity	G01	Percentage of Low Weight Babies	2.5%	2.9%	0.9%	2%	4.6%	3.2%	2%	3.2%	3.2%	2.1%	4.2%	2.8%	2.5%	-	2.5%	2.8%	3.1%	2.7%
	G01A	Number of Low Weight Babies	119	56	4	7	18	13	7	12	12	8	15	11	10	0	29	32	35	21
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	64.2%	61.5%	61.9%	34.6%	48.5%	57.7%	45.5%	60%	72.7%	59.3%	53.3%	45%	70%	60%	47.5%	54.8%	64%	58.3%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	61.6%	97%	47.6%	69.2%	60.6%	69.2%	77.3%	92%	97%	100%	93.3%	100%	100%	90%	60%	79.5%	97.3%	96.7%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	34.8%	54.8%	28.6%	26.9%	24.2%	38.5%	22.7%	48%	63.6%	48.1%	46.7%	45%	70%	50%	26.3%	37%	54.7%	55%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	53.3	75.9	58.6	64.8	65.7	81.5	48.7	72.7	50.6	61.3	79.3	63.6	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	62.6%	48.6%	60.7%	55.6%	60.9%	57.9%	61.3%	54.3%	58.1%	30.8%	65%	41.2%	42.9%	-	59.1%	57.4%	51.6%	41.8%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	85.8%	85.3%	96.4%	83.3%	87%	84.2%	93.5%	80.4%	81.4%	76.9%	90%	88.2%	95.2%	-	88.2%	85.2%	82.8%	90.9%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	54.6%	47%	66.7%	70%	42.9%	50%	36.4%	20%	15.4%	54.5%	63.2%	30.8%	66.7%	46.7%	62.9%	34.2%	46.5%	47.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	89.3%	80.8%	87.7%	93.7%	87.9%	90.7%	87.3%	86.3%	87.3%	84.8%	77.6%	74.7%	80.2%	79.8%	89.6%	88.2%	83.6%	78%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	96.2%	93.5%	94%	97.4%	100%	93.8%	86%	96.5%	95%	91.9%	89.5%	94.9%	97.7%	91.2%	96.9%	92%	92.2%	94.9%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.9%	91.7%	75%	100%	100%	100%	-	100%	-	0%	100%	100%	100%	100%	87.5%	100%	50%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	60%	100%	-	-	-	100%	-	33.3%	-	-	100%	-	-	-	-	50%	100%	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9098	4023	558	499	730	1411	1120	1377	800	945	543	531	507	697	1787	3908	2288	1735

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			17/18	18/19 YTD	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	91	92	90	91	92	92	93	91	92	90	92	92	91	92	92	91
	P01g	Patient Survey - Kindness and Understanding	-	-	95	95	95	96	95	95	97	97	96	95	96	97	95	96	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	91	89	90	88	88	88	91	89	90	91	89	90	89	89	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35%	35.3%	39.5%	33.2%	28.4%	34.9%	36.2%	30.3%	40.7%	37.6%	33.7%	35.6%	35.4%	29.1%	33.9%	33.7%	37.2%	33.5%
	P03b	Friends and Family Test ED Coverage	17.3%	17.4%	17.9%	17.9%	14.6%	17.8%	17.4%	15.2%	17.3%	17.2%	18.4%	17.3%	17.4%	17%	16.9%	16.8%	17.6%	17.2%
	P03c	Friends and Family Test MAT Coverage	19%	15.2%	21%	12.4%	23.1%	17.5%	17.7%	18.2%	19.8%	13.2%	11.2%	14%	9.8%	23.1%	19%	17.8%	14.8%	15.6%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.7%	97.9%	97.9%	98.1%	97.8%	97.7%	98.3%	97.8%	97.4%	97.3%	97.3%	98.8%	98.6%	98.1%	98%	97.9%	97.3%	98.5%
	P04b	Friends and Family Test Score - ED	81%	82.4%	83.3%	80.3%	77%	81.8%	83.2%	77.7%	80.1%	81.1%	84.6%	81.4%	84.1%	83.4%	80.5%	81%	81.9%	82.9%
	P04c	Friends and Family Test Score - Maternity	96.9%	96.5%	98%	97.5%	98.1%	94.6%	96.8%	97.1%	94.6%	95.5%	99.3%	96.8%	99.3%	95.9%	98%	96.1%	96%	96.9%
Patient Complaints	T01	Number of Patient Complaints	1815	889	154	155	98	143	121	159	149	157	140	148	143	152	407	423	446	443
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	83%	86%	85.1%	87.1%	83.8%	87.8%	82.8%	77.9%	83.1%	91%	84%	85.2%	86.8%	86.3%	85.4%	82.3%	85.9%	86.1%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	83.2%	83.6%	90%	82.4%	91.8%	82.8%	77.9%	85.9%	82.1%	78.7%	85.2%	86.8%	82.2%	85.4%	83.4%	82.2%	84.4%
	T04c	Percentage of Responses where Complainant is Dissatisfied	10.68%	11.24%	10.45%	7.14%	2.94%	8.16%	8.62%	13.23%	9.86%	13.43%	9.33%	12.96%	-	-	6.83%	10.29%	10.8%	12.96%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.19%	1.19%	1%	1.26%	1.2%	1.53%	1.63%	1.91%	1.37%	1.9%	0.59%	1.15%	0.79%	1.39%	1.15%	1.69%	1.29%	1.1%
	F01a	Number of Last Minute Cancelled Operations	919	471	68	85	71	102	98	121	85	125	39	79	54	89	224	321	249	222

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Quarterly Totals 17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	87%	89.6%	88.7%	90%	88.9%	88.3%	88.1%	88.4%	87%	88.2%	89.1%	88.6%	88.9%	88.7%	88.5%	89.1%	87.8%	88.6%	88.7%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3300	2927	3085	3138	3308	3783	3510	3244	3377	3208	3290	3354	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	209	64	10	13	9	1	15	18	15	12	9	11	7	10	32	34	36	28
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	-	-	155	136	158	160	148	164	154	141	129	126	119	113	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.3%	95%	94.6%	95.5%	94.8%	92.2%	96.9%	92.1%	92.6%	95.1%	95.3%	96.5%	95.5%	-	95%	93.6%	94.3%	96%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	58.9%	55.6%	64.2%	57.6%	54.4%	58.8%	59.6%	54.6%	41.3%	53.1%	56.7%	60.6%	66.4%	-	59%	57.7%	50.6%	63.5%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	95.8%	96.1%	95.4%	98.1%	96.7%	92.9%	95.1%	95.8%	94.4%	95%	94.7%	97.4%	99.2%	-	96.7%	94.5%	94.7%	98.3%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.6%	97.5%	99.3%	98.7%	98.9%	98.7%	98.6%	98.4%	97.6%	96.6%	97.6%	96.1%	100%	-	99%	98.6%	97.2%	98%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	92%	94.1%	95.7%	96.8%	93%	96.6%	87.7%	79.5%	93%	85%	95.6%	98.2%	96.2%	-	95.2%	89%	91.4%	97.2%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.3%	94.4%	96.4%	96.1%	97.6%	92.9%	97.9%	96.4%	98.5%	85.4%	91.6%	97.1%	97.4%	-	96.6%	95.6%	92.2%	97.2%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	81.7%	85.6%	84.3%	88.6%	82.9%	78.4%	81.3%	87.3%	84.1%	82.4%	86%	85.7%	88.9%	-	85.4%	82.4%	84.2%	87.3%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	74.8%	54.5%	66.7%	76.5%	71.4%	100%	58.3%	28.6%	66.7%	37.5%	41.7%	100%	60%	-	73.3%	61.5%	43.5%	80%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	85.4%	80.5%	74.7%	88.5%	85.7%	88.7%	83.9%	90.9%	79.3%	77.9%	84.4%	77.7%	84.7%	-	83%	87.9%	80.4%	80.7%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	47.5	21	3.5	2	4.5	3	2.5	2	3	5	5.5	2	5.5	-	10	7.5	13.5	7.5
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.19%	1.19%	1%	1.26%	1.2%	1.53%	1.63%	1.91%	1.37%	1.9%	0.59%	1.15%	0.79%	1.39%	1.15%	1.69%	1.29%	1.1%
	F01a	Number of Last Minute Cancelled Operations	-	-	919	471	68	85	71	102	98	121	85	125	39	79	54	89	224	321	249	222
	F02	Cancelled Operations Re-admitted Within 28 Days	95%	85%	94.2%	93%	96.6%	91.2%	94.1%	88.7%	94.1%	92.9%	90.9%	88.2%	95.2%	97.4%	94.9%	94.4%	93.8%	92.3%	91.8%	95.3%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.61%	1.7%	1.28%	1.9%	1.38%	1.81%	2.08%	2.31%	2.26%	2.36%	1.67%	0.41%	1.53%	2.05%	1.53%	2.06%	2.1%	1.31%
	F07a	Number of Admissions Cancelled Day Before	-	-	1244	669	87	128	82	121	125	146	140	155	110	28	105	131	297	392	405	264
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	76.1%	79.4%	73.8%	77.4%	63.8%	80.9%	71.1%	65.2%	86.2%	80%	81.8%	70.6%	79.3%	-	70.8%	74.1%	82.4%	74.6%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.2%	93.9%	92.9%	93.5%	93.6%	95.7%	97.4%	91.3%	93.1%	92.5%	100%	91.2%	93.1%	-	93.3%	95.4%	95.1%	92.1%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.29%	97.56%	98.19%	98.28%	97.62%	97.81%	99.19%	98.51%	96.8%	97.64%	97.83%	97.88%	97.13%	98.13%	98.03%	98.53%	97.41%	97.72%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	10.7%	9.8%	9.9%	9.7%	10.1%	9.4%	11.1%	11.6%	9.7%	9.5%	10%	9.6%	10%	10.1%	9.9%	10.6%	9.7%	9.9%
	R05	Outpatient DNA Rate	5%	10%	7.2%	6.9%	7.1%	7.1%	7.6%	6.8%	6.4%	7.3%	6.4%	7.2%	6.7%	7.1%	6.8%	7%	7.2%	6.8%	6.8%	7%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.19	2.07	2.1	2.15	2.2	2.22	2.17	2.1	2.06	1.99	2.05	2.1	2.11	2.13	2.15	2.16	2.03	2.11
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	20.2%	20.6%	20.2%	22.3%	20.8%	20.8%	22.6%	14.6%	18.6%	21.5%	23.8%	22.9%	22.1%	15.5%	21.1%	19.4%	21.4%	19.9%

A3

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Quarterly Totals 17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	279	109	26	17	23	27	23	19	22	18	25	17	11	16	66	69	65	44
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	103	42	10	8	9	9	9	5	5	8	8	4	9	8	27	23	21	21
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	8466	3281	774	854	606	836	715	696	576	471	632	503	586	513	2234	2247	1679	1602
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	3106	1409	315	273	255	272	182	204	291	161	207	204	225	321	843	658	659	750
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	46	44	47	53	54	52	59	56	60	54	42	55	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	22	11	13	15	26	17	18	14	21	17	19	24	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1461	1555	1532	1757	1652	1989	1832	1574	1836	1571	1621	1562	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	671	451	479	593	453	501	614	451	459	618	570	753	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.05	3.81	3.87	4	3.74	4.15	4.15	3.96	4.01	3.93	3.66	3.8	3.92	3.52	3.87	4.08	3.87	3.75
	J04D	Percentage Length of Stay 14+ Days	-	-	6.8%	6.3%	6.8%	6.9%	6%	6.6%	6.9%	7.1%	6.5%	6.4%	6.3%	6.5%	6.5%	5.8%	6.5%	6.9%	6.4%	6.2%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	240	213	243	242	252	238	234	207	243	234	211	233	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	2.8%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7.1%	6%	2%	1.3%	0.5%	0%	5.6%	3.3%	5.1%	0.6%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	35.7%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	32.2%	38.5%	50%	25%	25%	-	48.3%	50.6%	37%	25%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	90%	86.48%	88.87%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.26%	90.07%	85%	88.64%	81.54%	89.3%	88.44%
This is measured against the national standard of 95%																						
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	86.48%	88.87%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.26%	90.07%	85%	88.64%	81.54%	89.3%	88.44%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	78.35%	82.03%	84.11%	88.22%	77.24%	71.39%	73.24%	65.06%	73.92%	85.56%	89.08%	84.8%	83.37%	75.44%	83.2%	69.78%	82.81%	81.27%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	94.89%	95.83%	96.34%	91.54%	92.56%	93.91%	94.5%	95.08%	94.45%	96.25%	96.26%	96.39%	97.9%	94.16%	93.42%	94.49%	95.67%	96.02%
	BB04	BEH ED - Percentage Within 4 Hours	99%	99%	96.26%	97.09%	97.43%	94.21%	98.34%	96.63%	94.35%	92.9%	94.4%	98.11%	97.66%	96.19%	98.75%	97.46%	96.59%	94.62%	96.7%	97.49%
This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																						
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	8	0	0	0	5	3	0	0	0	0	0	0	0	0	5	3	0	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.9%	95.9%	98.8%	98.6%	98.2%	97.6%	96.5%	96.3%	96.8%	94.8%	98.4%	94.3%	95.1%	96.1%	98.5%	96.8%	96.7%	95.1%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	94.4%	91.3%	94.2%	94.8%	99.4%	99.4%	98.4%	93.7%	91.9%	90.2%	92.8%	91.4%	90.6%	91%	96.2%	97.2%	91.6%	91%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.2%	51.5%	53.2%	48.4%	51%	54.4%	52.4%	48%	49.5%	53.8%	51.3%	50.8%	55.6%	48%	50.8%	51.6%	51.6%	51.4%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	97.4%	96.8%	97.1%	97.8%	98%	98%	97.6%	96.5%	96.5%	96.7%	97.3%	96.8%	97.1%	96.6%	97.6%	97.4%	96.8%	96.8%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.8%	2.9%	2.9%	3.3%	3.3%	3.1%	2.9%	2.9%	3%	3%	2.8%	2.9%	2.7%	3.2%	3.2%	3%	2.9%	2.9%
	B05	ED Left Without Being Seen Rate	5%	5%	1.9%	1.7%	1.1%	1.1%	1%	1%	1.1%	1.5%	1.4%	1.6%	1.7%	1.9%	1.6%	2.2%	1.1%	1.2%	1.5%	1.9%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	840	294	63	63	87	62	59	85	75	48	54	45	58	14	213	206	177	117
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	2.8%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7.1%	6%	2%	1.3%	0.5%	0%	5.6%	3.3%	5.1%	0.6%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	35.7%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	32.2%	38.5%	50%	25%	25%	-	48.3%	50.6%	37%	25%

University Hospitals Bristol
NHS Foundation Trust

Meeting of the Private Board on Wednesday 31 October 2018 in the Conference Room, Trust Headquarters

Report Title	**Quality and Outcomes Committee – Chair's Report**
Report Author	**Julian Dennis, Chair of the Quality and Outcomes Committee and Non-Executive Director**
Executive Lead	**n/a**
Agenda Item No:	**10**

1. Report Summary

This is the Chair's Report of the Quality and Outcome Committee meeting of 26 October 2018.

2. Key points to note

(Including decisions taken)

The report covers the key items discussed by the Committee, including the, BHOC Fire Harm Panel Review, the NHS England Major Incident Investigation Report, the Board Assurance Framework for delivering the Cardiac Review recommendations, and the Committee Self- Assessment.

3. Risks

The risks associated with this report include:

n/a

4. Advice and Recommendations

(Support and Board/Committee decisions requested):

- This report is for **ASSURANCE.**
- The Committee is asked to **NOTE** the report**.**

5. History of the paper – n/a

Board Assurance Framework: Strategic Risk Register and Corporate Risk Register

The Committee received the strategic and corporate risk registers for Q2. The reports have been reworked over the past 3-6 months to ensure they better reflect current risk and to make clear the distinction between the strategic and corporate risk. The Committee liked the new style of the report, which was received for assurance.

Quality and Performance Report

The Committee received the standing Quality and Performance Report for August, noting the following point in particular:

- The 62 Day Cancer standard achieved 88.9 % for August (above the national standard).
- The measure for percentage of A&E patients seen in less than 4 hours was 85.0% for September, below the 95% national standard and the improvement trajectory of 90.84%.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.52% as at end of September, in line with the improvement trajectory target but below the national standard of 92%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of September was 98.1%, lower than the 99% national standard. The Trust recovery trajectory is set to achieve 99% in February.
- The Trust was maintaining 'standing still' waiting lists, one of the few Trusts nationally to do so (rather than increasing lists).
- There had been good progress on diagnostics performance, with issues narrowed to a couple of services which the Trust was now working with directly: some issues related to staffing vacancies which would be addressed by new appointments in January.
- The On-hold Patients recovery project is now formally closed.
- Good performance in quality of care was sustained in the month, however, antibiotic prescribing performance declined. It was noted that the introduction of e-prescribing should help improve the resilience and reliability of prescribing processes.
- NEWS 2 had gone live in October.
- I case of MRSA had been reported in August 2018, in a patient in a high risk group: the Trust was satisfied it had tested and responded appropriately.
- There is currently detailed work to review complaints where the complainants were dissatisfied with the Trust's response.

Harm Panel Review – BHOC Major Incident

Deputy Medical Director Mark Callaway has led this work to establish if the fire in the Bristol Haematology and Oncology Centre in May 2018 had led to any patient harm. The report has been sent to NHS Improvement and the Clinical Commissioning Group.

It was noted that it was easier to identify potential harm for radiotherapy patients than chemotherapy patients. The report had identified a lot of good work to mitigate risk to patients and the report provided assurance that, as far as it was possible to ascertain,no patient had been harmed by interruption to treatment as a result of the fire. There would be some follow up work in

the divisions around business continuity, looking for decant options in the event of evacuations and a more co-ordinated network response.

Serious Incident Report and the Root Cause Analysis Reports

The Committee Received the Serious Incident Report, which confirmed that all reports had been completed within the required timescales and progress against overdue actions outstanding for three incidents. The Committee also received one Root Cause Analysis Report, noting that key learning had been identified around making sure procedures for complex and difficult cases were strengthened, including administrative processes. The Committee noted that this was a concerning case but were satisfied that the investigation and identified actions were robust.

Progress Report Against Quality Objectives

The Committee received the Q2 Progress Report against Quality Objectives. The report gave assurance that work was progressing to achieve these – the Committee noted in particular that the Director of Pharmacy, Jon Standing, was working to address insulin prescribing issues. The Committee highlighted that there were some challenges in understanding parts of the report as some areas included reference to Q1 as well as Q2. It was agreed that in future the update would focus on the latest quarter's progress only.

The Committee asked for clarity on how the actions proposed in the report to improve the quality of care for the treatment of dying patients would build confidence in those doctors treating these patients.

Quarterly Impact Assessment Report

The Committee noted that there were no additional QIAs for the quarter. It was noted that this report was a national requirement.

Annual Clinical Audit Report

Clinical Audit and Effectiveness Manager, Stu Metcalfe, presented the Annual Clinical Audit Report to the Committee for assurance. It was noted that the Trust had undertaken a high volume of audits this year, 595, an increase from 550 in the previous year. Every audit completed had an action plan, and the Clinical Audit Team was working hard to close these. Going forward, he would like to reduce the time from data collection to collating an action plan to help speed up the process.

The Committee asked how the recommendations arising from the national falls audit were being actioned. It was confirmed that there was an action plan sitting behind the report which was being picked up, and a number of specific internal Clinical Audits were being undertaken off the back of the national audit.

Infection Control Report – Q2 Update

The Committee received the Q2 update on the Infection Control Report for assurance. There were no major issues identified, but the Committee asked if they could see benchmarking data to help understand how well the Trust was performing in comaprision with similar trusts

NHS England Major Incident Investigation Report

The Major Incident report relating to the BHOC fire had been finalised on 23 October and presented to the committee for information> An action plan had not yet been formulated. The report would now go through the Civil Contingencies Committee and would be presented to the Senior Leadership Team to develop an action plan.. This would be aligned with other strands of work related to the BHOC fire, including the harm panel findings.

The Committee praised the frankness and clarity of the report, and noted that despite the concerns highlighted staff training had been successfully applied in protecting patients and staff. The Committee noted that if there was another major incident of this kind (i.e. fire) and the Trust had not fixed the identified problems and demonstrated 'lessons learned' there would beserious repercussions. It was noted that vital equipment (such as horizontal evacuation equipment and walkie talkies) needed purchasing without delay and would be purchased without a tendering process.

Monthly Nurse Safe Staffing Report

The Committee received the Monthly Nurse Safe Staffing Report. It was noted that the Trust had challenges covering some shifts, including enhanced care. The Trust remained confident that the wards were safely staffed, but it had been a challenging few months.

The Committee noted some problem areas in the Children's Hospital. The Chief Nurse was confident they were making the appropriate risk based decisions, but they had specific challenges including the need to use tier 3 and 4 (high cost) agency staff which meant they could not always fill vacancies.

Board Assurance Framework for the delivery of Independent Cardiac Review Recommendations 2017

The Committee received the framework for actions arising from the Paediatric Cardiac Review, which had been identified during the review but were not required actions for the completion of the report process. QOC had not wanted these actions to be lost and the internal audit team had recommended an update be received by the Committee a year after the report. The report provided assurance that these actions had been addressed. Apart from some minor delays and changes, the actions had been completed satisfactorily.

Committee Self- Assessment

The Committee received the results of the self-assessment survey completed by members for discussion, and approved changes to the Terms of Reference for 2018/19. The Committee noted that the survey outcomes were very positive, but there were some areas where further information and understanding would be helpful. It was noted that the Trust Chair would be reviewing the self-assessment work that all the Board Committees were currently undertaking as part of a broader Board Evaluation planned for the next Board Seminar.

Other reports

The Committee received the Clinical Quality Group Meeting Report and the Quarterly Inquest Report for assurance.

Meeting of the Private Board on Wednesday 31 October 2018 in the Conference Room, Trust Headquarters

Report Title	**People Committee – Chair's Report**
Report Author	**Alison Ryan, Chair of the People Committee and Non-Executive Director**
Executive Lead	**n/a**
Agenda Item No:	

1. Report Summary

This is the Chair's Report of the People Committee meeting of 26 October 2018.

2. Key points to note
(Including decisions taken)

The committee discussed the Terms of reference, Risk management, Doctors in Training, Apprentices and OFSTED and the Quality and Performance report Workforce section.

3. Risks

The risks associated with this report include:

n/a

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **ASSURANCE.**
- *The Board/Committee* is asked to **NOTE** the report.

5. History of the paper – n/a

We welcomed Madhu Bhabuta who has joined the committee as a NED.

Terms of Reference and Regular reporting

The Committee is still evolving a sense of its remit, the sources of assurance and the nature of the reporting it needs. In the second meeting we looked at the need to develop a dashboard of indicators which links to the Terms of Reference and also the Strategic Priorities adopted by the Trust, so we can see where we are going and look at trends. Both Executives and NEDs are putting their thoughts together on this.

Risk Management

The Committee is also getting to grips with the Strategic and Corporate Risks for which it has responsibility. We received a report identifying these with explanations of scoring and movements. The Committee agreed that the right risks had been identified and in future will only receive updates on these, allowing far greater focus on Risk Management of People Issues. (A similar process is happening with the other Board Committees). More information on sources of Assurance in the Register would help understanding of mitigation activities. The People Committee will in future receive minutes from the Workforce and OD Executive Committee so that the underpinning work for the process is clear.

One of the risks to our People comes from assault and this is clearly identified. However NEDs had not previously been sighted on the extent of this problem, or how it was mitigated and managed. The protection of staff is obviously extremely important and the current reporting line is to the Health and Safety side of the organisation not “People”. The Committee wished to be kept appraised of trends and hotspots in this area in future.

Junior Doctors

The Committee received a very thorough and helpful update on the implementation of the new contract for Junior Doctors from Dr Alistair Johnstone the Safe Working Hours Guardian. The challenge of covering all the necessary rotas in the Trust, especially those in narrow specialities, is now very clear. The gaps arise for many different reasons. To manage the situation without breaching safe hours, or the contract, while still providing the proper educational input to the doctors requires complex management. It is very much hoped that a new e-Rostering program will make this much less labour intensive. The committee also received a report on the implementation of this program which is being rolled out next year.

The Committee expressed concern about the intractability of the rota-filling problem – not least because of the financial impact using locums has on the Trust. There are no easy fixes. We were also concerned about the burden on supervisors of managing the exceptions, when excess hours are worked. We were told that supervisors had to be both clinical and also fairly senior to perform the role. Taking their time from clinical work can make the issue worse not better. It is therefore important that as much support is given them from the HR systems and personnel as possible. There were however some concerns that we were not adequately resilient in this area.

We were encouraged that the degree of concern and engagement with this new arrangement shown by the Trust is seen to be at a high level. The Committee had every confidence that the Safe Working Hours Guardian would facilitate solutions wherever possible but ensure the Committee was informed when problems persisted.

The implementation of the e-rostering system also gave rise to some concerns as it appeared that a considerable reworking of the HR business processes needed to

accompany it and it was not clear that this was adequately resourced. The Committee would be seeking further assurance on this area in the near future.

Apprentices and OFSTED

The Committee received a presentation and the pre inspection Self-Assessment Report and Quality improvement Programme for the OFSTED inspection which is likely in the next few months. The consequences of receiving a poor rating in the inspection are serious and the Committee sought assurance that a contingency plan was in place. As the Self-Assessment was that the Trust was performing at the "Good" level it was hoped that this would not occur but we have no experience in this field and could not be complacent. Some of our statistics for retention are not as strong as we would like.

A major weakness in the evidence being produced for OFSTED is the lack of an electronic tracking system for both students and advisers, to evidence individual learning. There was a discussion about the reason that funding for this was not available and it was pointed out that the Levy for training apprentices paid by the government did not remotely cover the costs of doing it to the required standard. A bid for the investment would be made for the next Operational plan. However this would not help in the first Inspection. There was a brief discussion about the Business Planning Process which preceded the decision to go ahead with Apprentices. It was agreed that the whole scheme, including the long term benefits of filling future workforce gaps by "growing our own" through the scheme would be examined by the Committee.

Quality and Performance Report – Workforce

The Committee noted that some of the charts in the report supplied were for the previous month (though the data in the report was correct), the report would be updated in time to circulate to Board.

Alison Ryan

Chair

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Board of Directors meeting to be held on Wednesday 31 October 2018 at 09:00 – 11:00 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	
Meeting Title	Finance Committee		
Report Title	Chair's Report of the Finance Committee		
Author	Eric Sanders, Trust Secretary		
Executive Lead(s)	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Summary of key matters considered by the Committee and any related decisions made.

This report provides a summary of the key issues considered at the Finance Committee meeting held on 26 October 2018, chaired by Martin Sykes, Non-executive Director.

Finance Director's Report
The Director of Finance and Information Paul Mapson presented the report. Key points of discussion included the following:

- The Operational Plan requirement to September was a surplus of £7.599m excluding technical items, and the Trust was reporting a surplus of £7.620, £0.0251 favourable to plan.
- The key areas of concern were the divisional positions reported for Surgery, Medicine and Women's and Children's, with the overall clinical divisional deficit now reported at £3.803m. This was a deterioration of £0.829m compared to the previous month.
- The Committee discussed the process for the Executive to seek assurance about the actions being taken by the Divisions to control the financial position. This included updates on the conversations from the Divisional Quarterly Reviews where this had been discussed. The main issues related to the level of nursing pay in the Medicine Division, level of pay for Consultants in the Surgery Division and the level of non-pay in the Women's and Children's Division.
- The Trust had reported the achievement of its plan at the end of Quarter 2 and whilst forecasting to achieve the plan for the year, the risk associated with achieving this has increased.
- The Director of Finance agreed to share the details of the mitigations to support delivery of the quarterly position taken with the Board as part of his verbal update when presenting the Finance report.

Contract Income and Activity Reports
The Assistant Director of Finance, Richard Smith, presented the report. Key points noted included the following:

- Contract income for 2018/19 was £0.28m higher than plan in September 2018, and included part year income of £0.66m to offset the impact of HRG4+ from Welsh commissioners.
- The Committee discussed the issue of HRG4+ and received an update from the

Director of Finance who outlined the current position of the negotiations. Whilst not yet agreed it was believed that the HRG4+ income would be received in year, hence why this had been played into the positon.

Report of Medicine Division Nursing Overspend
The Committee received a detailed report which sought to explain the reasons for overspending in the Medicine Division on nursing pay.

- The analysis showed a significant uplift in expenditure on nursing spend from May 2018, with the overall overspend at month 6 being almost £1m.
- The reasons for the uplift were being further investigated but it was believed that whilst controls remained in place, a change in personnel and a potential change in acuity of patients may have resulted in increased agency usage.
- It was noted that there were almost 50 registered nurse vacancies in the Division, and whilst EU and non-EU recruitment was underway, this would take time to help fill the gaps.
- The senior nurses in the Division were reviewing the use of enhanced care staff, particularly at night, with senior nurses joining night shifts to review the requirements.

Detailed Divisional Financial Reports
The detailed Divisional reports were presented and the following discussed:

- The main risks to the divisional positon related to the workforce and ensuring vacancies were filled.
- The overall risk to delivery of the Trust's operational plan had been reviewed given the deterioration in the divisional positon and the risk increased to 12. The severity had been increased from 3 to 4 to reflect the increased consequences of not achieving the divisional positions. The likelihood had not changed.
- There was challenge from the Non-Executives to understand how the Women's and Children's Division were forecasting to deliver their nursing spend Cost Improvement Plan (CIP) yet were currently overspending year to date on nursing pay.

Service Profitability and Efficiency
The Committee received the updated service profitability and efficiency report which included data for the full year 2017/18.

- The report showed an overall deterioration in margin of £2.5m, with the biggest variation in surgery, which was £5.6m worse.
- The Committee discussed the report and noted that the potential benefit of the Trust of achieving top quartile performance in all areas was £89m; but noted that it would not be possible to achieve this everywhere.
- The impact of the Sustainability and Transformational Funding was discussed and it was noted that this would have an equal benefit across all areas, and would likely increase the profitability of services.
- The Committee discussed how the report could be used to target productivity and efficiency improvements into specific specialties, with an initial focus on the surgical specialties where the greatest benefit was perceived to be.

Savings Programme
The Committee noted the report, including the current position which was £1m adverse, and that given the expected timeline for delivery of the schemes was weighted towards the end of the financial year, the forecast outturn was expected to be delivered with a small deficit (£78k).

Capital Income and Expenditure Report

The Committee considered the report and discussed:

- The plan had been revised to reflect the additional public dividend capital received and the Board approved medium term financial plan. The revised plan was to spend £30m as opposed to the original plan of £47m.
- In considering the variation, the Committee sought assurance that the impact of the delays to capital schemes had been assessed and any impact would be monitored. It was confirmed that the Capital Planning Steering Group and Capital Planning Group oversaw the programme and monitored for any negative impact.

<u>The following were received for assurance:</u>

- Minutes of Capital Programme Steering Group
- Statement of Financial Position
- Quarterly Treasury Management Report
- Month 6 NHS Improvement Submission

Key risks and issues/matters of concern and any mitigating actions
None identified.
Matters requiring Committee level consideration and/or approval
None identified.
Matters referred to other Committees

Date of next meeting	27 November 2018