University Hospitals Bristol
NHS Foundation Trust

August 2018 Published Papers

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Quality and Performance Report

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University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

August 2018

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 86.0 % for June and 84.2% for Quarter 1. So the national standard of 85% was achieved in June but not for the quarter. However, the improvement trajectory of 82.5% was achieved for the quarter.
- The measure for percentage of A&E patients seen in less than 4 hours was 90.3% for July. This did not achieve the 95% national standard and is slightly below the improvement trajectory target of 90.53%. However, with the addition of Walk-In Centre data (as part of NHS England's "Trust Footprint" publication), UHBristol's A&E performance for July will deliver the trajectory. The Children's Hospital has sustained consistently good performance and exceeded the 95% standard in July, at 96.4%. The Bristol Royal Infirmary performance had risen to 84.8% in July.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.9% as at end of July. This did not achieve the national 92% standard. The improvement trajectory target for this measure has been set at 88.5% so this was achieved. The Trust was 895 patients away from the national compliance of 92%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of July was 97.9%, with 190 patients waiting 6+ weeks. This is lower than the national 99% standard. Also, the improvement trajectory of a maximum of 140 breaches was not met either. The maximum allowed breaches to achieve 99% was 90.

Headline Indicators

Performance against patient falls, pressure ulcers and patient experience remain above target. However there was one category 3 pressure ulcer this month which is subject to a full root cause analysis. For Trust-apportioned infections there were no MRSA cases and three c.difficile cases.

Last Minute Cancelled Operations (LMCs) were at 1.2% of elective activity and equated to 80 cases. However, there was only one breach of the 28 day standard (LMCs from last month had to be re-admitted within 28 days).

100% of patients with fractured neck of femur were seen by an ortho-geriatrician within 72 hours in July, which is also the fifth consecutive month the 90% requirement for this component of Best Practice Tariff has been achieved.

Workforce

Agency usage increased by 11.3 full time equivalents (FTEs) to 1.2%, with the largest increase seen in Medicine and the largest reduction was seen in Women's and Children's. The largest staff group increase was within Nursing & Midwifery. Bank usage increased by 12.0 FTEs to 5.2%.

Overall vacancies increased to 6.1% compared to 5.4% in the previous month with no reductions in any staff groups. The overall Admin and Clerical / Senior Managers vacancy position increased to 105.0 FTE from 83.2 FTE the previous month. Turnover reduced to 13.8% from 14.1% last month, with decreases across all but one division (Diagnostic & Therapies). The largest increase in staff group was seen within Healthcare Scientists (1.4 percentage points) and the biggest reduction in staff group was seen in Administrative and Clerical (1.3 percentage points).

Sickness absence increased from 3.4% to 3.9%, with increases in all divisions. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, this increased by 31.1% compared with last month.

July 2018 compliance for the Core Skills (mandatory/statutory) training remained static at 90% 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	84.0%	91.1%	92.8%	90.3% *								
	"Trust Footprint"	92.05%											
	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)	84.1%	82.4%	86.0%									
	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	88.2%	89.1%	88.6%	88.9%								
	Trajectory	88%	88%	88.5%	88.5%	88.7%	88.5%	88.5%	88.0%	87.0%	86.0%	87.0%	87.0%
6-week wait diagnostic Standard: 99%	Actual	96.8%	97.6%	97.8%	97.9%								
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

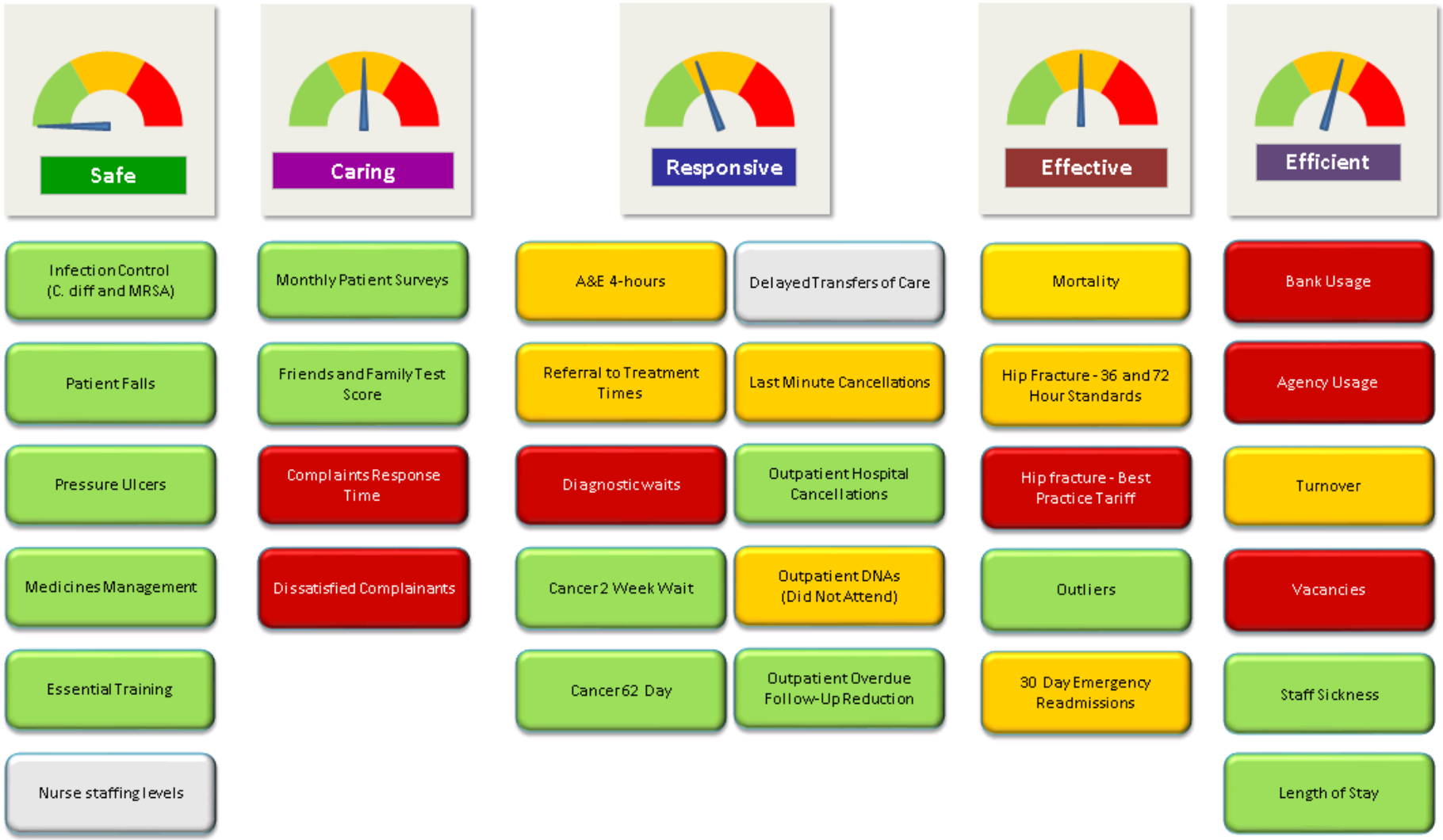
GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

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 July will deliver 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 (86%) and Two week wait first appointment standard for quarter 1 achieved and on track for quarter 2 • Referral To Treatment (RTT) Performance remains above recovery trajectory (88.9% for end of July against target of 88.5%) • The On-Hold revalidation project has achieved sign-off by the Intensive Support Team (24th July 2018) with no harm identified and any follow-up appointments required have been completed or are booked for on-going review • Emergency Department 4 Hour performance was at 90.3% for July, and with Walk-In Centre data, this will deliver the recovery trajectory. • Sleep Studies breaches of 6 week wait target have reduced (down from 70 to 12). • The Theatre "Start The Day" project is having a positive impact. From the survey of staff involved: 84% were aware of the project, 62% said it had a positive difference to their department and 67% said it had a positive difference to patient experience.	• Delivery of GP Cancer 62 Day recovery trajectory of 83% for July (currently at 84.4%) and deliver the national standard of 85% in August and maintain thereafter • Sustain A&E 4 hour performance, particularly at the Children's Hospital where an increase in attendances has occurred (9% Apr-Jul 2018 compared to 2017) • Ensuring all processes are in place to report against the amended national rules for cancer performance • Monitoring of on-hold at the weekly Performance Meeting and continue working with our PAS provider to prevent reoccurrence • Ensure effective winter planning for 2018/19. Weekly meetings are now in place for each Wednesday. • Work with our commissioners to continue the review of the local patient access policy, to agree standards for levels of patient choice and cancellation. • Commence review of booking practices in Children's services and review theatre slot utilisation • Re-enforce the repatriation policy with Weston Hospital; for emergency patients who would have been seen at Weston's ED overnight.
	Opportunities	**Risks and Threats**
ACCESS	• Introduce new cancer performance management framework (due October 2018), ensuring greater focus on outcomes and better integration with other Trusts. Finance approval received for new "breach busting" role to support this process. Expressions of Interest (EoIs) published on 23rd Aug. • Opportunity to improve cancer performance with new national rules for allocation of performance between providers ("breach busting") • Pilot launch of Laparoscopic surgery in South Bristol Community Hospital from 10th September 2018. • Launch of Virtual Fracture clinic in June 2018 to improve patient flow and experience through orthopaedic services. Impact to be assessed. • Cataract Services are piloting the booking of patients directly from the pre-op appointment, starting August 2018 with plan of directly booking 260 per week. Reviewing the opportunity for a one-stop service from October. • Fixed Surgical Bronze role to support ED has been agreed; induction planned with consultants, Clinical Site Managers (CSMs) and matrons.	• Volume of predicted breaches of the 6 Week Diagnostic Wait for Echocardiographies remains above tolerance (100 breaches predicted). • Ongoing concern regarding chemotherapy capacity provision due to nursing vacancy and recruitment issues. • Ongoing pressures at North Bristol ED resulting in requests for diverts. • Rising demand in Dermatology is causing pressures in service delivery (division are reporting an 11% increase in 2018/19 referrals). Commissioners are sighted on this increase, discussions ongoing. • 52 week breaches did not achieve the target of ZERO for end of July. The Trust report 11 breaches due to a high level of patient cancellation, patient choice and an element of re-validation particularly in Children Services. • Without an agreed re-work of the local access policy to support the high level of cancellation/patient choice achieving no long waiting patients would be extremely difficult to achieve

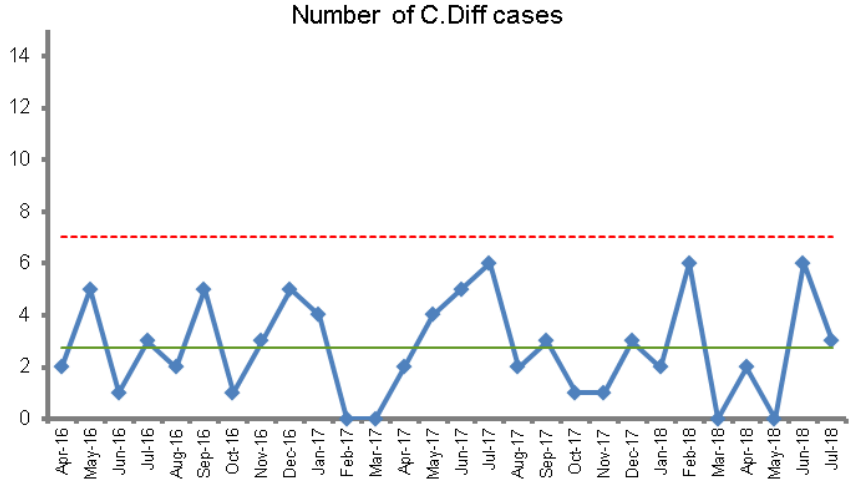
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

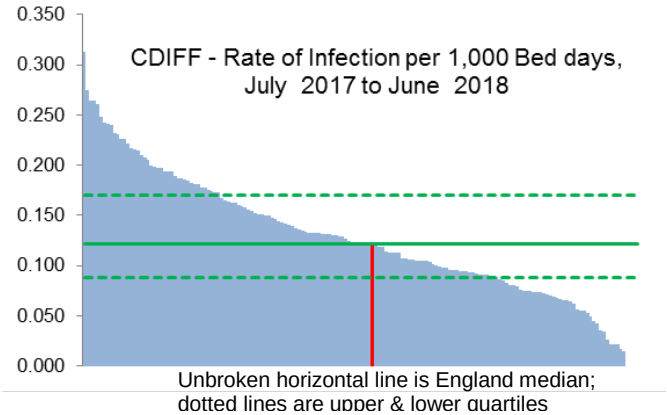
	Successes	Priorities
QUALITY	• 100% of patients with fractured neck of femur were seen by an ortho-geriatrician within 72 hours in July, which is also the fifth consecutive month the 90% requirement for this component of Best Practice Tariff has been achieved. • In-patient screening for sepsis is 100%, data is now taken from the e-observations system. Whilst antibiotic administration within an hour is 33%, this represents one out of three in-patients. The next version of the e-observations system, likely to be implemented by October 2018, will include more prompts for Sepsis 6. Reassuringly, the latest Intensive Care national Audit and Research Centre (ICNARC) data for the 12 months to June 2018 shows that our patients with sepsis are being transferred and treated in ITU promptly compare to other hospitals with similar ITUs and have less organ failure as a result.	• Maternity FFT coverage remains below the green threshold, however there are two additional pieces of patient experience work planned in maternity: a 15-steps challenge using the NHS 15-steps model for maternity and a focussed piece of work 'Patient Experience at Heart' in November.
	Opportunities	**Risks and Threats**
QUALITY	• Although the Trust SHMI is 101.7, it is still in the "SHMI As Expected" category. The Learning from Deaths process is well embedded within the Trust and the Board received the 2017/18 annual mortality report in July detailing that none of the deaths reviewed under this process showed strong evidence of avoidability. As part of the West of England Patient Safety Collaborative, we are participating in a system-wide work stream regarding earlier conversations with patients in the last years of their lives to avoid patients at the end of life being brought to hospital rather than dying in their preferred circumstances. • The Trust's performance in responding to complaints via formal resolution within a timescale agreed with the complainant was 83% in July, below the amber threshold. Starting on 2nd August 2018, Clinical Quality Group started receiving a monthly report providing details of all breaches and causes to identify learning.	• Only 45% of patients with fractured neck of femur qualified for best practice tariff. Whilst the figure of 45% is within the upper and lower confidence limits, the upper confidence limit at 88% is below the 90% best practice tariff target, suggesting the system as it stood was not capable of meeting the target. However, there is a significant piece of transformation work within the Trust on improving theatre efficiency which has so far achieved 85% of theatres starting earlier and on time.

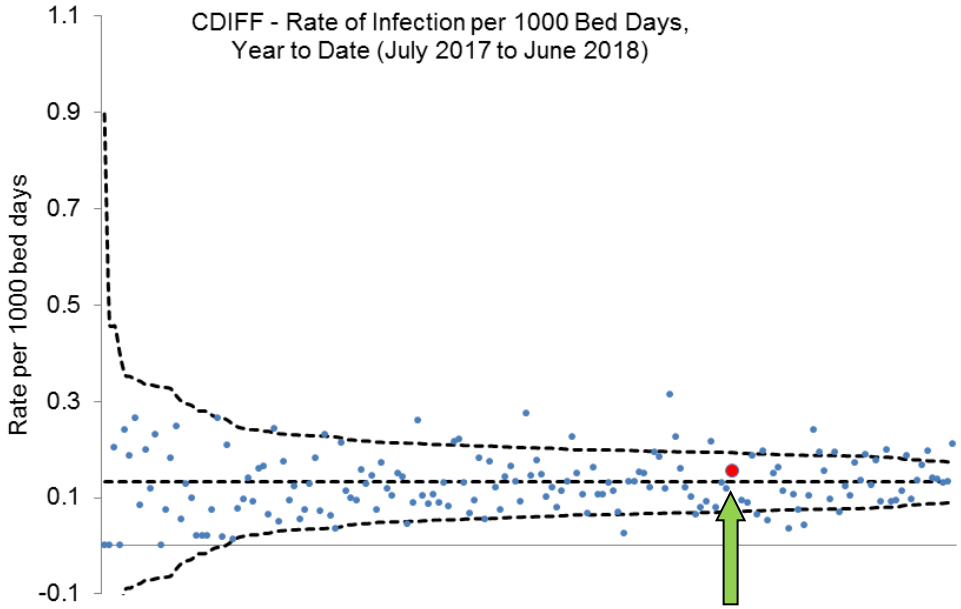
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	• **Successes**	• **Priorities**
WORKFORCE	• Based on the 11 Core Skills, 90% overall compliance for the third consecutive month has been achieved. Compliance for other Essential Training programmes also remains at 93% overall, with CORPAK NG Tube eLearning making another large 7% gain. • Overall YTD sickness rate low for first 4 months of the year. • A cohesive wellbeing menu has been developed and launched across the organisation, reflecting staff support for physical and psychological wellbeing. • Response rate to exit questionnaires continues to reach 50% target. • Monthly reporting for Divisions on responses to the Happy App commenced in July.	• The Rostering & eJob Planning system is being configured which requires significant amounts of data collection & input. This work needs concluding before roll out can commence. • Flu Campaign 2018; achievement of the 75% CQUIN target for immunising all front line staff must be achieved in order to deliver £190k of CQUIN monies. • Ongoing development of a medical recruitment website to support marketing and attraction plans.
	Opportunities	**Risks and Threats**
WORKFORCE	• Electronic Staff Survey commences in September. It is anticipated this methodology will increase return rates. • The 2018 pay award has been applied to Bank rates, more closely harmonizing pay rates with NBTs Bank rates, supporting the vision of longer term collaboration. • External training session to implement a support programme for apprentices with learning needs.	• There were 3 minor reductions of 1% each; Fire Safety reduced to 87% from 88%, Information Governance reduced to 85% from 86%, and Preventing Radicalisation reduced to 91% from 92%. Clinical pressures may have significant impact, especially on two programmes requiring annual updates - Fire and Information Governance. • Lowest unemployment levels for 43 years are making recruitment to A&C and Ancillary roles challenging. • There remains a significant risk that junior doctors are continuing to work hours in excess of their contract because of the manual systems in place for locum management and exception reporting.

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 three trust apportioned C.Diff cases in July 2018, giving 11 cases year-to-date. This is below the year-to-date trajectory of 15 cases
Commentary:	The Trust performed well in this area in 2017/8 and in the 12 months August 2017 to July 2018 the rate of C. Difficile Infection per 1,000 bed days is low, remaining below the benchmark value. There were three cases of C. Difficile identified in July 2018 that require review with our commissioners before determining if any of these are Trust apportioned. Once reviewed in August, if any are deemed attributable to the Trust then any outstanding appropriate actions will be implemented.
Ownership:	Chief Nurse



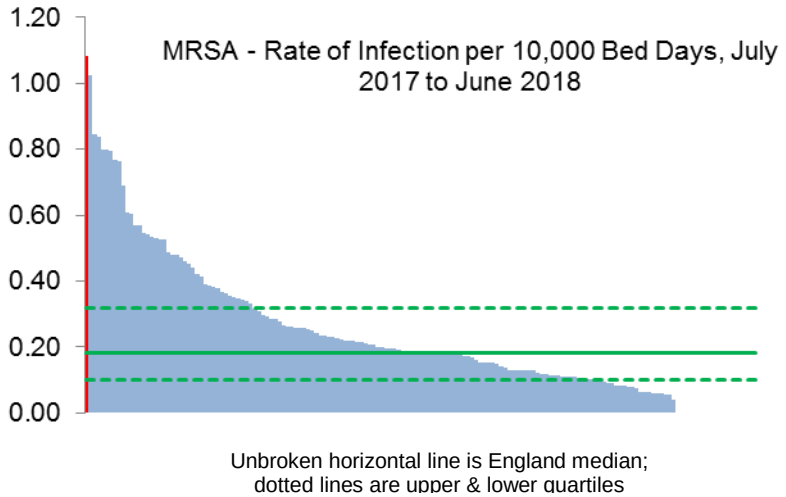




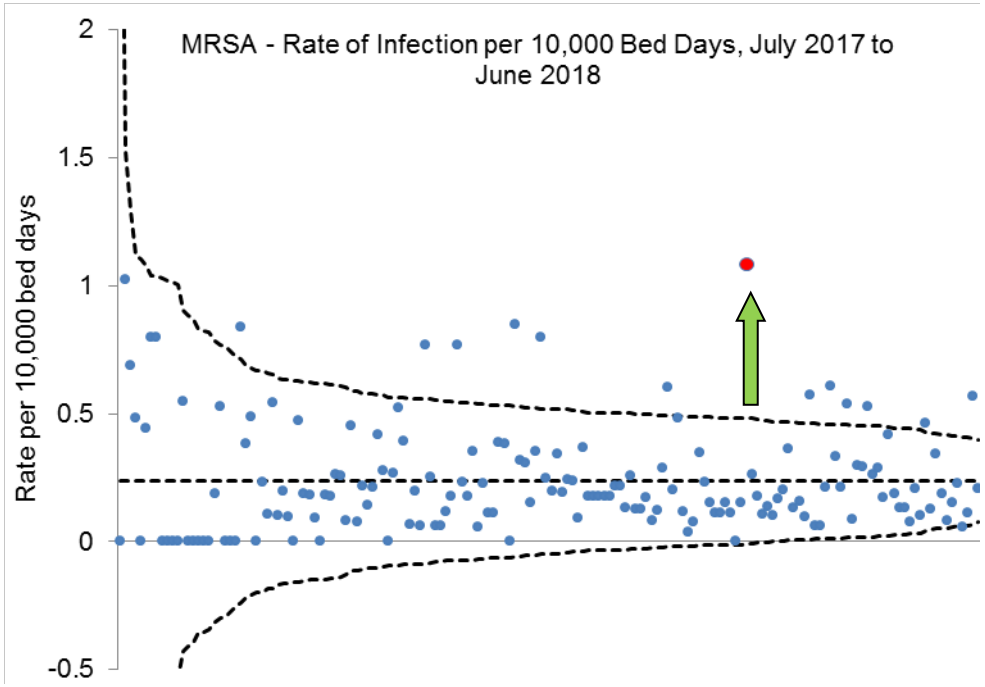
CDIFF Cases	Jul-18	2018/2019
Medicine	0	1
Specialised Services	2	5
Surgery	0	2
Women's and Children's	1	3
Grand Total	0	0

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There were no trust apportioned MRSA cases in July, making three cases year-to-date.
Commentary:	Whilst there were no MRSA Trust apportioned cases in July, we are undertaking a review of cannula related blood stream infections and plan some focussed work where practice has deviated from standards. The e-observations system is helping to make visible to senior nursing staff in real time where cannulae have been in place longer than expected to support this work. There is ongoing training and reporting mechanisms are continuously being reviewed to ensure any learning is identified and shared accordingly. There is also some system-wide discussion about working together to reduce the incidence MRSA in Bristol.
Ownership:	Chief Nurse

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

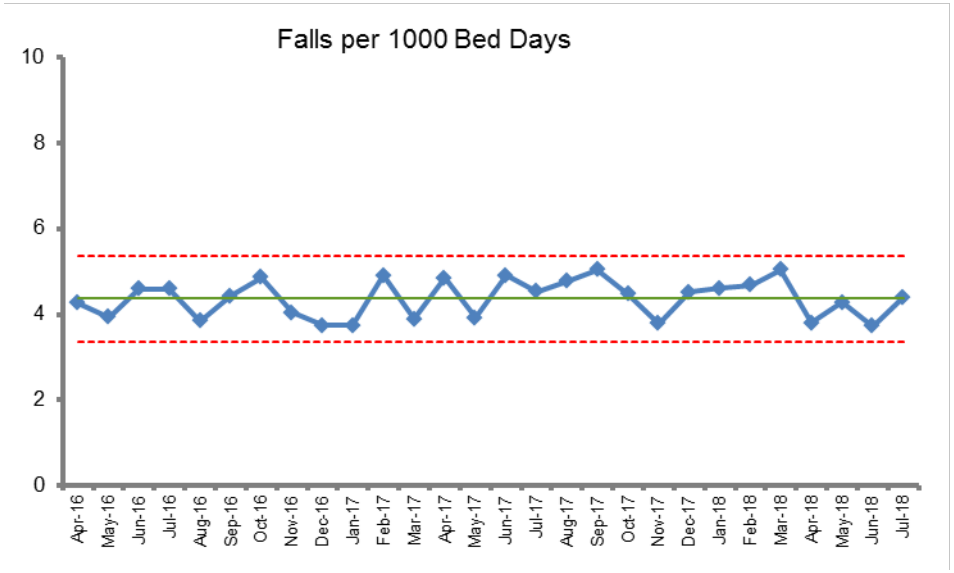


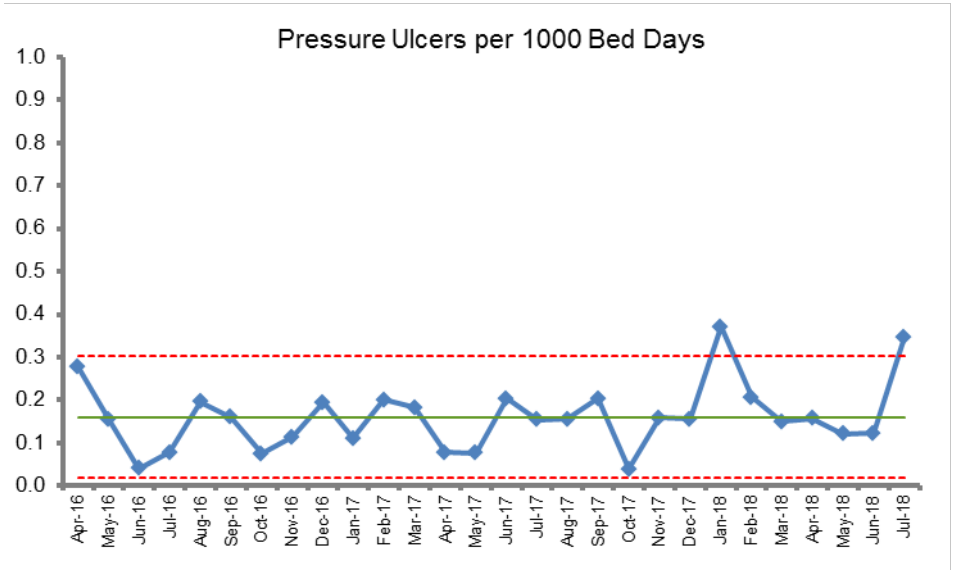
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles



2.1 PERFORMANCE – Safe Domain

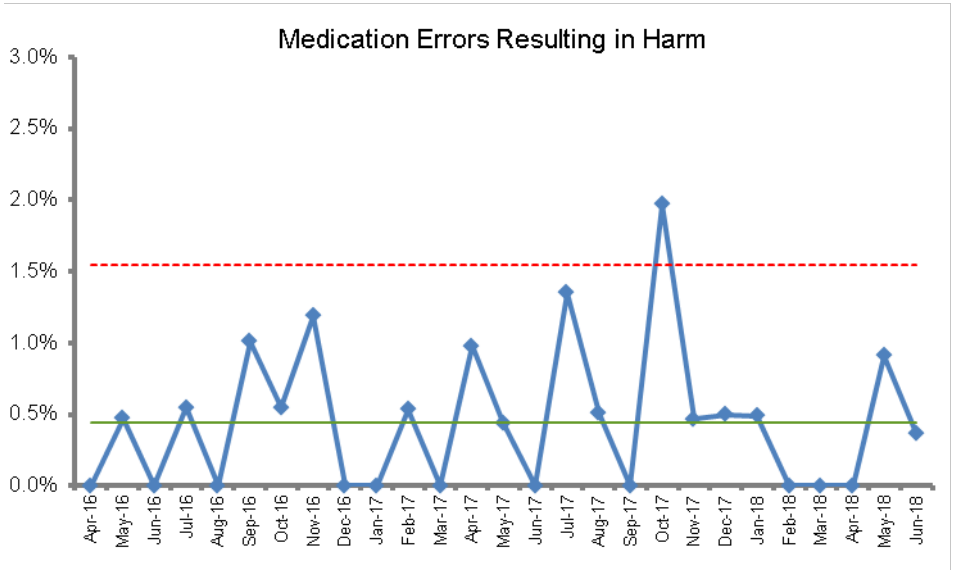
Patient Falls and Pressure Ulcers	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above) Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Falls rate for July was 4.40 per 1,000 beddays. This was 114 Falls with one resulting in harm. Pressure Ulcers rate for July was 0.35 per 1,000 beddays. There were nine Pressure Ulcers in July, with one at Grades 3 or 4.
Commentary:	The overall number of falls per 1,000 bed days and falls with harm remains below the green threshold and within the upper and lower confidence limits. The aim of the 18/19 work plan is to see an overall reduction in the number of falls and falls with harm by delivering a number of practice and education and training related objectives. Incidence of category 2-4 pressure ulcers for July remains below the green threshold overall, but the figure of nine for July is outside the upper confidence limit. Disappointingly there was one new category 3 pressure ulcer which is subject to a full root cause analysis investigation. All category 2 pressure ulcers are reviewed to identify whether additional preventable measures could have been deployed and any learning shared. Pressure ulcer prevention and reduction work 18/19 focuses on our ambition to reduce pressure ulcers category 1-3 across the organisation, focusing on high reporting areas and delivering a number of practice and training related objectives.
Ownership:	Chief Nurse

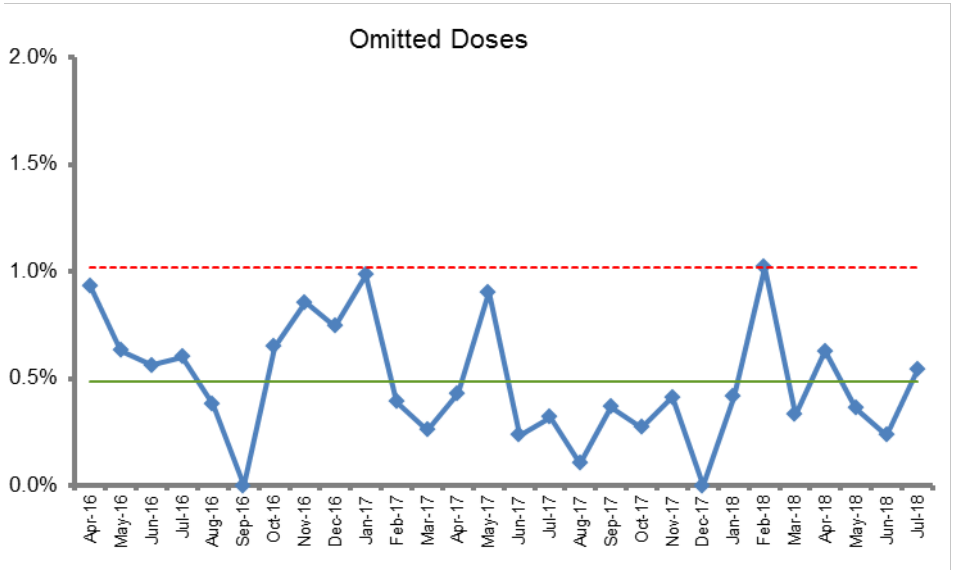




2.1 PERFORMANCE – Safe Domain

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:	0.37% of medication errors in June resulted in harm (1 error out of 273 cases reviewed). Omitted doses were at 0.54% in July (3 cases out of 554 reviewed).
Commentary:	**Errors Resulting in Harm**. In July this was below our internal limit of 0.5% with one reported incident in July, and the ratio of harm: no harm medication incidents remains below the national target figure of 0.14. These incidents are reviewed monthly by the pharmacy department and risk management leads for the Divisions and bi-monthly by the Medicines Governance Group; with actions for the Divisions as appropriate. **Omitted Doses**. This measure is currently in two parts with the majority of wards subject to previous data sampling of paper drug charts, but our Electronic Prescribing and Medicines Administration (EPMA) has been implemented in adult cardiology wards which uses a different methodology for measuring non-purposeful omitted critical medication. The figure for July from sampling paper drug charts is slightly above our internally set stretch limit of 0.5% at 0.54%, but below the green threshold of 0.75% and within the upper and lower confidence limits. The figure for cardiology areas using Medway EPMA is derived from real time data, but 'Critical' medicines cannot be immediately identified in Medway, only through Business Intelligence reporting. This measure is new for the Trust so no internal benchmark has been set; and there is no current gauge for a national benchmark figure. The calculated figure is the omitted medicines due to for no stock being available at the time. This can be investigated to patient level to review stock medication on wards or the availability of these medicines out-of-hours though emergency drug cupboards etc. Administrations that are later than the prescribed time can also be measured from EPMA which is an additional benefit.
Ownership:	Medical Director





2.1 PERFORMANCE – Safe Domain

Essential Training	
Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%
Performance:	In July Essential Training overall compliance remained static at 90% compared with the previous month (excluding Child Protection Level 3).
Commentary:	July 2018 compliance for the Core Skills (mandatory/statutory) training remained static at 90% overall across the eleven core skills programmes. There were 3 reductions: Fire Safety reducing to 87% from 88%, Information Governance reducing to 85% from 86%, and Preventing Radicalisation reducing to 91% from 92%. There were two increases: Conflict Resolution increasing to 95% from 94% and Resuscitation increasing to 87% from 86%. Compliance for all other Essential Training remained static at 93% compared to the previous month.
Ownership:	Director of People

Essential Training	Jul-18	KPI
Conflict Resolution Training	95%	90%
Equality, Diversity and Human Rights	92%	90%
Fire Safety	87%	90%
Health, Safety and Welfare (formerly Health & Safety)	94%	90%
Infection Prevention & Control	94%	90%
Information Governance	85%	95%
Moving and Handling (formerly Manual Handling)	82%	90%
Preventing Radicalisation	91%	90%
Resuscitation	87%	90%
Safeguarding Adults	90%	90%
Safeguarding Children	90%	90%

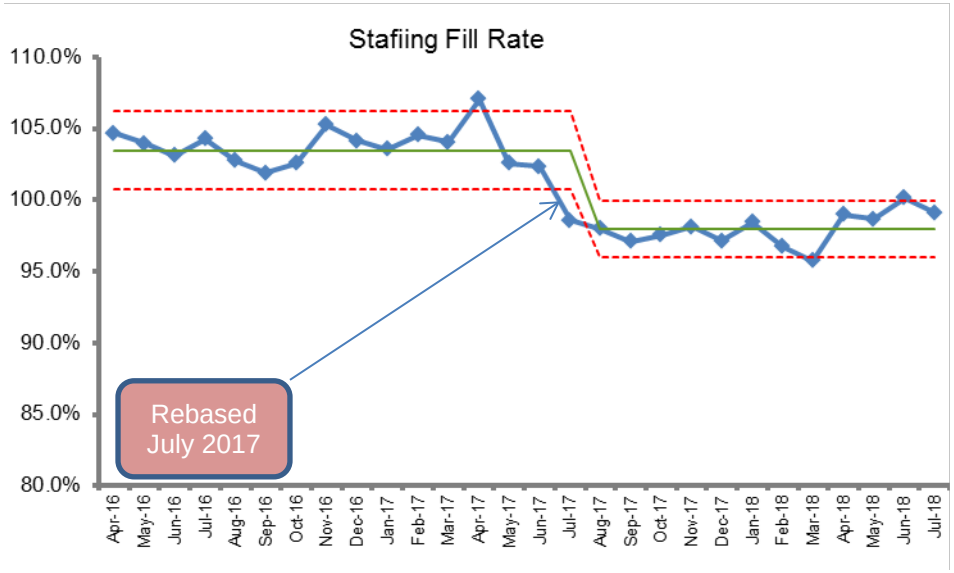
Essential Training	Jul-18	KPI
UHBristol NHS Foundation Trust	90%	90%
Diagnostics & Therapies	90%	90%
Facilities & Estates	91%	90%
Medicine	89%	90%
Specialised Services	90%	90%
Surgery	89%	90%
Trust Services	91%	90%
Women's & Children's	89%	90%

2.1 PERFORMANCE – Safe Domain

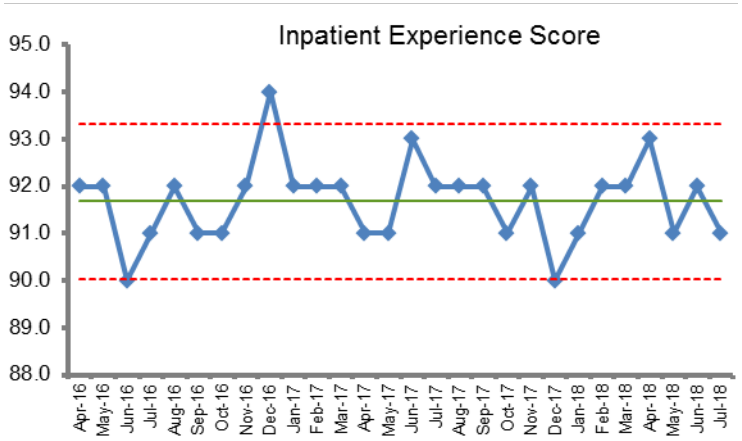
Nursing Staffing Levels	
Standards:	Staffing Fill Rate is the total hours worked divided by total hours planned. A figure over 100% indicates more hours worked than planned. No target agreed
Performance:	July's overall staffing level was at 99.1% (236,139 hours worked against 238,258 planned). Registered Nursing (RN) level was at 94.2% and Nursing Assistant (NA) level was at 111.5 %
Commentary:	Overall for the month of July 2018, the trust had 94% cover for RN's on days and 95% RN cover for nights. The unregistered staffing level of 105% for days and 120% for nights reflects the activity seen in July 2018. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell adult patients, particularly at night.
Ownership:	Chief Nurse

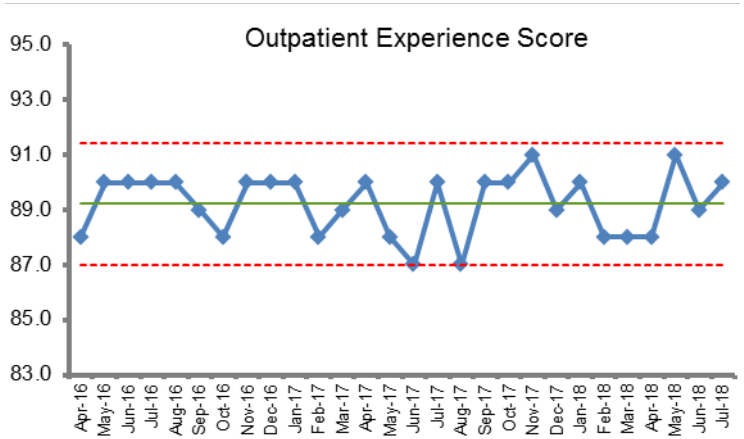
	Day	Night	TOTAL
Registered Nurses	93.5%	95.1%	94.2%
Nursing Assistants	105.3%	120.2%	111.5%
TOTAL	**97.0%**	**101.7%**	**99.1%**

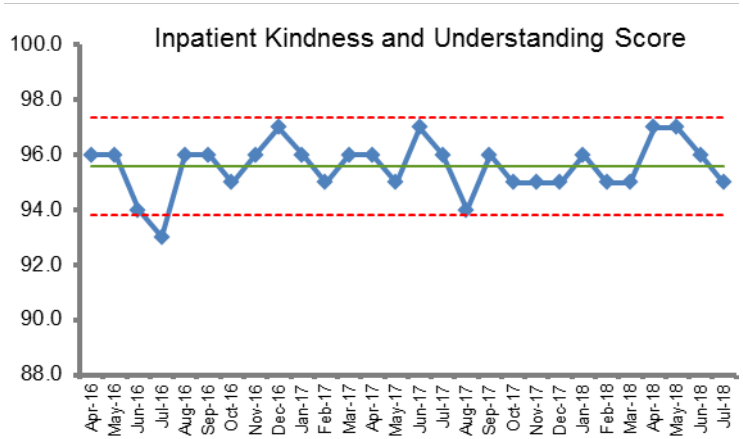
Medicine	110.4%
Specialised Services	101.6%
Surgery	99.4%
Women's and Children's	89.8%
TOTAL	**99.1%**



Monthly Patient Survey	
Standards:	For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over.
Performance:	For July 2018, the inpatient score was 91/100, for outpatients it was 90. For the kindness and understanding question it was 95.
Commentary:	The headline measures from these surveys remained above their minimum target levels in July 2018 and within the upper and lower confidence limits, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse

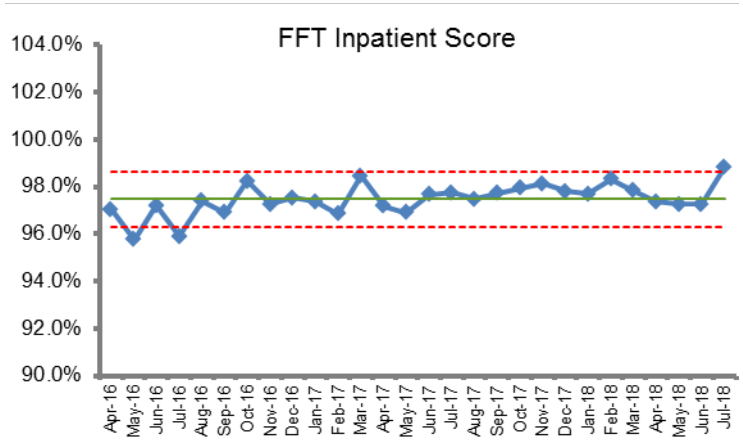


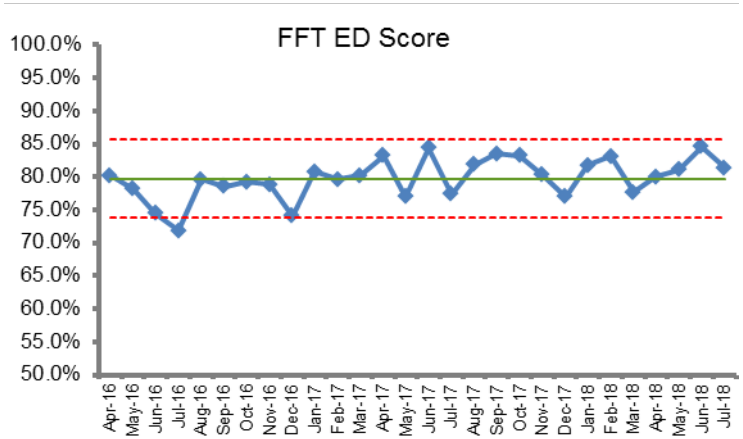


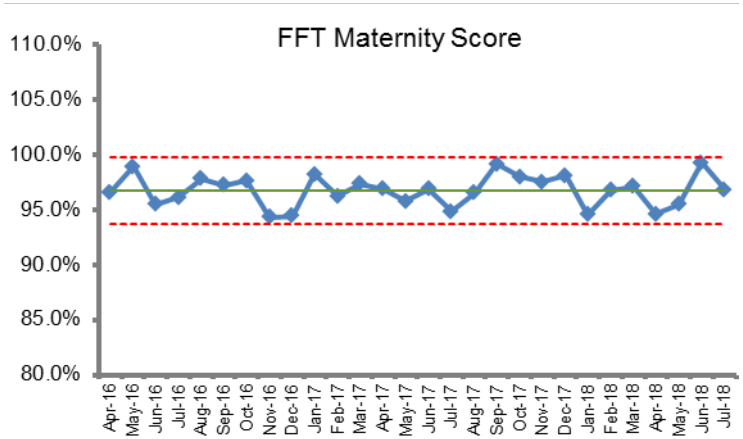


2.2 PERFORMANCE – Caring Domain

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:	July's FFT score for Inpatient services was 98.8% (2287 out of 2314 surveyed). The ED score was 81.4% (1269 out of 1559 surveyed). The maternity score was 96.8% (184 out of 190 surveyed).
Commentary:	The Trust's scores on the Friends and Family Test were above the green thresholds and within the upper and lower confidence limits in July 2018. Maternity FFT coverage remains below the green threshold, however there are two additional pieces of patient experience work planned in maternity: a 15-steps challenge using the NHS model for maternity and a focussed piece of work 'Patient Experience at Heart' in November.
Ownership:	Chief Nurse



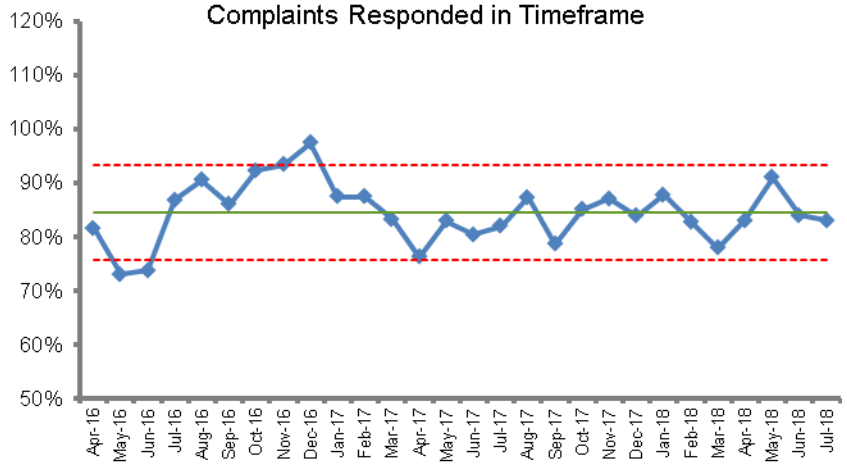


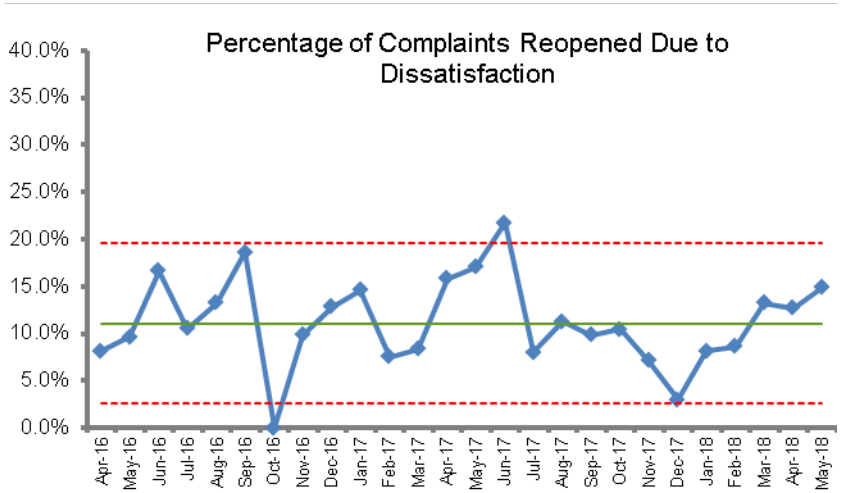


	Response Rate		Score	
	Jul-18	2018/2019	Jul-18	2018/2019
Inpatients				
Medicine	35.8%	38.9%	98.4%	97.0%
Surgery	34.4%	36.2%	98.7%	98.2%
Specialised Services	42.9%	33.9%	98.5%	97.0%
Women's and Children's	33.7%	37.4%	99.8%	97.8%
TOTAL	**35.6%**	**36.8%**	**98.8%**	**97.7%**
Emergency Department				
Bristol Royal Infirmary	11.3%	11.7%	64.6%	66.5%
Children's Hospital	19.6%	20.9%	85.5%	85.3%
Eye Hospital	26.6%	24.2%	92.1%	92.4%
TOTAL	**17.3%**	**17.5%**	**81.4%**	**81.8%**
Maternity				
TOTAL	**14.0%**	**14.6%**	**96.8%**	**96.2%**

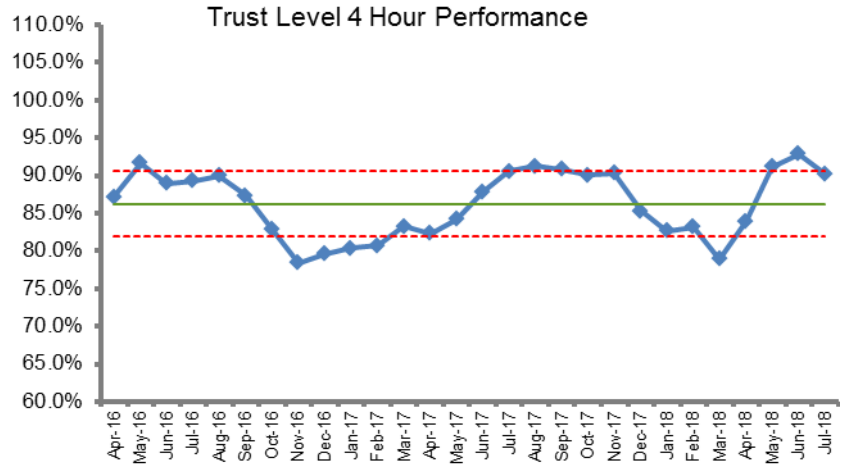
2.2 PERFORMANCE – Caring Domain

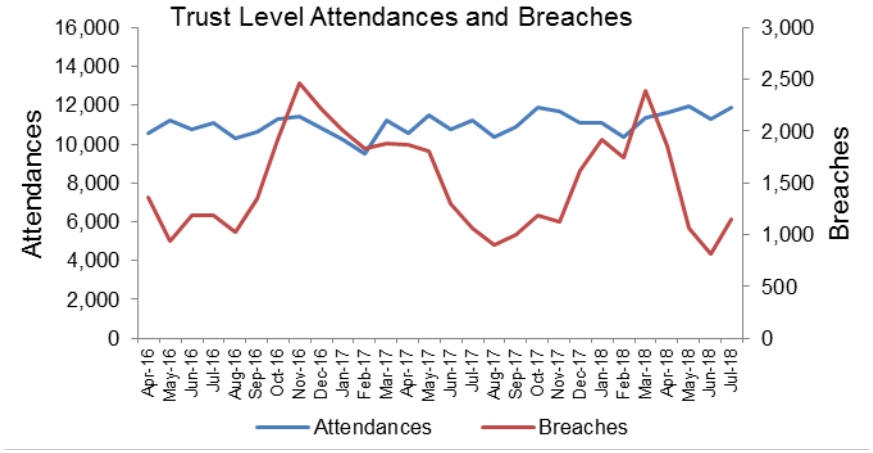
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe. Of all formal complaints responded to, less than 5% should be re-opened because complainant is dissatisfied.
Performance:	In June, 63 out of 75 formal complaints were responded to with timeframe (84.0%) Of the 71 formal complaints responded to in April, 9 resulted in the complainant being dissatisfied with the response (12.9%)
Commentary:	The rate of dissatisfied complaints increased to 14.9% in May, below the amber threshold and within the upper and lower confidence limits. This represents ten cases from the 67 responses sent out in May. The Trust's performance in responding to complaints via formal resolution within a timescale agreed with the complainant was 83% in July, below the amber threshold and within the upper and lower confidence limits. This represents nine breaches from the 53 responses sent out in July. Starting on 2nd August 2018, Clinical Quality Group started receiving a monthly report providing details of all breaches and causes to identify learning.
Ownership:	Chief Nurse

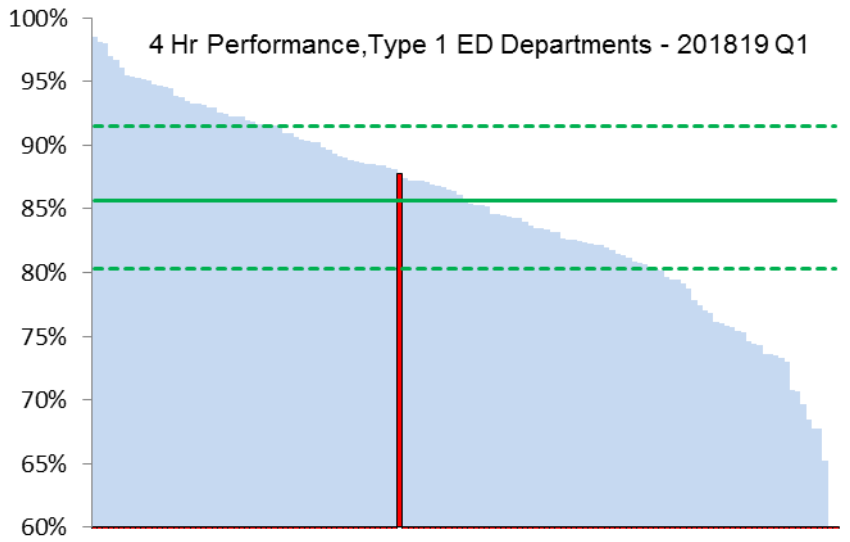




Emergency Department 4 Hour Wait	
Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. The Trust's improvement trajectory is 90.53% for July
Performance:	Trust level performance for July was 90.26% (11863 attendances and 1155 patients waiting over 4 hours).
Commentary:	Performance at the Children's Hospital remained above 95% in July, with 96.4% performance. This is alongside a 9% rise in attendances (Apr-Jul 2018 vs Apr-Jul 2017). The Bristol Royal Infirmary achieved 84.8%. With the addition of local Walk-In Centre (WIC) data, Trust performance will exceed the recovery trajectory of 90.53% in July.
Ownership:	Chief Operating Officer



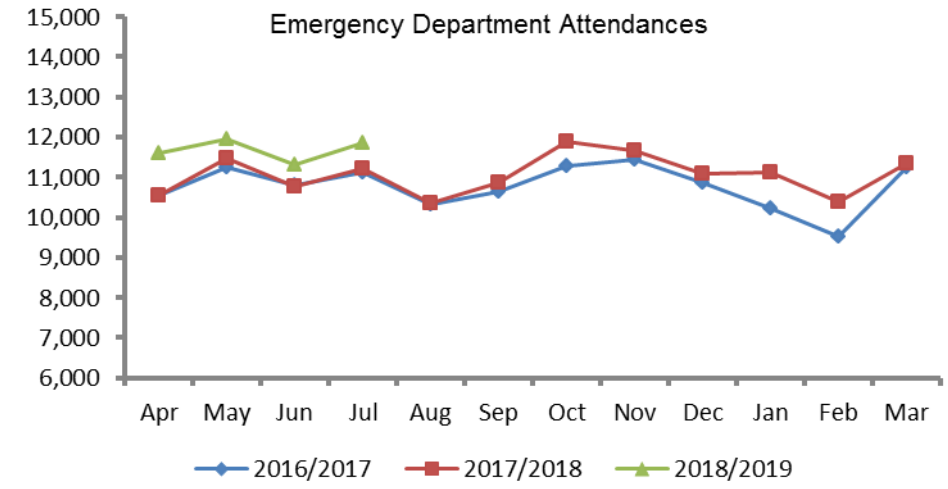


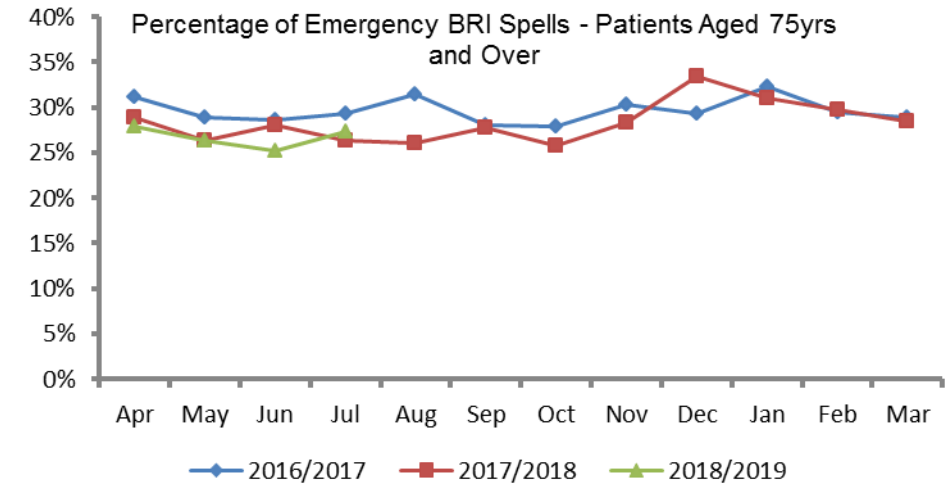


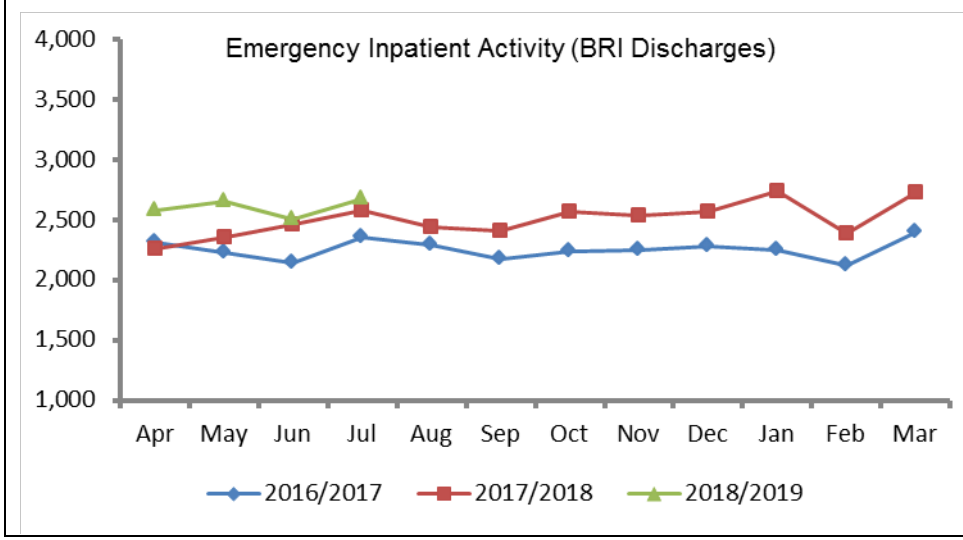
Unbroken horizontal line is England median;
dotted lines are upper & lower quartiles

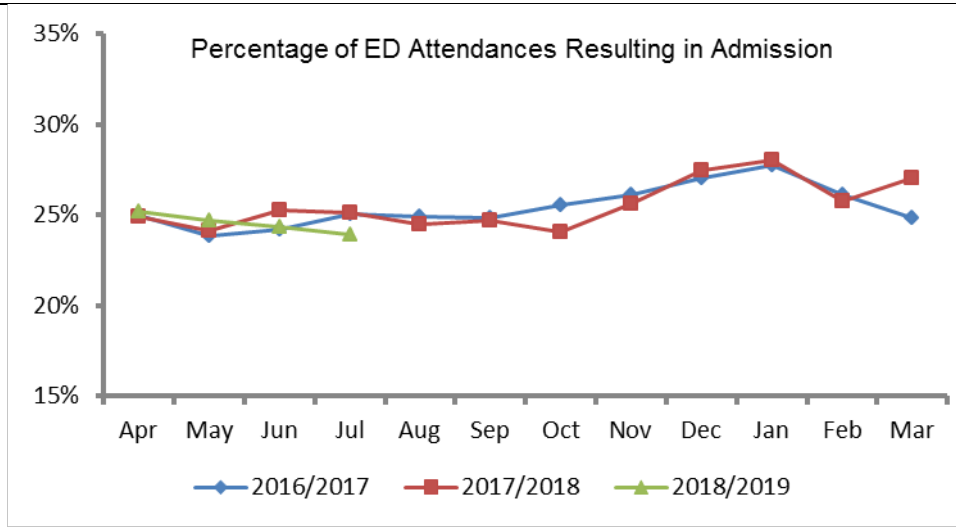
	Attendances		Under 4 Hours		Performance	
	Jul-18	2018/2019	Jul-18	2018/2019	Jul-18	2018/2019
BRI	6239	23980	5291	19983	84.81%	83.33%
Trust	11863	46714	10708	41830	90.26%	89.54%

2.3 PERFORMANCE – Responsive Domain



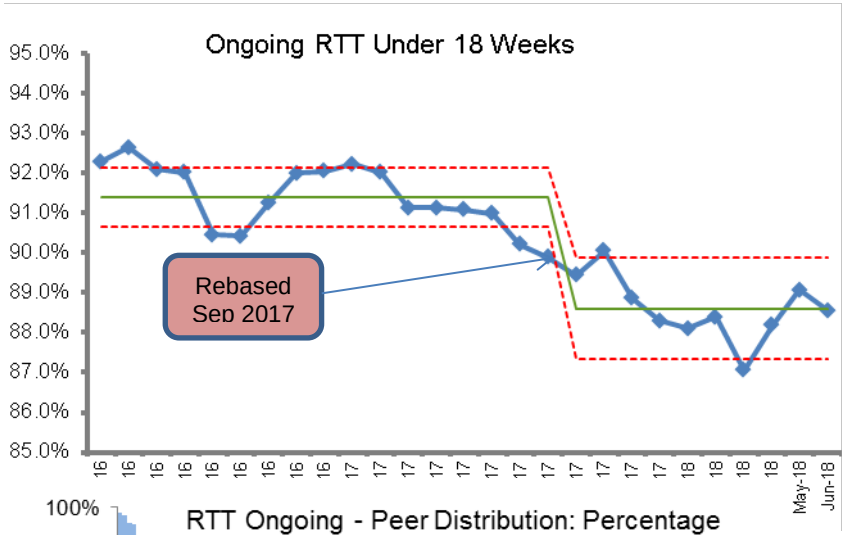


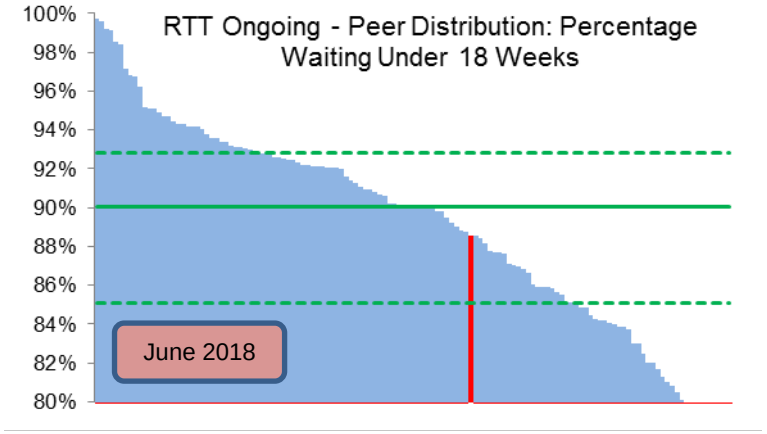




2.3 PERFORMANCE – Responsive Domain

Referral to Treatment (RTT)	
Standards:	At each month-end, we report 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 July, 88.9% of patients were waiting under 18 week (25,708 out of 28,916 patients). 11 patients were waiting 52+ weeks
Commentary:	The 92% national standard was not met at the end of July, with performance at 88.9%. However, this was above the recovery trajectory target of 88.5%. Early sight for August is holding at 89%. There were 11 patients waiting 52+ weeks at end of July due to high levels of patient cancellation and patient choice,
Ownership:	Chief Operating Officer

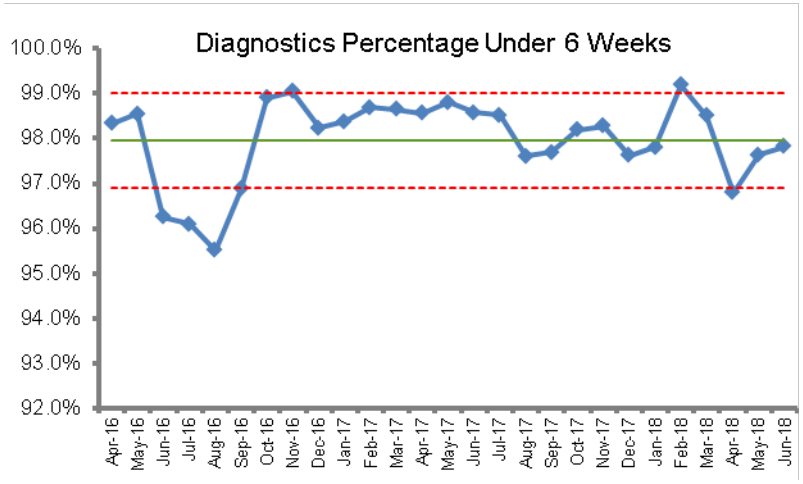


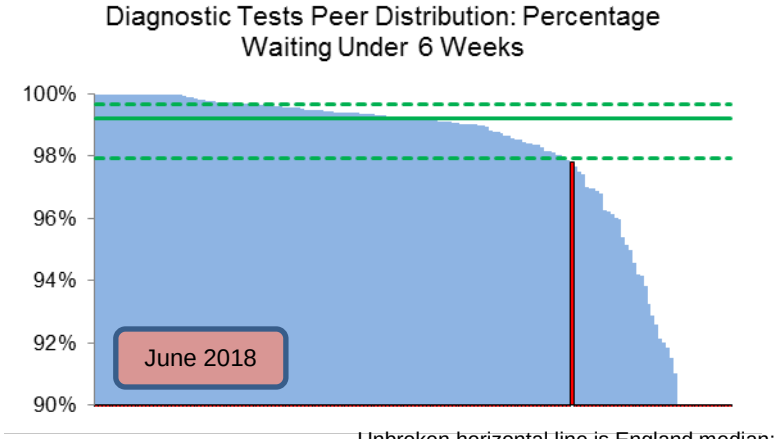


Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,011	329	83.6%
Cardiothoracic Surgery	298	48	83.9%
Dermatology	2,384	153	93.6%
ENT	2,096	92	95.6%
Gastroenterology	605	2	99.7%
General Medicine	18	0	100.0%
Geriatric Medicine	61	2	96.7%
Gynaecology	1,223	131	89.3%
Neurology	375	148	60.5%
Ophthalmology	4,451	408	90.8%
Oral Surgery	2,806	297	89.4%
Other (Clinical Genetics)	1,253	181	85.6%
Other (Dental)	2,147	184	91.4%
Other (General Surgery)	1,273	267	79.0%
Other (Haem/Onc)	136	1	99.3%
Other (Medicine)	640	64	90.0%
Other (Other)	439	6	98.6%
Other (Paediatric)	5,278	919	82.6%
Other (Pain Relief)	138	0	100.0%
Other (Thoracic Surgery)	125	25	80.0%
Plastic Surgery	1	0	100.0%
Rheumatology	482	28	94.2%
Thoracic Medicine	558	11	98.0%
Trauma & Orthopaedics	705	81	88.5%
TOTAL	**29,503**	**3,377**	**88.6%**

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 July, 97.9% of patients were waiting under 6 weeks (8,758 out of 8,948 patients). There were 190 breaches of the 6-week standard.
Commentary:	The Trust did not achieve the 99% national standard at end of July and was 50 patients above the recovery trajectory of having fewer than 190 breaches. The Trust needed fewer than 90 breaches to achieve the 99% standard. The areas carrying the largest volume of breaches are Paediatric MRI and Echocardiography..
Ownership:	Chief Operating Officer





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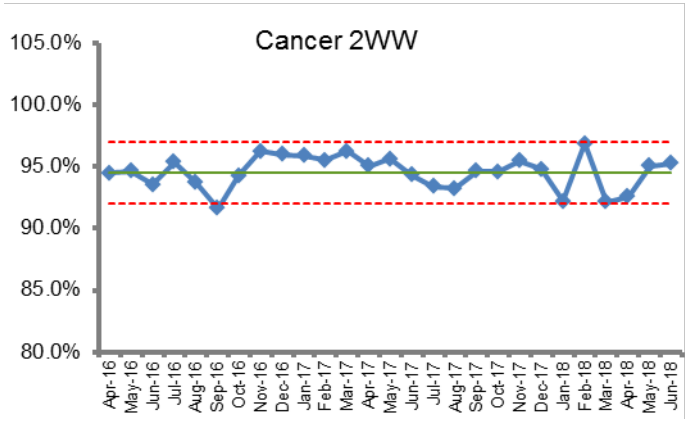
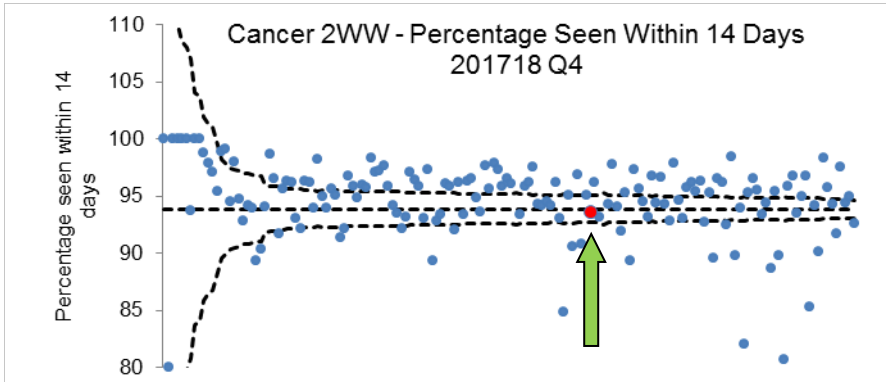
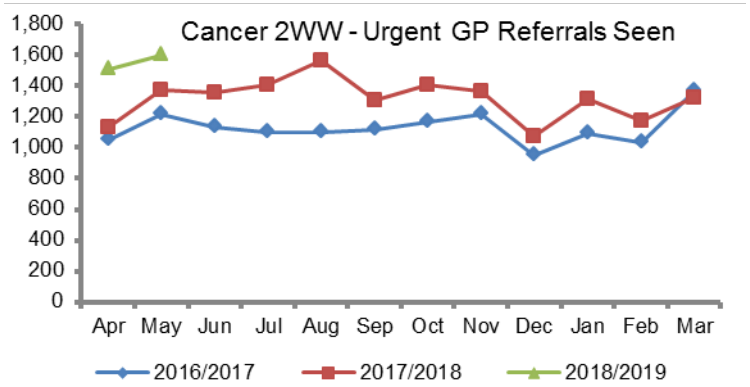
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	1,244	0	1,244	100.0%
Colonoscopy	159	2	161	98.8%
CT	999	6	1,005	99.4%
Cystoscopy	5	0	5	100.0%
DEXA Scan	342	0	342	100.0%
Echocardiography	929	93	1,022	90.9%
Flexi Sigmoidoscopy	42	0	42	100.0%
Gastroscopy	181	4	185	97.8%
MRI	1,949	73	2,022	96.4%
Neurophysiology	200	0	200	100.0%
Sleep Studies	132	12	144	91.7%
Ultrasound	2,576	0	2,576	100.0%
Grand Total	**8,758**	**190**	**8,948**	**97.9%**

2.3 PERFORMANCE – Responsive Domain

Cancer Waiting Times – 2WW	
Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that each Trust should achieve at least 93%
Performance:	For June, 95.3% of patients were seen within 2 weeks (1488 out of 1562 patients). Quarter 1 overall achieved 94.3%. Both the month and quarter-have achieved the national standard.
Commentary:	The standard was achieved in quarter 1 2018/19 and is comfortably on track for quarter 2.
Ownership:	Chief Operating Officer



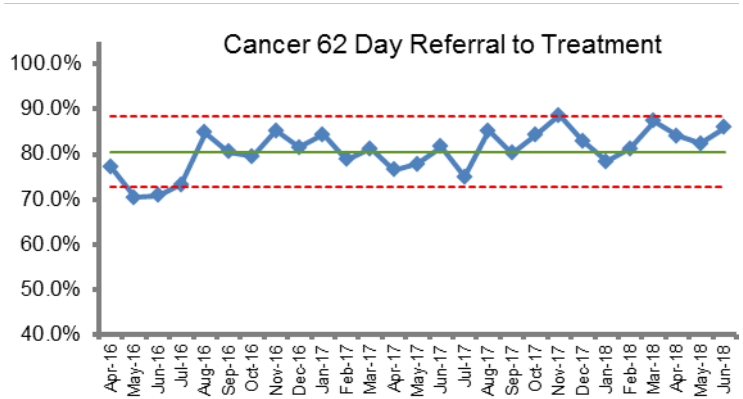


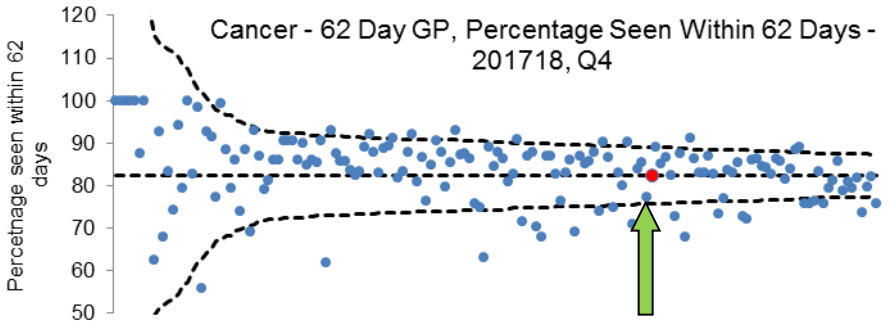


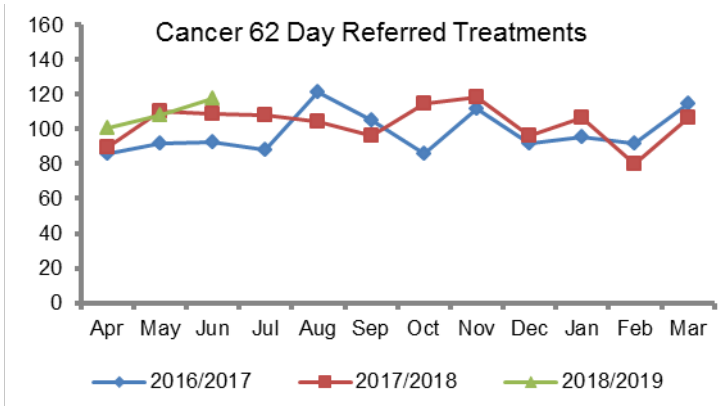
	Cancer 2WW - Jun-18		
Cancer Site	Under 2 Weeks	Total Pathways	Percentage
Sarcoma	0	0	
Suspected children's cancer	72	81	88.9%
Suspected gynaecological cancers	255	264	96.6%
Suspected haematological malignancies excluding ac	27	27	100.0%
Suspected head and neck cancers	1,203	1,218	98.8%
Suspected lower gastrointestinal cancers	465	495	93.9%
Suspected lung cancer	84	87	96.6%
Suspected skin cancers	2,058	2,184	94.2%
Suspected upper gastrointestinal cancers	291	318	91.5%
Grand Total	4,465	4,687	95.3%

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 June, 86.0% of patients were seen within 62 days (101 out of 117.5 patients). The quarter-finished at 84.2%.
Commentary:	June exceeded the trajectory and met the national standard. July is on track to achieve the trajectory. National standard to be recovered by August 2018 and sustained thereafter.
Ownership:	Chief Operating Officer



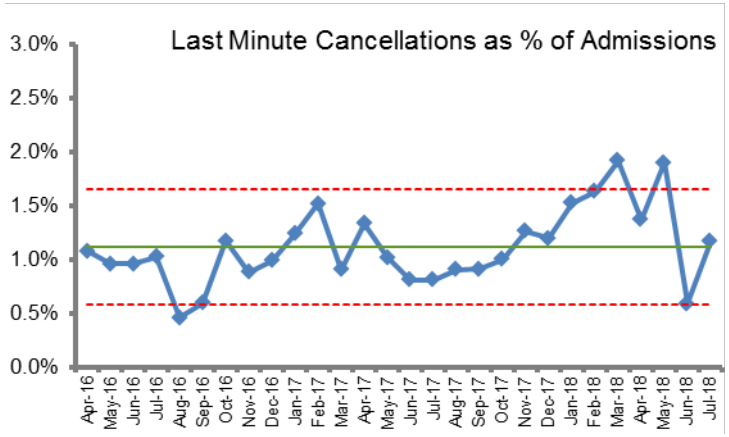


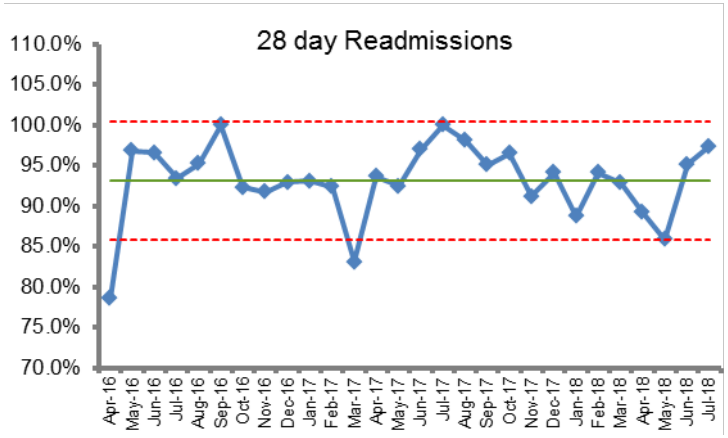


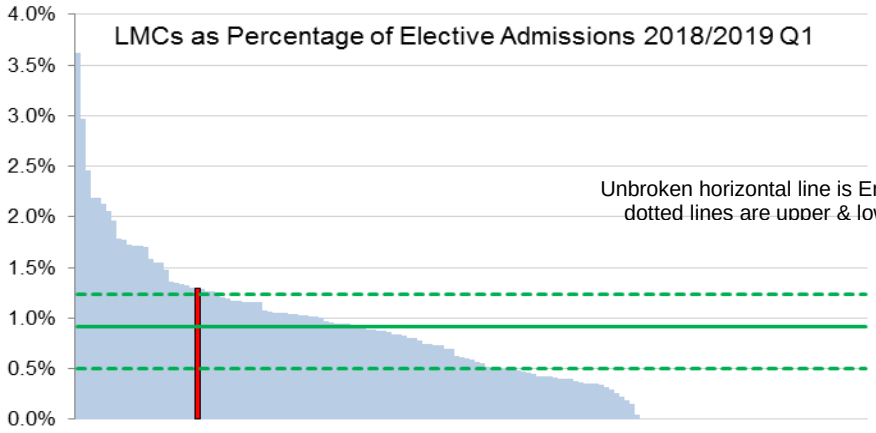
	Cancer 62 Day - Jun-18		
Cancer Site	First Treatment - Within Target	First Treatment - Total	First Treatment - Performance
Breast	2.0	3.0	66.7%
Gynaecological	9.5	10.0	95.0%
Haematological	6.5	8.5	76.5%
Head and Neck	8.0	10.0	80.0%
Lower Gastrointestinal	1.0	3.0	33.3%
Lung	11.0	16.5	66.7%
Other	3.0	3.0	100.0%
Skin	51.0	52.5	97.1%
Upper Gastrointestinal	8.5	10.5	81.0%
Urological	0.5	0.5	100.0%
Grand Total	101.0	117.5	86.0%

2.3 PERFORMANCE – Responsive Domain

Last Minute Cancelled Operations	
Standards:	This covers elective admissions that are cancelled on the day of admission by the hospital, for non-clinical reasons. The total number for the month should be less than 0.8% of all elective admissions. Also, 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In July there were 80 cancellations, which was 1.2% of elective admissions. Of the 39 cancelled in May, 38 (97.4%) had been re-admitted within 28 days.
Commentary:	July saw an increase in the number of last minute cancellations, with Cardiac services seeing a high number (27). However, all bar one of June's last minute cancellation patients were re-admitted within 28 days, so the 95% standard for this measure was achieved in July.
Ownership:	Chief Operating Officer



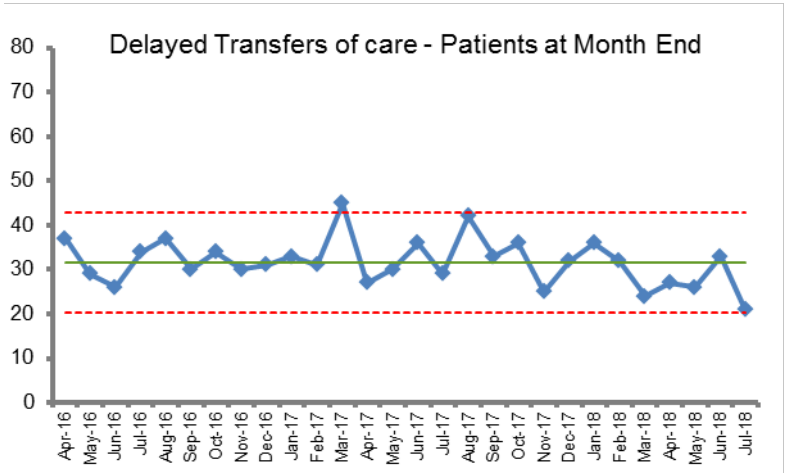


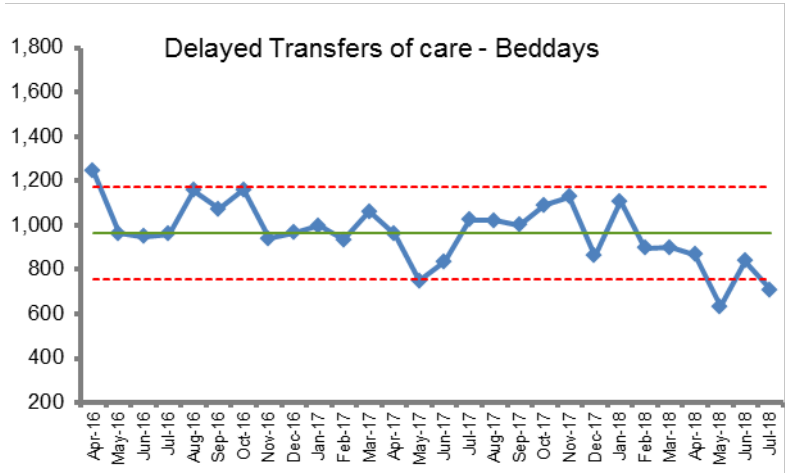


Cancellation Reasons	
Other Emergency Patient Prioritised	21
No Beds Available	12
Other clinically complicated Patient in theatre	9
Anaesthetist Unavailable	5
Surgeon Unavailable	5
No Theatre Staff	5
AM list over-ran	5
Booking Error	4
Surgeon Taken Ill	3
Equipment Unavailable	2
List Overbooked	2
Patient to be treated at another Trust	1
No Critical Care Bed	1
No Ward Staff	1
Theatre Repairs required	1
No HDU Beds	1
Other Non Emergency Patient Prioritised	1
No Lab Staff	1
Grand Total	**80**

2.3 PERFORMANCE – Responsive Domain

Delayed Transfers of Care (DToC)	
Standards:	Patients who are medically fit for discharge should wait a "minimal" amount of time in an acute bed.
Performance:	In July there were 21 Delayed Transfer of Care patients as at month-end, and 707 beddays consumed by DToC patients,
Commentary:	Renewed focus at a divisional level, using information from Clinical Utilisation Review is being implemented to improve the understanding, escalation and actions required to reduce delayed patients both internally and externally. Three key initiatives with Bristol City Council – changes to the provider care home market procurement processes, improved access to home care providers and increased capacity in re-ablement. Trajectory agreed for improvement of target against actions by December 2018 being linked to our overarching plans for this improvement.
Ownership:	Chief Operating Officer





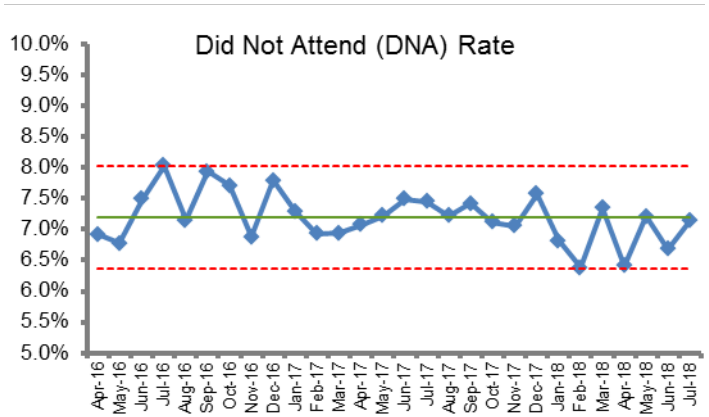
Month	Jul-18					
National DTOC Code	National DTOC Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	1	12	0	8
		NHS	2	31	0	4
		Social Care	1	117	1	61
B	Public Funding	Social Care	0	2	0	4
C	Further non acute NHS Care	NHS	1	20	0	0
Di	Care Home Placement	NHS	1	6	0	3
		Social Care	0	63	0	4
Dii	Care Home Placement	NHS	2	38	1	25
		Social Care	1	33	0	38
E	Care package in own home	NHS	1	21	0	8
		Social Care	3	73	1	36
F	Community equipment / adaptions	Social Care	1	13	0	7
G	Patient or family choice	NHS	1	40	1	6
I	Housing - patient not covered by NH	NHS	2	34	0	0
Grand Total			17	503	4	204

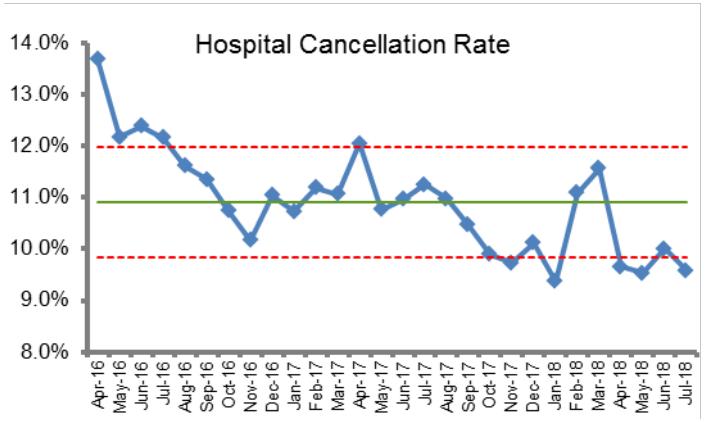
Length of Stay of Inpatients at month-end

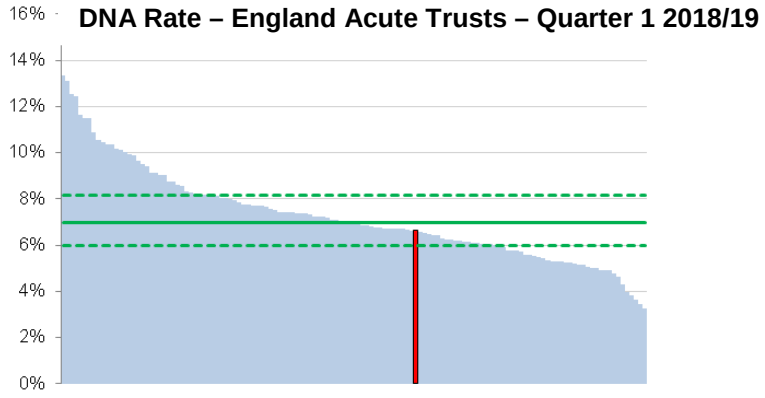
Jul-18	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	56	39	28	21
Bristol Haematology & Oncology Centre	25	14	8	6
Bristol Royal Infirmary	193	116	67	43
South Bristol Hospital	53	46	38	31
St Michael's Hospital	31	19	13	12
TRUST TOTAL	358	234	154	113
Bristol Royal Infirmary Divisional Breakdown:				
Medicine	109	74	47	29
Specialised Services	43	21	10	6
Surgery, Head & Neck	41	21	10	8

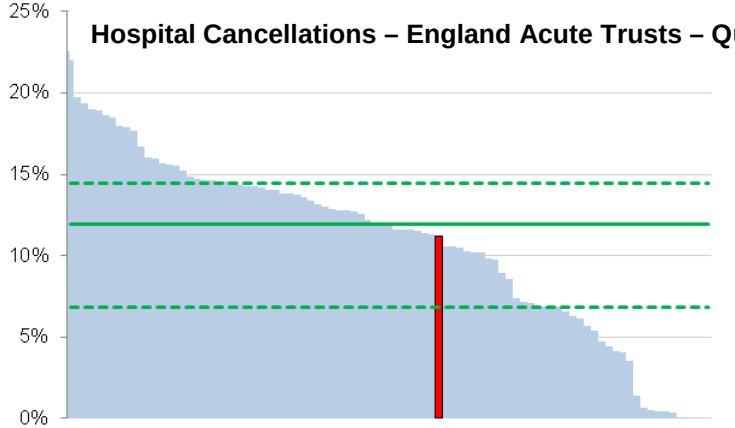
2.3 PERFORMANCE – Responsive Domain

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 July there were 8929 hospital-cancelled appointments, which was 9.6% of all appointments made. There were 4800 appointments that were DNA'ed, which was 7.1% of all planned attendances.
Commentary:	Speciality level DNA targets reviewed monthly at Outpatient Steering Group (OSG). The need to manage GP referrals through e-RS and setting polling ranges to match waiting times may impact on hospital cancellations. This will be closely monitored at OSG and will be added to the weekly performance meeting agenda with divisions.
Ownership:	Chief Operating Officer









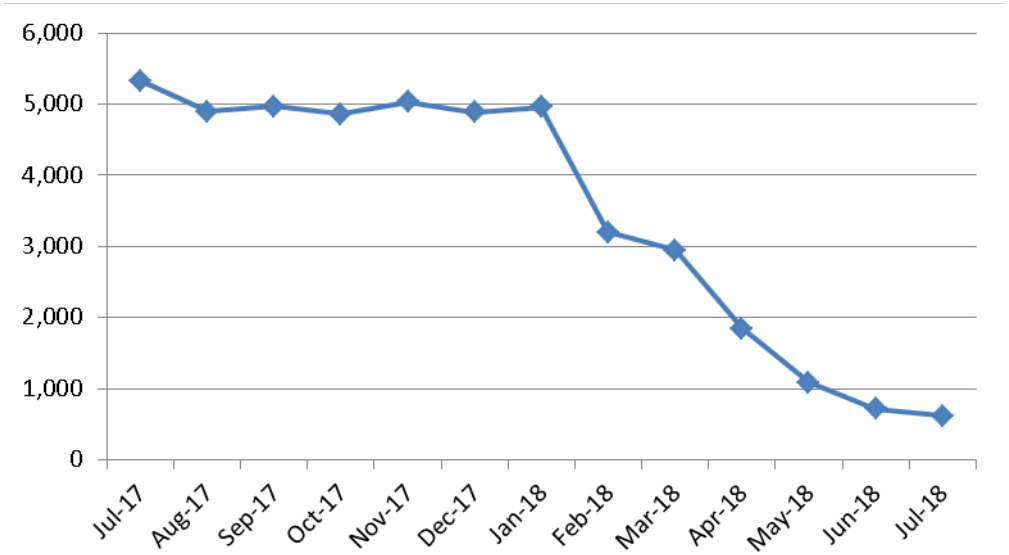
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

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 July, number overdue by 12+ months has fallen to 617.
Commentary:	Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting. The Trust aims to have eliminated the number of 12+ month overdue follow-ups by end of August. Targets will then be set to remove the 6+ month overdue follow-ups.
Ownership:	Chief Operating Officer

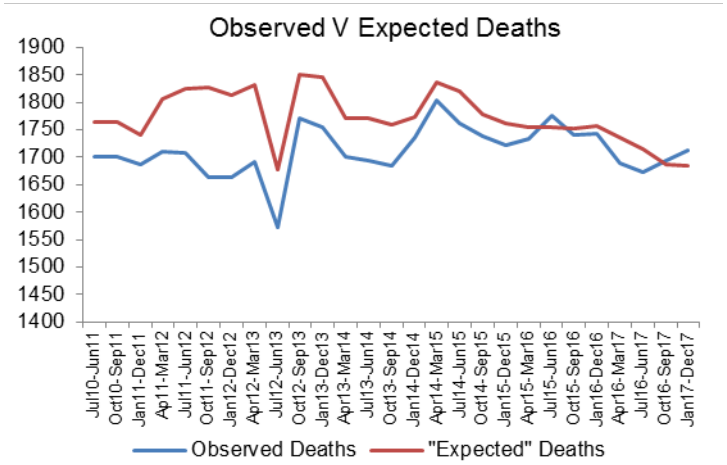
Number of Outpatients Overdue by 12+ Months as at Month End

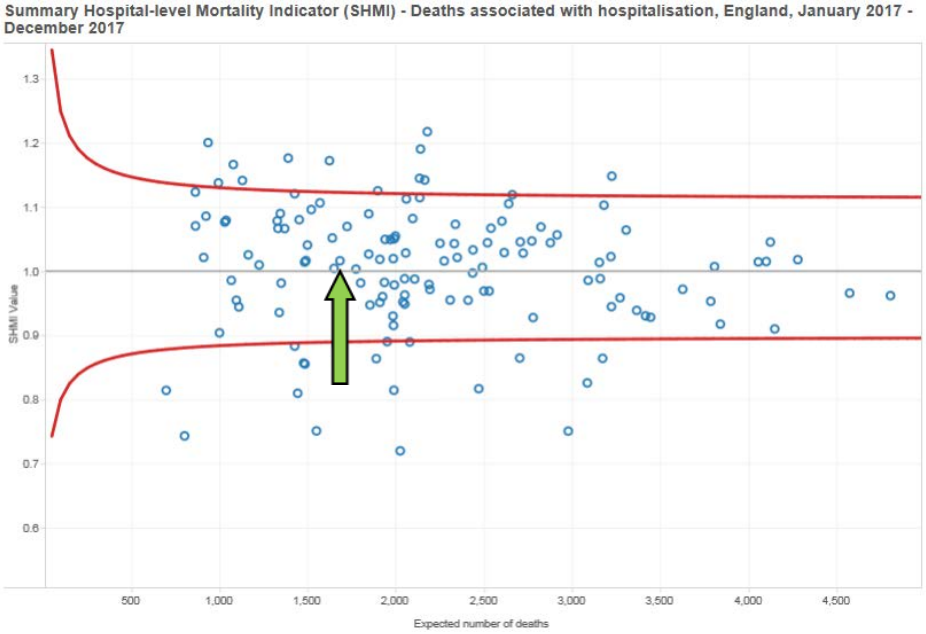
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicine	1,113	1,045	1,111	1,252	1,336	1,276	1,345	1,245	1,105	461	133	23	5
Specialised Services	563	432	442	295	353	387	400	367	383	188	206	214	208
Surgery	1,200	1,058	1,015	934	947	922	887	717	573	444	221	92	17
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
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**



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 Jan-17 to Dec-17. The SHMI was 101.7 (1712 deaths and 1684 "expected"). Data is updated quarterly, so no update since last month,
Commentary:	Although the Trust SHMI is 101.7 but is still in the "SHMI As Expected" category and statistically there are insufficient data points to determine any trend. The Learning from Deaths process is well embedded within the Trust, and as part of the West of England Patient Safety Collaborative, we are participating in a work stream regarding earlier conversations with patients in the last years of their lives to avoid patients at the end of their lives being brought to hospital rather than dying in their preferred circumstances. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

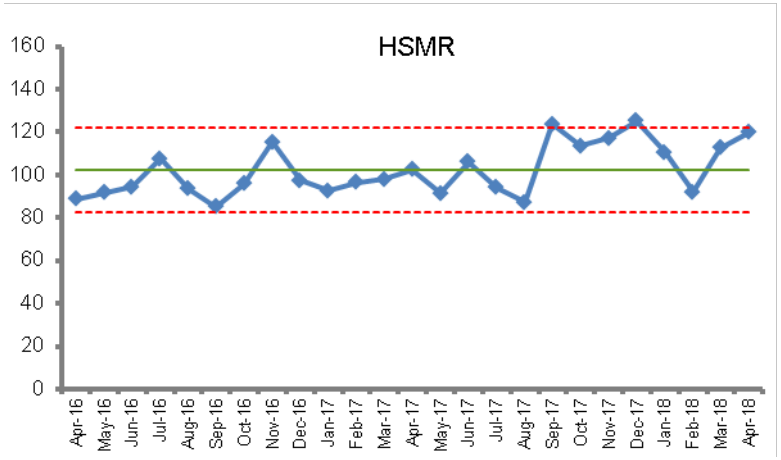
Time Period	Observed Deaths	"Expected" Deaths	SHMI	Banding
Jul15-Jun16	1,775	1,754	101.2	As Expected
Oct15-Sep16	1,741	1,752	99.4	As Expected
Jan16-Dec16	1,743	1,758	99.1	As Expected
Apr16-Mar17	1,690	1,737	97.3	As Expected
Jul16-Jun17	1,674	1,715	97.6	As Expected
Oct16-Sep17	1,693	1,686	100.4	As Expected
Jan17-Dec17	1,712	1,684	101.7	As Expected

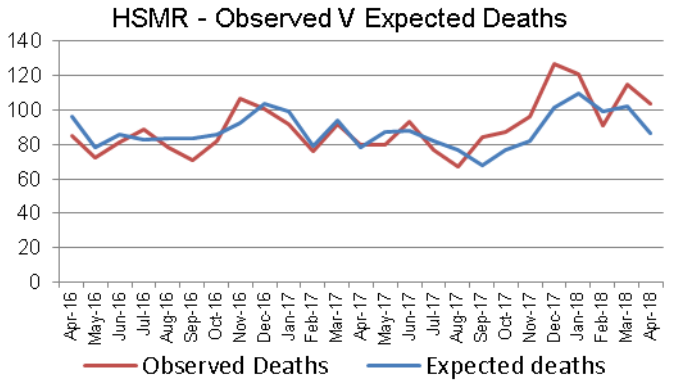




2.4 PERFORMANCE – Effective Domain

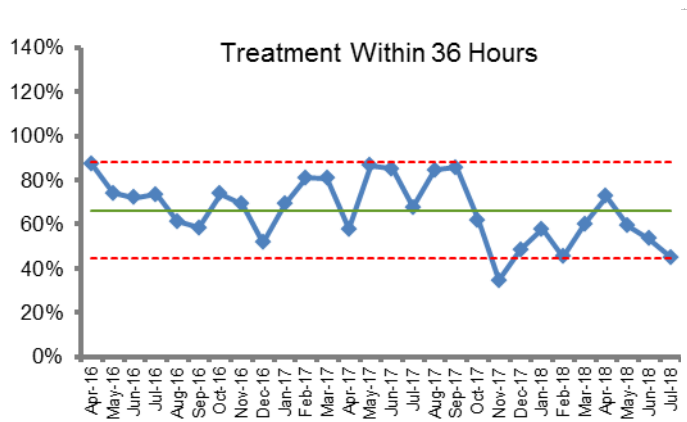
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for April 2018. The HSMR was 120 (104 deaths and 87 "expected")
Commentary:	The national HSMR data has been re-based, which happens once a year, and so the "expected deaths" (the denominator) has changed and seems to have significantly increased our HSMR. The resulting increase will be reviewed through the Quality Intelligence Group to understand the detail behind these headline figures and will be reported to the Quality and Outcomes Committee in due course via the Clinical Quality Group.
Ownership:	Medical Director

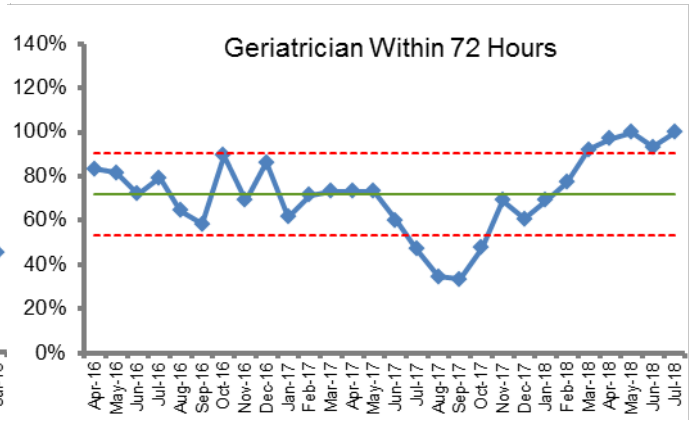


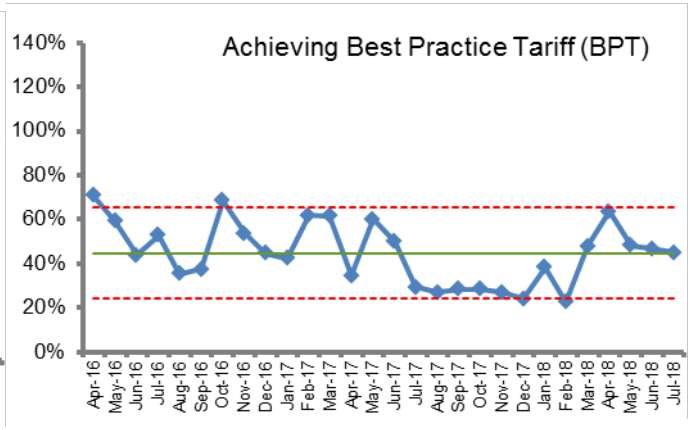


2.4 PERFORMANCE – Effective Domain

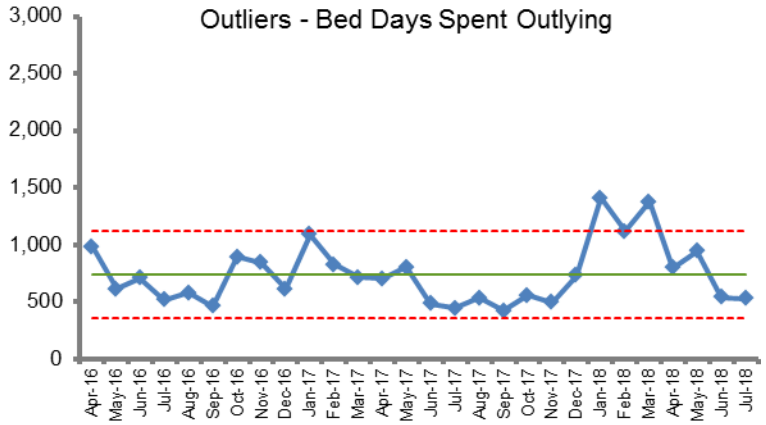
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	Latest data is July, where 20 Fracture NOF patients were admitted. For the 36 hour target, 45% were seen with target. For the 72 hour target, 100% were seen within target 9 patients (45%) achieved all elements of the Best Practice Tariff.
Commentary:	In July, there were 23 patients discharged following an admission for fractured neck of femur, and twenty of them were eligible for best practice tariff. Eleven of these patients (55%) were not operated on in theatre within the required 36 hours due to other urgent trauma cases being prioritised, therefore did not qualify for best practice tariff. Whilst the figure of 45% for patients who did qualify for best practice tariff is within the upper and lower confidence limits, the upper confidence limit at 88% is below the 90% best practice tariff target.
Ownership:	Medical Director

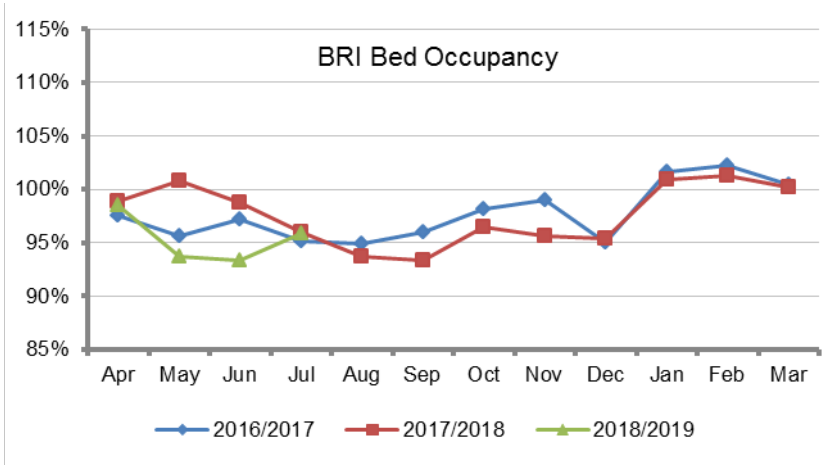


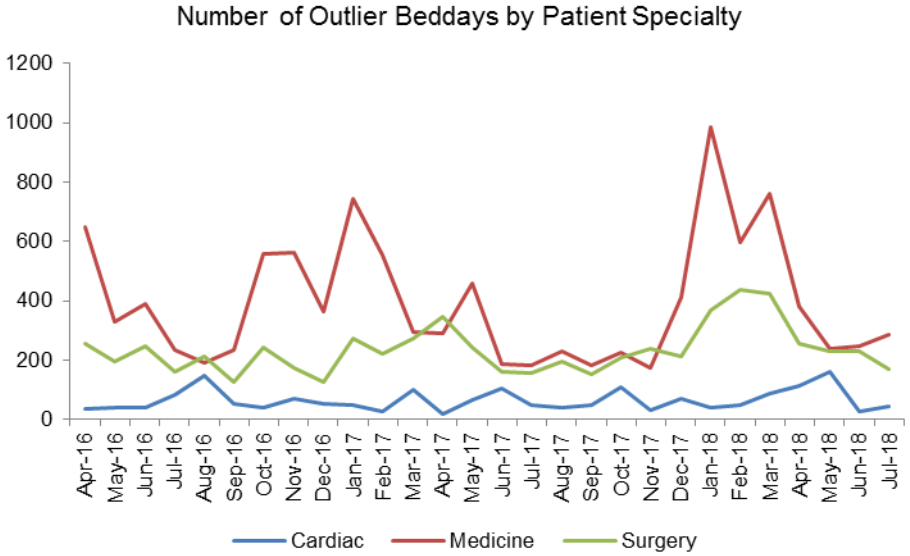




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In July there were 531 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary:	The July target of no more than 562 beddays was achieved. Of all the outlying beddays 285 were Medicine patients, 62 were Specialised Services patients and 175 were Surgery patients. There were only 29 beddays spent outlying overnight on escalation wards. Implementation of Clinical Utilisation Review ongoing with a focus on increasing the use of this data at all patient flow meetings, and divisional targets to reduce the number of internal delays.
Ownership:	Chief Operating Officer

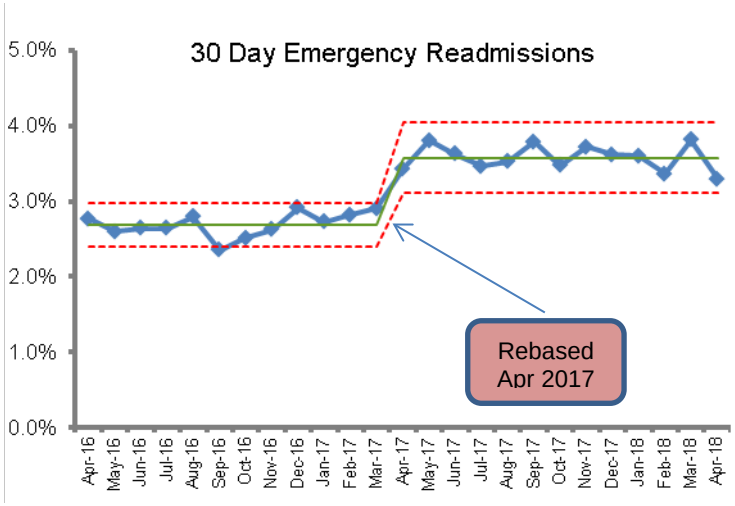






2.4 PERFORMANCE – Effective Domain

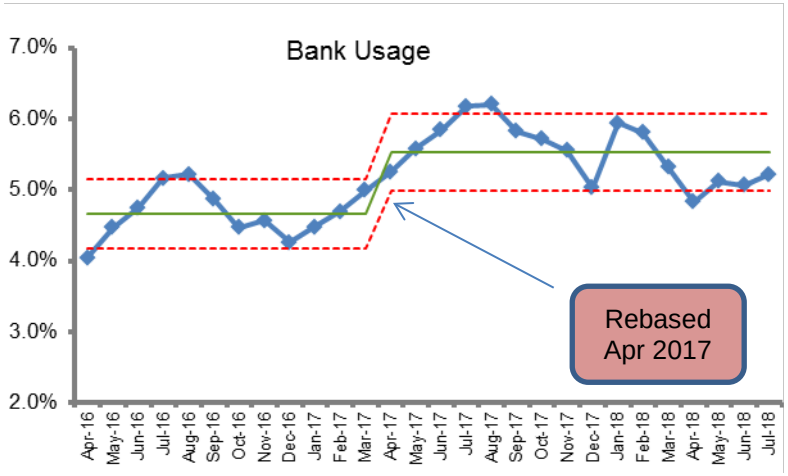
30 Day Emergency Readmissions	
Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain pathways such as Cancer and Maternity. The target for the Trust is to remain below 2017/18 maximum of 4.0%, with an amber tolerance down to 3.5% (2017/18average).
Performance:	In June, there were 12454 discharges, of which 459 (3.69%) had an emergency re-admission within 30 days.
Commentary:	Note that due to a technical error, the incorrect figures for April and May were reported last month. This has now been corrected and the ongoing performance for 2018/19 is now being measured against 2018/18 actual performance
Ownership:	Chief Operating Officer

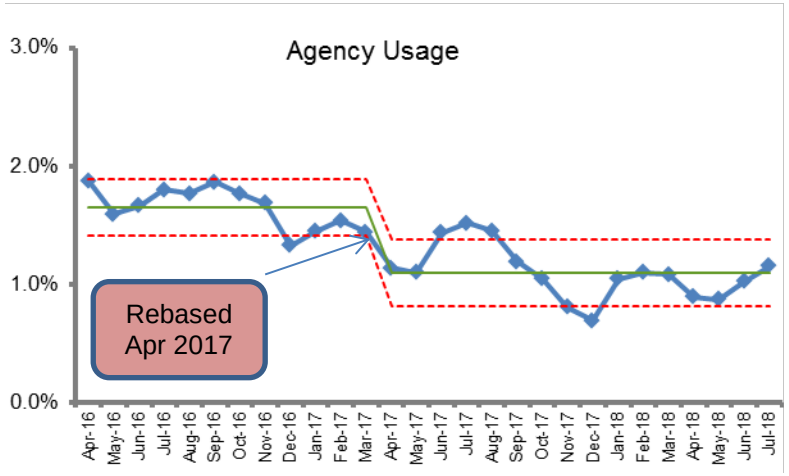


Discharges in June 2018

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	2	27	7.41%
Medicine	228	2314	9.85%
Surgery	149	3377	4.41%
Specialised Services	24	2751	0.87%
Women's and Children's	56	3985	1.41%
TOTAL	**459**	**12454**	**3.69%**

Bank and Agency Usage	
Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2018/19. The red threshold is 10% over the monthly target.
Performance:	In July, total staffing was at 8613 FTE. Of this, 5.2% was Bank (449 FTE) and 1.2% was Agency (99.4 FTE)
Commentary:	**Agency usage** increased by 11.3 FTE, with the largest increase seen in Medicine with 31.6 FTE compared to 23.6 FTE in the previous month. The largest reduction was seen in Women's and Children's, decreasing to 27.6 FTE from 30.0 FTE the previous month. The largest staff group increase was within Nursing & Midwifery increasing to 76.5 FTE from 70.0 FTE in the previous month. **Bank usage** increased by 12.0 FTE, with the largest increase seen in Specialised Services; 74.8 FTE compared to 68.9 FTE in the previous month. The largest reduction was seen in Trust Services, decreasing to 28.3 FTE from 29.6 FTE the previous month. The largest staff group increase was within Nursing & Midwifery increasing to 295.3 FTE from 288.3 FTE in the previous month.
Ownership:	Director of People



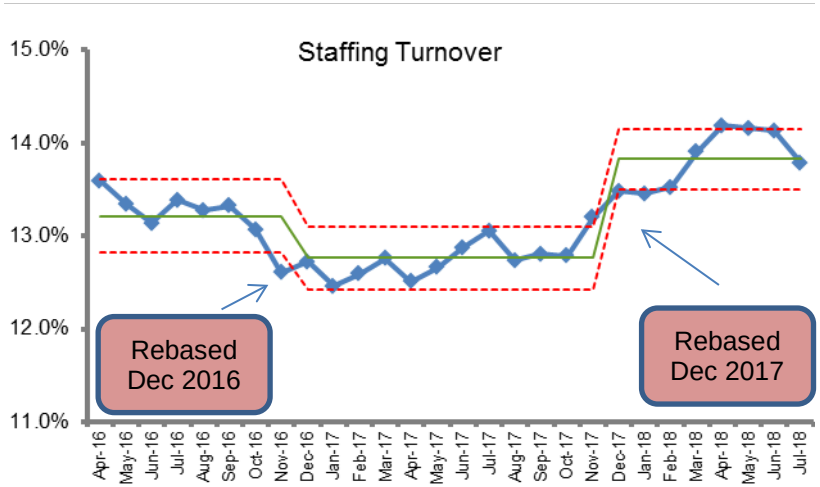


Bank	FTE	Actual %	Target
UHBristol	**449.15**	**5.2%**	**4.4%**
Diagnostics & Therapies	12.7	1.3%	1.5%
Facilities and Estates	47.9	6.4%	6.6%
Medicine	133.2	10.2%	10.9%
Specialised Services	74.8	7.3%	5.5%
Surgery	86.3	4.8%	3.1%
Trust Services	28.3	3.5%	2.7%
Women's & Children's	66.0	3.4%	1.9%

Agency	FTE	Actual %	Target
UHBristol	**99.4**	**1.2%**	**0.9%**
Diagnostics & Therapies	3.7	0.4%	1.1%
Facilities and Estates	1.8	0.2%	0.7%
Medicine	31.6	2.4%	1.8%
Specialised Services	13.8	1.4%	0.9%
Surgery	16.4	0.9%	0.7%
Trust Services	4.6	0.6%	0.3%
Women's & Children's	27.6	1.4%	0.6%

2.5 PERFORMANCE – Efficient Domain

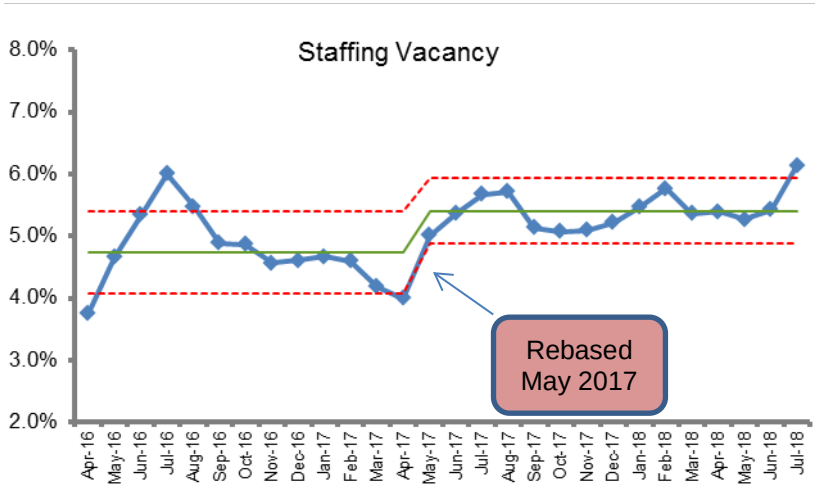
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In July, there had been 962 leavers over the previous 12 months with 6975 FTE staff in post on average over that period; giving a Turnover of 962 / 6975 = 13.8%
Commentary:	Turnover reduced to 13.8% from 14.1% last month, with decreases across all but one division (Diagnostic & Therapies). The largest divisional reduction was seen within Trust Services reducing to 14.6% from 15.7% the previous month. The largest increase in staff group was seen within Healthcare Scientists (1.4 percentage points). The biggest reduction in staff group was seen in Administrative and Clerical (1.3 percentage points).
Ownership:	Director of People



Turnover	Jul-18	Target
UH Bristol NHS Foundation Trust	**13.8%**	**13.4%**
Diagnostics & Therapies	11.1%	11.7%
Facilities & Estates	17.8%	17.3%
Medicine	14.3%	14.3%
Specialised Services	15.1%	14.6%
Surgery	13.9%	12.5%
Trust Services	14.6%	15.2%
Women's & Children's	12.1%	11.3%

2.5 PERFORMANCE – Efficient Domain

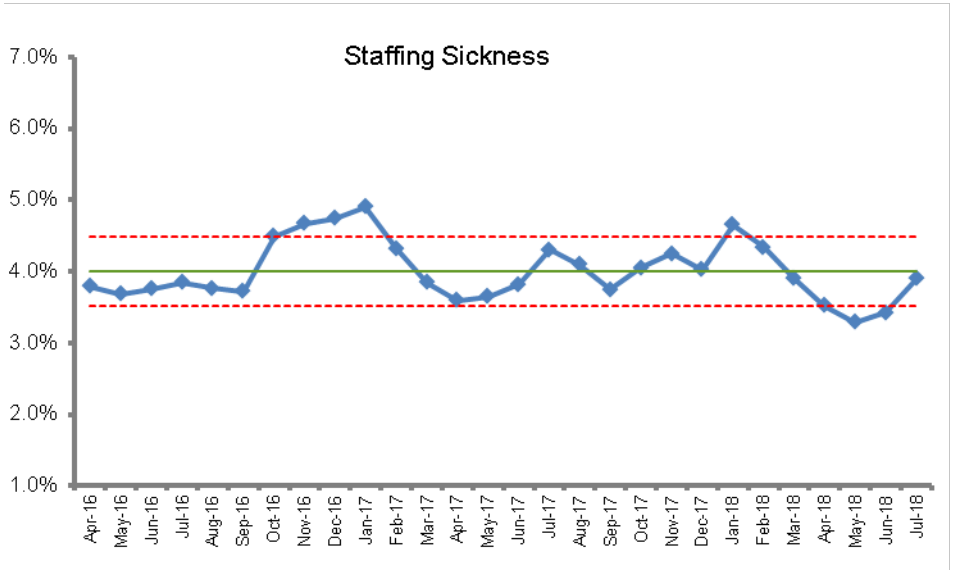
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In July, funded establishment was 8591, with 527 as vacancies (6.1%).
Commentary:	Overall vacancies increased to 6.1% compared to 5.4% in the previous month. There were no reductions in any staff groups. Specialised Services had the largest Divisional reduction to 75.1 FTE from 80.9 FTE the previous month. The overall Admin and Clerical / Senior Managers vacancy position increased to 105.0 FTE from 83.2 FTE the previous month. The biggest Divisional increase in this staff group was seen in Trust Services where Admin and Clerical / Senior Managers vacancies increased to 38.3 FTE from 24.9 FTE the previous month.
Ownership:	Director of People



Vacancy	Jul-18	Target
UH Bristol	**6.1%**	**5.0%**
Diagnostics & Therapies	6.7%	5.0%
Medicine	7.0%	5.0%
Specialised Services	7.4%	5.0%
Surgery	6.5%	5.0%
Women's & Children's	2.9%	5.0%
Trust Services	4.9%	5.0%
Facilities & Estates	10.6%	5.0%

2.5 PERFORMANCE – Efficient Domain

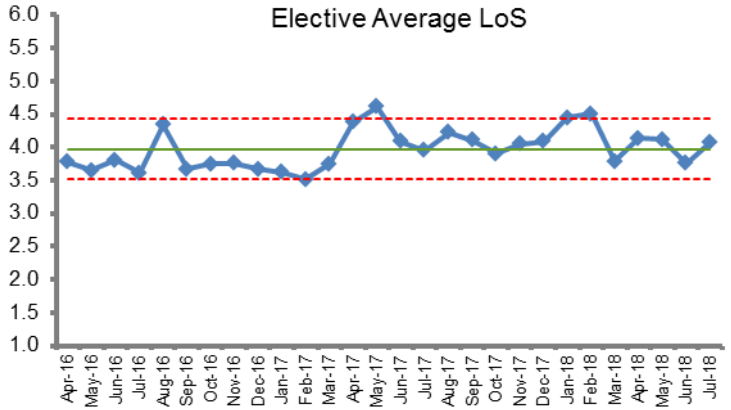
Staff Sickness	
Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In July, total available FTE days were 251,377 of which 9,758 (3.9%) were lost to staff sickness.
Commentary:	Sickness absence increased from 3.4% to 3.9%, with increases in all divisions. The largest divisional increase was seen in Facilities and Estates increasing to 6.4% from 4.6% the previous month. The largest staff group increase was seen in Estates and Ancillary, rising to 6.2% from 5.2% the previous month. This was followed by Nursing and Midwifery Unregistered increasing to 7.7% from 7.0% the previous month Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, this increased by 31.1% compared with last month. Other musculoskeletal problems are the second highest cause of sickness and this reason increased by 30.5% compared with last month. The third highest reason, Gastrointestinal problems reduced by 5.9% compared to the previous month..
Ownership:	Director of People

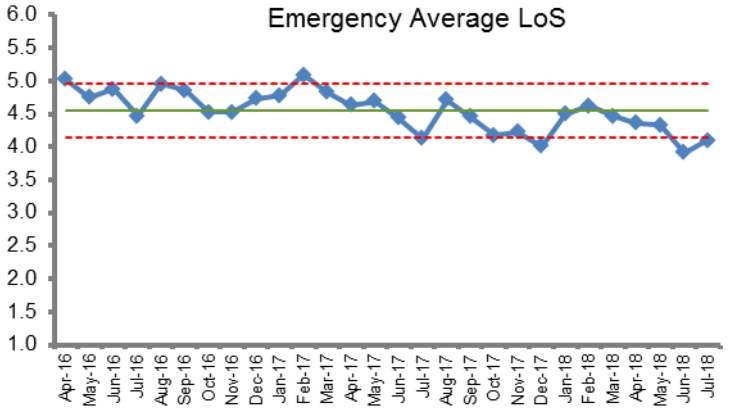


Sickness	Jul-18	Target
UH Bristol NHS Foundation Trust	**3.9%**	**3.9%**
Diagnostic & Therapies	2.8%	3.0%
Facilities & Estates	6.4%	6.4%
Medicine	4.5%	5.0%
Specialised Services	3.4%	3.5%
Surgery	4.0%	3.6%
Trust Services (exc Facilities & Estates)	2.5%	2.7%
Women's & Children's	3.9%	3.6%

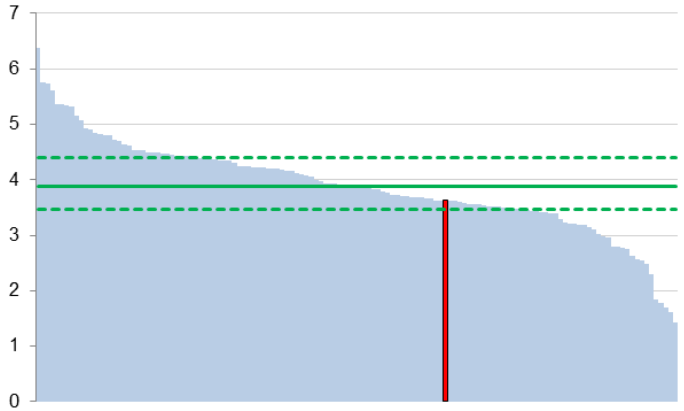
2.5 PERFORMANCE – Efficient Domain

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 July there were 6666 discharges that consumed 25,312 beddays, giving an overall average length of stay of 3.80 days.
Ownership:	Chief Operating Officer

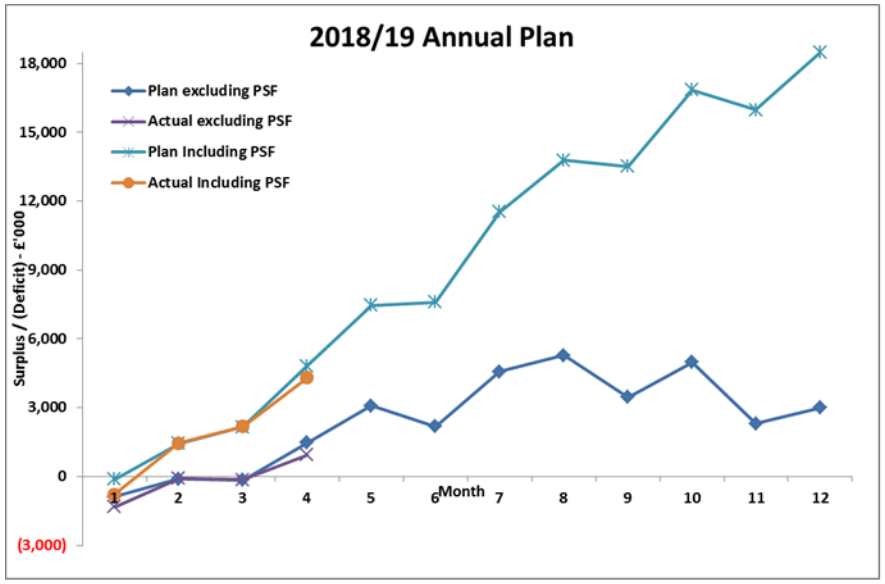


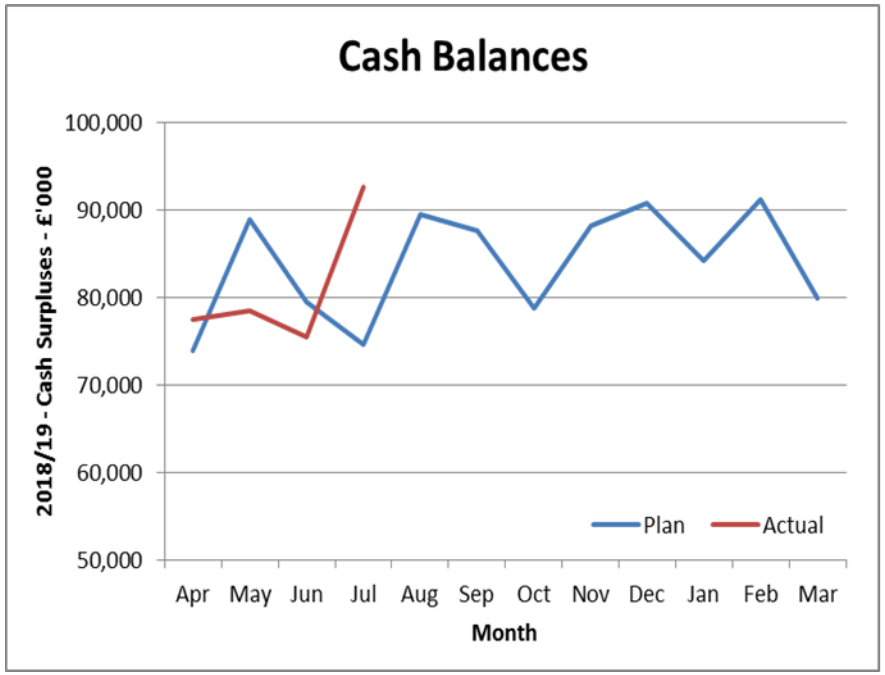


Average Length of Stay – England Acute Trusts – 2018/19 Quarter 1



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

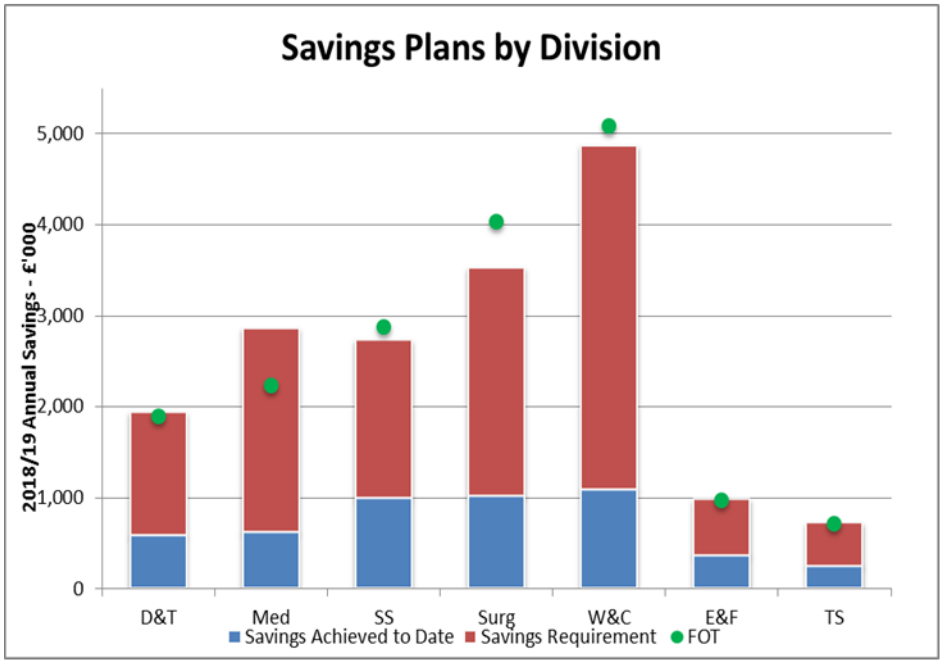




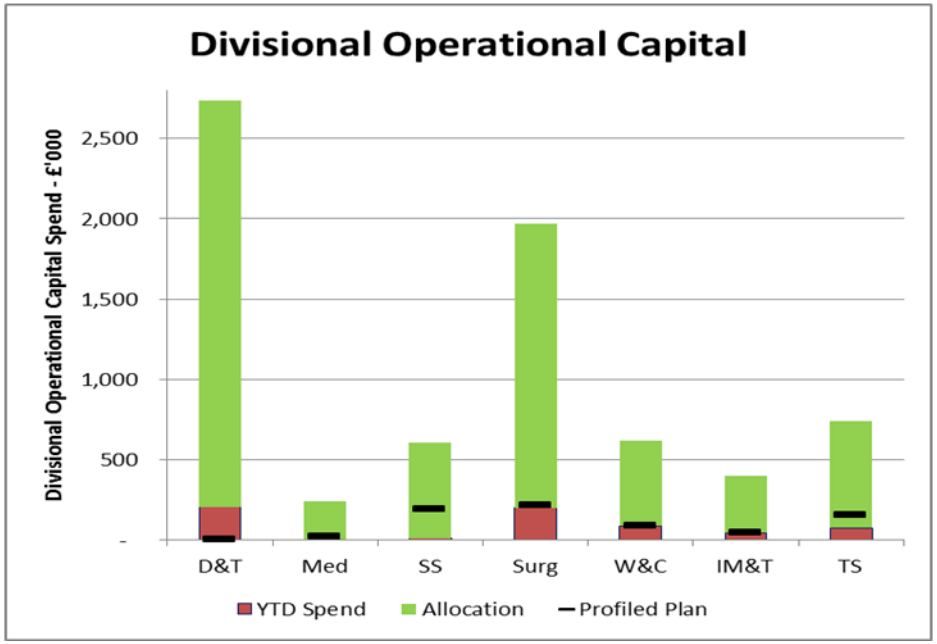
Actual Spend - £'000						
Agency	In Month				Plan for Year	Straight Line Projection
	Apr	May	Jun	Jul		
Nursing & Midwifery	448	443	515	549	**3,277**	**5,865**
Medical						**0**
Consultants	17	25	14	71	**184**	**381**
Other Medical	17	35	54	71	**276**	**531**
Other	31	85	73	126	**1,701**	**945**
Total	**513**	**588**	**656**	**817**	**5,438**	**7,722**

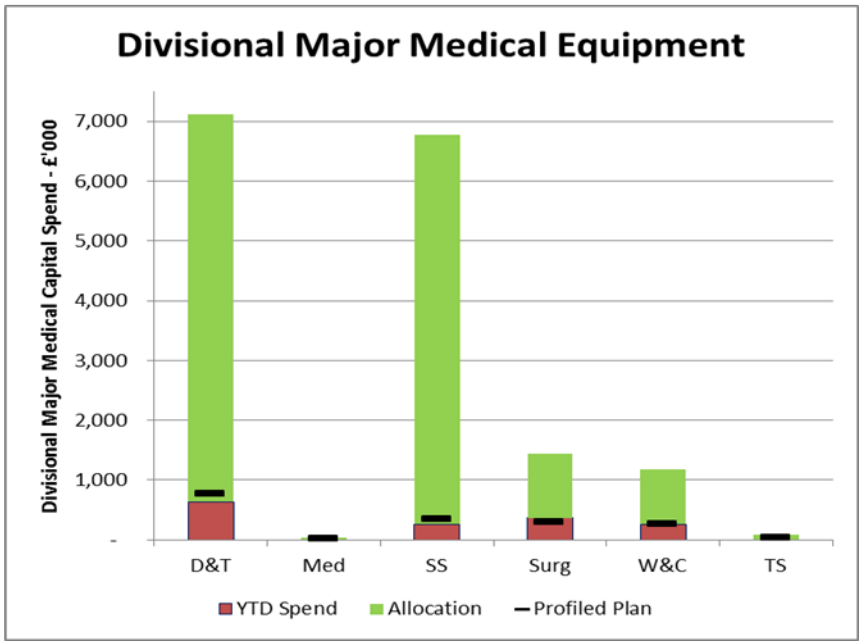
YTD Variance to Budget Surplus/(Deficit) - £'000				
Division	Apr	May	Jun	Jul
Diagnostics & Therapies	12	71	156	161
Medicine	(72)	(145)	(449)	(844)
Specialised Services	(175)	65	335	275
Surgery	(75)	(191)	(651)	(995)
Women's & Children's	(145)	(332)	(78)	(121)
Estates & facilities	3	(6)	(18)	16
Trust Services	(8)	(10)	(18)	(18)
Other Corporate Services	18	127	152	246
Total	**(442)**	**(421)**	**(571)**	**(1,280)**

Variance to Budget Surplus/(Deficit) - £'000					
Subjective Heading	In Month				YTD
	Apr	May	Jun	Jul	Total
Nursing & Midwifery Pay	(256)	(329)	(430)	(338)	**(1,353)**
Medical & Dental Pay	(358)	(322)	(353)	(340)	**(1,373)**
Other Pay	128	74	126	260	**588**
Non Pay	2	(728)	(361)	(475)	**(1,562)**
Income from Operations	(69)	0	42	75	**48**
Income from Activities	111	1,327	825	109	**2,372**
Total	**(442)**	**22**	**(151)**	**(709)**	**(1,280)**



2018/19 Capital Programme			Year To Date		
Operational Plan	Subjective Heading	Internal Plan	Internal Plan	Actual spend	Variance (over) /under
£'000		£'000	£'000	£'000	£'000
	Sources of Funding				
1,600	PDC	1,600			
3,189	Loan	3,189			
3,000	Donations	3,000	700	594	(106)
	Cash:				
24,338	Depreciation	24,338	7,914	7,817	(41)
14,962	Cash balances	15,100	(2,121)	(2,049)	(12)
47,089	**Total Funding**	**47,227**	**6,493**	**6,362**	**(159)**
	Application/Expenditure				
(11,618)	Strategic Schemes	(10,565)	(197)	(97)	100
(17,620)	Medical Equipment	(17,697)	(1,680)	(1,567)	113
(16,415)	Operational Capital	(15,399)	(1,837)	(1,817)	20
(7,468)	Information Technology	(7,716)	(2,311)	(2,436)	(125)
(2,367)	Estates Replacement	(2,311)	(468)	(445)	23
(55,488)	**Gross Expenditure**	**(53,688)**	**(6,493)**	**(6,362)**	**131**
8,399	In-Year Slippage	6,461			
(47,089)	**Net Expenditure**	**(47,227)**	**(6,493)**	**(6,362)**	**131**

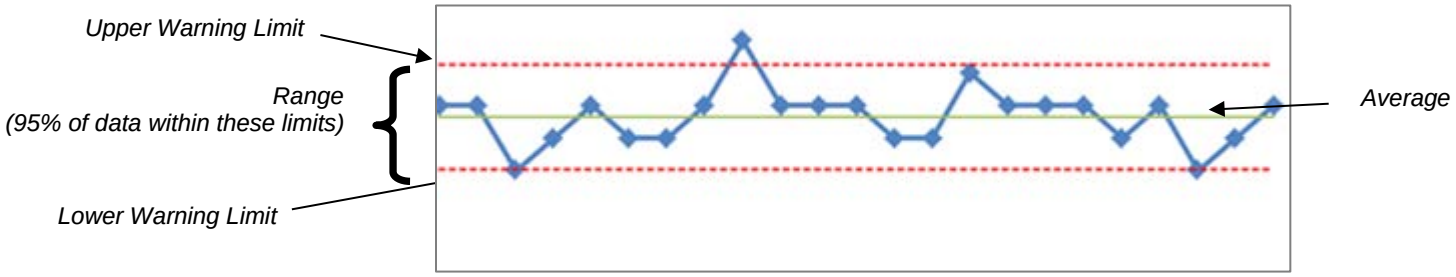




A1 APPENDIX 1 – Explanation of SPC Charts

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 17/18	Annual 18/19 YTD	Monthly Totals Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	4	3	0	0	0	1	1	1	0	0	1	0	2	0	0	2	1	3
	DA02	MSSA Trust Apportioned Cases	25	14	3	0	5	4	1	2	3	3	3	5	4	2	3	10	8	12
	DA03	CDiff Trust Apportioned Cases	35	12	2	3	1	1	3	2	6	0	2	0	6	3	11	5	8	8
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	7	1	1	1	0	0	0	0	0	0	1	0	0	0	4	0	0	1
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	12	10	0	0	0	1	3	2	6	0	0	0	6	4	0	4	8	6
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.6%	97.4%	97.7%	96.3%	96.4%	97.6%	97.3%	98.4%	98.2%	96.9%	96.8%	97.8%	97.4%	97.7%	97%	97.1%	97.8%	97.3%
	DB02	Antibiotic Compliance	86.4%	83%	81.3%	84.4%	85.1%	89.1%	85.4%	85.2%	89.6%	85.3%	82.8%	81.3%	83%	84.6%	84.3%	86.4%	86.6%	82.5%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	97%	97%	96%	96%	95%	98%	94%	95%	95%	96%	95%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	96%	97%	98%	97%	97%	98%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	97%	97%	96%	97%	96%	93%	96%	96%	96%	95%	96%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	57	21	3	9	2	4	4	6	2	7	3	10	4	4	17	10	15	17
	S02a	Number of Confirmed Serious Incidents	53	5	3	9	2	3	4	6	2	6	3	2	-	-	17	9	14	5
	S02b	Number of Serious Incidents Still Open	-	16	-	-	-	-	-	-	-	-	-	8	4	4	-	-	-	12
	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%	95.2%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	75%	100%	80%	100%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.2%	94.1%	100%	100%	100%	100%	100%	83.3%	100%	100%	100%	75%	100%	100%	100%	100%	93.3%	92.9%
	S04a	Overdue Exec Commissioned Non-SI Investigations	19	7	1	2	1	1	3	3	1	1	2	2	1	2	4	5	5	5
Never Events	S01	Total Never Events	8	0	0	0	2	0	0	1	0	1	0	0	0	0	1	2	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	15656	5750	1249	1229	1311	1332	1193	1347	1379	1480	1428	1311	1445	1566	3766	3836	4206	4184
	S06b	Patient Safety Incidents Per 1000 Beddays	50.86	57.07	48.38	49.91	50.19	52.96	46.38	50.04	57.11	55.29	55.84	52.85	59.13	60.39	49.25	49.82	54.04	55.92
	S07	Number of Patient Safety Incidents - Severe Harm	92	34	7	7	4	9	9	10	7	7	6	13	10	5	20	22	24	29
Patient Falls	AB01	Falls Per 1,000 Beddays	4.59	4.05	4.76	5.04	4.48	3.78	4.51	4.61	4.68	5.04	3.79	4.27	3.72	4.4	4.77	4.26	4.78	3.93
	AB06a	Total Number of Patient Falls Resulting in Harm	25	8	0	3	2	2	5	2	0	2	2	4	1	1	3	9	4	7
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.162	0.189	0.155	0.203	0.038	0.159	0.156	0.372	0.207	0.149	0.156	0.121	0.123	0.347	0.17	0.117	0.244	0.134
	DE02	Pressure Ulcers - Grade 2	45	16	4	4	1	4	4	10	5	4	2	3	3	8	10	9	19	8
	DE04A	Pressure Ulcers - Grade 3 or 4	5	3	0	1	0	0	0	0	0	0	2	0	0	1	3	0	0	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.4%	98.3%	97.4%	98.3%	98.4%	98.2%	98%	98%	98.3%	98.3%	98.1%	98.4%	98.5%	98.3%	98.2%	98.2%	98.2%	98.3%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	94.1%	94.9%	92.3%	97.1%	94%	92.3%	91.4%	94.4%	97.1%	93.8%	96.1%	91.1%	95%	94.7%	94.5%	94.1%	93.8%
	N04	Number of Hospital Associated VTEs	50	12	2	3	6	1	3	8	3	7	3	4	0	5	9	10	18	7
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	4	8	0	0	0	0	1	0	1	2	1	2	0	5	0	1	3	3
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	92.1%	-	94.6%	92.6%	91%	95.2%	88.8%	95%	91%	93.7%	-	-	-	-	94.5%	91.3%	93%	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	89.9%	92%	-	92%	-	-	88.9%	-	-	86.3%	-	-	92%	-	92%	88.9%	86.3%	92%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.8%	99.8%	99.9%	99.8%	99.2%	99.8%	100%	99.8%	99.7%	99.9%	99.7%	99.7%	99.9%	99.8%	99.6%	99.8%	99.7%

APPENDIX 3 – Trust Scorecards

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	17/18	18/19 YTD	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Medicines	WA01	Medication Incidents Resulting in Harm	0.55%	0.42%	0.51%	0%	1.97%	0.47%	0.5%	0.49%	0%	0%	0%	0.91%	0.37%	-	0.64%	0.97%	0.15%	0.42%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.4%	0.46%	0.11%	0.37%	0.27%	0.41%	0%	0.42%	1.02%	0.33%	0.63%	0.36%	0.24%	0.54%	0.25%	0.24%	0.57%	0.43%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	-	96.9%	97.7%	97.5%	98.8%	98.3%	98.8%	98.2%	98.2%	-	-	-	-	97.4%	98.2%	98.4%	-
	AK04	Safety Thermometer - No New Harms	98.8%	-	98.2%	98.7%	98.9%	99.1%	99%	99.9%	98.4%	98.5%	-	-	-	-	98.6%	99%	98.9%	-
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	96%	-	97%	100%	90%	93%	97%	95%	91%	100%	-	-	-	-	99%	94%	95%	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	9.5%	10.9%	9.7%	9.1%	9.4%	9.1%	8.7%	8.2%	9%	10.2%	8.8%	8.9%	10.3%	9.7%	9.2%	8.6%	9.3%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.4%	21.5%	21.9%	24%	24.2%	24%	20.8%	20.5%	20.9%	21.9%	20.3%	22.4%	21.7%	21.4%	22.9%	23%	21.1%	21.5%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11138	3574	909	983	1024	1010	863	867	814	945	834	963	875	902	2854	2897	2626	2672
Staffing Levels	RP01	Staffing Fill Rate - Combined	98.9%	99.2%	98%	97.1%	97.5%	98.1%	97.2%	98.5%	96.8%	95.7%	99%	98.7%	100.1%	99.1%	97.9%	97.6%	97%	99.2%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99.9	-	-	100.4	-	-	101.7	-	-	-	-	-	-	-	100.4	101.7	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	106.4	120	87.3	123.7	113.5	117.1	125.3	110.5	91.9	112.6	120	-	-	-	100.7	119.2	105.2	120
Readmissions	C01	Emergency Readmissions Percentage	3.28%	0.62%	3.51%	3.76%	3.43%	3.66%	3.57%	3.5%	2.17%	2.07%	1.91%	0%	0%	-	3.53%	3.55%	2.6%	0.62%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	51.1%	95.7%	50%	16.7%	20%	33.3%	46.7%	64.7%	87%	83.3%	87.1%	100%	100%	-	29.7%	35.5%	79.7%	95.7%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	77.4%	57.1%	100%	100%	50%	-	100%	-	100%	50%	75%	-	33.3%	-	88.9%	75%	75%	57.1%
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	93.3%	100%	100%	100%	66.7%	-	75%	-	100%	-	100%	-	-	-	100%	71.4%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	83.4%	89.3%	95%	92.9%	91.7%	76%	68%	86%	88%	88%	80%	89.2%	92.8%	-	94%	75.8%	87.3%	89.3%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	85.5%	81.1%	88.2%	100%	94.1%	86.2%	91.7%	90%	74.2%	94.1%	75%	91.3%	76.9%	-	90%	90%	83.8%	81.1%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	93.1%	94.9%	100%	100%	88.9%	84%	90.9%	100%	82.1%	100%	100%	95.1%	92.9%	-	100%	87.7%	91.2%	94.9%
Maternity	G01	Percentage of Low Weight Babies	2.5%	3.1%	3.3%	3.4%	0.9%	2%	4.6%	3.2%	2%	3.2%	3.2%	2.1%	4.2%	-	2.7%	2.5%	2.8%	3.1%
	G01A	Number of Low Weight Babies	119	35	13	13	4	7	18	13	7	12	12	8	15	-	32	29	32	35
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	64.2%	60%	84.6%	85.7%	61.9%	34.6%	48.5%	57.7%	45.5%	60%	72.7%	59.3%	53.3%	45%	77.8%	47.5%	54.8%	64%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	61.6%	97.9%	34.6%	33.3%	47.6%	69.2%	60.6%	69.2%	77.3%	92%	97%	100%	93.3%	100%	39.5%	60%	79.5%	97.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	34.8%	52.6%	26.9%	28.6%	28.6%	26.9%	24.2%	38.5%	22.7%	48%	63.6%	48.1%	46.7%	45%	28.4%	26.3%	37%	54.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	43.8	37.1	53.3	75.9	58.6	64.8	65.7	81.5	48.7	72.7	50.6	61.3	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	62.6%	51.6%	61.9%	70%	60.7%	55.6%	60.9%	57.9%	61.3%	54.3%	58.1%	30.8%	65%	-	68.5%	59.1%	57.4%	51.6%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	85.8%	82.8%	81%	92.5%	96.4%	83.3%	87%	84.2%	93.5%	80.4%	81.4%	76.9%	90%	-	85.4%	88.2%	85.2%	82.8%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	54.6%	42.9%	66.7%	75%	66.7%	70%	42.9%	50%	36.4%	20%	15.4%	54.5%	63.2%	30.8%	55.9%	62.9%	34.2%	46.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	89.3%	81.2%	89.9%	93.5%	87.7%	93.7%	87.9%	90.7%	87.3%	86.3%	87.3%	84.8%	77.6%	74.7%	91.5%	89.6%	88.2%	83.6%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	96.2%	92.9%	97.7%	97.9%	94%	97.4%	100%	93.8%	86%	96.5%	95%	91.9%	89.5%	94.9%	98.6%	96.9%	92%	92.2%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.9%	75%	100%	100%	75%	100%	100%	100%	-	100%	-	0%	100%	100%	100%	87.5%	100%	50%
	AC04	Percentage of Dementia Carers Feeling Supported	60%	100%	-	-	-	-	-	100%	-	33.3%	-	-	100%	-	-	-	50%	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9098	2819	537	424	558	499	730	1411	1120	1377	800	945	543	531	1409	1787	3908	2288

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			17/18	18/19 YTD	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	92	91	92	90	91	92	92	93	91	92	91	92	91	92	92
	P01g	Patient Survey - Kindness and Understanding	-	-	94	96	95	95	95	96	95	95	97	97	96	95	95	95	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	87	90	90	91	89	90	88	88	88	91	89	90	89	90	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35%	36.8%	35.1%	35.3%	39.5%	33.2%	28.4%	34.9%	36.2%	30.3%	40.7%	37.6%	33.7%	35.6%	35.4%	33.9%	33.7%	37.2%
	P03b	Friends and Family Test ED Coverage	17.3%	17.5%	18.5%	18.3%	17.9%	17.9%	14.6%	17.8%	17.4%	15.2%	17.3%	17.2%	18.4%	17.3%	18%	16.9%	16.8%	17.6%
	P03c	Friends and Family Test MAT Coverage	19%	14.6%	17.3%	18.3%	21%	12.4%	23.1%	17.5%	17.7%	18.2%	19.8%	13.2%	11.2%	14%	18.6%	19%	17.8%	14.8%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.7%	97.7%	97.5%	97.7%	97.9%	98.1%	97.8%	97.7%	98.3%	97.8%	97.4%	97.3%	97.3%	98.8%	97.6%	98%	97.9%	97.3%
	P04b	Friends and Family Test Score - ED	81%	81.8%	81.9%	83.5%	83.3%	80.3%	77%	81.8%	83.2%	77.7%	80.1%	81.1%	84.6%	81.4%	81%	80.5%	81%	81.9%
	P04c	Friends and Family Test Score - Maternity	96.9%	96.2%	96.5%	99.2%	98%	97.5%	98.1%	94.6%	96.8%	97.1%	94.6%	95.5%	99.3%	96.8%	96.8%	98%	96.1%	96%
Patient Complaints	T01	Number of Patient Complaints	1815	446	146	138	154	155	98	143	121	159	149	157	140	-	430	407	423	446
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	83%	85.9%	87.3%	78.7%	85.1%	87.1%	83.8%	87.8%	82.8%	77.9%	83.1%	91%	84%	83%	83%	85.4%	82.3%	85.9%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	82.2%	81.7%	86.9%	83.6%	90%	82.4%	91.8%	82.8%	77.9%	85.9%	82.1%	78.7%	-	85.7%	85.4%	83.4%	82.2%
	T04c	Percentage of Responses where Complainant is Dissatisfied	10.68%	12.68%	11.27%	9.84%	10.45%	7.14%	2.94%	8.16%	8.62%	13.23%	12.68%	14.90%	-	-	9.89%	6.83%	10.29%	12.68%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.19%	1.26%	0.91%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.92%	1.37%	1.9%	0.59%	1.17%	0.88%	1.15%	1.69%	1.29%
	F01a	Number of Last Minute Cancelled Operations	919	329	61	58	68	85	71	102	98	121	85	125	39	80	173	224	321	249

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	87%	89.6%	88.7%	89.9%	89.4%	90%	88.9%	88.3%	88.1%	88.4%	87%	88.2%	89.1%	88.6%	88.9%	89.8%	89.1%	87.8%	88.6%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3372	3524	3300	2927	3085	3138	3308	3783	3510	3244	3377	3208	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	209	47	32	19	10	13	9	1	15	18	15	12	9	11	81	32	34	36
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	-	-	240	182	155	136	158	160	148	164	154	141	129	126	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.3%	94.3%	93.2%	94.6%	94.6%	95.5%	94.8%	92.2%	96.9%	92.1%	92.6%	95.1%	95.3%	-	93.7%	95%	93.6%	94.3%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	58.9%	50.6%	62.4%	59.9%	64.2%	57.6%	54.4%	58.8%	59.6%	54.6%	41.3%	53.1%	56.7%	-	62%	59%	57.7%	50.6%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	95.8%	94.7%	97.9%	96.9%	95.4%	98.1%	96.7%	92.9%	95.1%	95.8%	94.4%	95%	94.7%	-	97.3%	96.7%	94.5%	94.7%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.6%	97.2%	98.6%	98.5%	99.3%	98.7%	98.9%	98.7%	98.6%	98.4%	97.6%	96.6%	97.6%	-	98.6%	99%	98.6%	97.2%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	92%	91.4%	96.3%	94.7%	95.7%	96.8%	93%	96.6%	87.7%	79.5%	93%	85%	95.6%	-	94.3%	95.2%	89%	91.4%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.3%	92.2%	97.3%	98%	96.4%	96.1%	97.6%	92.9%	97.9%	96.4%	98.5%	85.4%	91.6%	-	96.3%	96.6%	95.6%	92.2%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	81.7%	84.2%	85.2%	80.2%	84.3%	88.6%	82.9%	78.4%	81.3%	87.3%	84.1%	82.4%	86%	-	80.1%	85.4%	82.4%	84.2%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	74.8%	43.5%	100%	100%	66.7%	76.5%	71.4%	100%	58.3%	28.6%	66.7%	37.5%	41.7%	-	96.3%	73.3%	61.5%	43.5%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	85.4%	80.4%	84.8%	90.7%	74.7%	88.5%	85.7%	88.7%	83.9%	90.9%	79.3%	77.9%	84.4%	-	84.6%	83%	87.9%	80.4%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	47.5	13.5	5	3	3.5	2	4.5	3	2.5	2	3	5	5.5	-	16	10	7.5	13.5
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.19%	1.26%	0.91%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.92%	1.37%	1.9%	0.59%	1.17%	0.88%	1.15%	1.69%	1.29%
	F01a	Number of Last Minute Cancelled Operations	-	-	919	329	61	58	68	85	71	102	98	121	85	125	39	80	173	224	321	249
	F02	Cancelled Operations Re-admitted Within 28 Days	95%	85%	94.2%	91.4%	98.1%	95.1%	96.6%	91.2%	94.1%	88.7%	94.1%	92.9%	89.3%	85.9%	95.2%	97.4%	97.6%	93.8%	92.3%	90.6%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.61%	1.65%	0.88%	1.73%	1.28%	1.9%	1.38%	1.81%	2.08%	2.31%	2.26%	2.36%	1.67%	0.41%	1.26%	1.53%	2.06%	2.1%
	F07a	Number of Admissions Cancelled Day Before	-	-	1244	433	59	110	87	128	82	121	125	146	140	155	110	28	249	297	392	405
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	76.1%	82.4%	80.6%	84.8%	73.8%	77.4%	63.8%	80.9%	71.1%	65.2%	86.2%	80%	81.8%	-	80.2%	70.8%	74.1%	82.4%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.2%	95.1%	94.4%	97%	92.9%	93.5%	93.6%	95.7%	97.4%	91.3%	93.1%	92.5%	100%	-	93.1%	93.3%	95.4%	95.1%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.29%	97.52%	97.61%	97.7%	98.19%	98.28%	97.62%	97.81%	99.19%	98.51%	96.8%	97.64%	97.83%	97.88%	97.94%	98.03%	98.53%	97.41%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	10.7%	9.7%	11%	10.5%	9.9%	9.7%	10.1%	9.4%	11.1%	11.6%	9.7%	9.5%	10%	9.6%	10.9%	9.9%	10.6%	9.7%
	R05	Outpatient DNA Rate	5%	10%	7.2%	6.9%	7.2%	7.4%	7.1%	7.1%	7.6%	6.8%	6.4%	7.3%	6.4%	7.2%	6.7%	7.1%	7.4%	7.2%	6.8%	6.8%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.19	2.05	2.26	2.16	2.1	2.15	2.2	2.22	2.17	2.1	2.06	1.99	2.05	2.1	2.22	2.15	2.16	2.03
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	20.2%	21.4%	16.8%	15.8%	20.2%	22.3%	20.8%	20.8%	22.6%	14.6%	18.6%	21.5%	23.8%	-	17.1%	21.1%	19.4%	21.4%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	279	82	31	22	26	17	23	27	23	19	22	18	25	17	71	66	69	65
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	103	25	11	11	10	8	9	9	9	5	5	8	8	4	33	27	23	21
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	8466	2182	647	757	774	854	606	836	715	696	576	471	632	503	2149	2234	2247	1679
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	3106	863	374	243	315	273	255	272	182	204	291	161	207	204	895	843	658	659
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	51	36	46	44	47	53	54	52	59	56	60	54	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	17	22	22	11	13	15	26	17	18	14	21	17	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1580	1502	1461	1555	1532	1757	1652	1989	1832	1574	1836	1571	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	572	515	671	451	479	593	453	501	614	451	459	618	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.05	3.85	4.37	4.12	3.87	4	3.74	4.15	4.15	3.96	4.01	3.93	3.66	3.8	4.09	3.87	4.08	3.87
	J04D	Percentage Length of Stay 14+ Days	-	-	6.8%	6.4%	7%	6.8%	6.8%	6.9%	6%	6.6%	6.9%	7.1%	6.5%	6.4%	6.3%	6.5%	6.7%	6.5%	6.9%	6.4%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	255	237	240	213	243	242	252	238	234	207	243	234	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	4%	4.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	2%	1.3%	4.2%	5.6%	3.3%	5%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	35.5%	50%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	50%	25%	40.9%	48.3%	50.6%	36.5%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	90%	86.48%	89.55%	91.26%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.26%	90.87%	88.64%	81.54%	89.3%
	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%	89.55%	91.26%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.26%	90.87%	88.64%	81.54%	89.3%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	78.35%	83.33%	86.82%	86.53%	84.11%	88.22%	77.24%	71.39%	73.24%	65.06%	73.92%	85.56%	89.08%	84.8%	86.14%	83.2%	69.78%	82.81%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	94.89%	95.84%	96.35%	94.99%	96.34%	91.54%	92.56%	93.91%	94.5%	95.08%	94.45%	96.25%	96.26%	96.39%	95.97%	93.42%	94.49%	95.67%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	96.26%	96.57%	97.04%	96.58%	97.43%	94.21%	98.34%	96.63%	94.35%	92.9%	94.4%	98.11%	97.66%	96.19%	96.74%	96.59%	94.62%	96.7%
	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	0	0	5	3	0	0	0	0	0	0	0	5	3	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.9%	96%	99.3%	97.8%	98.8%	98.6%	98.2%	97.6%	96.5%	96.3%	96.8%	94.8%	98.4%	94.3%	98.5%	98.5%	96.8%	96.7%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	94.4%	91.6%	92.6%	90.7%	94.2%	94.8%	99.4%	99.4%	98.4%	93.7%	91.9%	90.2%	92.8%	91.4%	91.7%	96.2%	97.2%	91.6%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.2%	51.4%	55.4%	54.1%	53.2%	48.4%	51%	54.4%	52.4%	48%	49.5%	53.8%	51.3%	50.8%	54.5%	50.8%	51.6%	51.6%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	97.4%	96.8%	97.3%	97.5%	97.1%	97.8%	98%	98%	97.6%	96.5%	96.5%	96.7%	97.3%	96.8%	97.4%	97.6%	97.4%	96.8%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.8%	2.9%	1.9%	2.3%	2.9%	3.3%	3.3%	3.1%	2.9%	2.9%	3%	3%	2.8%	2.9%	2.3%	3.2%	3%	2.9%
	B05	ED Left Without Being Seen Rate	5%	5%	1.9%	1.6%	2.1%	3.7%	1.1%	1.1%	1%	1%	1.1%	1.5%	1.4%	1.6%	1.7%	1.9%	2.6%	1.1%	1.2%	1.5%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	840	222	54	44	63	63	87	62	59	85	75	48	54	45	144	213	206	177
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	4%	4.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	2%	1.3%	4.2%	5.6%	3.3%	5%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	35.5%	50%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	50%	25%	40.9%	48.3%	50.6%	36.5%

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Trust Public Board meeting to be held on Thursday 27 September 2018, 10:00 – 12:30 in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Report Title	Quality and Outcomes Committee Chair's Report		
Author	Julian Dennis, Non- Executive Director		
Executive Lead(s)	Carolyn Mills, Chief Nurse William Oldfield Medical Director	Mark Smith, Deputy Chief Executive and Chief Operating Officer	
Freedom of Information Status	Open		

Reporting Committee	Quality and Outcomes Committee
Chaired by	Julian Dennis, Non-Executive Director
Date of last meeting	28 August 2018

Key risks and issues/matters of concern and any mitigating actions

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 28 August 2018.

Quality and Performance Report
Chief Operating Officer and Deputy Chief Executive Mark Smith, Carolyn Mills, Chief Nurse, and Matt Joint, Director of People presented the report to the Committee. The following key points were highlighted:

- Emergency department activity remained high, although the predictive tool used to plan was showing a high level of accuracy, and was helping staff to better understand arrival patterns.
- The Emergency Department trajectory had been delivered for July at 90.26%
- The Trust was on track against its Referral to Treatment (RTT) trajectory, and staff were being given additional training to ensure they understood the booking system.
- Despite the fire at the Bristol Haematology and Oncology Centre, the Trust was meeting the GP Cancer 62 Day recovery trajectory, with performance at 86% in June. The forecast suggested that the Trust would achieve its trajectory for the quarter.
- In relation to diagnostics, the biggest risk related to cardiac echo's, with a number of staff absences. A plan was in place and improvements were expected, but this would take several months to materialise.
- A rebasing of the Hospital Standardised Mortality Ratio (HSMR) data had occurred and this now showed the Trust at 120, which whilst within the expected range, would be considered by the Medical Director.
- Challenges remained to respond to complaints within the timescales CQG were

receiving detailed performance reports on this KPI each month to understand reasons for delays/support specific actions to improve performance. Specific work was ongoing in Women's and Children's to strengthen processes and oversight as this was the poorest performing division.
- Essential training compliance and levels of sickness were good, but turnover remained a concern.

On-hold Update
Deputy Chief Executive and Chief Operating Officer Mark Smith presented this update to the Committee. Key points discussed included the following:

- Significant work had been undertaken by the Performance Team to conclude the validation of the circa 87,000 on-hold pathways.
- From the 87,000 patients records, 77 were sent to the harm panel for review and resulted in no identified harm; one serious incident had been reported.
- There had been positive recognition from the Intensive Support Team of the hard work undertaken and the completion of the task to a successful conclusion in a short timescale.
- NHS Improvement had asked that the Performance Team to present on this nationally as an exemplar of how this has been successfully delivered.
- 1,000 patients left were left on the register who were considered the lowest risk
- A bi-annual paper on the status of on-hold patients would be presented to the Audit Committee for ongoing assurance.

Workforce and Organisational Development Report – Q1
Matt Joint, Director of People, presented the report. Key points discussed included the following

- The focus in quarter 1 was on the outcomes of the staff survey and availability and awareness of staff support and wellbeing services as well as building user confidence in e-appraisal.
- Average sickness rates were good and essential training compliance stable, but turnover was a concern, although this was noted as reducing in Facilities.
- There were challenges in recruiting to specialist roles.
- Nursing recruitment initiatives were being explored to support recruitment from London and Portugal.
- Divisions were being encouraged to review the use of Happy App, which had provided rich data to back up staff engagement work.

Assessment of Governance for Opioid Prescribing and Administration
Director of Pharmacy, Jon Standing, presented the report to the Committee to provide assurance to the Board following the publication of the report from The Gosport Independent Panel into deaths at Gosport War Memorial Hospital. Key points discussed included the following:

- Gosport was an isolated care delivery unit, with limited medical support and predominantly one prescriber.
- Opioids were prescribed within a large dose range, which were not necessarily appropriate for the patients

- There was a culture issue within Gosport around use of opioids – common practice for patients to be prescribed and doses escalated relatively quickly to levels which were clinical concerning.
- There was no sense of challenge back to prescriber from nurses or pharmacists.
- Following a review of practice in UH Bristol there were no concerns identified.

Reports also received by the Committee included:

- **Serious Incident Report**
- **Root Cause Analysis Reports**
- **Monthly Nurse Safe Staffing Report**
- **Infection Control Annual Report and Q1 Update**
- **Clinical Quality Group Meeting Report**

Matters requiring Committee level consideration and/or approval	
None.	
Matters referred to other Committees	
None.	
Date of next meeting	25 September 2018

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on Thursday 27 September 2018 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Agenda Item	18
Meeting Date	Thursday, 27 September 2018

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

Reporting Committee	Finance Committee
Chaired by	Martin Sykes, Non-Executive Director
Lead Executive Director (s)	Paul Mapson, Director of Finance and Information
Date of last meeting	28 August 2018

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 of 28 August 2018.

Dermatology Demand Management
The Committee received an update on increases in demand for dermatology services and mechanisms to manage this, in particular improved usage of facilities at South Bristol Community Hospital.

Surgery Non-Pay Update
The Committee received an update on the non-pay position of the surgery division, including an analysis of the overspend and mitigating actions.

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 July was a surplus of £4.882m excluding technical items, and the Trust was reporting a surplus of £4.305m, £0.517m adverse to plan.
- The key areas of concern were the divisional positions reported for Surgery and Medicine. The focus was on returning the divisions to a sustainable run rate for 2019/20.
- Capital expenditure was slightly behind internal planning, and the forecast was a significant underspend on the capital plan, predominantly relating to strategic capital. This had resulted in higher than plan cash balances.

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 £0.03m higher than plan in July 2018.
- Uncoded activity was higher than expected and thus the risk around income estimate was higher.
- The 2019/20 tariff engagement document was now likely to be published in November at the earliest which would affect planning for 2019/20.

Detailed Divisional Financial Reports
The detailed Divisional reports were noted, as the detail around the Medicine and Surgical division's performance had been discussed earlier in the meeting.

Savings Programme
The Committee noted the following:

- The Trust had achieved savings of £7.507m against a plan of £7.680m, an underachievement of £173k.
- The majority of plans were expected to deliver towards the end of the financial year and therefore focus was required to ensure delivery and address the under delivery to date.

Capital Income and Expenditure Report
The Committee noted the following:

- Capital expenditure to the end of July was £6.362m compared to an internal plan of £6.493m. This was against an overall capital programme of £47.089m.

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

- **Minutes of Capital Programme Steering Group**
- **Statement of Financial Position**
- **Month 4 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	
None identified.	
Date of next meeting	25 September 2018