Royal Brompton and Harefield Hospitals Clinical Quality Report M1 - M2 2021 – 22

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Safe: Infection Prevention and Control Data owner: Lucy Everett – Matron Lead - Infection Prevention and Control (IPC)

Blood stream infection rates

No objectives for *Clostridium difficile* (*Clostridioides difficile*) have been applied at a national level for 2021-22. In line with the changes made during 2020-21, lapses in care will be assessed at a local level and will not be assessed at national level.

For 2021-22, the IPC Dashboard has been modified to reflect changes in infection control priorities and infection incidents. *Klebsiella sp.* has been added to the table as Royal Brompton & Harefield Hospitals saw an increase in blood stream infections relating to this organism during 2020-21. A review of the 2021-21 cases determined that there was no association between these. These species can cause a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections and meningitis. It can be acquired endogenously (from the patient's own gut flora) or exogenously from the healthcare environment. Post infection reviews are undertaken on all blood stream infection cases with findings reported to the Infection, Prevention & Control Committee, which in turn reports to Governance and Quality Committee.

*Covid-19 HOPHA & HODHA:-

Hospital-Onset Probable Healthcare-Associated (HOPHA):- Positive sample 8-14 days

Hospital-Onset Definite Healthcare-Associated (HODHA):- Positive sample >= 15 days

Royal Brompton & Harefield Hospitals Infection Prevention and Control Key Performance Indicators Dashboard													
May 21	Mandatory Reporting						Compliance with Infection Prevention and Control Policy						Training
	Total number of incidents reported						Hand Hygiene Compliance Audit (Observed /Opportunities)				PPE Compliance Audit	Covid-19 HOPHA & HODHA*	IPC Training Compliance
Division/ Ward	MRSA BSI >48 hrs	MSSA BSI >48 hrs	E. coli BSI >48 hrs	Kleb BSI > 48 hrs	P.A** BSI>48 hrs	CDT >48 hrs	Nurse	Dr	AHP	Total	Total	Total	Monthly Total
RBH	0	1	0	0	0	0	96%	92%	98%	95%	96%	0	94%
HH	0	0	0	1	0	0	100%	93%	98%	97%	97%	0	94%
RBH, HH & WS Clinical Group	0	1	0	1	0	0	97%	92%	98%	96%	96%	0	93%

An increased incidence of Vancomycin-resistant enterococci (VRE) on Harefield ITU has been investigated. Five patients were identified. Typing results have excluded cross infection.

Enhanced cleaning has been put in place, along side increased environmental auditing. Also, there is an additional focus on antimicrobial stewardship and PPE. In addition, an increased focus on hand hygiene and line care surveillance has been implemented with monitoring taking place .

Safe: Incident management and reporting

Data owners: Penny Mortimer, Waseem Raja and Charlotte Von Crease – Divisional Quality and Safety Leads

The divisional quality leads have confirmed that there has been 0 serious incidents reported in 21/22 during M2. However, at the time of writing, 1 serious incident has been reported in M3.

The Risk and Safety Committee continues to have oversight of serious incidents and receives updates on learning and subsequent actions resulting from the investigation of serious incidents. This includes the following actions from recently concluded investigations:

- Guidelines for securing and dressing peripheral cannulas in ECMO patients have been updated
- DNACPR audit has been carried out and results shared
- Pain management added to the Junior Doctor induction
- Education and training on SRWW in care and treatment of patients with pulmonary hypertension
- Central oversight of the ACHD surgical waiting list with a priority allocation implemented

Duty of candour compliance

	Red and amber incidents declared					
	Moderate harm (amber)	Severe harm (Red)	Total with stage 1 complete	*Total with stage 2 complete	*Total with both stages complete	*Percentage fully compliant
Jan-21	7	0	7	6	6	86%
Feb-21	2	1	3	1	1	33%
Mar-21	4	0	4	2	2	50%
Apr-21	7	1	8	6	6	75%
May-21	4	1	5	0	0	0%

Safe: Staffing M2

Data owner: Peter Doyle – Divisional Lead Nurse / Associate General Manager Harefield Hospital

Royal Brompton Hospital M02		
% of registered nurse ***day*** hours filled as planned	96%	of planned level
% of registered nurse ***night*** hours filled as planned	81%	of planned level
% of unregistered care staff ***day*** hours filled as planned	67%	of planned level
% of unregistered care staff ***night*** hours filled as planned	72%	of planned level

Harefield Hospital M02		
% of registered nurse ***day*** hours filled as planned	116%	of planned level
% of registered nurse ***night*** hours filled as planned	91%	of planned level
% of unregistered care staff ***day*** hours filled as planned	84%	of planned level
% of unregistered care staff ***night*** hours filled as planned	89%	of planned level

The month of May saw ongoing activation of Covid-19 recovery plans with high levels of occupancy on both sites. Sickness absence rates continued to reduce in most nursing teams though these remain above pre-pandemic levels.

Covid-19 pathway guidance continues to result in the need for increased numbers of nursing staff in some ward areas. This particularly applies in mixed pathway areas admitting high numbers of non-elective patients.

Additional efforts to recruit non-registered nursing staff are being made. This is due to the reduced supply of registered nursing staff, and the improved quality of applicant seen in response to recent Health Care Assistant adverts.

Safe staffing was achieved throughout the month and no NICE Red Flags were reported.

Safe / Caring: Local Quality Priorities

Data owners: Catherine Bouchard, Deputy Chief Pharmacist/Deputy Clinical Director of Medicines Optimisation
Lauren Berry, Associate Director R&T – Patient Services

The Trust Quality Priorities for 2021-22 are set out in full in the Trust's Annual Quality Report. The Clinical Group is actively engaging in delivering the following Quality Priorities at a local level:

Medication Safety

We will reduce medicines-related problems at transfer including admission to hospital, discharge from hospital and during internal transfer.

This priority supports delivery of our quality goal to reduce avoidable harm

End of life care

We will promote holistic care for patients towards the end of their life, and those important to them in hospital and the community

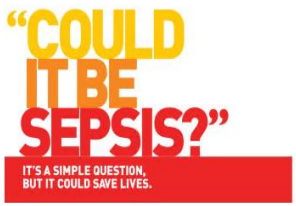
This priority supports delivery of our quality goal to improve end of life care.

Risk and Safety Committee will receive updates from leads, as and when key achievements or exceptions are to be reported.

Clinical Group Board will receive an end of year position statement for both Local Quality Priorities.

Safe: Sepsis

Data owners: Dr Caterina Vlachou, Consultant in Anaesthesia and Critical Care RBH and Dr Orinta Kviatkovske, Consultant in Anaesthesia and Critical Care HH



During Q4 2020-21 a total of 16 patients were found to have suspected sepsis. Following a case review, one of these patients was identified as not receiving the prescribed antibiotics within one hour. As a result, further education for nursing staff has been provided and local monitoring continues to take place to ensure that prescribed antibiotics are administered as soon as prescribed.

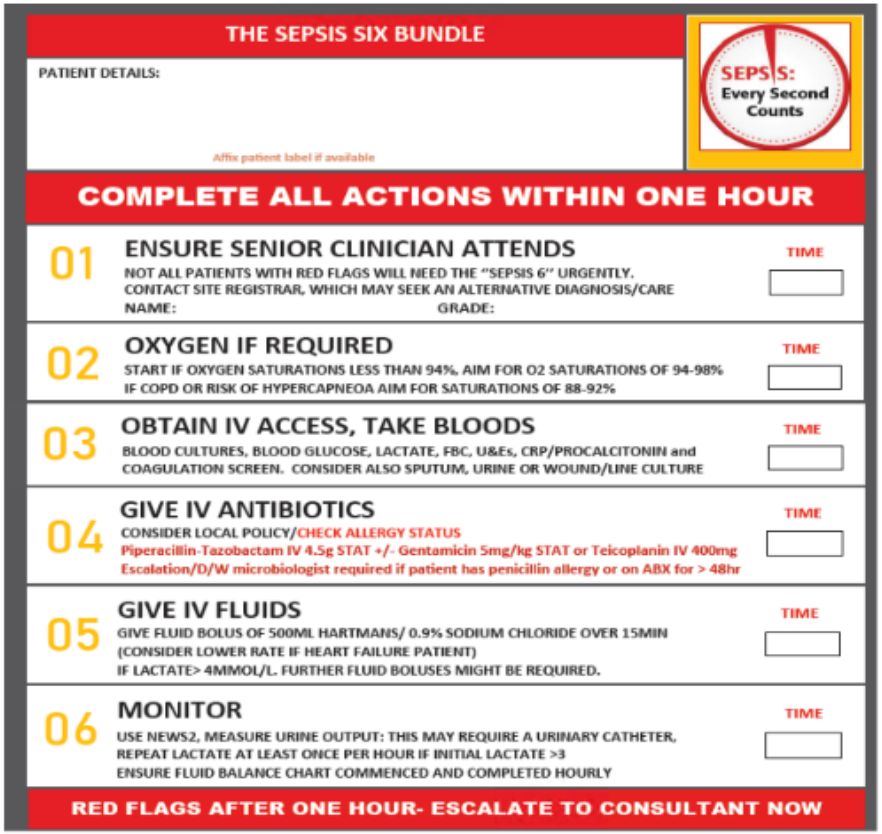
	HH	RBH	Total	% compliance
Total number of patients found to have suspected sepsis in inpatient departments who are positively screened for sepsis received IV antibiotics within 1 hour of this diagnosis.	12	3	15	94%
The total number of patients who were diagnosed with suspected sepsis in inpatient departments	13	3	16	

Due to the nature of patients admitted to Harefield Hospital, the number of patients found to have suspected sepsis is higher than at Royal Brompton Hospital. In recent months there has been a focus on sepsis at Harefield Hospital to help clinical and nursing teams to further enhance their knowledge of identifying those patients at risk and managing all patients found to have suspected sepsis. Leading this work on the Harefield Hospital, with Dr Orinta Kviatkovske, is the newly appointed 'Sepsis Nurse' Claudia Berbecar.

Improvements implemented at the Harefield Hospital site during Q1 2021-22 include:

- New updated sepsis screening forms introduced (according to updated sepsis guidelines)
- Ensuring sepsis trolleys are visible, accessible and have all information for nurses and doctors at hand
- Improving awareness and communication about sepsis
- Identifying sepsis champions on wards and working with practice educators
- Exploring options for online sepsis mandatory training
- Ensuring sepsis forms/breaches are reviewed on time
- Collaboration with the Trust Sepsis Team

A key focus within the improvements being made is for a senior clinician to attend and review the patient, as not all patients with red flags will need urgent implementation of the Sepsis 6 bundle.


THE SEPSIS SIX BUNDLE

PATIENT DETAILS:

Affix patient label if available

SEPSIS: Every Second Counts

COMPLETE ALL ACTIONS WITHIN ONE HOUR

01 ENSURE SENIOR CLINICIAN ATTENDS — TIME
NOT ALL PATIENTS WITH RED FLAGS WILL NEED THE "SEPSIS 6" URGENTLY.
CONTACT SITE REGISTRAR, WHICH MAY SEEK AN ALTERNATIVE DIAGNOSIS/CARE
NAME: GRADE:

02 OXYGEN IF REQUIRED — TIME
START IF OXYGEN SATURATIONS LESS THAN 94%. AIM FOR O2 SATURATIONS OF 94-98%
IF COPD OR RISK OF HYPERCAPNEOA AIM FOR SATURATIONS OF 88-92%

03 OBTAIN IV ACCESS, TAKE BLOODS — TIME
BLOOD CULTURES, BLOOD GLUCOSE, LACTATE, FBC, U&Es, CRP/PROCALCITONIN and COAGULATION SCREEN. CONSIDER ALSO SPUTUM, URINE OR WOUND/LINE CULTURE

04 GIVE IV ANTIBIOTICS — TIME
CONSIDER LOCAL POLICY/CHECK ALLERGY STATUS
Piperacillin-Tazobactam IV 4.5g STAT +/- Gentamicin 5mg/kg STAT or Teicoplanin IV 400mg
Escalation/D/W microbiologist required if patient has penicillin allergy or on ABX for > 48hr

05 GIVE IV FLUIDS — TIME
GIVE FLUID BOLUS OF 500ML HARTMANS/ 0.9% SODIUM CHLORIDE OVER 15MIN (CONSIDER LOWER RATE IF HEART FAILURE PATIENT)
IF LACTATE> 4MMOL/L. FURTHER FLUID BOLUSES MIGHT BE REQUIRED.

06 MONITOR — TIME
USE NEWS2, MEASURE URINE OUTPUT: THIS MAY REQUIRE A URINARY CATHETER,
REPEAT LACTATE AT LEAST ONCE PER HOUR IF INITIAL LACTATE >3
ENSURE FLUID BALANCE CHART COMMENCED AND COMPLETED HOURLY

RED FLAGS AFTER ONE HOUR- ESCALATE TO CONSULTANT NOW


COMPLETE ALL ACTIONS WITHIN ONE HOUR

01 ENSURE SENIOR CLINICIAN ATTENDS — TIME
NOT ALL PATIENTS WITH RED FLAGS WILL NEED THE "SEPSIS 6" URGENTLY.
CONTACT SITE REGISTRAR, WHICH MAY SEEK AN ALTERNATIVE DIAGNOSIS/CARE
NAME: GRADE:

Safe: Surgical Site Infections (SSI)

Data owner: Melissa Rochon, Quality & Safety Lead for Surveillance

In 2019 Royal Brompton and Harefield NHS Foundation Trust participated in the Getting It Right First Time (GIRFT) SSI national audit and achieved positive outcomes, with SSI rates amongst the lowest reported in the national audit:

- our hospitals ranked 2 out of 10 for SSI rates in SSI iso-CABG (1.9% vs GIRFT SSI mean 4.2%)
- we ranked 3 out of 10 for valve+/-other surgery (0.5% vs GIRFT SSI mean 2.8%)
- in the cardiac subgroup, 'other', we reported no (0) SSI (0% vs GIRFT SSI mean 0.4%). However, we were ranked 7 out of 11, reflecting the fact that other centres with no SSI were ranked higher because they had a higher volume of activity than our sites in this category.

Although the Trust performed well in the review, the generic recommendations for improvement were considered and have been used to strengthen the governance processes that underpin SSI surveillance. This work has continued though out the Covid-19 pandemics.

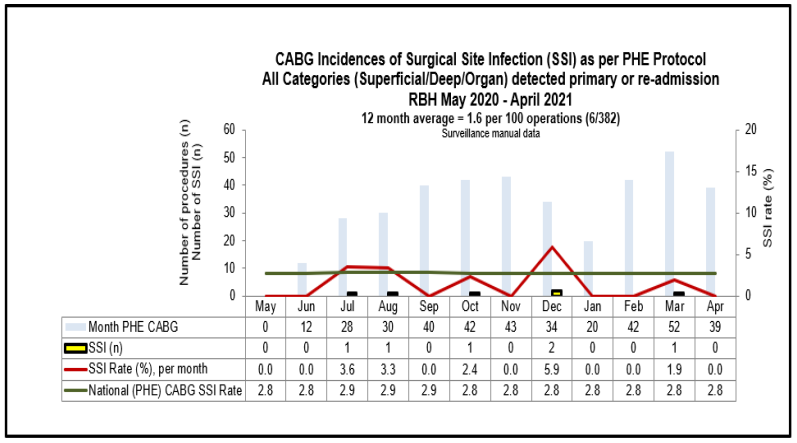
Achievements in the last year include:

- Digital SSI identification surveillance system (Isla) implemented in October 2020, which includes post-discharge surveillance.
- Following our RB-H successful manufacture and supply of our patented cardiac BHIS bra, the team is now trialing a CT vest with colleagues from St Bartholomew's Hospital. Prototype 6, final version planned August 2021.

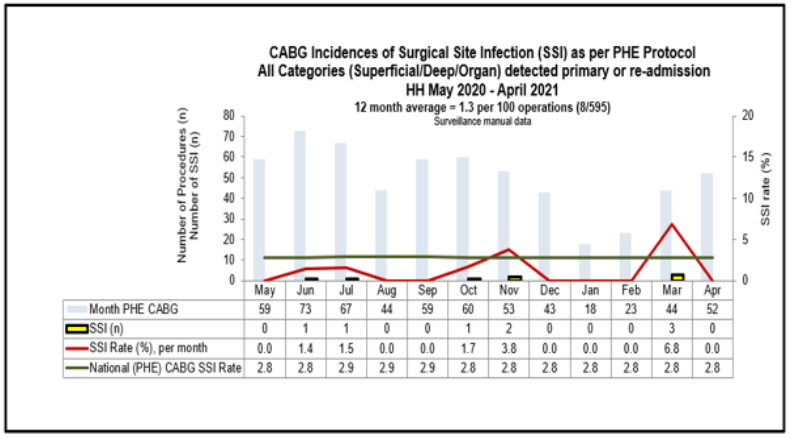
Further goals have been set for 2021-22:

- Implementation of a new system to report NICE assurance / care bundle compliance to reduce SSIs for all patients (not just those with SSIs).
- Participation in the nation NHIR Target Wound Infection study focused on reducing variation in practices to prevent SSI (cardiac surgery).
- Improving patient wound care documentation & training for digital images. Planned July/August 2021

In addition to the above, data continues to be submitted to the Public Health England (PHE) coronary artery bypass graft (CABG) and Cardiac programmes for surveillance. SSI rates continue to be lower than the national average and two low outlier notifications from PHE have been received since the 2019 GIRFT review. The graphs below show a snapshot of outcomes for CABG SSI rates at Harefield Hospital and at Royal Brompton Hospital.



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Month PHE CABG	0	12	28	30	40	42	43	34	20	42	52	39
SSI (n)	0	0	1	1	0	1	0	2	0	0	1	0
SSI Rate (%), per month	0.0	0.0	3.6	3.3	0.0	2.4	0.0	5.9	0.0	0.0	1.9	0.0
National (PHE) CABG SSI Rate	2.8	2.8	2.9	2.9	2.9	2.8	2.8	2.8	2.8	2.8	2.8	2.8



	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Month PHE CABG	59	73	67	44	59	60	53	43	18	23	44	52
SSI (n)	0	1	1	0	0	1	2	0	0	0	3	0
SSI Rate (%), per month	0.0	1.4	1.5	0.0	0.0	1.7	3.8	0.0	0.0	0.0	6.8	0.0
National (PHE) CABG SSI Rate	2.8	2.8	2.9	2.9	2.9	2.8	2.8	2.8	2.8	2.8	2.8	2.8

Caring: Patient and Public Engagement

Data owners: Karen Taylor - Lead for Arts and Patient & Public Engagement

Friends and Family Test – Feedback And Suggestions For Improvement

Work continues to maximise response rates for outpatient services as response rates continue to be much lower than pre-Covid-19. The majority of this feedback is captured from virtual appointments. Positive approval ratings received for outpatient services during April were lower than usual, however positive approval ratings increased during May.

Month	Number of responses	Positive	Negative
M1	125	86%	10%
M2	161	94%	2%

Out-Patient Feedback And Suggestions For Improvement

"We were seen almost straight away. The staff we saw were incredibly friendly and professional and so good with my daughter. We saw lots of people and did lots of tests but were able to stay in one room and we were never left waiting. We could ask any questions we wanted they all listened to everything we had to say and at no point were we rushed. It felt like we were important to them and that they genuinely cared."
Brompton Paediatrics

"I missed the call of my telephone appointment at 1030 as I was trying to log in to the videocall and find my new mobile number. Appointment was at 1030 and I logged in to videoconference at 1032 no one answered waited until 1052 also called back the number and left a message."
Brompton Respiratory Medicine

Suggestions for Improvement

"Clinical staff very efficient, everything explained clearly at every stage. No major delays in waiting. However, non-medical staff in reception in the department were decidedly average job: no smile, no good morning. Definite room for improvement!"
Brompton Nuclear Medicine

In-Patient Feedback And Suggestions For Improvement

"The cherry tree ward is a lovely friendly ward the staff are brilliant they do care and look after all the patients; the staff could not do any more than they already do." **Cherry Tree Ward**

"It's the anguish of waiting for a bed when you have been told you operation is URGENT and then cancelled at last minute and as a cancer patient it adds to your anxiety and not good for anyone's mental health...Not a pleasant experience at all and specially as this was second time for a procedure that came back inconclusive but waited 2 weeks for those results ..2 months awaiting results and still no further to treatment if any ..Makes you feel you just want to give up."
Cherry Tree Ward

Suggestions for Improvement

"My care was excellent until discharge. I have had many palpitations since I came home. I was not given any information on what to expect once I was discharged. I phoned the ward only to be told to ring the Specialist Arrhythmia Nurse. I did this and a recorded message informed me someone will reply within 48-72 hours. I feel as though I have no help until I get an appointment in 3-4 months."
Paul Wood Ward

All feedback and suggestions for improvement are shared with the teams for consideration and action.

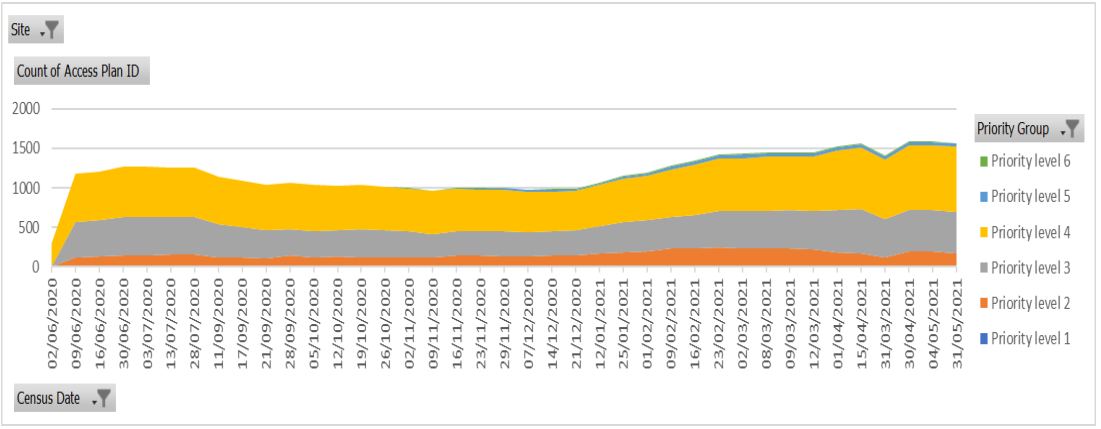
Safe: **Keeping patients safe whilst waiting – surgical prioritisation M2**

Data owner: Jagdesh Grewal - Clinical Service Manager for RBH Heart Division and Michael White - General Manager HH Heart Division

Patients awaiting cardiac surgery and cardiology services on RTT pathways have undergone a full clinical review, including reassessment of priority level. Patients continue to be scheduled for surgery and interventions based on clinical priority. The tables and charts below show the position as of 31st May 2021.

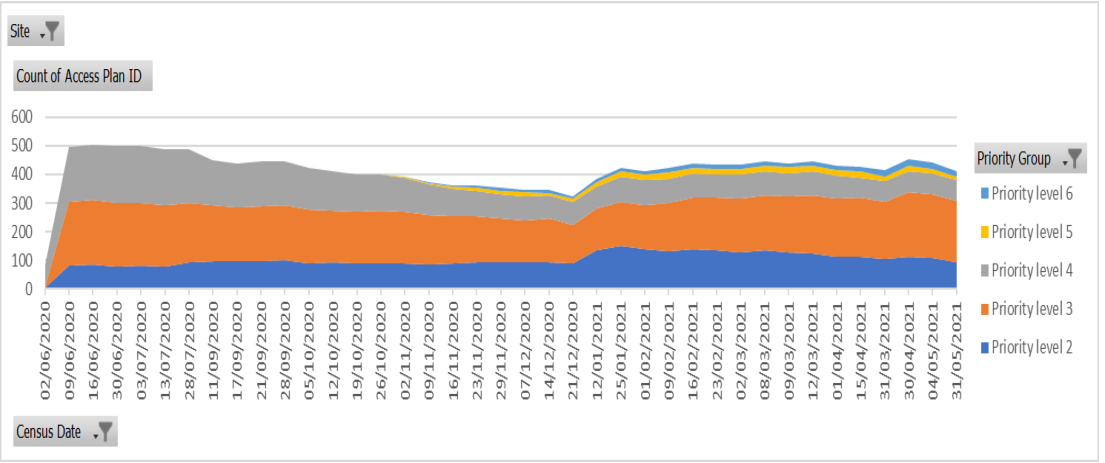
Cardiology

Priority	Brompton	Harefield	Grand Total
Priority level 2	68	98	166
Priority level 3	290	237	527
Priority level 4	479	356	835
Priority level 5	19	10	29
Priority level 6	1	9	10
Grand Total	**857**	**710**	**1567**



Cardiac Surgery

Priority	Brompton	Harefield	Grand Total
Priority level 2	39	53	92
Priority level 3	124	91	215
Priority level 4	47	26	73
Priority level 5	10	3	13
Priority level 6	11	6	17
Grand Total	**231**	**179**	**410**



Responsive: Referral to Treatment waiting times

Data owners: Derval Russell – Harefield Hospital Director and Ross Ellis – Royal Brompton Hospital Director
Stewart Neale – Head of Performance and Information

RTT Incomplete Performance: 79.31%

Patients Waiting > 52 Weeks: 111

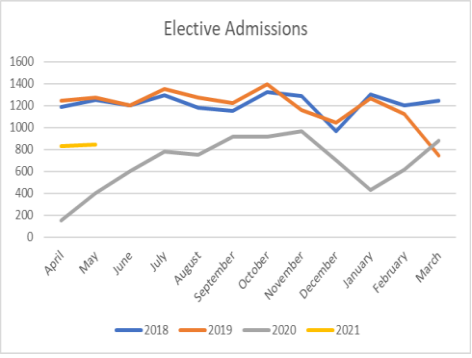
At the end of May 79% of incomplete patent pathways were under 18 weeks. This is an improvement on the end of April position (77% incomplete patient pathways under 18 weeks).

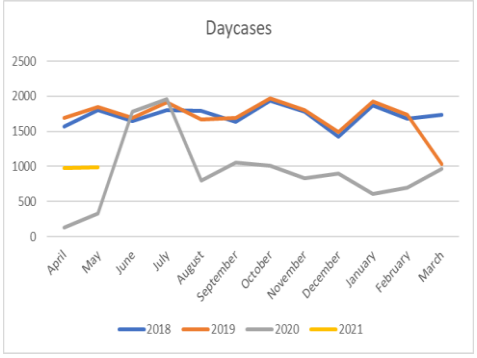
The number of patients waiting >52 week has decreased to 111. This was predicted to deteriorate further in June however performance was better in May than predicted and the same is now expected for June. The majority of patients waiting >52 week are waiting for cardiology services (93). Patients waiting on an admitted pathway have the following priorities P2- 0 patients, P3- 10 patients, P4 – 75 patients, P5 – 5 patients and P6 – 3 patients.

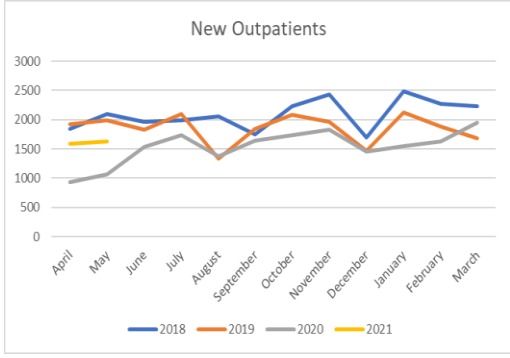
Treatment Function Data		<18 weeks waiters	>=18 weeks waiters	Incomplete Pathways	Incomplete Performance	52+
Cardiology	Brompton	773	225	998	77.45%	43
	Harefield	1,087	436	1,523	71.37%	51
Cardiothoracic Surgery	Brompton	208	91	299	69.57%	11
	Harefield	144	41	185	77.84%	3
	Thoracic Surgery	241	28	269	89.59%	
Thoracic Medicine		1,756	341	2,097	83.74%	
Other	Paediatrics	458	63	521	87.91%	3
	Transplant	54	3	57	94.74%	
	Other	67	21	88	76.14%	
Total		4,788	1,249	6,037	79.31%	111

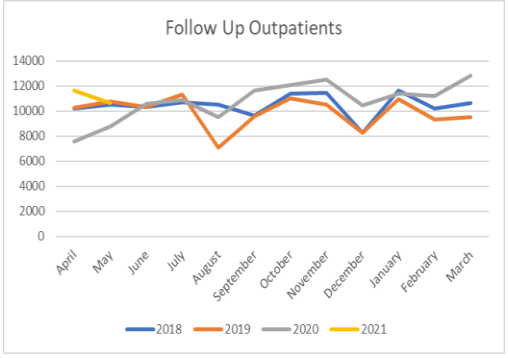
Responsive: Elective recovery planning – Month 2

Data owner: Data owners: Derval Russell – Harefield Hospital Director and Ross Ellis – Royal Brompton Hospital Director
Stewart Neale – Head of Performance and Information









Elective activity. Day-case admissions are approximately 53% of the May 2019 level. This is largely driven by respiratory performance at 43%, where changes in day case pathways have resulted in a reduction of elective activity levels by approximately 20%. Ordinary elective admissions are at 67% of May 2019 level. This is less than the national planning target of 70% in April rising to 85% by July.

Outpatient activity continues to have reached levels pre-pandemic levels with the successful shift to virtual appointments. The Clinical Group is very strongly placed to continue meet the national aspiration to deliver 25% of outpatients virtually.

Additional Information

Single Oversight Framework And Quality Performance Metrics – 12 Months Rolling

Key Performance Indicators		Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	12 Month	Comments
Safe			M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2	Rolling	
1.1 Incident reporting	Serious incidents		1	0	1	0	2	1	0	2	2	3	1	1	1	14	
	Incidents resulting in unexpected death	0	0	0	0	0	0	1	0	0	1	1	0	1	1	5	M1 TBC following SI investigation
	Incidents resulting in severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2 Harm free care	Pressure ulcer acquisitions (category 2 and above) attributable to Trust		4	8	6	5	3	7	6	10	9	7	5	9	5	80	A review of 2020-21 pressure ulcers is underway and will report to G&Q once concluded
	Total falls		9	14	14	14	15	20	13	12	17	19	16	16	10	180	
1.3 Infection control and cleanliness	Clostridium difficile (C. difficile) reported number: (no target set by NHS England)		2	1	0	0	1	0	1	2	1	2	1	0	0	9	
	Clostridium difficile (C. difficile) ***healthcare associated***: (no target set by NHS England)		2	1	0	0	0	0	1	2	1	2	0	0	0	7	
	C-Diff acquisitions resulting from lapse in care		0	1	0	0	0	0	0	0	0	0	0	0	0	1	
	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	MRSA bacteraemia ***(Hospital onset)***		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias		2	0	2	2	0	0	2	1	2	3	1	2	1	16	
	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias ***(Hospital onset)***		1	0	2	2	0	0	1	1	2	3	1	1	1	14	
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)		1	0	0	0	1	0	0	0	1	0	3	0	0	5	
	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) ***(Hospital onset)***		1	0	0	0	1	0	0	0	1	0	3	0	0	5	
	Klebsiella species BSI		0	0	1	0	3	1	1	1	1	4	2	1	1	16	
	Klebsiella species BSI ***(Hospital onset)***		0	0	1	0	3	1	1	1	1	4	2	1	1	16	
	Pseudomonas BSI		0	1	0	0	0	0	1	0	3	1	0	1	0	7	
	Pseudomonas BSI ***(Hospital onset)***		0	1	0	0	0	0	1	0	3	1	0	1	0	7	

Single Oversight Framework And Quality Performance Metrics – 12 Months Rolling

Key Performance Indicators		Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	12 Month Rolling	Comments
Safe			M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M1	M2		
1.4 Screening on admission	VTE screening (externally reported)		97%	98%	94%	98%	97%	98%	97%	97%	96%	99%	99%	99%	99%	98%	
1.5 Safe Staffing	Ratio of actual to planned hours RBH		76%	69%	84%	75%	86%	99%	101%	94%	102%	104%	95%	83%	86%	90%	M1 Commentary included in the report
	Ratio of actual to planned hours HH		111%	107%	113%	99%	103%	104%	92%	99%	91%	112%	100%	98%	101%	101%	
Caring																	
2.2 Friends and Family Test - Inpatient	Number of eligible patients		863	1209	1549	1222	1532	1807	2008	1993	1232	1401	2039	2115	2160	20267	Suggestions for improvement received - 52. Examples given in the report
	Number of responses		303	410	483	373	505	624	748	682	437	478	680	770	733	6923	
	Response rate		35%	34%	31%	30%	33%	34%	37%	34%	36%	34%	33%	36%	34%	34%	
	Friends and Family test - % positive experience		96%	95%	95%	96%	95%	95%	96%	94%	97%	97%	96%	94%	93%	95%	
	Friends and Family test - % negative experience		1%	3%	2%	2%	3%	3%	2%	3%	2%	1%	3%	2%	3%	2%	
2.3 Friends and Family Test - Outpatient care	Number of responses		26	89	85	No data collection	2	1	3	81	155	141	122	125	161	965	Suggestions for improvement received - 6. Examples given in the report
	% Positive experience		89%	88%	87%		100%	100%	100%	91%	87%	87%	91%	86%	94%	92%	
	% Negative experience		4%	9%	6%		0%	0%	0%	5%	7%	9%	4%	10%	2%	5%	
3.1 Complaints Management	Complaints opened in month		2	9	1	7	10	11	5	7	6	5	13	11	3	88	
	Number of above acknowledged within 3 working days		1	8	0	6	10	11	5	7	6	5	13	8	2	81	
	Complaints re-opened in month		0	0	0	0	1	3	1	1	1	0	1	1	0	9	
	Complaints closed in month		1	5	0	2	7	8	0	5	7	0	0	4	2	40	
	Number of above closed within agreed timescales		0	1	0	2	3	3	0	4	5	0	0	0	0	18	
	Number of complaints referred to PHSO		0	0	0	0	0	0	2	0	0	0	0	0	0	2	
	Number of complaints confirmed as no action by PHSO		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of complaints Upheld by PHSO		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of complaints partially upheld by PSHO		0	0	1	0	0	1	0	0	0	0	0	0	0	2	
	Number of complaints not upheld by PHSO		0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Single Oversight Framework And Operational Performance Metrics – 12 Months Rolling

Key Performance Indicators		Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	YTD Total	
Responsive			M2	M3	M4	M5	M5	M7	M8	M9	M10	M11	M12	M1	M2		
4.1 Elective treatment access - referral to treatment (RTT) performance	RTT - Incomplete pathways < 18 weeks	92%	74.04%	60.52%	61.01%	65.16%	66.40%	70.14%	72.97%	73.47%	74.62%	75.19%	73.43%	76.82%	79.31	725%	
	RTT - Incomplete pathways over 52 weeks	0	1	5	11	15	11	17	9	10	40	75	98	135	111		
	RTT - Total incomplete pathways		5,580	6,351	6,010	6,057	6,136	6,205	5,868	6,032	6,238	6,212	6,337	5,963	6037		
4.2 Cancer services - *reported one month in arrears*	All cancers – maximum 62-day wait for first treatment from: a) urgent GP referral for suspected cancer																
	Seen / treated		6.0	4.0	10.0	4.0	8.0	4.0	5.0	9.0	7.0	7.0	5.0	7.0	TBC		Reported one month in arrears. Patient 1: Referred Day 131, treated Day 166 (35 days). RBH OPA delay & theatre capacity. Patient 2: . Referred Day 40, treated Day 70 (30 days). Required Cardiac and Anaesthetic reviews before cleared for surgery. Patient 3: Referred on Day 98, treated Day 135 (37 days). Required additional diagnostic procedures post referral
	Compliant (Using 0.5 score)		1.0	1.0	2.5	1.0	1.0	1.0	1.0	4.0	3.5	1.0	2.5	2.0	TBC		
	Breaches (Using 0.5 score)		4.0	2.0	5.0	2.0	6.0	3.0	3.0	2.0	1.5	5.00	3.00	3.00	TBC		
	Cancer Target – 31-day decision to treat to first definitive treatment																
	Seen / treated		32	24	34	24	39	36	38	20	29	33	40	37.0	TBC		Reported one month in arrears. M1 breaches occurred due to theatre capacity at RBH
	Compliant		32	23	34	23	39	36	38	20	29	32	40	28.0	TBC		
	Breaches		0	1	0	1	0	0	0	0	0	1	0	3	TBC		
	Cancer Target – 31-day decision to treat to subsequent treatment																
	Seen / treated		16	19	13	13	20	20	16	18	16	22	25	10.0	TBC		Reported one month in arrears. M1 breach - planned date cancelled due to RBH theatre capacity.
	Compliant		16	19	12	13	20	19	15	17	16	21	25	9.0	TBC		
	Breaches		0	0	1	0	0	1	1	1	0	1	0	1	TBC		
4.3 Diagnostic access	Number of diagnostic waits over 6 weeks		218	143	6	3	2	3	17	39	43	50	111	153	130		