NHS Foundation Trust

Agenda for a Public Meeting of the Trust Board of Directors to be held on 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes and Actions from Previous Meetings To consider the Minutes of a Public Meeting of the Trust Board of Directors dated 27 March 2014 for **approval,** and to **review** the status of actions agreed.	Chairman	1
4. Minutes and Actions from the Extraordinary Public Board Meeting To consider the Minutes of a the Extraordinary Public Meeting of the Trust Board of Directors dated 14 April 2014 for **approval**, and to **review** the status of actions agreed.	Chairman	14
5. Chief Executive's Report To receive this report from the Chief Executive to **note**.	Chief Executive	20
Delivering Best Care		
6. Patient Experience Story To receive the Patient Experience Story for **review**.	Chief Nurse	23
7. Quality and Performance Report To receive the Quality and Performance Report for **review**. a. **Quality & Outcomes Committee Chair's Report** b. **Patient Experience – Chief Nurse** c. **Performance Overview – Director of Strategic Development** d. **Board Review**	Director of Strategic Development and Deputy Chief Executive	27
8. Infection Control Quarterly Report To receive this report by the Chief Nurse for **review**.	Chief Nurse	107

Item	*Sponsor*	*Page*
9. Transforming Care Report To receive this report from the Chief Operating Officer to **note**.	Chief Operating Officer	124
10. National Institute for Health Research Clinical Research Network, West of England. Annual Plan and Financial Plan To receive this report from the medical Director for **review.**	Medical Director	128
11. Research and Innovation Strategy Update Report To receive this report form the Medical Director for **review**	Medical Director	183
12. Estates Strategy Update To receive this report from the Director of Strategic Development and Deputy Chief Executive to **note.**	Director of Strategic Development and Deputy Chief Executive	196
13. Action Plan in Response to the Care Quality Commission Inspection of Dementia Care (Action 262). To receive this report from the Chief Nurse to **note.**	Chief Nurse	208
Delivering Best Value		
14. Finance Report To receive this report by the Director of Finance and Information for **review**.	Director of Finance and Information	236
15. Finance Committee Chair's Report To receive this verbal report by the Chair of the Finance Committee for **review**.	Director of Finance and Information	
Building Capability		
16. Teaching and Learning Strategy Update To receive this report from the Director of Workforce and Organisational Development for **review.**	Director of Workforce and Organisational Development	258
Leading in Partnership		
17. West of England Health Science Network Board To receive this verbal report by the Chief Executive to **note.**	Chief Executive	
18. Quarterly Capital Projects Status Report To receive this report by the Director of Strategic Development and	Director of Strategic	278

Item	*Sponsor*	*Page*
Deputy Chief Executive to **note.**	Development and Deputy Chief Executive	
Corporate Governance		
19. Governors' Log of Communications Nil return with no additions since the previous report.	Chairman	284
20. Q4 Compliance Framework Monitoring and Declaration Report To receive this report by the Chief Executive to **approve.**	Chief Executive	286
21. Board Assurance Framework Report To receive this report by the Chief Executive for **review.**	Chief Executive	313
22. Corporate Risk Register To receive this report by the Chief Executive for **review**.	Chief Executive	325
Information and Other		
23. Any Other Business To note any other relevant matters (not for decision).	Chairman	
24. Date of Next Meeting: Public Trust Board meeting, 28 May 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

Minutes of a Public Meeting of the Trust Board of Directors held on 27 March 2014 at 10:30 in The Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

Board Members Present

- Emma Woollett – Chair
- Robert Woolley – Chief Executive
- Paul Mapson – Director of Finance & Information
- Sue Donaldson – Director of Workforce & Organisational Development
- Carolyn Mills – Chief Nurse
- Sean O'Kelly – Medical Director
- Deborah Lee – Director of Strategic Development and Deputy Chief Executive
- James Rimmer – Chief Operating Officer
- Lisa Gardner – Non-executive Director
- Guy Orpen – Non-executive Director
- Alison Ryan – Non-executive Director
- Julian Dennis – Non-executive Observer
- Jill Youds – Non-executive Observer
- David Armstrong – Non-executive Director
- John Moore – Non-executive Director

Others in Attendance

- Charlie Helps – Trust Secretary
- Florene Jordan – Staff governor
- Peter Holt – Patient governor
- Joan Bayliss – Partnership governor
- Sue Silvey – Public governor
- Ian Davies – Staff governor
- Mark Griffiths – Approved governor
- John Steeds – Patient governor
- Clive Hamilton – Public governor
- Angelo Micciche – Patient governor
- Benjamin Trumper – Staff governor
- Pauline Holt (Management Assistant to the Trust Secretary)

Item	*Action*
1. Chairman's Introduction and Apologies The Chairman called the meeting to order. A quorum of directors was present. Apologies were noted from John Savage and Iain Fairbairn.	
2. Declarations of Interest In accordance with Trust Standing Orders, all Board members (including observers) present were required to declare any conflicts of interest with items on the Meeting Agenda. *The Chief Executive restated his previous declaration that he was a Director of the Academic Health Science Network.*	
3. Minutes and Actions from Previous Meeting The Board considered the Minutes of the meeting of the Trust Board of Directors dated 27 February 2014 and **approved** them as an accurate record with no amendments.	

DRAFT

Actions:

221: The Chief Executive – Partnership Programme Board. Histopathology Services – the Senior Leadership Team had received in March and supported a proposed model for the future configuration of cellular pathology services in Bristol and agreed what the next steps should be. A detailed financial appraisal and the seeking of clarity regarding the balance between a centralised laboratory and satellite services, would follow with update to the Board in due course.

238: James Rimmer advised that management instruction had been issued to the division to enact a name change. Item Closed.

245: Access targets covered in the Performance Report. Item Closed.

247: The date of the extraordinary Board Meeting was to be 14 April 2014. Item Closed.

249: The Chief Executive confirmed that he had spoken to the lead officer of the Academic Health Science Network and conveyed the Board's reservations regarding the report. Item Closed.

248: The Chief Nurse advised that discussions had been had and a report had gone to Quality and Outcomes Committee. The Chair said this item was now within the remit of the Quality and Outcomes Committee and they would report to Board in due course. Item Closed.

250: The Trust Secretary advised that the Governor's Log of Communications was live on the website. Item Closed.

Matters Arising:

Guy Orpen asked when a report on Teaching and Learning incorporating the Trust's contractual service commitment to provide training facilities to external partners, would come to Board. (He reminded the meeting that he had a potential conflict of interest).

Sue Donaldson said that the first report would be available in June. The Chief Executive asked that a base-line description come to April Board with the full report in June.

Action 202

The Chief Executive updated the Board on the Care Quality Commission inspection surrounding dementia care and advised that the report found a non-compliance with Outcome 4 (Care and welfare of people who use services in relation to dementia care). This was judged to have a minor impact, and the Care Quality Commission was expecting submission of an action plan, which was to be shared with the Board in April.

Action 262

4. Chief Executive's Report

The Chief Executive wished to update the Board on the following matters:

1. In regard to the position of the NHS England commissioned independent review of children's congenital heart services in Bristol, led by Sir Ian Kennedy, the Chief Executive said that he understood that discussions were still ongoing between Sir Ian, NHS England and the families concerned, regarding the review's terms of reference. No further information regarding decisions for the scope, design or timescales of the review were available. A further update to the Board would follow.
2. The Care Quality Commission had published the second of their Intelligent

DRAFT

Monitoring reports on providers across the country and had confirmed for Bristol a continuation of a band 6 risk rating. Robert confirmed this as the lowest rating that could be assigned and that out of 180 indicators of safety and care quality, the Trust received a score of 2, showing improvement since the last report in November where whistleblowing and Methicillin-Resistant Staphylococcus Aureus (MRSA) were flagged. This latest report flagged Never Events (2) and 62-day cancer waits. He wished the Board to recognise that this was part of the Care Quality Commission's redesigned approach to assessing safety and quality of health services, and that the Trust was doing well on external statistical analysis.

3. The Chief Executive reported the news that Professor Andy Ness, Professor of Epidemiology and Oral and Dental Science at Bristol Dental School had been selected as a Senior Investigator by the National Institute for Health Research. This prestigious 5 year award, starting from April includes the most pre-eminent researchers in the country, and the most outstanding leaders of clinical and applied health and social care research. He wished to pass on the Board's congratulations to Professor Ness, and advised that additional National Research Capability Funding would be received by the Trust to support Professor Ness in his research work.

There being no further questions the Chief Executive concluded his report.

Delivering Best Care

5. Patient Experience Story

The Board received the Patient Experience Story for review.

Carolyn Mills described the Patient Experience story as a letter that had been received from a mother who had lost her daughter, and wished to proactively advise the Trust of the positive aspects of the care her daughter had received, and to share some of the wider issues that would have improved the care for herself and her daughter, in the last days of her life.

Carolyn said that there were some key issues to note, for example the management of the transition of care from children's services to adult services, not only for the patient but for the family, the communication and technical language used with families and the assumptions made about of the level of understanding that families had.

She concluded that there was learning to be gained surrounding proactively talking to families about end of life, and that this sad story had positive aspects as well as areas where care could have been improved.

Jill Youds described the report as insightful feedback from the mother. Compassion was frequently discussed, she said, but how often was empathy considered? For example, ward rounds where people were introduced and the patient/families asked if they were happy for the observers/students/others to be there. She described empathy as remembering the 'subtleties that make human interaction a bit friendlier'.

Lisa Gardner asked how easy the Trust made it for patients/families, to identify staff by rank and position. Carolyn advised that the Francis report asked a question on how Trusts supported people who accessed services, to differentiate between registered or unregistered nurses. The Trust dealt with this by using the same uniform with a change in epaulets to denote rank, she said concluding that further investigations into the best way to

DRAFT

communicate this would be undertaken, be it by website or posters. The results of this would come back to Board as part of the Francis Report update. John Moore expressed dissatisfaction that the patient in the story was "stood around and talked over". He sought assurance that, as part of core values, the training of staff addressed this situation and treated this as a trust-wide learning opportunity. Sean O'Kelly agreed and advised that as a teaching hospital, teaching occurs on ward rounds. He added that good teachers are able to carry out that teaching in an entirely sympathetic and empathetic way and part of the teaching in a clinical environment, was to make sure patients were entirely comfortable with what was happening. If this situation was not being addressed then that amounted to a deficiency in teaching ability, he said. Sue Donaldson replied that the Essential Training Programme was looking at how well Trust values are embedded and what type of customer care training was being provided on a regular basis. David Armstrong asked if organisational learning was viewed as an opportunity to learn rather than noting the learning that had been received. He suggested that an action log could be written to crystallize the things that were needed to secure that learning. Guy Orpen said that he felt proud that the Trust and the Board put patient experience stories at the top of the agenda but said there was the further need to think how it communicates with families when they have abrupt and painful experiences. Clive Hamilton, a governor who was in attendance, asked about staffing at night and the use of bank staff during the period discussed. Carolyn Mills replied that the levels of staff were adequate and the unit was a fully staffed unit that would meet the recommendations in terms of staffing levels required. Mark Griffiths, a governor who was also in attendance, asked how ward staff education and bedside teaching, in a compassionate way and by putting the patient at the centre, would be recorded and monitored. Sue Donaldson replied that individual training could be logged through an electronic system, but further thought was required into how that teaching was performed. The Chief Executive concluded that the Board were pinpointing the need for the Executive to consider the application of empathy in a systematic and more visible way, considering the specific features of the organisation and its staff, communicating with families who have serious concerns or who are bereaved or about to be bereaved. He said that the executive would report back to the Board in due course. *There being no further questions the Chair drew this item to a close.*	Action 263
6. Quality and Performance Report *The Board received the Quality and Performance Report for review.* **Performance Overview** Deborah Lee advised that the health of the organisation had remained relatively stable with an additional red indicator, pertaining to deterioration in the Monitor Governance Risk rating. She said that there continued to present a mixed picture with continued poor performance around many of the key access targets, but with some very positive improvements in quality of care, in particular falls, pressure ulcers, anti-biotic compliance	

DRAFT

and fractured neck of femur management. Finance showed a positive continuing picture, despite the under achievement around cash reducing efficiency savings, and this was being managed in the totality of the resources available to the Trust and did not impact on other indicators which remained green. The summary indicated the high risk of the Trust not achieving five of the Monitor indicators. The 62-day standard performance had been discussed at Board but was at very high risk of failure. The 31-day standard would come as a surprise to the Board she said, and advised that as a team, reflection would be made on if risk could have been better anticipated. She concluded that this item would have further cover in the Extraordinary Board meeting to be held on 14 April 2014. **Quality and Outcomes Committee Chair's Report** Alison Ryan advised that the Quality and Outcomes Committee had met and had examined quality indicators to see if progress was being sustained in right direction. She said they had been anxious about access and waits, and the bottle necks in intensive care due to bed shortages. They had looked at winter pressures, and it was clear that the Trust was "working on a knife edge" with respect to balancing demand and throughput, with insufficient headroom to entertain any possible disruptions of access. The Committee had examined the access paper and applauded the excellent ideas and commitment shown to managing access and the commitment to external partners in helping resolve problems by their involvement in 'Breaking the Cycle', whilst still looking at internal processes to streamline the Trust's own performance. She said that Dementia was an area of concern and there had been discussion of the part to play that issues with data capture had, in failure of the dementia target. An action list had been sent back to be looked at carefully. Alison concluded that the Chairman had asked her to take over the Chair of the Quality and Outcomes Committee, and to look at how it operated to provide the Board the best assurance on issues that were their responsibility. As a part of that they would examine how to measure in different ways than the Trust have used previously. The Chair reminded the Board that they had the opportunity to attend either Finance Committee or Quality and Outcomes Committee in order to fulfil their duties. Guy Orpen asked that Quality and Outcomes Committee and Finance Committee papers be sent to all non-executives as a matter of course. *There being no further questions the Chair drew this item to a close.*	Action 264
7. Access Standards Recovery Plan *To receive the recommendation of the Chief Operating Officer to ratify.* James Rimmer noted that the Board were 'unable to be happy' about access to performance standards and in response had produced the Access Standards recovery Plan, concentrating on the 4-hour standard, referral to treatment and the cancer standards. He said the Plan featured 7 key projects, starting with 'Breaking the Cycle'. James advised that the 4-hour standard had been broken down into the Bristol Royal Infirmary, the Emergency Department, minors and children's. He noted that a step change	

DRAFT

needed to be made to the way of working.

The well- known issues surrounding non-admitted referral to treatment would take longer to resolve and work was in train to put clear trajectories, with clearance targets, in the three phase recovery plan of long term sustainability, week by week activity plans, and a wider training programme looking more broadly at issues.

Cancer targets proved more challenging with 62-day waits giving challenges through the portfolio and pathways. He described this as a reflection of how the Trust worked with partners and advised the Board that if UH Bristol cleared all its attributable breaches for quarter 4 they would still have failed the standard, due to late referrals.

He described the failure of the 31-day cancer standard as having taken the Trust by surprise, having last been failed in 2010. He said that 31% of breaches were intensive care breaches due to acuity of patients, and in the quarter the critical care network needed to share issues across the network. More details would be given in the Extraordinary Board Meeting on 14 April.

Jill Youds said she was encouraged by a well-put-together report, but noted that with the Transforming Care Programme and now the Access Standards Recovery projects there was a big agenda for change. She asked the Board to consider how to get momentum, engagement and sufficient priority to drive the plan forward, in what may be a change-weary organisation. James Rimmer replied that Breaking the Cycle was designed to show the whole organisation commitment to addressing issues and advised that the Clinical Chairs had been keen to see involvement and change.

Clive Hamilton welcomed the report and asked if the achievement of the 62-day cancer target was specifically in the hands of others. James Rimmer replied that there were improvements that the Trust themselves could make and improvements that partners could make. It was all about working together.

John Moore welcomed the report and noted that it was showing how transformation was being added to the title of every team member. He said the report showed the point where a project was no longer a project, but inbuilt into the thinking and responsibility of everyone.

Alison Ryan asked how the plan fed into the objectives of individuals and identified the changes in behaviours that would be needed to make change happen. Sue Donaldson replied that a recent paper taken to Transformation Board had detailed the linking of the appraisal process directly to the business objectives and saw no reason why this shouldn't happen.

In response to a question from Alison, James Rimmer replied that the outcomes would feed into routine performance reports. She said there was a need to keep the Board focussed on the identification of where energy and effort should be made rather than prioritising everything and putting undue pressure on the system. The Chair agreed that prioritisation should be given as to how to report back on actions, and not allow pressure to build for some things that were of a lower priority.

There being no further questions the Chair drew this item to a close.

8. Trust Operational Plan 2014-16

Deborah Lee advised that the widely considered documents reflected all comments made, and formed the first of two submissions to Monitor, to support the 2 year operational

DRAFT

activities of the Trust in preparation for more challenging times ahead. Contained in the Plan was the Annual Declaration of Compliance against Monitor's risk assessment framework for which the Trust would be disappointingly, declaring three of Monitor's standards, to be a risk in the coming year for one quarter or more. These being, the Accident and Emergency standard, the referral to treatment non- admitted pathways, and the 62-day GP cancer standard.

Deborah advised that wider consultation with the health community and colleagues in the Clinical Commissioning Groups, local authorities and the local team had not received significant engagement and that the Trust would seek, for the Strategic Plan submission to strengthen the way it engaged with the community. She presented the Plan to the Board for approval.

Guy Orpen, noting that the audience for the Plan was Monitor, said that it did not say a great deal about the Trust's teaching and research mission and how they added value to their clinical strategy. He felt it important that with the Trust having a tri-part mission, at every point they should reflect on how to mutually reinforce this. He added that he was not seeking a change to the document. Deborah thanked Guy for his insight and replied that this would be contained in the Strategic Plan.

Clive Hamilton, noted that the Royal Devon and Exeter hospital had a short stay rehabilitation ward. He asked if the Trust had plans for similar in the future. Deborah replied that the model was already in place with 160 community beds available to the Trust with the operational model to develop more. To further support early patient discharge into their own homes was depicted in the Plan, and was already working very successfully for stroke victims.

There being no further questions the Chair drew this item to a close.

Delivering Best Value

9. Finance Report

The Board received the Finance Report from the Director of Finance and Information, to review.

Paul Mapson, regarding the year end 2013/14 said that the Trust was heading to achieve the year end plan. Issues that would determine the end of year related to the level of provisions that had to be made and the risk of payment by commissioners for low performance. There had been challenges by commissioners and it had only recently become clear what their positions were. He said that discussions were ongoing and that he didn't anticipate those conversations would compromise the year end position.

The Trust had not managed to bring the run rate down to a level that would put it in good standing for the next year; of particular concern were the Divisions of Medicine and Surgery.

The Chair added that the run rate was of grave concern and although the Trust was meeting their end year financial target, it was largely through the use of reserves.

John Moore noted that £7m of reserves had been drawn down and noted that without the drawdown and without the success of previous years the loss would be £2m. The £5m

DRAFT

surplus had been made by the use of £7m of reserves, giving a negative run rate. He said that divisions needed to understand that there was a 'central pot' that was bailing them out.

Deborah Lee said there was very little future flexibility and delivery of plans and the avoidance of unforeseen circumstances was critical to success. Framing the technical point in the context of loss of flexibility and inability to manage unforeseen circumstances was a message that divisions might understand more easily and might shape the right actions at divisional level. There was no flexibility for the divisions to not deliver their plans despite the history of them not delivering their plans.

Paul Mapson described this as a behavioural issue, saying that there had been a level of non-recurrent flexibility for the past few years which had been entirely deliberate, waiting for the major development costs coming through. Therefore that loss of non-recurrent flexibility would be a factor and the importance of delivering the operating plan was so much higher than had been the case in the past.

Guy Orpen said that he was hearing that the Trust had new facilities that it was about to exploit, giving a different platform for new operational methods that were more cost effective, and that financial sustainability was bound up with clinical sustainability. He reminded the Board that the Trust could not be clinically sustainable if they were not financially sustainable. Clinical sustainability would motivate clinicians to buy into financial sustainability, he said.

Paul Mapson replied that once the year end 2013/14 was completed then there was another debate to be had about the approach and delivering the 2014/5 plan.

There being no further questions the Chair drew this item to a close.

10. Finance Committee Chair's Report

The Board received the verbal report by the Chair of the Finance Committee for review.

Lisa Gardner, Chair of the Finance Committee advised the Board that focus was being placed on next year and the year after. The resources book would be placed as an item on the agenda and a 'fresh pair of eyes' had been engaged to look at cost improving and savings plans. The savings programme for next year showed a £5.2m shortfall on where the Trust would want to be.

She advised that the Committee recommended the Resources Book and the Treasury Management Policy to the Board for approval.

There being no questions the Chair drew this item to a close.

11. 2014/15 Financial Resources

The Board received this report by the Director of Finance and Information for approval.

Paul Mapson introduced the budget for the new year. He said it was in line with the long term financial plan but contained a number of estimates, for example the level of income (which was still in negotiation with Commissioners). He felt the estimate to be broadly correct and was the satisfactory settlement that the Trust might make.

He described 2014/15 as a 'red letter' year for the Trust where major developments would

DRAFT

come on stream, some having been 20 years in the making. He said that the effect of those had been built into the budget, but it would be a challenging year and there was the need to manage the plan more tightly than in the past.

The pay award announced had a possible cost to the Trust of £1.2m (depending on the interpretation of incremental earnings). An allowance had been made in the budget of £800,000 on the assumption of a low pay award and would partly fund the pay award. Another recent change was the unexpected announcement by Her Majesty's Revenue and Customs that there would be a major change in the Value Added Tax rules for the NHS. He said the implication of this could be £0.5m per annum on revenue, and all current fees for capital schemes would become non- reclaimable with a possible effect to the Trust of £2m. He concluded that this did not compromise the budget, but did make the budget tighter than expected. The cash balance was healthy to enable to Trust to ride out difficulties until 2015/16.

The Chair advised that the Finance Committee had discussed the subject in detail and recommended the resources Book to the Board for approval.

In response to a question from John Moore, Paul advised that the tariff was set by Monitor and was fixed. Only 60% of Trust income was earned from payment by results tariffs.

Guy Orpen mentioned the new facilities coming on stream. He asked how much risk mitigation the Trust had in place. Paul Mapson had budgeted for transitional costs but in terms of unplanned events these had not been budgeted for specifically. The Trust contingency had not been reduced, to allow some flexibility.

Alison Ryan asked if the Trust had the capacity to put resources into investments currently 'not thought of'. Paul replied that if that investment were community beds that would lead to shutting a ward, then that made sense. If it related to finding funds off the bottom line then this would not be possible. He concluded that this was what the Better Care Fund is all about. He said it was not a question of taking tariffs that were funded for acute services and spending them in the community, unless it gave a benefit which meant that costs could be taken out of the hospital, which were usually much higher.

Julian Dennis asked if Monitor allowed for, within the capital costs, revenue charges as part of the capital programme. Paul advised that the impact in the capital programme, including revenue charges, had been built in and the impact in the ten year plan had been allowed for as a cash commitment on capital and an income/expenditure commitment to pay the interest and depreciation required.

The Chief Executive drew the Board's attention to the high level of risk in the plan. He said that it was inevitable that there was far less flexibility going into the year than in previous years, and it was incumbent on the executive to manage teams to deliver on plans. Four divisions had deficit plans going forward and therefore the year would be started with difficulty, plus there was risk around the moves into new facilities, and those business cases were predicated on a significant efficiency improvement that needed to be delivered immediately. He concluded that there was challenge in in the plan but it was deliverable and reflected the pressure bearing down on the health service and acute services as a whole, on diminishing resources for an increasing profile of demand and acuity from the population.

The Chair thanked Paul Mapson for delivering the year and noted that it was a significant achievement and one that not many trusts had managed to achieve.

DRAFT

*There being no further questions the Chair noted the **Board's approval** and drew this item to a close.*	
12. Treasury Management Policy *The Board received this report by the Director of Finance and Information for approval.* Paul Mapson advised that the report had been to Finance Committee and asked if the Board were happy to approve the report. *There being no questions the Chair noted the **Board's approval** and drew this item to a close.*	
13. Loan Facility Agreements – Conditions Precedent. *The Board received this report by the Director of Finance and Information for approval.* Paul Mapson asked the Board to authorise his taking up of the loan agreement. *There being no questions the Chair noted the **Board's approval** and drew this item to a close.*	
Corporate Governance	
14. Governor's Log of Communications Nil return with no additions since the previous report. The Chair advised the Board that the log was available in an accessible place on the website, and urged governors to use it. Sue Silvey, a governor who was also in attendance asked if all the questions were shown on the log or just the one question from the current year. The Trust Secretary advised that there was a page explaining the log and its purpose, with links to the records within the minutes of the Council of Governors meetings, plus a set of sample questions. All changes would be published. Clive Hamilton said there was a strong feeling that the questions should be published from the beginning of the last financial year. The Chief Executive felt that historical questions and responses were made without the concept that they would be published for external consumption. Whilst this did not necessarily change the way in which the questions were asked or the responses given, he said, it raised a risk and it was preferable to start from the place where both parties were aware that questions asked would be published openly. He reminded the meeting that governors may question whether they wished their historical questions to be published. The Chair also noted that a document published now, but presenting historical questions was not helpful. Clive reminded the Board that 2014 was an election year and he wished his constituents to know which questions had been asked and similarly allow the non-executive directors to see the questions.	

DRAFT

David Armstrong added that the culture had been changed and proposed a fresh start. Deborah Lee suggested the circulation of the questions to the Board. Clive expressed a wish for this to be done. Florene Jordan, a governor who was also in attendance, did not support the idea of historical questions being published in the log. The Chair summarised that the log was on the website but only one question had been asked in year and suggested the log be left for a 12 month period to see how worthwhile the exercise was, before further review. *There being no further questions the Chair drew this item to a close.*	Action 265
15. Register of Seals The Chief Executive advised that two documents had been sealed since the last report and asked the Board to note.	
16. Audit Committee Chair's Report John Moore, Chair of the Audit Committee advised that the Audit Committee met on March 10th and was fully represented by all relevant parties. The meeting studied reports from :- 1. External Auditors 2. Internal Auditors 3. Counter Fraud There were no exceptional items to report. He advised that the Committee had reviewed new guidance from the UK Corporate Governance Code, and decided that there was no need for the Trust to change their current polices. Also reviewed, were the Internal Audit Function and the 2014/15 Internal Audit Annual Plan, which was approved. There were 2 notable items to report; 1. The ongoing work on analysis of non- pay spending, including the controls affecting these processes. The Committee noted that significant work was being done throughout the Trust to ensure managers understood the procedures and their responsibilities. Additionally, the internal auditor would be reviewing controls across the Trust and would carry out transaction testing. Further work was being done on the review of non- purchase order procurement, and a full report would be brought to the September committee meeting. 2. Cloud computing and Information Security. Following a report from Internal Audit regarding the risk of data security across the mobile environment, the Committee received a report from the executive. They were pleased to learn that no cloud storage was used by the Trust with all data kept on internal servers. They learnt that there was ongoing work to remind staff of the importance of not using non-trust email systems for work purposes, with further updates to be given to the committee in due course.	(Audit Action 258)

DRAFT

There being no questions the Chair drew this item to a close

17. Report Results of Q3 Compliance Framework Monitoring

The Chief Executive presented the reply from Monitor confirming the declaration that the Trust had made in quarter 3. He confirmed that continuity of services had been given a risk rating of 4, governance a risk rating of green and advised that Monitor had decided not to open an investigation into the Trust's C difficile performance or Accident and Emergency performance, at quarter 3. He reminded the Board that they may consider action if performance deteriorated further.

He drew the Board's attention to Monitor's that warning (in regard to the current year plan) that use of reserves to mitigate overspend, and cost improvement plan slippage, may put pressure on delivery of the plan. He concluded that this was exactly the case, but regardless the plan was being delivered. The Board were asked to note Monitor's assessment of the Trust's Quarter 3 position.

There being no questions the Chair drew this item to a close.

Information and Other

18. Any Other Business

There being no further business the meeting closed at 12.45

19. Date of Next Meeting

Public Trust Board meeting, 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.

DRAFT

Action by	ID	Meeting Date	Public / Private	Minute number & title	Description (minute)	Action to be Taken	Date to Report Back
Chief Executive	221	28/11/2013	Public	10. Partnership Programme Board	The feasibility of options for further integrationof histopathology services, including, location and phasing timescales for physical integration were being discussed. Further information to be provided to the Board meeting in January 2014.	27/03/14 The Chief Executive – Partnership Programme Board. Histopathology Services – the Senior Leadership Team had received in March and supported a proposed model for the future configuration of cellular pathology services in Bristol and agreed what the next steps should be. A detailed financial appraisal and the seeking of clarity regarding the balance between a centralised laboratory and satellite services, would follow with update to the Board in due course 27/02/2014 Further progress not reported. 30/01/14 The Chief Executive advised that options were being considered with partners at North Bristol Trust, in fulfilling the one main outstanding recommendation in the Mishcon Inquiry report of 2010 (re the integration of the two cellular pathology departments in Bristol). He advised that the Joint Clinical Director had been leading that process – further information was expected in the next month. Further information to be provided to the Board meeting in January 2014.	28/05/2014
Chief Executive	246	27/02/2014	Public	4.Chief Executive's Report	John Moore asked to hear at the next Board meeting what actions are being taken to support the staff in the service in light of Kennedy review. The Chief Executive replied that on receipt of the terms of reference and a greater understanding of how the review would work, there would be a commitment to describing to the Board how staff would be supported.	**27/03/14 Describe to the Board how staff will be supported in regard to the Kennedy Review at a future Board meeting.**	**28/04/2014**
Chief Executive	263	27/03/2014	Public	Patient Experience Story	The Chief Executive concluded that the Board were pinpointing the need for the Executive to consider the application of empathy in a systematic and more visible way, considering the specific features of the organisation and its staff, communicating with families who have serious concerns or who are bereaved or about to be bereaved. He said that the executive would report back to the Board.	27/03/14 Report back at future Board meeting	28/05/2014
Chief Nurse	218	28/11/2013	Public	6. National Cancer Survey & Action Plan	Wendy Gregory stressed the importance of Cancer Nurse Specialists and asked for reassurance that the lack of a nurse specialist for Melanoma would be addressed. Ruth Hendy advised that a strategy was being discussed by divisions for cross-working as people progressed on their pathways and would form part of divisional operating plan.	28/11/13 Emma Woollett suggested an update to the Board be provided after six months.	30/05/2014
Chief Nurse	262	27/03/2014	Public	Matters Arising	The Chief Executive updated the Board on the Care Quality Commission inspection surrounding dementia care and advised that the report found a non-compliance with Outcome 4 (Care and welfare of people who use services in relation to dementia care). This was judged to have a minor impact, and the Care Quality Commission was expecting submission of an action plan, which was to be shared with the Board in April.	**28/04/14 Item on meeting agenda. Item Closed** 27/03/14 Provide CQC Action Plan to April meeting	**28/04/2014**
Director of Workforce and Organisational Development	158	27/06/2013	Public	3 - Actions from Previous Meetings	Emma Woollett referred to Item 7 of the minutes of 31 May 2013 (National Staff Survey Results: Page 12 of the Board pack), regarding the Trust's performance in relation to previous years and engagement with nursing staff. She requested that the Board was kept informed about this work.	27/2/14 Sue Donaldson advised that a fuller report in trend with staff feedback and in context of current work in staff engagement would follow to Board in May 2014. 15/1/14 Meeting to be held 15/1/14 with Sue Donaldson regarding engagement. Future Board date to follow. Update 26/9 H Morgan advised paper being worked on currently and will be available at the end of the year To keep the Board informed about the Trust's work on engagement with nursing staff.	28/05/2014
Director of Workforce and Organisational Development	161	27/06/2013	Public	5d - Quality and Performance Report - Board Review	John Moore referred to the Workforce report, requesting a greater understanding of the process by which the Trust planned its staff numbers. He particularly wanted to know how the Trust reconciled its increase in Bank and Agency spend with the focus on providing cost savings and high quality care. Claire Buchanan confirmed that she would provide a detailed summary of workforce planning as part of a future Board Seminar on the topic.	Detailed summary of workforce planning to be provided at May 2014 Board Seminar.	30/05/2014
Director of Workforce and Organisational Development	202	26/09/2013	Public	9. Teaching & Learning Strategy Update Review	5 year strategy - review and refresh strategy to ensure it is still in line and up to date.	**14/1/14 To be brought to the Board in April 2014 to align to the ten strategic priorities within the existing strategy and aligning this to the work with David Relph on the Clinical strategy** To be brought back to the board in December	**28/04/2014**
Trust Secretary	264	27/03/2014	Public	6. Quality and Performance Report	The Chair reminded the Board that they had the opportunity to attend either Finance Committee or Quality and Outcomes Committee in order to fulfil their duties. Guy Orpen asked that Quality and Outcomes Committee and Finance Committee papers be sent to all non-executives as a matter of course.	**Papers to be sent. Secretariat and Finance advised. Item Closed.**	**28/04/2014**
Trust Secretary	265	27/03/2014	Public	14. Governor's Log of Communications	David Armstrong, added that the culture had been changed and proposed a fresh start. Deborah Lee suggested the circulation of the questions to the Board. Clive expressed a wish for this to be done. Florene Jordan, a governor who was also in attendance, did not support the idea of historical questions being published in the log.	**Trust Secretary circulated the non-executives the governors log of communications. Item Closed.**	**28/04/2014**

Minutes of an Extraordinary Meeting of the Trust Board of Directors held on 14 April 2014 at 13:00 in the Conference Room, Trust Head Quarters, Marlborough Street, Bristol, BS1 3NU

Board Members Present

- Robert Woolley - Chief Executive
- Paul Mapson - Director of Finance & Information
- Sean O'Kelly- Medical Director
- James Rimmer - Chief Operating Officer
- John Savage - Chairman
- Emma Woollett - Non-executive Director
- Guy Orpen- Non-executive Director
- Alison Ryan - Non-executive Director
- Jill Youds - Non-executive Observer

Others in Attendance

- Xanthe Whittaker - Head of Performance Assurance & Business Intelligence and Deputy Director of Strategic Development
- Alex Nestor - Deputy Director of Workforce and Organisational Planning
- Helen Morgan - Deputy Chief Nurse
- Charlie Helps (Trust Secretary)
- Pauline Holt (Management Assistant to the Trust Secretary)

Item	*Action*
1. Chairman's Introduction and Apologies The Chair welcomed everyone to the meeting and advised that apologies had been noted from David Armstrong, John Moore, Carolyn Mills, Sue Donaldson, Julian Dennis, Deborah Lee, Iain Fairbairn and Lisa Gardner.	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the Meeting Agenda. *There were no declarations of interest.*	
3. Chief Executive's Update *The Chief Executive updated the Board on the following matters:* The Chief Executive advised the Board that the Trust had no further information regarding the scope of the proposed review of Children's Cardiac Services to be led by Sir Ian Kennedy. He would update the Board when further information became available. *There being no further questions or discussion, the Chief Executive concluded his update.*	

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4. Performance Overview and Recovery Plans Report

The Board received this report from the Chief Operating Officer for ***approval.***

James Rimmer gave a brief overview advising that the paper set out the recovery plan for the Board to consider and approve. Containing four areas it focussed on access issues with analysis, steps taken to date, what the recovery should be and the action needed to deliver that recovery. Risks to that recovery were also provided in the back of the document. James said this was a high level plan underpinned by Divisional plans prepared by each Division and Specialties. The document, if approved, would be used for any meeting, if required, with Monitor.

Self-certification

James advised that Monitor had a new system of notification effective from Q3 2013/14 onwards. The Trust had self-certified in agreement with Monitor's assessment for the previous 4 quarters, showing the robustness of the Board's processes.

4-hour Analysis

The Monitor standard was 95% of patients to wait less than 4 hours or less in the emergency department before being treated, discharged or transferred.

James said that the Trust had had ongoing issues for many years, the root causes of which were a large rise in winter ambulance arrivals, an 8% increase in the over 75's (compared to the previous winter), and higher levels of admission to the Children's Hospital for 2 years, with the third year even higher showing winter pressures during Q3 year on year.

Work with KPMG had been undertaken to identify the root causes. Successes included reductions in ambulance delays and elective cancellations, development of ambulatory care pathways and utilisation of beds in the community.

The two-phase Patient Flow Programme led to fewer delayed ambulance hand-overs, patients spending less time on the wrong ward, and fewer cancelled operations. The one area where little progress had been made was that of delayed discharges, which highlighted a greater need for community care beds.

Breaking the Cycle Together had focussed on better care for patients and saw improvements in the Bristol Royal Infirmary achieving the 95% target across the Trust in the week. Outliers dropped from 30 to 3, 'green to go patients' dropped by over 20, occupancy was down to 92% and 4-hour performance went up. James added that no new standards had formed part of Breaking the Cycle Together; it was the result of cohesive working not only across the hospitals but with involvement

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from partner organisations, community health and social care.

Looking forward – 7 elements of necessary change to the operating model had been identified. Breaking The Cycle had been one element and James said the rest needed to be delivered 'with pace'. He warned that Q1 was at risk but by embedding the operating plan quarters 2&3 would show improvement leaving Q4 at risk from winter pressures.

He concluded that the challenge was how to respond as a system. Meetings were to take place with the Clinical Commissioning Group and the Emergency Care Intensive Support Team with a view to working together to review the whole system to address issues for Q4. NHS England were also to look at winter pressures now rather than later.

Emma Woollett (in regard to the Children's Hospital) asked if the issues underlying performance were the same as those issues underlying at the Bristol Royal Infirmary. James replied that this was being examined and there would be no assumptions that root causes were the same.

Alison Ryan asked if Breaking the Cycle put other standards at risk. James replied that he could not see any negative output and that corporate meetings had stopped with key focus on safer care, clinical engagement, and escalating specific incidents for specific patients. As a result care had improved across the board.

The Chief Executive added that if Breaking the Cycle were operated on a continual basis normal business would stop. Volunteers had performed roles they were not employed for and the Chief Executive of Bristol Community Health had done a shift as Ward Liaison to assist the Trust. He concluded that the commitment from partner organisations was 'phenomenal and showed real engagement with the Trust'.

Clive Hamilton asked if Breaking the Cycle was an initiative to be kept in the Trust toolbox. The Chief Executive replied that it would, following evaluation to work out how the Trust derived learning from the exercise, and what they would do with that learning and what arrangements needed to be changed for the future.

Guy Orpen asked if the increased utilisation of community beds would lead to capacity issues in the community. James Rimmer advised that the next stage was to see if there was a need to increase these yet again and to analyse what the length of stay was in the community. He said that the Better Care Fund was working to change the mind set and get the whole community to move care closer to home.

In reply to a question regarding staff buy- in James advised that a daily wash up meeting had allowed staff access to executive directors and served as a feedback session. In addition a thank you event and chance for wider feedback was to be held.

DRAFT

The Chairman, on behalf of Board, said they wanted to hear that the Trust were as focussed as they could be to hit targets in each area. He cautioned against forecasting to Monitor a red for another quarter at the end of the year.

The Chief Executive replied that the Executive would examine what they could sensibly forecast as realistic delivery and evaluate what the forward performance should be, and make sure this was consistent with the Annual Plan declaration.

Action 267

Jill Youds asked how the plans for the Operating Model would be handled and delivered. James replied that it had clinical and executive leadership in order to gain maximum ownership and with rigorous project management and senior clinical ownership adding value, this would increase pace, momentum and visibility.

Non-admitted Pathway

James explained that the standard called for 95% of patients to be treated within 18 weeks of referral. He said that it was flagged last year that there was a risk due to the transfer of head and neck patients from North Bristol. He said that it had been anticipated that Q1 and Q2 would be failed, however it was Q2 before any impact was seen, Q3 and Q4 were subsequently failed with predictions for a further 2 quarters. The root cause was not solely North Bristol patients but also some underlying process issues within the Trust. However progress had been made and the backlog reduced.

Emma Woollett said that she understood that the transfer had been problematic as the Trust had not understood the size of the backlog that had built up before the transfer and additionally that ongoing demand had created capacity issues. She asked how much of this was backlog and how much was capacity versus demand in outpatients, or how much was a loss of high performance specialities. James replied that high performing specialities were primarily a cancer issue, but there had indeed been quite a significant increase in demand and business cases were addressing the capacity requirements. Emma noted that causes were ‘outside issues’ once again. James added that was partly true but also that if the Trust had been better sighted they may have seen the demand coming in order to get on top of it.

Alison Ryan asked to what extent consultants reviewed the way they did follow-up appointments. Sean O'Kelly advised that there had been a certain amount of change but techniques and technologies could be used to better advantage. He concluded that there was scope for improvement but this needed to be closely aligned with primary care.

Clive Hamilton asked how the absorption of specialised paediatric services would impact on access targets. Xanthe replied that the issues surrounding the transfer of head and neck had been examined with a view to making sure that the same

DRAFT

mistakes were not repeated and that there was a clear protocol for the transfer of patients.

Cancer Standards

James explained the standard was that 85% of patients needed to be treated within the 62 day pathway, after referral by GP.

Regarding the more complex tertiary pathways he advised that over 80% of the tumour sites that failed the national standards now sat in the Trust's portfolio, leading to some unavoidable breaches.

Concerning the 31-day standard this had not been failed for 4.5 years. He described this as a 'robust target' that was predicted for achievement in the coming year. Q4 had seen unusual pressure on critical care beds and a large number of cancellations, leading to an unexpected potential failure of the quarter. However, the predictions for the year ahead were positive.

Wendy Gregory asked for clarification regarding critical care cancellations and said that other similar trusts appeared to be achieving better on tackling the 15% of patients who were not being treated in an appropriate timescale. James replied that the 85% 62-day target was not an aim and by taking a more specialised portfolio the need was to get better at delivering that portfolio. Xanthe added that telephone questionnaires with 5 trusts considered to be better performing equivalent providers had recently been undertaken with disappointing results. It had been difficult to identify things they were doing to improve pathways that the Trust was not already doing.

C Difficile

James advised that there had been a year on year reduction in C difficile and whilst the Trust had missed the target there had been significant improvement on the previous year. The limits for next year had increased and the Trust would have the opportunity to discount cases that were not hospital acquired. He concluded that regardless, the focus on making sure the Trust was doing all it could to reduce cases was key.

Summary

The Chief Executive said that the Board were asked to support the trajectories that were in the report, accepting that a risk assessment and not a trajectory for 4-hour Accident and Emergency waits had been shown. He said that it was not yet known how Monitor would escalate with the Trust, in the light of the Q4 performance, and the report was the basis of the briefing that would be supplied to them. However, this would be further developed in the coming weeks particularly around the

DRAFT

operating model initiatives. Non-executives and governors alike welcomed the Breaking the Cycle initiative and noted that the motivation for delivering better patient care was evident. **The Chairman offered thanks to staff that had worked on the plan and said that subject to the caveat on the Accident and Emergency performance forecast, the Board approved the plan.**	
6. Any Other Business *There being no further business the meeting closed at 14.30.*	
7. Next Meeting 28 April 2014 at 09:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.	

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Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

5. Chief Executive's Report
Purpose
To report to the Board on matters of topical importance to the Trust, including a report of the activities of the Senior Leadership Team.
Abstract
The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in the month.
Recommendations
The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.
Report Sponsor
Robert Woolley, Chief Executive
Appendices
• Appendix A – Senior Leadership Team Report

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – APRIL 2014

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in April 2014.

2. COMMUNICATIONS

The Senior Leadership Team **noted** the monthly report on the activities of the Communications Department.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the Trust's performance against Monitor's Compliance Framework. There continued to be significant performance issues in respect of accident and emergency 4-hour waits, 18 week Referral to Treatment times for Non-Admitted patients and 62-day GP Cancer standards. The weekly meetings to oversee recovery, chaired by the Chief Executive, continued.

The group received the Monitor Quarter 4 Declaration of Governance Compliance 2013/2014 and **approved** the recommendation to the Trust Board to declare the standards failed to be the clostridium difficile objective, the Referral to Treatment Non-Admitted, Accident and Emergency 4-hour, 62-day GP cancer and 31-day first definitive standards. It was recommended that the likely failure of the Referral to Treatment non-admitted and 62-day GP cancer standards for a further quarter are flagged with Monitor as part of the narrative that accompanied the declaration, along with the potential failure to achieve the Accident and Emergency 4-hour standard due to the ongoing risks posed by year-on-year increases in ambulance arrivals, increasing age profile of emergency admissions and the closure of Frenchay Emergency Department in Quarter 1.

4. STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the business planning round 2014-2016, development of Divisional Operating Plans for that period, an update on the position with regard to CQUIN schemes and an update on contract negotiations with commissioners, both locally and nationally.

The group received and **noted** an update on the financial position.

The group received and **noted** an update on the Trust's proposed Operating Model for 2014/5, including the status of seven priority projects.

The group received and **supported** a proposal to rename the main departments within the Bristol Haematology and Oncology Centre as the Bristol Cancer Institute and Bristol Haematology Unit, respectively.

The group received and **noted** an update on progress on work being undertaken to improve staff experience and staff engagement.

The group received and **approved** recommendations to implement the Staff Family and Friends Test by 30 June 2014.

The group received and **approved** an action plan and recommendations around the new regime for generator testing.

The group received and **approved** key actions and next steps to support the ongoing programme of work to deliver the transformational leadership agenda.

The group received and **supported** the documentation for consulting with staff in respect of the allocation of car parking places.

The group received and **approved** the business case for the proposed Critical Care Information System.

5. RISK, FINANCE AND GOVERNANCE

The group received and **approved** the Board Assurance Framework Quarter 4 update report, for onward submission to the Trust Board.

The group received and approved the Corporate Risk Register, subject to some revision, for onward submission to the Trust Board.

The group received and **noted** progress on the implementation of Internal Audit recommendations.

The group received and **noted** the partnership review report acknowledging that all partnerships presented a low or medium risk, with the exception of the Healthy Futures Programme which was noted as high risk.

Reports from subsidiary management groups were **noted**, including an update on the work of the Transforming Care programme

The group **noted** risk exception reports from Divisions.

6. RECOMMENDATIONS

The Board is recommended to note the content of this report and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.

Robert Woolley
Chief Executive
April 2014

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

6. Patient Story from the Division of Specialised Services

Purpose

To share a patient story with the Trust Board and demonstrate the learning which has occurred following this patient story

Abstract

Background:

This patient story relates to a complex discharge of an elderly gentleman suffering with dementia, admitted from a sheltered accommodation environment to hospital due to deterioration in his physical condition. The gentleman was treated for his presenting medical condition, however during his hospital stay his general mental and physical health deteriorated meaning that he was not able to return to his sheltered accommodation. Alternative accommodation in a nursing home was secured via social services with active involvement of the son via his attendance at a best interest meeting. Following his father's discharge the son raised a formal complaint with the Trust related to the lack of communication/involvement that he had regarding his father's discharge. A meeting took place following the formal complaint response being received with the son, Medical Consultant, and ward manager to resolve any outstanding issues, the son remained unhappy.

Key Issues:

Mr S's son felt that communication with him relating to his father's discharge was not effective – he did not feel fully informed/understanding of discharge plans.

Record keeping by the Trust could have been improved which would have provided a robust audit trail of communication with son and other agencies.

The discharge of the Mr S to a nursing home was appropriate. However there were issues in the nursing home that the patient was discharged to which the Trust was not aware of at the time – the nursing home was subject to a safeguarding process. This resulted in a breakdown in the trust and confidence that the son had with the home/care delivered within it.

Risks:

There are no outstanding Trust wide risks identified through this patient story

Recommendations

The Trust Board is asked to review the patient story and note the learning which has occurred both within the Division and Trust wide

Report Sponsor

Carolyn Mills – Chief Nurse

Appendices

- Appendix A –

Patient story for April 2014 Patient Experience Group

Division of Medicine

Mr S's story

This story relates to the experience of a son who raised concerns about his father's discharge from Bristol Royal Infirmary to a nursing home and the communication that took place at that time.

The complaint highlighted a number of issues:

- Poor communication about Mr S's discharge from hospital to a nursing home bed, following admission from a sheltered living environment with a package of care
- The poor care delivered by the nursing home which was dealt with separately under a Bristol City Council Safeguarding investigation
- The nursing home's understanding that the gentleman was discharged to them for end of life terminal care
- The son's belief that his father would not have died if we had not discharged him inappropriately to the nursing home.

This story highlights the importance of health and social care working together to achieve a safe discharge and how poor communication can lead to uncertainty and unnecessary upset for families and carers.

Communication relating to discharge

Social Care Communication – At the time of this incident, there was no unified record of social work involvement with inpatients unless the social worker updated the social work record held in the medical notes or nursing staff recorded any conversations with the social worker in the nursing records. The social work records are held remotely on a non-Trust IT system to which we do not have access. During the investigation into the complaint, Trust staff were unable to access the social worker records to confirm their involvement in the discharge planning process. However an informal conversation confirmed that there had been discussions with the son (we checked it was the correct son) and the social work team were comfortable with the decisions made, as a Best Interest Meeting had been arranged to discuss suitable care provision for discharge involving the son.

Nursing/Medical Staff Communication – There are robust nursing and medical staff entries in the nursing and medical records of the ongoing plan of active care for this patient throughout his stay. There were less concise nursing entries relating to his discharge planning and communication with the son who was the nominated next of kin. Whilst there are entries that state ward staff contacted the son, the son disputes that these conversations took place. This was difficult to respond to both in the complaint response letter and at a subsequent complaint meeting as the nursing records appear to show this contact took place.

Discharge for End of Life Terminal Care – Whilst the patient was on the ward, he was actively treated for pneumonia and then a subsequent chest infection with appropriate antibiotics. His nutrition and hydration needs were met following dietetic review and monitoring of his food and fluid intake. At a subsequent meeting (not highlighted initially in the complaint), Mr S's son said that he believed his father wasn't taking enough to eat and that often when he visited, his father was only eating ice-cream, which he believed was inadequate. The nursing records demonstrate that towards the end of the day his father tired and tended to eat less at suppertime than at other meal times. However this reflected poor communication in that the son wasn't provided with the information and assurance that his father was being well cared for during his evening visits.

When Mr S's son visited the nursing home a couple of days after discharge, he found that they were only providing end of life care and that this was what his father's discharge to them had been for. There is no evidence in any hospital records that supports this view. The hospital consultant had reviewed Mr S the day prior to his discharge and had recorded that he was medically fit for discharge. Mr S was still requiring all nursing care, so a discharge to a nursing home where 24 hour nursing care was available was a reasonable discharge destination.

Safeguarding issues – dealt with by Bristol City Council

Good practice

- Notes of a meeting between the Mr S's son and a consultant were recorded during the patient's stay. After this, he tended to visit his father after work when the medical team were not so available and he did not raise any concerns or request to see a consultant during the remainder of his father's stay. At a subsequent meeting(the patient's son wished to meet with the medical and ward staff following the formal Trust response to his concerns) he expressed his thanks for the quality of the care on the ward
- There are nursing records of contact made with Mr S's son in the days prior to Mr S's discharge, although not on the actual day of discharge. These contacts are disputed by the son but are clearly recorded in the nursing records

Concerns

- This story highlights the importance of good communication and clear and accurate record keeping
- It also highlights the gap between ward level discharge planning and the discharge planning process managed by social services via the social worker. There are very few entries by social workers in the nursing and medical records and therefore when investigating the complaint it was difficult to see how the decision to discharge this patient to a nursing home bed had been made, particularly as the patient had dementia
- There is no record in the medical notes of the transfer letter to the nursing home and therefore we were unable to clearly demonstrate to Mr S's son that his father's discharge had not been planned for end of life care but for access to 24 hour nursing care

Actions and shared learning

- The new patient logger on the eHandover system has greatly improved the shared communication between hospital and social care: it is clear at a glance where the patient is in their journey towards discharge and gives the names of the individuals involved. The subsequent complaint meeting enabled us to share the different approach we are now taking and highlighted the need for live updating on the system
- We have increased our vigilance about how we share and record the conversations we have with carers and relatives throughout a patient's stay to ensure both the nurses and relatives/carers have discussed and agreed appropriate discharge planning arrangements.. We are piloting a patient diary at South Bristol Community Hospital to inform our thinking and understand whether recording discharge plans and rehabilitation goals in a patient/carer/nurse record held at the patient's bedside, can improve communication and reduce complaints relating to poor communication as this had been a theme we have previously identified.
- We are currently piloting a transfer document to be used when transferring patients to residential and nursing care settings. This will enable us to record the discharge care needs of a patient and maintain a copy in the medical records. We will need to be clear about the expectations of our staff and the supporting teaching requirements to launch the new nursing documentation, to ensure it is completed in full and accurately reflects the individual's care needs. We will use the pilot records and specific feedback from the nursing/residential homes that have worked with us on this project, to review the quality of information submitted and the usefulness for the homes involved.

Carole Tookey
Head of Nursing, Division of Medicine

Report for a Public Meeting of the Trust Board of Directors to be held on 28 April 2014 at 10.30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 7 – Quality and Performance Report

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

Abstract

The monthly Quality & Performance Report details the Trust's current performance on national frameworks, and a range of associated Quality, Workforce and Access standards. Exception reports are provided to highlight areas for further attention and actions that are being taken to restore performance.

The report has previously been considered by the Board's Quality and Outcomes Committee.

Recommendations

The Board is recommended to **review** the current performance of the Trust and to ratify the actions being taken to improve performance.

Executive Report Sponsor or Other Author

'**Health of the Organisation**' – Deborah Lee (Director of Strategic Development)

'**Quality**' – Carolyn Mills (Chief Nurse) & Sean O'Kelly (Medical Director)

'**Workforce**' – Sue Donaldson (Director of Workforce & Organisational Development)

'**Access**' – James Rimmer (Chief Operating Officer)

Authors:

Xanthe Whittaker (Head of Performance Assurance / Deputy Director of Strategic Development)

Anne Reader (Head of Quality (Patient Safety))

Heather Toyne (Assistant Director of Workforce Planning)

Previous Meetings

Date the paper was presented to the relevant Group or Committee:

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
		24th April 2014			

SUMMARY QUALITY & PERFORMANCE REPORT

April 2014

CONTENTS

PERFORMANCE OVERVIEW

A Performance Overview ______________

B Organisational health barometer ______________

C Monitor's Compliance Framework ______________

1. QUALITY

1.1 Quality dashboard ______________

1.2 Summary ______________

1.3 Changes in the period ______________

1.4 Exception reports ______________

1.5 Supporting Information ______________

2. WORKFORCE

2.1 Summary ______________

2.2 Exception Reports ______________

2.3 Supporting Information ______________

3. ACCESS STANDARDS

3.1 Summary

3.2 Access dashboard

3.3 Changes in the period

3.4 Exception reports

SECTION A – Performance Overview

Summary

There has been a small improvement in the overall 'health' of the organisation, with an increase in GREEN rated indicators by one. The key changes in indicators include the number of inpatient falls returning to a GREEN rating, with five of the seven indicators of patient experience, quality of care and clinical effectiveness now being GREEN rated. In addition, improvements seen across a range of quality indicators in recent months, including antibiotic prescribing compliance levels, and the incidence of falls and pressure ulcer for patients under our care, have been maintained. The level of patient complaints has, however, increased in the period moving this indicator to a RED rating for the month. The rise in complaints reflects the continued challenges faced in improving access times against a backdrop of increasing patient complexity and demand for services.

Two of the three measures of efficiency remain RED, although in both cases there are underlying improvements in performance. Length of Stay of patients discharged in the month increased by 0.24 days relative to the previous month. However, this reflects a higher proportion of long stay patients being discharged in the month, and importantly, in contrast to previous months, there were fewer patients that had stayed over 14 days that were in hospital at month-end indicating improvements in patient flow had been realised. The Outpatient Appointment Hospital Cancellation Rate showed a further modest decrease in the period, but continues to be RED rated due to the actions being taken to bring-forward patients' appointments to support achievement of the Referral to Treatment Time (RTT) Non-Admitted standard.

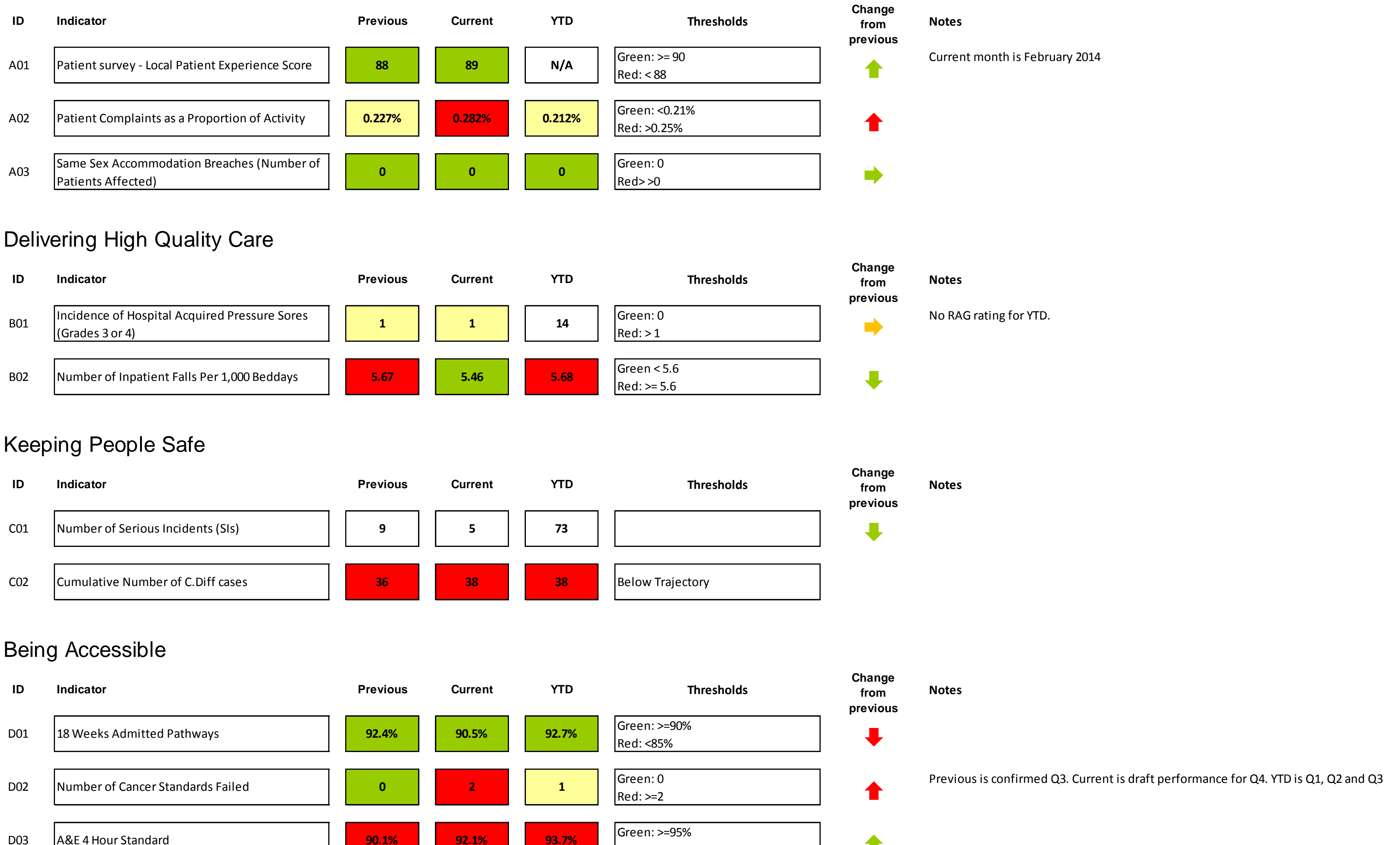
In contrast to the previous month all four measures of financial performance were GREEN rated in the period. This followed a significant improvement in the level of Cash Releasing Efficiency Savings (CRES) realised in the month, which moved the indicator to a GREEN rating and improved the year-end position to 80% achievement. The forecast for CQUINS continues to be GREEN rated, but has also improved significantly in the month. There has been a slight deterioration in the forecast out-turn for Contract Penalties, although again this indicator remains GREEN rated. Staff sickness rates continue to be the focus of significant attention and have reduced, with this indicator now being AMBER rated for the first time since December. Appraisal compliance rate remains well above the 85% target. Both indicators of the Trust's Research activities have also retained their GREEN rating for a further month.

Of significant concern, the Trust has a draft score of 5.0 against Monitor's Risk Assessment Framework. This score reflects the failure of the A&E 4-hour standard, the failure to achieve the Referral to Treatment Time (RTT) Non-admitted standard, as continues to be forecast following the Head & Neck service transfer from North Bristol Trust, the failure to recover the *Clostridium difficile* (C. diff) cumulative trajectory for the year to date, despite the significant recovery against this trajectory in the past three months, and the failure of the 62-day GP cancer standard for the quarter, the latter being due to high volumes of breaches for unavoidable reasons including clinical complexity. Included in the score of 5.0 is the 31-day first definitive treatment cancer standard, which is subject to final validation and reporting but is considered to be at high risk of being failed. The failure to recover the *C. diff* trajectory during quarter 4 constitutes the fourth consecutive quarter failed. Monitor has already requested further information in order to investigate the failure of this standard as a

potential governance concern and has recognised the challenge such a low number of target cases represents, for this and other trusts in the same position. It is expected Monitor will also request further information on the reasons for the failure of the 95% 4-hour standard and the RTT Non-Admitted pathways standard, which together with the two cancer standards, give a Service Performance score above the trigger threshold (4.0 or more) for which Monitor will seek to understand any potential governance concerns.

PERFORMANCE OVERVIEW

SECTION B – Organisational Health Barometer



Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
A01	Patient survey - Local Patient Experience Score	88	89	N/A	Green: >= 90 Red: < 88	↑	Current month is February 2014
A02	Patient Complaints as a Proportion of Activity	0.227%	0.282%	0.212%	Green: <0.21% Red: >0.25%	↑	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	0	0	Green: 0 Red> >0	→	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	1	1	14	Green: 0 Red: > 1	→	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	5.67	5.46	5.68	Green < 5.6 Red: >= 5.6	↓	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
C01	Number of Serious Incidents (SIs)	9	5	73		↓	
C02	Cumulative Number of C.Diff cases	36	38	38	Below Trajectory		

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	92.4%	90.5%	92.7%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	0	2	1	Green: 0 Red: >=2	↑	Previous is confirmed Q3. Current is draft performance for Q4. YTD is Q1, Q2 and Q3
D03	A&E 4 Hour Standard	90.1%	92.1%	93.7%	Green: >=95% Red: <95%	↑	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
E01	Summary Hospital Mortality Indicator (SHMI) - In Hospital Deaths	61.2	61.9	66.4	Green: <80 Red: >=90	↑	Previous is November 2013 and Current is December 2013.
E02	30 Day Emergency Readmissions	322	293	3198	Below 12/13 Readmission Rate	↓	Previous is January's discharges where there was an emergency Readmission within 30 days. Current is February's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.26	4.50	4.34	Green: <= Quarterly target 3.9 Red: >= Quartrely target 3.9	↑	The target for 2013/14 for this overall indicator of Length of Stay has been derived from the Trust's bed model.
F03	Theatre Productivity - Percentage of Sessions Used	90.4%	90.5%	91.9%	Green: >= 90% Red: < 90%	↑	
F04	Outpatient appointment hopsital cancellation rate	11.3%	11.2%	11.1%	Green: <=6.0% Red: >=10.7%	↓	

Valuing Our Staff

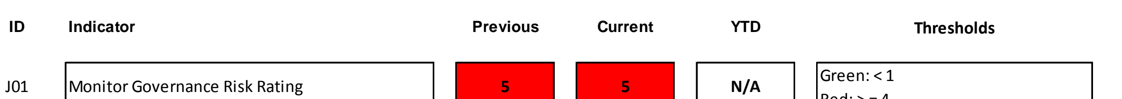
ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Appraisal Compliance	87.9%	85.9%	N/A	Green: 85% and above Red: below 85%	↓	
G02	Staff Sickness	4.3%	4.4%	4.0%	Green: up to 0.2 % pts above target Red: >=0.5% pts above target	↓	Arrow indicates change in terms of variance from target.

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
H02	Cumulative Weighted Recruitment	35,036	3,291	3,291	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Dec 2013 and Current is Jan 2014
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	42.9%	52.0%	52.0%	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	↑	Current is Q4 2012/13 – Q3 2013-14. Previous is Q3 2012/13 - Q2 2013/14. Updated Quarterly

PERFORMANCE OVERVIEW

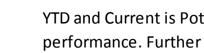
Governing Well



ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	5	5	N/A	Green: < 1 Red: > = 4	→	Previous shows the draft Q4 poisition as at the end of February. Current shows the draft Q4 quarter-end position.

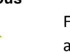
Delivering Our Contracts

The Previous column represents Month 11 2013/14. Current (and YTD) represents Month 11 Accounts 2013/14



ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£8.47	£8.54	£8.54	> 50% Green < 50% Red	↑	YTD and Current is Potential year-end rewards based on best assessment of likely year end performance. Further refinements of this forecast continue to be made.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	-£0.36	-£0.30	-£0.30	Green: Below Plan Red: Above Plan	↑	Data is variance above (+) or below (-) plan, with a higher negative value representing better performance. YTD and Current is variance reported for February based on best known data where available taking funding provision into account. This includes Readmissions and Emergency Marginal Tariff Adjustment.

Managing Our Finance



ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
L01	Monitor Continuity of Service	3.5	4	4	Green: >=3.0 Red: <2.5	↑	For financial measures except CRES, Current and YTD is Current Year To Date. For CRES there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	Liquidity	3.0	4.0	4.0	Green: >=3.0 Red: <2.5	↑	
L03	Capital Service Capacity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	
L04	CRES Achievement	75%	103%	80%	Green: >=90% Red: < 75%	↑	

Notes

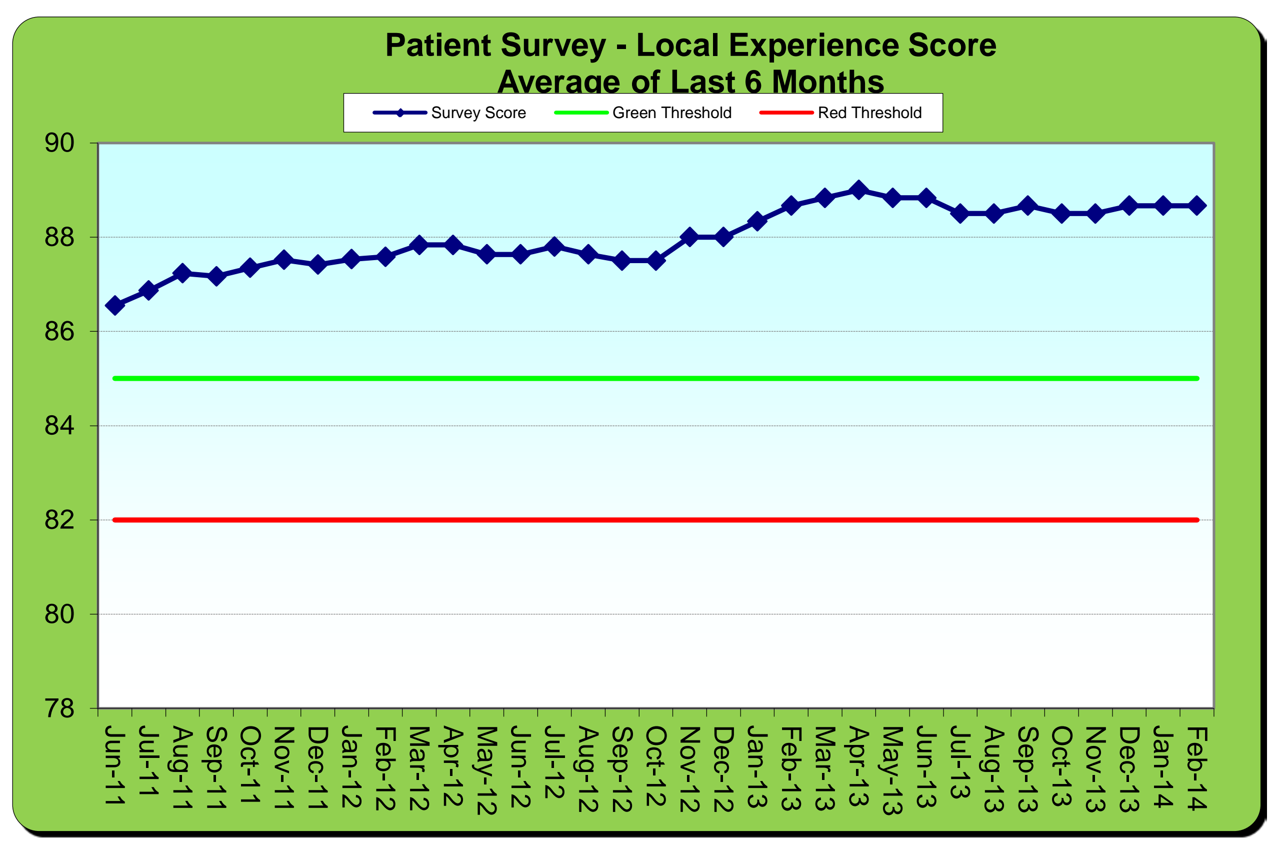
Unless otherwise stated, Previous is February 2014 and Current is March 2014

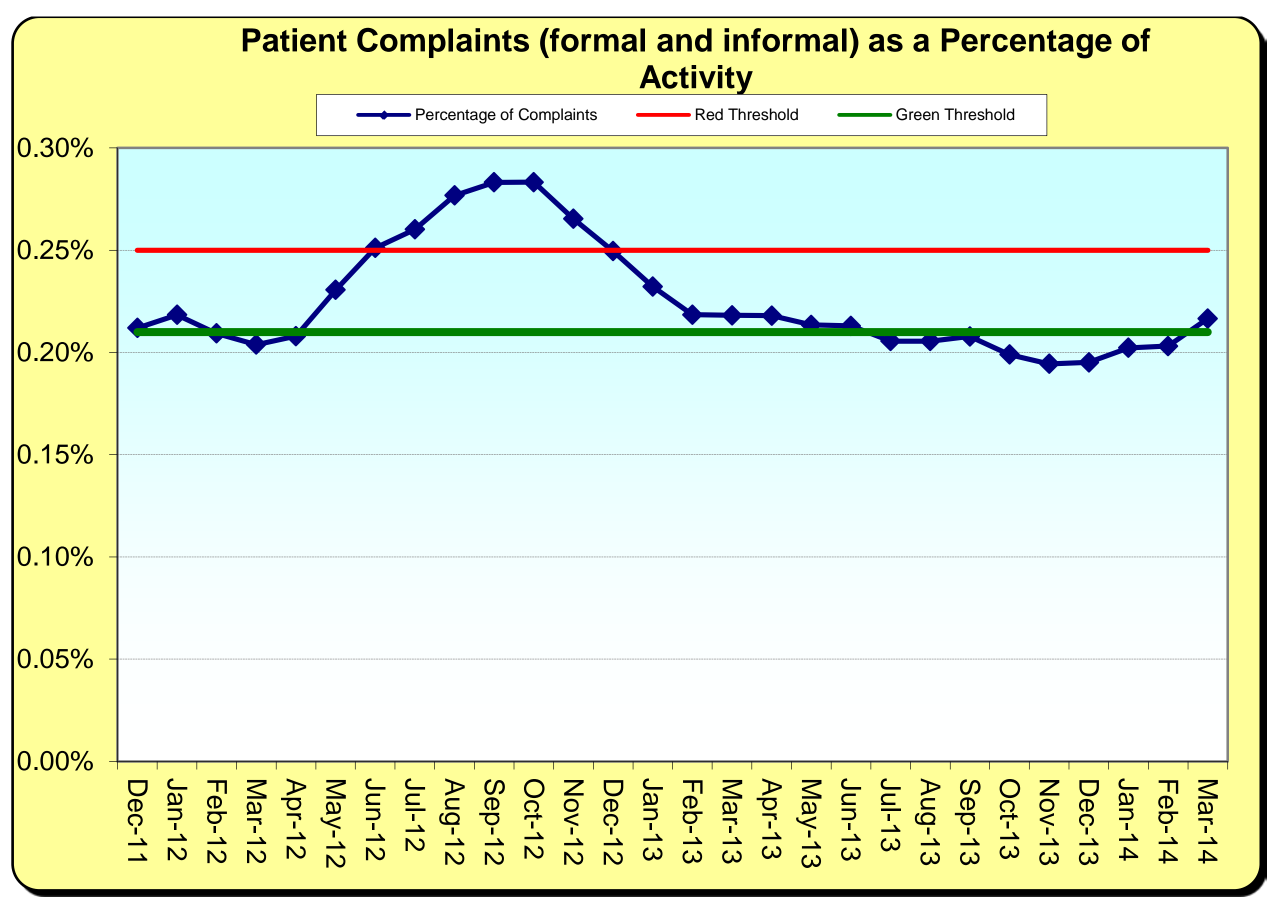
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2012 up to and including the current month

RAG (Red/Amber/Green) rating only applied to YTD where an agreed target number of cases/score exists.

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Patient complaints as a proportion of activity	In the *Quality* section of this report	
Cumulative number of C. diff cases	In the *Quality* section of this report	
A&E 4hour standard	In the *Access* section of this report	
Length of Stay	See *Additional Information*	There was an increase in the Length of Stay of patients discharged in the month, from 4 4.26 days in February to 4.50 in March. Analysis shows that a high proportion of long stay patients were discharged in the month. In contrast to the previous two months, the number of long-stay patients in hospital at month-end also decreased, suggesting an overall improvement in patient flow.
Outpatient appointment hospital cancellation rate	See *Additional Information*	As part of the recovery plan for the Referral To Treatment Time (RTT) Non-Admitted standard, patients' appointments are being cancelled and brought forward. The deterioration in performance against this indicator was therefore forecast.
Monitor Governance Risk Rating	In *Overview* section	


Patient Survey - Local Experience Score
Average of Last 6 Months
Survey Score
Green Threshold
Red Threshold
90
88
86
84
82
80
78
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14


Patient Complaints (formal and informal) as a Percentage of Activity
Percentage of Complaints
Red Threshold
Green Threshold
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
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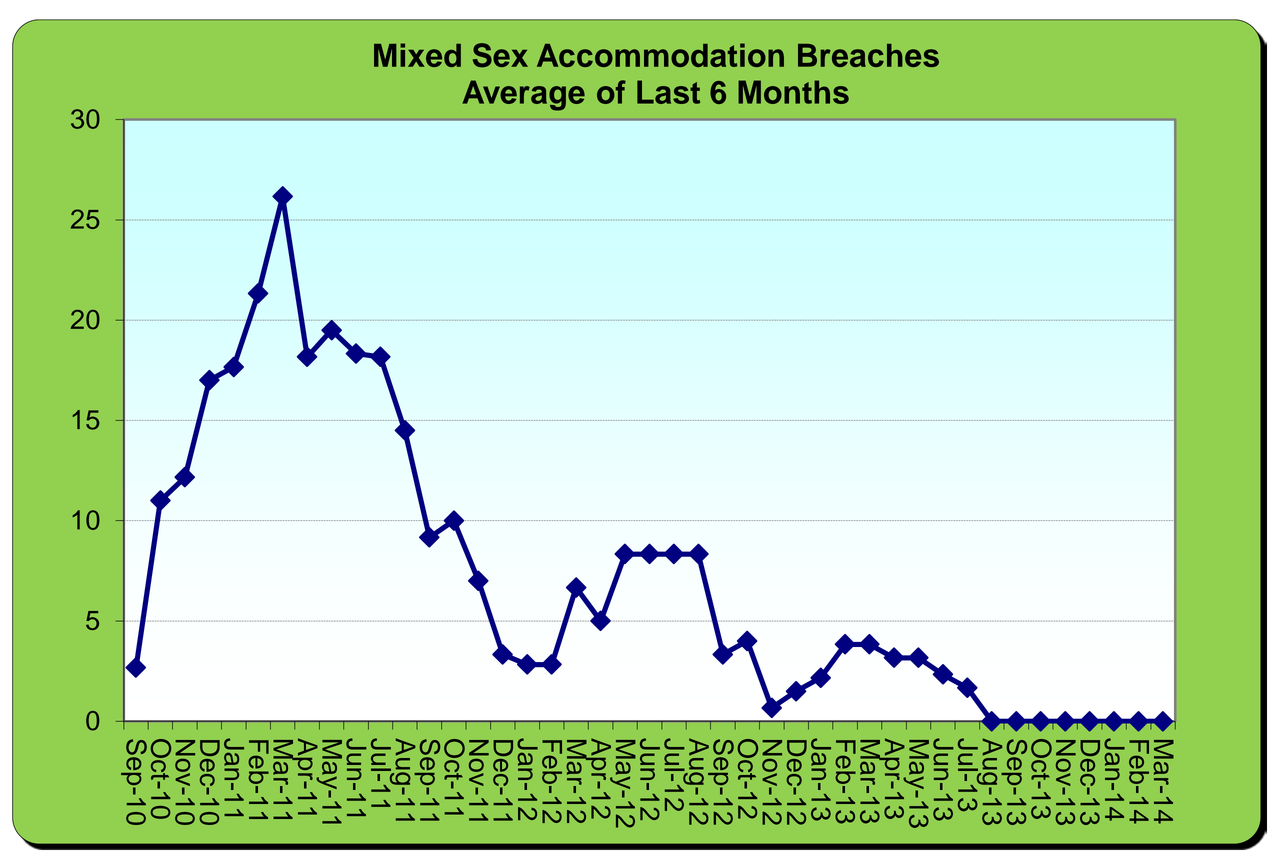
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14



Mixed Sex Accommodation Breaches
Average of Last 6 Months
30
25
20
15
10
5
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
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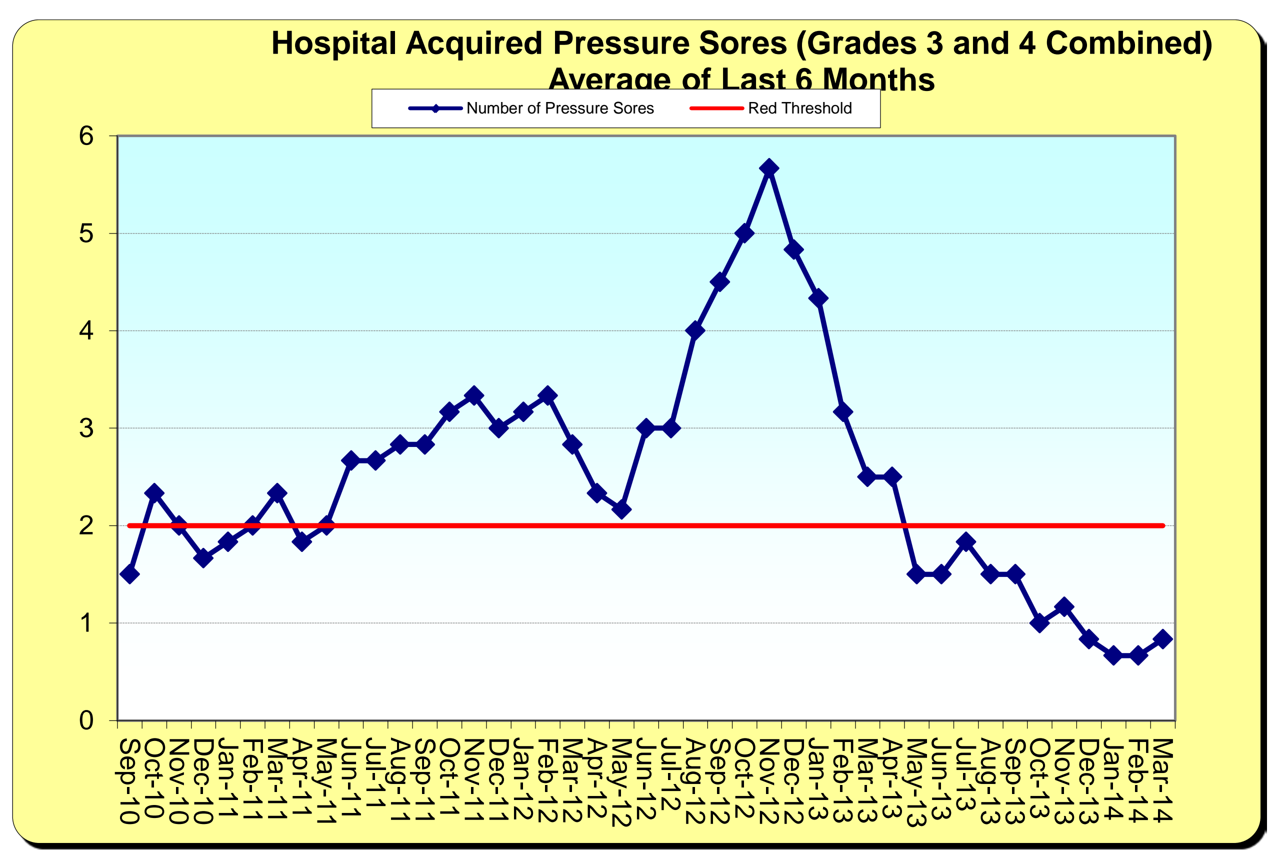
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
Number of Pressure Sores
Red Threshold
0
1
2
3
4
5
6
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
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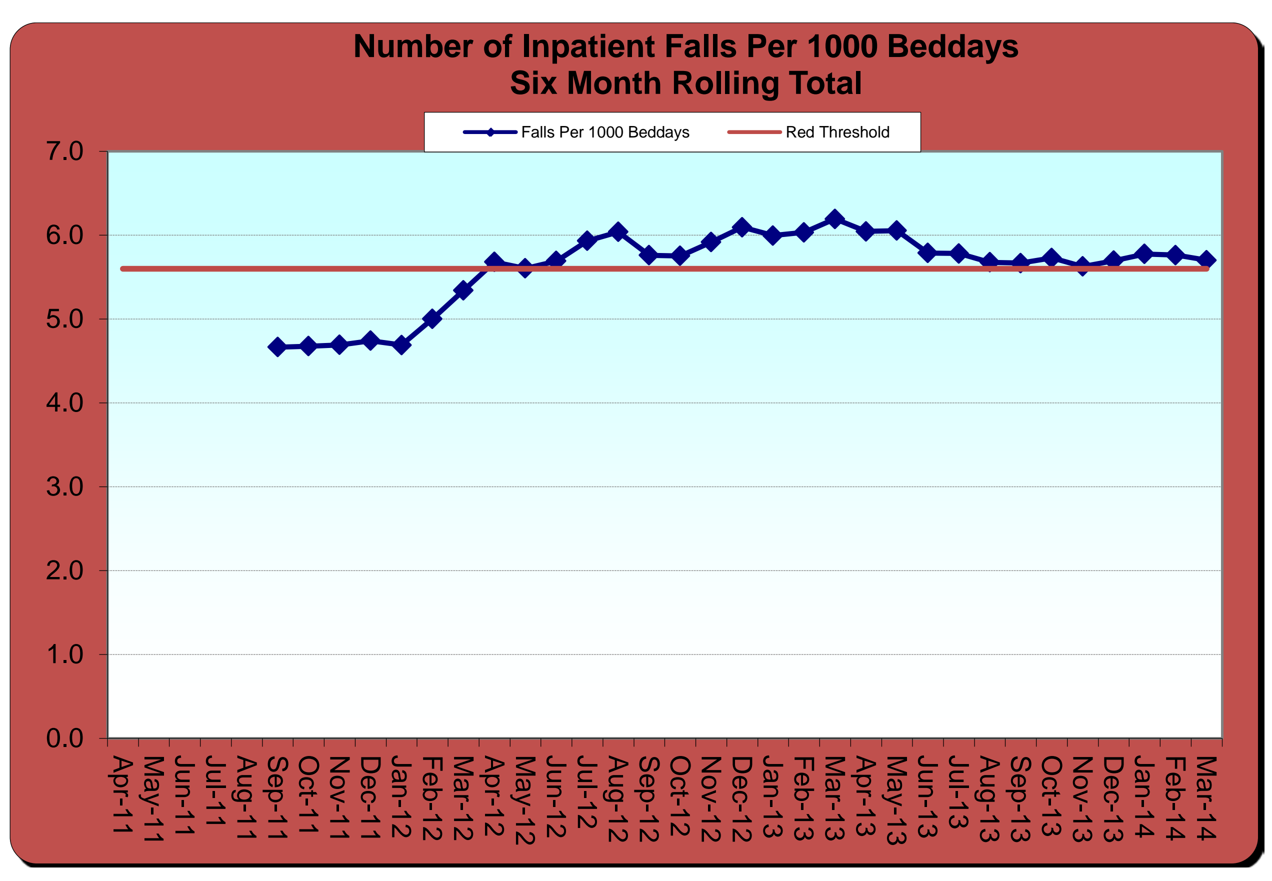
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Number of Inpatient Falls Per 1000 Beddays
Six Month Rolling Total
Falls Per 1000 Beddays
Red Threshold
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
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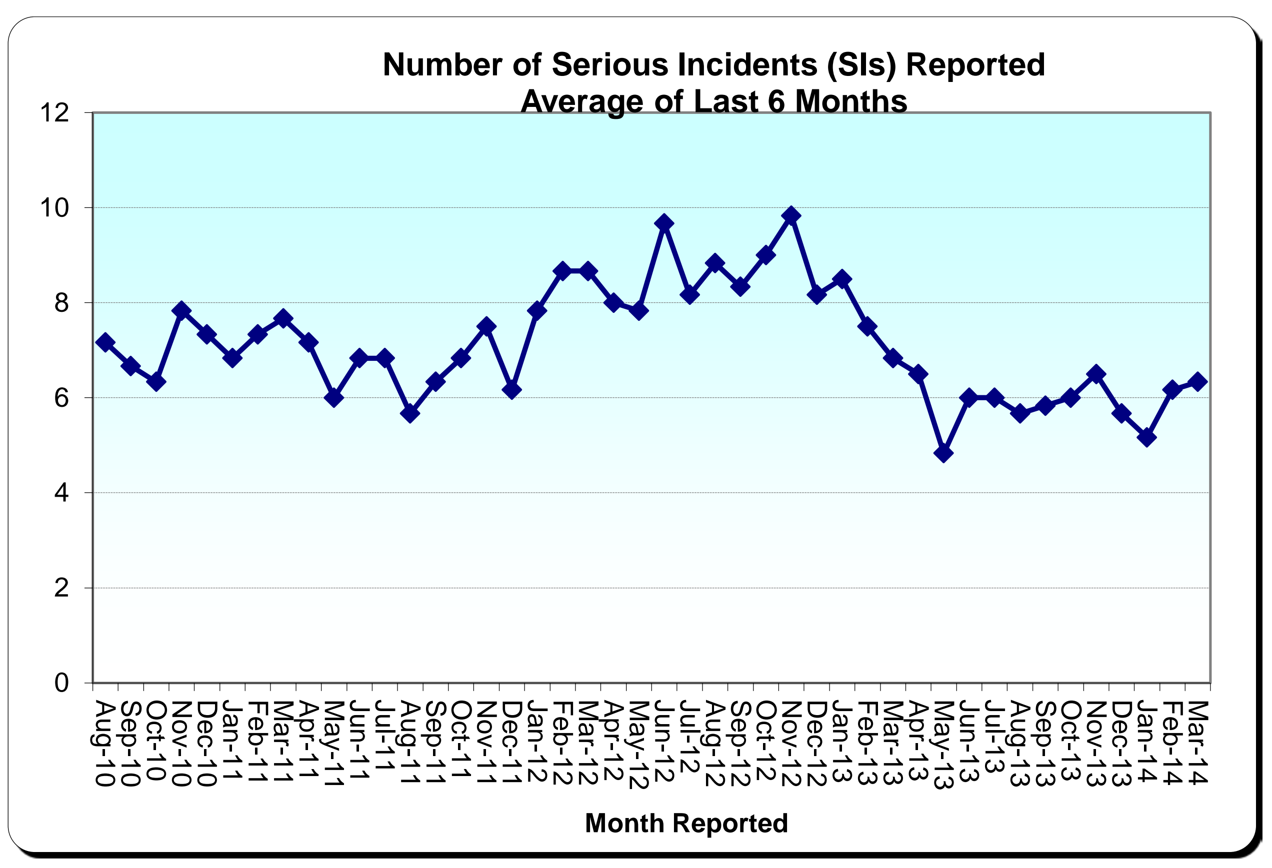
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Number of Serious Incidents (SIs) Reported
Average of Last 6 Months
12
10
8
6
4
2
0
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
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Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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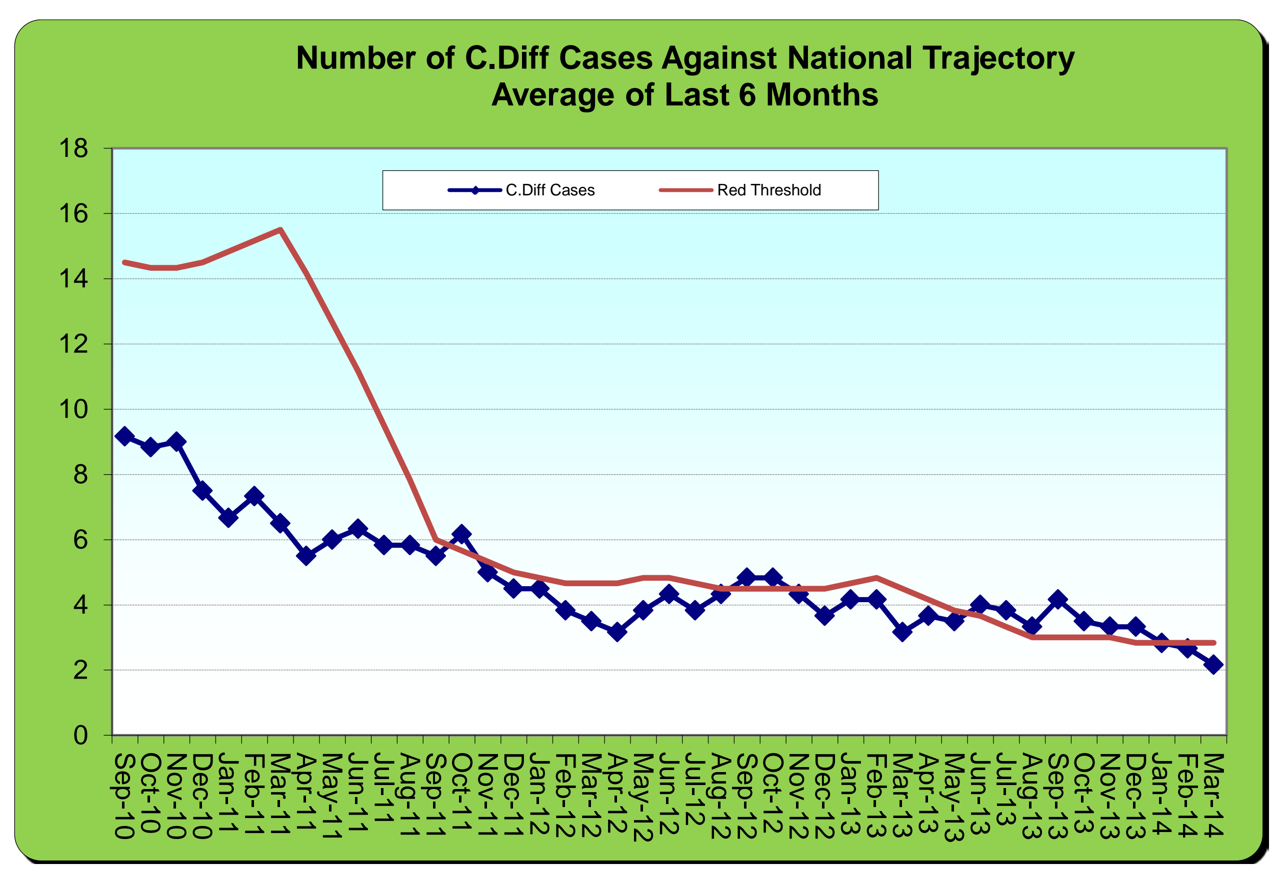
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Month Reported


Number of C.Diff Cases Against National Trajectory
Average of Last 6 Months
C.Diff Cases
Red Threshold
0
2
4
6
8
10
12
14
16
18
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
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Feb-13
Mar-13
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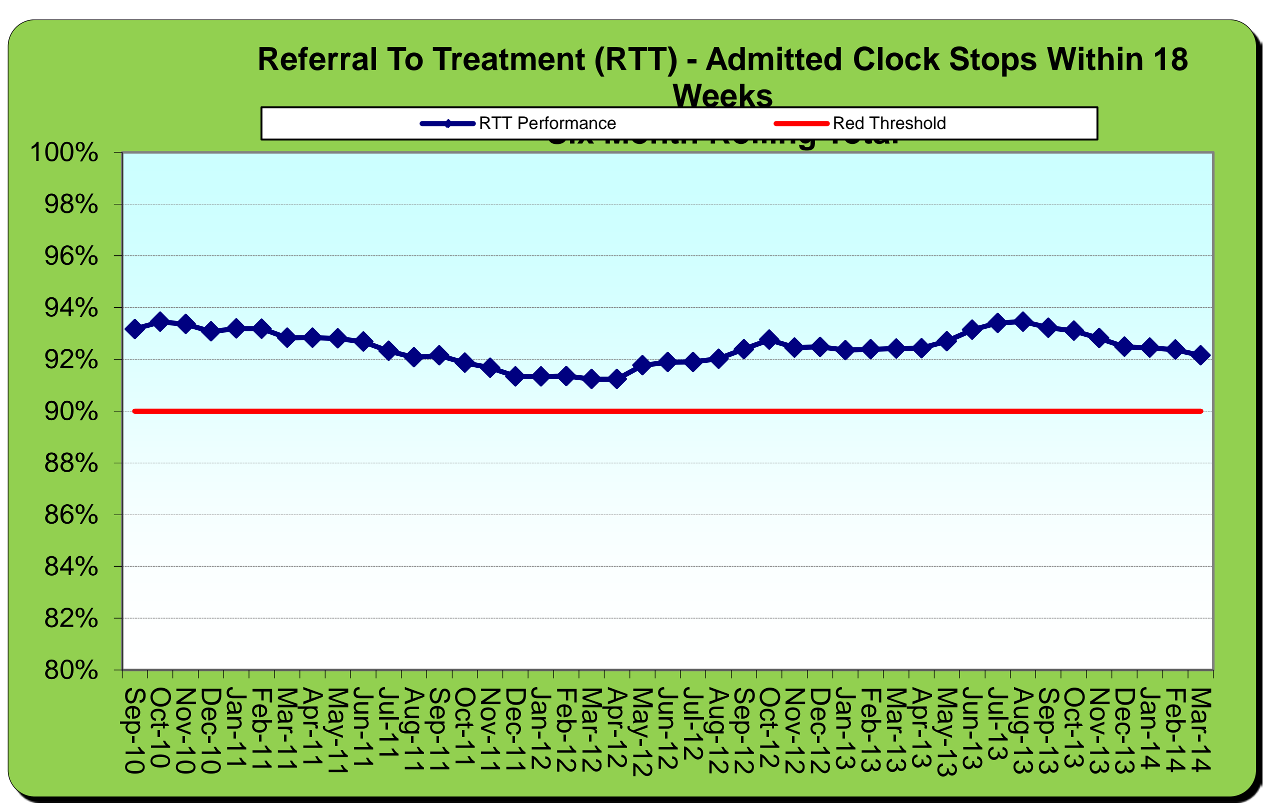
Jan-14
Feb-14
Mar-14


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
RTT Performance
Red Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
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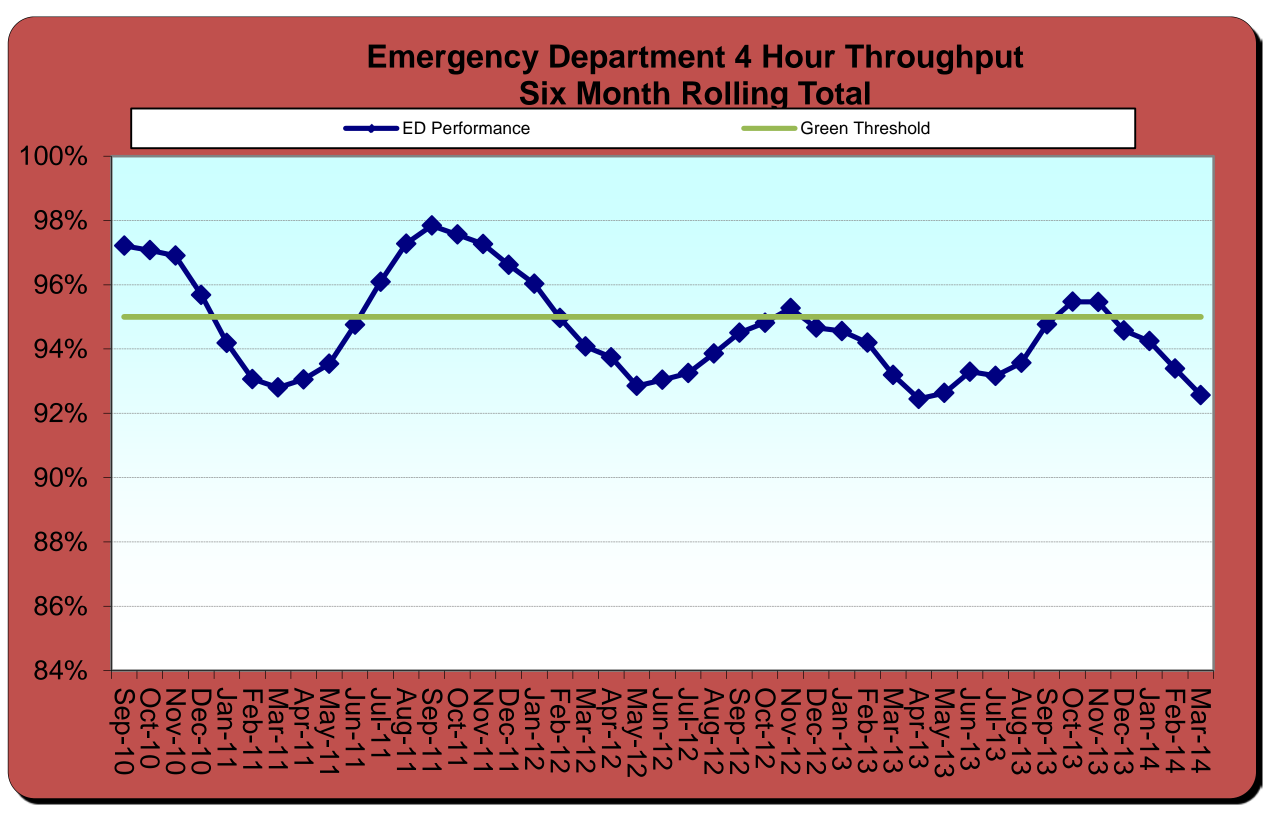
Mar-14


Emergency Department 4 Hour Throughput
Six Month Rolling Total
ED Performance
Green Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
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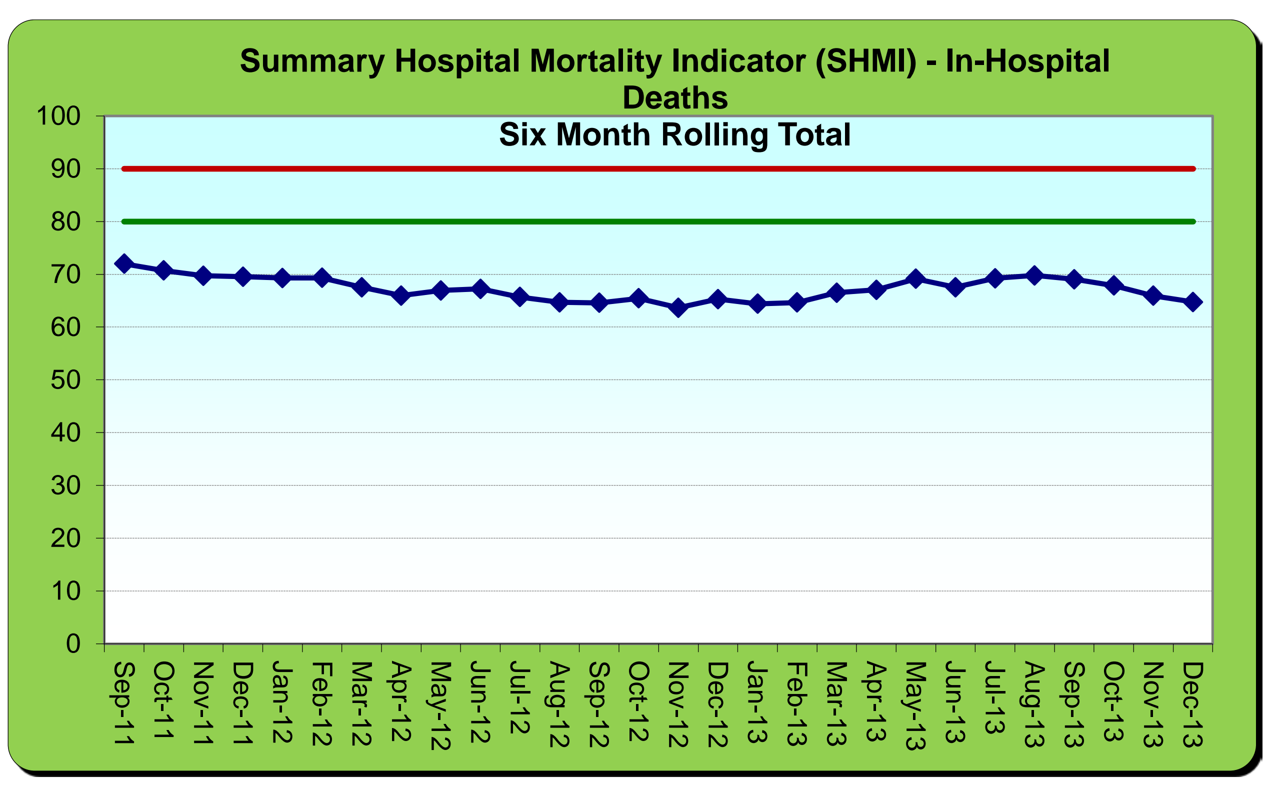
Mar-14



Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
100
90
80
70
60
50
40
30
20
10
0
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
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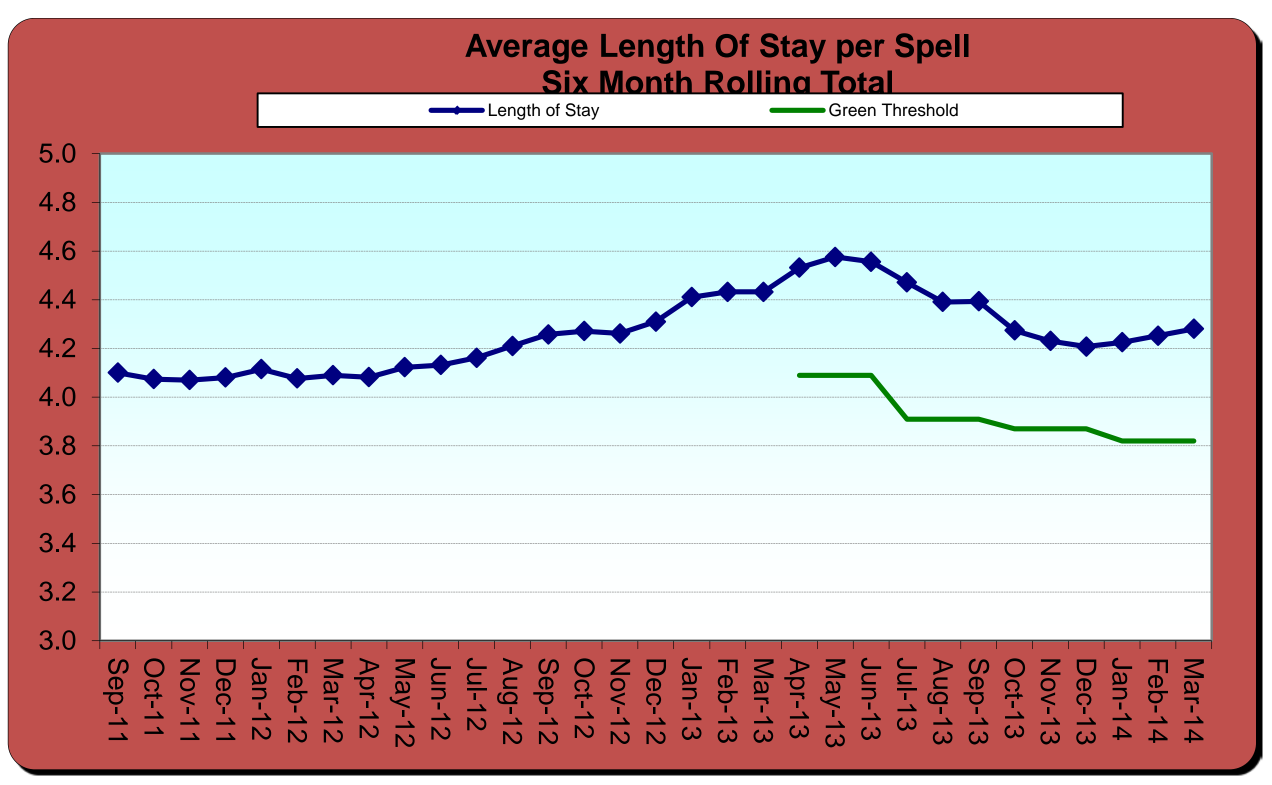
Oct-13
Nov-13
Dec-13



Average Length Of Stay per Spell
Six Month Rolling Total
Length of Stay
Green Threshold
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
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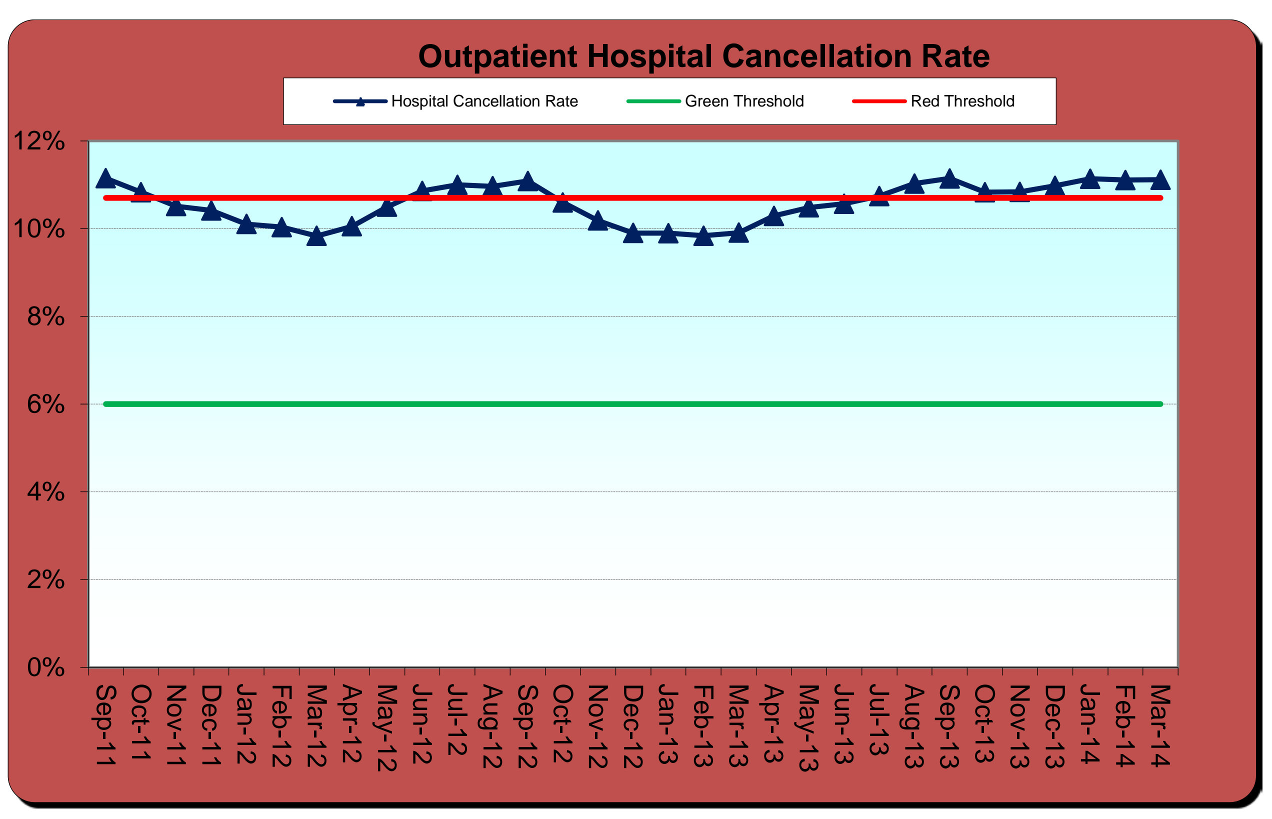
Dec-13
Jan-14
Feb-14
Mar-14


Outpatient Hospital Cancellation Rate
Hospital Cancellation Rate
Green Threshold
Red Threshold
12%
10%
8%
6%
4%
2%
0%
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14

SECTION C – Monitor's Compliance Framework

At the end of quarter 4 the Trust has failed to achieve, for the quarter as a whole, four of the standards in Monitor's 2013/14 Risk Assessment Framework. The 31-day first definitive treatment cancer standard is also considered at high risk of being failed when final reporting is completed. The following Exception Reports are therefore provided:

- A&E 4-hour maximum wait (1.0) – *Access section*
- *Clostridium difficile* cumulative trajectory (1.0) – *Quality section*
- RTT Non-admitted standard (1.0) – *Access section*
- 62-day Referral to Treatment GP Cancer standard (1.0) – *Access section*
- 31-day first definitive treatment cancer standard (1.0) – *Access section*

Overall the Trust has a draft score of 5.0 against the new Risk Assessment Framework, reflecting the four standards confirmed as failed and the standard considered to be at high risk of being failed. This would equate to a RED risk rating in terms of the Performance Service score alone. Because the Trust has exceeded the annual objective of 35 cases of *Clostridium difficile* Monitor has already requested further information in order to investigate the failure of this standard as a potential governance concern, but has also recognised the challenge such a low number of target cases represents, for this and other trusts in the same position. It is expected Monitor will also request further information on the reasons for the failure of the 95% 4-hour standard and the RTT Non-Admitted pathways standard.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 4 2013/14.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Compliance Framework: Q4 12/13	Compliance Framework: Q1 13/14	Compliance Framework: Q2 13/14	Risk Assessment Framework: Q3 13/14	Risk Assessment Framework: Q4 13/14*	Q4 Forecast quarter-end*	Notes	Q4 Forecast Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	38	✓	×	×	×	38	×	Cumulative trajectory: Q1 9; Q2 18; Q3 26; Q4 35	Not achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.8%	✓	✓	✓	✓	99.7%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	95.1%	✓	✓	✓	✓	94.0%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.6%	✓	✓	✓	✓	95.6%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	80.7%	×	✓	×	✓	75.6%	×	62-day GP standard not achieved, mainly due to late referrals, patient choice and medical deferrals	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	93.7%	✓	✓	✓	✓	94.4%	✓		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	92.7%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	92.0%	✓		Achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	93.1%	Achieved each month	Achieved each month	Not achieved	Not achieved	92.6%	×	Standard failed in each month in Q4.	Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.5%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	92.7%	✓		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.9%	✓	✓	✓	✓	95.9%	×	31-day first definitive standard at risk.	Not achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	96.6%	✓	✓	✓	✓	97.4%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	✓	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
	9	A&E Total time in A&E 4 hours (95th percentile)	1.0	95%	93.7%	×	×	✓	×	91.3%	×		Not achieved
	10	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Actions implemented	Not applicable	Not applicable		Achieved
					rating	AMBER-RED	AMBER-RED	AMBER-RED	GREEN	Triggering escalation	Triggering escalation		

Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole. Quarterly figures quoted for the **62-day CANCER STANDARDS** include the impact of breach reallocations for late referrals, which are allowable under Monitor's Compliance Framework. For this reason, the quarterly figures may differ from those quoted in the Access Tracker. For the period shown Q1 and Q3 2013/14 have had corrections applied to the 62-day GP performance figures for breach reallocations.

***Q4 Cancer figures based upon confirmed figures for January/February and draft figures for March. The C diff figures is shown as the cumulative position against the quarter-end target.**

5.0
Escalation for further investigation of issues

QUALITY

1.1 QUALITY TRACKER

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	12/13	13/14 YTD	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Patient Safety																						
Infection Rates	DA01a	MRSA Cumulative Cases Against National Trajectory	0	1	10	2	0	1	1	1	1	1	1	1	1	1	2	2	1	1	1	2
	DA03a	C.Diff Cumulative Cases Against National Trajectory	35	36	48	38	6	10	14	17	20	25	27	30	34	34	36	38	14	25	34	38
	DA02	MSSA Cases Against Trajectory	29	30	34	27	1	3	1	2	1	5	3	3	3	1	2	2	5	8	9	5
	DA05	Number of GRE Bacteraemias	2	4	16	15	0	1	2	2	1	1	1	2	2	0	3	-	3	4	5	3
	DA06	E. Coli Bloodstream Infections	-	-	236	223	15	18	12	21	17	17	18	17	21	26	22	19	45	55	56	67
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	DD02	MRSA Emergency Screenings	95%	80%	94.3%	94.8%	95.8%	94.8%	95.7%	92.3%	93.9%	94.8%	95.2%	94.9%	95.2%	95%	95.2%	95.3%	95.5%	93.6%	95.1%	95.2%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.3%	96.8%	97.8%	96.2%	97.6%	98.1%	92.4%	97.8%	96.4%	96.1%	96%	98.3%	98.3%	97.2%	97.2%	96%	96.2%	97.8%
	DB02	Antibiotic Compliance	90%	80%	84.8%	88%	89.2%	89.3%	89%	88.3%	85%	86.5%	85.9%	86.5%	86.5%	88.6%	90.1%	90.7%	89.2%	86.7%	86.2%	89.9%
Cleanliness	DC01	Cleanliness Monitoring - Overall Score	95%	70%	95%	95%	96%	93%	95%	95%	96%	94%	95%	95%	94%	94%	94%	96%	95%	95%	95%	95%
	DC02	Cleanliness Monitoring - Very High Risk Areas	95%	95%	96%	96%	97%	96%	97%	96%	98%	96%	95%	96%	96%	95%	96%	96%	97%	97%	96%	96%
	DC03	Cleanliness Monitoring - High Risk Areas	95%	70%	95%	95%	95%	93%	95%	96%	95%	95%	94%	96%	95%	95%	95%	96%	94%	95%	95%	95%
Serious Incidents	S02	Number of Serious Incidents Reported	-	-	91	73	6	2	11	9	3	4	7	5	6	6	9	5	19	16	18	20
	S02a	Number of Confirmed Serious Incidents	-	-	87	57	6	2	10	8	3	4	7	5	5	5	2	-	18	15	17	7
	S02b	Number of Serious Incidents Still Open	-	-	-	14	-	-	-	-	-	-	-	-	1	1	7	5	-	-	1	13
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	84.6%	83.6%	83.3%	100%	81.8%	66.7%	100%	25%	85.7%	100%	83.3%	100%	88.9%	100%	84.2%	62.5%	88.9%	95%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	80%	80%	89.8%	92.4%	50%	100%	100%	100%	100%	100%	87.5%	100%	100%	87.5%	75%	100%	86.7%	100%	93.8%	89.5%
	S01	Total Never Events	0	1	1	2	0	0	1	0	0	0	0	0	1	0	0	0	1	0	1	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	11128	11080	1083	998	965	1134	914	922	1062	1051	953	1055	943	-	3046	2970	3066	1998
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	8.55	9.25	10.22	8.87	9.22	10.05	8.38	8.45	9.07	9.56	9.36	9.39	9.17	-	9.43	8.97	9.33	9.28
	S06b	Patient Safety Incidents Per 100 Beddays	-	-	3.61	4.02	4.25	3.87	3.98	4.47	3.63	3.82	4.17	4.25	3.78	4.05	3.93	-	4.03	3.98	4.06	3.99
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	83	42	2	3	3	3	1	3	9	4	5	3	6	-	8	7	18	9
Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.98	5.68	5.61	6.01	5.16	5.64	5.76	5.8	5.96	5.42	5.59	6.1	5.67	5.46	5.6	5.73	5.66	5.74
	AB03	Repeat Inpatient Fallers	24%	24%	23.9%	23.3%	29.9%	21.5%	23.5%	26.7%	24.7%	25.9%	19.4%	25.3%	25%	20%	20.5%	18.8%	25%	25.7%	23.4%	19.7%
	AB02	Patient Falls - Patients Aged 65+	1408	1408	1408	1318	116	119	80	99	115	102	121	93	121	136	111	105	315	316	335	352
	AB06a	Total Number of Patient Falls Resulting in Harm	-	-	30	28	4	2	0	2	1	3	1	4	2	2	4	3	6	6	7	9
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	1.264	0.656	0.745	0.543	0.66	0.788	0.755	1.078	0.706	0.526	0.555	0.69	0.417	0.417	0.649	0.871	0.596	0.51
	DE02	Pressure Ulcers - Grade 2	84	120	348	184	15	14	14	18	18	26	17	12	14	17	9	10	43	62	43	36
	DE03	Pressure Ulcers - Grade 3	0	12	39	13	3	0	2	2	1	0	1	1	0	1	1	1	5	3	2	3
	DE04	Pressure Ulcers - Grade 4	0	1	3	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Pressure Ulcers Present on Admission	DE07	Pressure Ulcers Present On Admission - Grade 2	-	-	797	821	78	81	81	73	83	70	54	62	73	60	55	51	240	226	189	166
	DE08	Pressure Ulcers Present On Admission - Grade 3	-	-	173	113	9	15	12	8	11	12	14	5	9	6	5	7	36	31	28	18
	DE09	Pressure Ulcers Present On Admission - Grade 4	-	-	54	38	2	6	3	6	4	1	3	2	2	1	6	2	11	11	7	9
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	96.4%	98%	97.9%	97.1%	97%	96.6%	98.1%	97.9%	98%	98.5%	98.2%	98.6%	98.7%	98.5%	97.1%	97.5%	98.2%	98.6%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	93%	90%	93.6%	93.4%	86.1%	89.2%	93.2%	91.6%	92.5%	95.6%	94.6%	95.1%	97.1%	94.9%	96.6%	94.5%	89.4%	93.2%	95.6%	95.3%
Nutrition	WB04	Dietetics: Nutritional Assessments	85%	85%	-	86.2%	85.7%	79.9%	79.4%	77.4%	78.5%	83.5%	88.2%	89.8%	93.3%	92.9%	91.6%	91.2%	81.6%	79.7%	90.4%	91.9%
	WB03	Nutrition: Food Chart Review	90%	85%	-	82.5%	-	75.1%	77.4%	72.3%	92.4%	80.9%	83.8%	76.9%	84.1%	91.2%	91.8%	78.2%	76.2%	81.8%	82.1%	87.7%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.2%	99.6%	99.6%	99.7%	99.6%	99.7%	99.5%	99.5%	99.6%	99.5%	99.7%	99.9%	99.6%	99.6%	99.6%	99.6%	99.6%	99.7%
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2.84%	1.08%	0.76%	0.69%	2.84%	0.66%	0.74%	0%	0.7%	0.61%	0.56%	0%	1%	0.54%	-	1.37%	0.49%	0.41%	0.78%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	92%	97.9%	97%	89.1%	95.7%	99.1%	98.3%	99%	99.1%	100%	100%	99.1%	99%	100%	93.8%	98.8%	99.7%	99.4%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	-	92%	-	-	-	93.3%	97.5%	89.1%	89.5%	90.8%	83.3%	85%	100%	100%	-	93.6%	88.1%	94.1%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	2.25%	2.5%	2.99%	1.91%	2.66%	2.05%	1.7%	1.91%	2.1%	1.19%	2.75%	2.32%	2.6%	1.08%	0.91%	1.66%	2.19%	1.74%	2.56%	1.23%
NHS Safety Thermometer	AK01	Safety Thermometer - Coverage	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	AK03	Safety Thermometer - Harm Free Care	94.9%	91.3%	91.3%	94.1%	91.1%	93.1%	92%	91.9%	95.2%	94.5%	93.5%	95.8%	95%	95.6%	96.2%	95.2%	92.1%	93.9%	94.7%	95.7%
	AK04	Safety Thermometer - No New Harms	97.7%	95.9%	95.7%	97.2%	96.4%	96.4%	96.6%	95.9%	97.3%	98.3%	96.7%	97.4%	97.9%	98.5%	97.8%	97.6%	96.5%	97.2%	97.3%	98%
	DE05	Pressure Ulcers Reduction (Safety Thermometer)	300	348	390	198	19	14	16	20	19	26	18	13	14	18	10	11	49	65	45	39
	AR02	Early Warning Scores (EWS) Completed Correctly	95%	90%	95%	99%	-	99%	98%	99%	99%	99%	99%	98%	99%	98%	100%	100%	98%	99%	99%	99%
	AR04	Deteriorating Patient: SBAR	80%	70%	-	81.4%	-	76.9%	91.7%	40%	80%	66.7%	93.3%	75%	75%	87.5%	100%	85.7%	84%	66.7%	82.9%	90.5%

QUALITY

Clinical Effectiveness

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 12/13	Annual 13/14 YTD	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Mortality	X02	Hospital Standardised Mortality Ratio (HSMR) - 2009/10 Baseline	73.8	90	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	X03	Summary Hospital Mortality Indicator (SHMI 2012 Baseline) - In Hospital Deaths	80	91	65.6	66.4	67.5	72.4	69	67.1	67.8	70.3	61.1	61.2	61.9	-	-	-	69.7	68.4	61.4	-
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	-	-	92.2	93.7	-	-	93.7	-	-	-	-	-	-	-	-	-	93.7	-	-	-
Learning Disability	AA01	Learning Disability (Adults) - Percentage Risk Assessed	85%	85%	82.8%	87.4%	100%	93.8%	93.8%	37.5%	80%	88.2%	100%	85%	88.9%	90%	95.2%	100%	95.7%	65.8%	88.9%	94.4%
	AA03	Learning Disability (Adults) - Percentage Adjustments Made	58%	48%	-	83.9%	50%	81.3%	93.8%	50%	100%	88.2%	100%	95%	77.8%	95%	90.5%	92.3%	76.1%	73.7%	91.7%	92.6%
	AA02	Learning Disability (Paediatrics) - Percentage Risk Assessed	90%	85%	77.9%	89.7%	97.4%	98.2%	70.2%	100%	100%	61.1%	83.8%	90.7%	96.4%	100%	90.9%	96.9%	88.7%	83.8%	89.9%	95.9%
Readmissions	C01	Emergency Readmissions Percentage	3%	3%	3%	2.7%	2.9%	2.5%	2.4%	2.6%	2.5%	2.8%	2.7%	2.7%	2.8%	2.9%	2.9%	-	2.6%	2.6%	2.7%	2.9%
Maternity	G09	Number of Births in Midwife-Led Unit	100	70	-	681	-	-	-	72	67	81	80	83	71	79	81	67	-	220	234	227
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	95%	90%	57%	77.4%	60%	51.5%	73.5%	75.9%	77.1%	96.6%	90.5%	95.5%	87.8%	55.9%	92.6%	85.7%	61.9%	82.8%	90.5%	76.4%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	95%	90%	63.5%	78.8%	70%	36.4%	64.7%	62.1%	68.6%	75.9%	81%	95.5%	100%	97.1%	100%	100%	56.7%	68.8%	94%	98.9%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	36.5%	61.7%	43.3%	15.2%	47.1%	44.8%	54.3%	69%	71.4%	90.9%	87.8%	52.9%	92.6%	85.7%	35.1%	55.9%	84.5%	75.3%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	50%	50%	54.5%	45.2%	44.2%	48.7%	60%	53.7%	62.2%	58%	36.1%	66.7%	62.2%	56.8%	-	46%	58.5%	55.2%	59.6%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	79.3%	84%	69%	83.7%	84.6%	91.1%	82.9%	89.2%	86%	83.3%	87.5%	86.7%	79.5%	-	79%	87.8%	85.8%	83.1%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	58.8%	56.2%	40%	81.3%	50%	35.3%	62.5%	71.4%	73.3%	40%	61.1%	50%	45.5%	-	56.4%	55.3%	63.2%	48.3%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	-	67.7%	50%	85.7%	96.3%	80.1%	86.2%	86.6%	83.4%	74.9%	49.7%	46.6%	45.3%	46.9%	90.3%	84.5%	68.7%	46.3%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	-	60.6%	64.3%	87.5%	61.5%	40.4%	52.9%	53.4%	59%	57.7%	66.7%	75.5%	78%	66.7%	65.6%	49.2%	60.7%	73%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	-	65.4%	100%	100%	85.7%	66.7%	62.5%	62.5%	75%	75.9%	61.5%	57.9%	38.5%	52.4%	90.9%	63.6%	70.7%	48.5%

Patient Experience

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 12/13	Annual 13/14 YTD	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4
Mixed Sex Accom.	M01	Mixed Sex Breaches - Number of Patients	0	1	42	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monthly Patient Surveys	P01d	Patient Survey - Local Patient Experience Score	85	82	-	-	89	89	88	88	89	89	88	89	89	88	89	-	89	89	89	89
	P01e	Patient Survey - Explaining Medication Side Effects	64	61	-	-	59	62	63	63	59	63	58	64	61	55	61	-	61	60	61	58
	P01f	Patient Survey - Maternity Services	85	83	-	-	85	92	88	89	85	84	79	81	85	91	81	-	88	85	82	87
	P01g	Patient Survey - Kindness and Understanding	90	88	-	-	93	94	92	94	93	94	93	93	93	93	91	-	93	93	93	93
Friends and Family Test	P03	Friends and Family Test Coverage	20%	20%	-	17.6%	6.4%	8.2%	10.7%	12.4%	14.5%	22.1%	24.7%	25.2%	18.1%	19.7%	22.5%	31%	8.4%	16.2%	22.7%	24.5%
	P04	Friends and Family Test Score	63	43	-	72.7	75.1	72.3	70.2	74.7	73.5	73.8	73.6	73	70.5	72.7	72.9	71.2	72.1	74	72.6	72.1
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.25%	0.212%	0.245%	0.212%	0.195%	0.162%	0.232%	0.202%	0.192%	0.185%	0.199%	0.214%	0.227%	0.282%	0.218%	0.198%	0.192%	0.241%
	T03a	Complaints Responded To Within Trust Timeframe	98%	90%	54.8%	76.4%	47.4%	54.7%	66.7%	80.3%	77.2%	87.8%	84.9%	82.2%	88.1%	76.1%	92%	88.7%	56.5%	81.4%	85%	84.7%
	T04a	Complainants Disatisfied with Response	48	48	20	62	1	8	6	6	11	1	7	2	6	6	3	5	15	18	15	14

1.2 SUMMARY

This month there has been a significant improvement in the overall response rates for the Friends & Family Test from 22.5% in February to 31.0% in March. This follows a concerted effort across the Trust to encourage patients to tell us whether they would recommend our Trust to others. Also on a positive note, antibiotic prescribing compliance remained above the green threshold for the second consecutive month, with falls and pressure ulcer incidence per 1,000 bed days also sustaining recent improvements and meeting their green thresholds. As we are now at the end of 2013/14 we are able to report on our achievement of the small selection of the Commissioning for Quality Indicators (CQUINs) that we have been tracking via our quality dashboard during the year. We have achieved the vast majority of these CQUINs; further details are provided later on in this section of the report.

As reported last month we continue to be challenged by the Dementia metrics shown in the quality dashboard. It is important to note this represents one facet of the suite of Dementia standards being implemented across the Trust. A huge amount of work has been undertaken to improve the care of patients with dementia, but there is still more to do. We will continue to focus on this key group of vulnerable patients during 2014/15, and build upon and embed the work undertaken over the last twelve month.

Achieving set threshold (40)	**Thresholds not met or no change on previous month (4)**
- MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective - MRSA screening – emergency - Hand Hygiene Audit - Antibiotic prescribing compliance - Cleanliness monitoring: 1) overall Trust score, 2) very high risk areas and 3) high risk areas - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - Never Events - Inpatient falls incidence per 1,000 bed days - Repeat inpatient falls - Falls in inpatients over 65 - Total pressure ulcer incidence per 1,000 bed days - Number of grade 4 hospital acquired pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-	- GRE (Glycopeptide Resistant Enterococci) bacteraemias - WHO surgical checklist compliance - NHS Safety thermometer-no new harms - Fractured neck of femur patients achieving Best Practice Tariff

QUALITY

Embolism (VTE) risk assessment - Percentage adult in-patients who received thrombo-prophylaxis - Patients seen by dietician with 'MUST' (Malnutrition Universal Screening Tool) score of 2 or more - Medicines reconciliation performed within one day of admission (Assessment and cardiac wards) - Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards) - Non-purposeful omitted doses of listed critical medication - Reduction in medication errors resulting in moderate or severe harm - NHS Safety Thermometer – coverage + harm free care - Pressure Ulcer reduction (Safety Thermometer CQUIN) - Deteriorating patient: Early Warning Scores - Escalation of the deteriorating patient using a structured communication tool (SBAR) - Summary Hospital Mortality Indicator in-hospital deaths (SHMI) - Risk assessment of adult patients with known learning disability within 48 hours - Learning disability (adults)-percentage adjustments made - Risk assessment of paediatric patients with known learning disability within 48 hours - 30 day emergency re-admissions - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Stroke care: percentage receiving brain imaging within 1 hour - Number of breaches of the same sex accommodation standard - Patient experience local patient experience score - Monthly patient survey: kindness and understanding - Monthly patient survey: explaining medication side effects - Friends and Family Test (FFT) coverage + FFT Score	
Quality metrics not achieved or requiring attention (16)	**Quality metrics not rated (12)**
- MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory	**Metrics for information** – E coli *(Escherichia coli*) blood stream infections (surveillance only)

QUALITY	
- Clostridium difficile cases against national trajectory - Number of grade 2 hospital acquired pressure ulcers - Number of grade 3 hospital acquired pressure ulcers - 72 hour Food Chart review - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Number of births in midwifery led unit - Fractured neck of femur patients treated with 36 hours - Stroke care: percentage spending 90% + time on a stroke unit - Dementia admissions-case finding applied - Dementia admissions-assessment completed - Dementia admissions-referred on to specialist services - Monthly patient survey: maternity services kindness and understanding - Patient complaints as a proportion of all activity - Percentage of complaints resolved within agreed timescale - Number of complainants dissatisfied with our response (not responded in full)	– Number of serious incidents – Confirmed number of serious incidents – Total number of patient safety incidents reported – Total number of patient safety incidents per 100 admissions – Total number of patient safety incidents per 100 bed days – Number of patient safety incidents severe harm – Number of Grade 2 pressure ulcers present on admission – Number of Grade 3 pressure ulcers present on admission – Number of Grade 4 pressure ulcers present on admission – Hospital Standardised Mortality Ratio (HSMR) – Summary Hospital Mortality Indicator including out of hospital-deaths within 30 days of discharge (SHMI)

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Summary of Performance against Commissioning for Quality and Innovation (CQUIN) Quality Dashboard Metrics

The Board is asked to note the current position against 2013/14 CQUIN targets reported in the Quality Dashboard:

- Venous Thrombo-Embolism (VTE) risk assessment to be achieved each quarter - percentage for March was 98.5% against a target of 95%. We have achieved the risk assessment element of the VTE CQUIN. In order to achieve the second element of the VTE CQUIN we need to investigate all hospital associated VTE which occurred in Qs 2-4. The final figures for Quarter 4 will be confirmed at the end of May 2014.
- Percentage of patients with a Malnutrition Universal Screening Tool (MUST) score of 2 or more seen by dietician to be achieved in Quarter 4- performance in March was 91.2% against a target of 85%. Performance for Quarter 4 as a whole was 91.9%; we have therefore achieved this CQUIN.
- Review of food chart within 72 hours for patients requiring their nutritional intake to be monitored to be achieved in Quarter 4 - performance in March was 78.2% against a target of 90%. However, performance for Quarter 4 as a whole was 87.7%; we have therefore achieved 50% of this CQUIN for performance above 85%.
- Medicines Reconciliation for oncology and gynaecology wards - performance in March is 100% against a target of 85.0%. Overall performance in Quarters 2-4 was above 85%; we have therefore achieved this element of the medicines reconciliation CQUIN.
- Non-purposeful omitted doses of listed critical medication - performance in March was 1.66% against a target of 2.25% to be achieved for the year as a whole. Performance year as a whole is 1.91%; we have therefore achieved this CQUIN.
- National Safety Thermometer CQUIN - we have agreed with commissioners to reduce hospital acquired grade 2-4 pressure ulcers by 15% for the first six months of 2013/14 and sustain this for the second six months. Performance in March was 11 pressure ulcers against target of no more than 25 a month on average over the six-month period. Average over 2013/14 was 16.5 pressure ulcers a month; we have therefore achieved this CQUIN.
- Detection of the deteriorating patient: Early Warning Scores completed correctly as measured by monthly ward audits to be achieved in Q4 2013/14 - performance for March is 100% against at target of 95.0% to be achieved Quarter 4. Performance for Quarter 4 as a whole is 99%; we have therefore achieved this CQUIN.
- Deteriorating patient: escalation of patients with an early warning score of 4 or more using a structured communication tool SBAR (Situation, Background, Assessment, and Recommendation) - Performance for March is 85.7% against a target of 80.0% in Quarter 4. Performance for Quarter 4 as a whole is 90.5%; we have therefore achieved this CQUIN
- Risk assessment of adult patients with a known learning disability within 48 hours - performance in March was 100% against a target of 85%. Sustaining 85% of patients being risk assessed is a pre-requisite to achieving the new “reasonable adjustments” CQUIN target for 2013/14.
- Learning disability - reasonable adjustments put in place for identified adult patients - performance in February was 90.5% and March was 92.3% against a target of 58%; therefore we have achieved this CQUIN.

QUALITY

- Risk assessment of paediatric patients with a known learning disability within 48 hours - performance in March was 96.9% against a target of 90%. For Quarter 4 as a whole performance was 95.9%; therefore we have achieved this CQUIN.
- Patients admitted with dementia:
    1. Percentage of patients aged over 75 years identified with a clinical diagnosis of delirium or who have been asked the dementia case finding question - performance in March was 46.9% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in March was 66.7% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in March was 52.4% against a target of 90%

  The target is 90% for three consecutive months for all three stages. We have not achieved this CQUIN.
- Friends & Family Test coverage - the response rate in March was 31% against a target of 20%. For Quarter 4 as a whole performance was 24.5% therefore we have achieved the remaining 50% of the CQUIN.

1.3 CHANGES IN THE PERIOD

Performance against the following indicators changed significantly compared with the last reported month:

- 72 hour food chart review down ↓ from 91.2% in February to 78.2% in March.
- Births in Midwife Led Unit down ↓ from 81 in February to 67 in March.
- Friends & Family Test coverage up ↑ from 22.5% in February to 31% in March
- Patient Experience Explaining Medication side effects up ↑ from 55 in January to 61 in February
- Patient Experience Maternity Services down ↓ from 91 in January to 81 in February

1.4 EXCEPTION REPORTS

Exception reports are provided for fourteen of the RED rated indicators.

Please note: an exception report is **not** provided for MRSA cases although it is red on the dashboard. This is because the measure has been changed to a cumulative measure throughout 2013/14 rather than number of cases each month. The red threshold of one case was triggered in May 2013 and a second case was reported in February 2014, therefore this measure will automatically remain red for the rest of 2013/14. An exception report is **also not** provided for the number of hospital acquired grade 2 pressure ulcers. This is because this number is below an internally set target of no more than 15 per month, but this remains red rated because the green threshold in the dashboard was set based on a period of under-reporting of grade 2 hospital acquired pressure ulcers in 2010/11 and has not been rebased in subsequent years. The exception report for Grade 3 pressure ulcers covers of a range of robust actions to reduce the incidence of all pressure ulcers.

1. Clostridium difficile cases against national trajectory
2. Number of grade 3 hospital acquired pressure ulcers
3. 72 hour Food Chart review
4. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
5. Number of births in midwifery led unit
6. Fractured neck of femur patients treated with 36 hours
7. Stroke care: percentage spending 90% + time on a stroke unit
8. Dementia admissions-case finding applied
9. Dementia admissions-assessment completed
10. Dementia admissions-referred on to specialist services
11. Monthly patient survey: maternity services kindness and understanding
12. Patient complaints as a proportion of all activity
13. Percentage of complaints resolved within agreed timescale
14. Number of complainants dissatisfied with our response (not responded in full)

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Q1. EXCEPTION REPORT: *Clostridium difficile*	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

This applies to patients in hospital for more than 3 days, who have unexplained reasons for diarrhoea whose test positive for *Clostridium difficile.* The national reduction objective set centrally is 35 cases in the year. Financial penalties are linked to the national target and occur if a ceiling of 35 cases is breached in 2013/14

Monitor measurement period: Cumulative year-to-date trajectory, reported quarterly.

Performance in the period, including reasons for the exception:

Total number of cases at the end of March was 38 against a target of 35 for the year. There were two Trust apportioned cases of *Clostridium difficile* in March 2014. The Trust is 10 cases below, year-to-date, the same period last year.

Division	Target	Number of target cases
Medicine	2	1
Surgery, Head and Neck	1	1
Women's and Children	0	0
Specialised Services	0	0

All cases of *Clostridium difficile* infection are investigated by the Infection Control Team using a modified root cause analysis process.

Recovery plan, including expected date performance will be restored:

The action plan is ongoing and is monitored on a monthly basis by the Medical Director and the Chief Nurse in collaboration with the Director of Infection Prevention and Control (DIPC) and the Senior Infection Control Nurse/Deputy DIPC. Any outstanding actions will be incorporated in to the annual Infection Prevention and Control programme for 2014/15. The following actions continue to be taken:

- All new cases of *C difficile* are visited within 24 hours by the DIPC, or Infection Control Doctor. An Infection Prevention and Control Nurse and pharmacist will also assess clinical management and antibiotic therapy of the patient;
- New and existing cases are reviewed and implementation of prevention measures monitored. The management of *Clostridium difficile* positive patients continues on the cohort ward with daily monitoring of patients by the Infection Control Team.
- The results of each Root Cause Analysis are reviewed to determine whether the case was avoidable, and whether additional actions need to be

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included in the Trust's ongoing Infection Control work-programme in order to reduce the risk of further C. diff infections.

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Q2. EXCEPTION REPORT: Number of hospital acquired grade 3 pressure ulcers	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Pressure Ulcers identified at nursing/medical assessment are categorised 1-4 (Category 1 being red discolouration, Category 2 being a break or partial loss of skin, Category 3 being tissue damage through the superficial layers, Category 4 involving the most serious tissue damage, eroded through to the tendon/bone).

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above was 0.417 per 1,000 bed days in March (10 grade 2 and 1 grade 3) against a target of 0.651.

Division	Apr 13	May 13	Jun 13	July 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Medicine	0.88	0.73	1.0	1.3	1.00	1.49	0.84	0.55	0.74	0.71	0.43	0.40
Specialised Services	1.15	0.23	0.24	0.24	0.90	0.76	1.41	0.98	0.00	0.72	1.05	0.47
Surgery Head &Neck	0.99	1.08	1.19	1.10	0.70	1.63	0.73	0.43	1.21	1.00	0.48	0.61
Women & Children's	0.16	0.00	0.00	0.00	0.10	0.31	0.00	0.29	0.15	0.43	0.00	0.28
Trust	**0.75**	**0.54**	**0.66**	**0.78**	**0.75**	**1.08**	**0.71**	**0.53**	**0.56**	**0.69**	**0.42**	**0.42**

There was one Grade 3 hospital acquired pressure ulcer reported for the month of March on Ward 200. The pressure ulcer was on the patient's heel. An initial review of the case suggests that all appropriate measures were offered, including heel protectors and repositioning, all of which the patient declined. A pressure relieving mattress was in place. Family members were also involved to ensure as much support and encouragement as possible was in place. A detailed Root Cause Analysis investigation is underway.

When looking at the actual number of pressure ulcers against the number 'expected' given the age profile of the patients admitted in the month, the actual number remains significantly below that expected. In 2013/14 there have been 192 fewer hospital acquired grade 2-4 pressure ulcers than 'expected'.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Estimated Ulcers	32	33	31	34	31	33	35	33	32	33	30	33
Actual Ulcers	19	14	16	20	19	26	18	13	14	18	10	11

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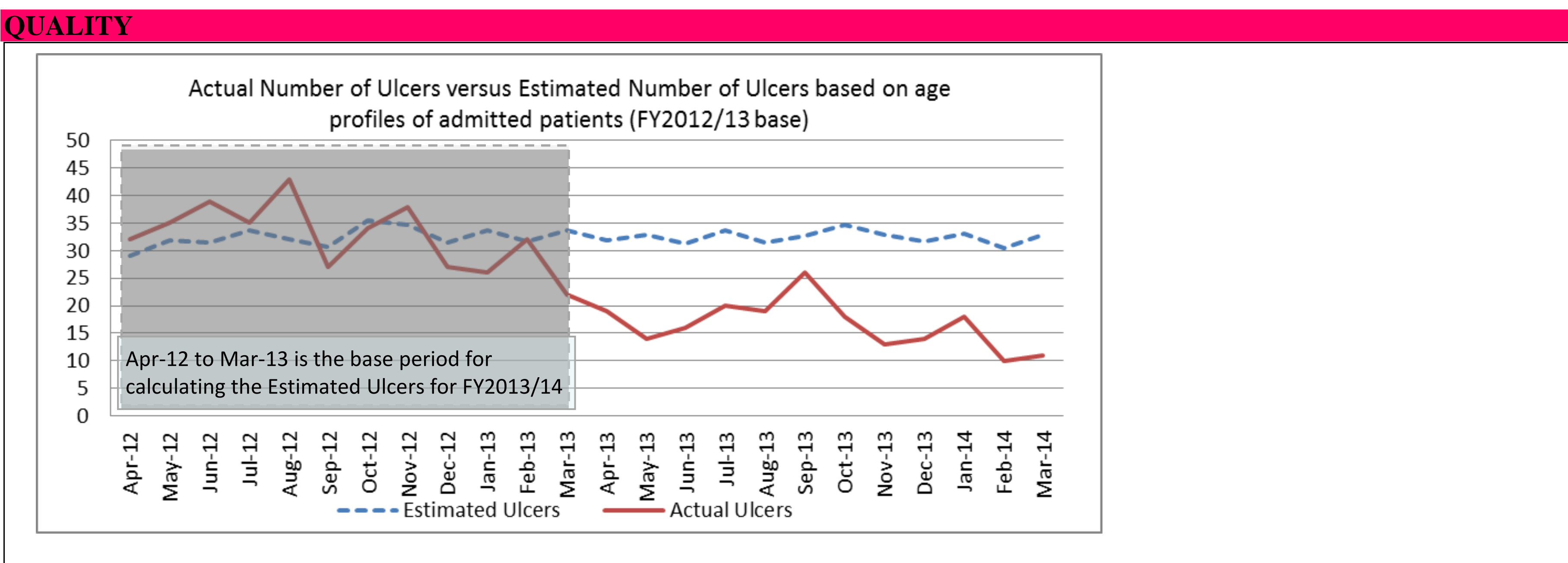

Recovery plan, including expected date performance will be restored:

- All Divisions continue to be required to complete and submit detailed recovery plans to the Executive-led Quarterly Divisional Reviews, where quality indicators are not achieved. The plans are monitored at the monthly Divisional Operational Performance meetings which either the Chief Nurse or Deputy Chief Nurse attend;
- A revised micro teaching package has been developed;

Information and plans for improvements from Divisions is provided in the monthly pressure ulcer report which is reviewed at the Tissue Viability Steering Group.

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Q3. EXCEPTION REPORT: 72 hour food chart nutrition review	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Completion of 72-hour food chart review for all adult patients with a Malnutrition Universal Screening Tool (MUST) score of 2 or higher. Data comes from the monthly audit of all inpatients, using the same one-day sample as the Safety Thermometer.

Performance in the period, including reasons for the exception:

Performance in March was 78.2% against a target of 90%, and a deterioration from the 91.8% achieved in February. Despite a considerable amount of work at ward level and focus, only 50% of the CQUIN measured in Quarter 4 was achieved (for performance over 85%). Overall performance for Quarter 4 was 87.7%.

Recovery plan, including expected date performance will be restored:

- Results of the 72-hour food chart review form part of the supervisory sister's Key Performance Indicators and are reported to the monthly Nutrition Steering Group. All actions are monitored by the group, which includes divisional matron representation. Actions and improvements required for wards that are not achieving the required level are a standing agenda item for the group;
- Each division has considered how to deliver compliance and have come up with different solutions depending on the patient caseload. Some examples are: including the date of review on the Patient Status at a Glance Board, a red card system that sits at the end of the bed, and food charts being placed on clipboards, at the foot of the patient's bed, to improve visibility.

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Q4. EXCEPTION REPORT: Number of Births on the Midwife Led Unit	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

We measure the standards using two methods to check for accuracy in our figures. An initial paper trawl of birth registers, incident forms and transfer forms is collated. We then subsequently run a report from Medway Maternity using exclusions to accurately report our figures and capture any missed data. We have set ourselves a challenging internal monthly target to encourage as many women as possible to give birth on the Midwife Led Unit (MLU) as this provides for a better experience for low risk deliveries. The targets are:

70 births or fewer = Red
71-99 births = Amber
100+ births = Green

Performance in the period, including reasons for the exception:

There were 67 births on the MLU in March 2014.

	July 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014
Number of Births	**72**	**67**	**81**	**80**	**83**	**71**	**79**	**81**	**67**

This month was a particular low month for births in St. Michael's Hospital. In March there were 453 births compared to a monthly average of 464.

Recovery plan, including expected date performance will be restored:

In addition to ongoing actions previously reported to the Board, we are considering running a weekly 36-week birth "chat" appointment for all low risk women booked at St. Michael's Hospital, in order to allow women to familiarise themselves with the birth environment and staff working there. The aim is to not only increase normal births, but to encourage all women to book for the MLU who may not be considering it as an option. This appointment will also ensure only women suitable for care in a low risk setting are attending. These sessions will be staffed with the help of community midwives, who will work on MLU whilst the MLU staff undertake the discussions with the women.

This would serve two purposes:

- Integrate the community team further into the hospital, and
- Improve continuity for the women attending MLU as they may see the midwife when they come in to give birth to their baby.

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Also in June we will hold an afternoon tea party to coincide with the first year opening anniversary which will be used as an opportunity to publicise and promote the Midwife Led Unit.

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Q5. EXCEPTION REPORT: Fractured neck of femur patients treated with 36 hours	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

Best practice tariff for patients with an identified hip fracture requires all of the following standards to be achieved:

1. Surgery within 36 hours from admission to hospital
2. Multi-disciplinary Team rehabilitation led by an Ortho-geriatrician
3. Ortho-geriatric review within 72 hours of admission
4. Falls Assessment
5. Joint care of patients under Trauma & Orthopaedic and Ortho geriatric Consultants
6. Bone Health Assessment
7. Completion of a Joint Assessment Proforma
8. Abbreviated Mental Test done on admission and pre-discharge

Performance in the period, including reasons for the exception:

Best Practice performance in March 2014 was 85.7%, meaning 24 of 28 hip fracture patients discharged in the month achieved all indicators.

Of the four patients who did not achieve best practice, the only indicator failed was time to theatre within 36 hours. Of the 4 patients who did not have surgery within 36 hours the reasons for the breaches were:

1. Patient required medical optimisation for chest sepsis prior to surgery;
2. Patient required renal dialysis pre-operatively and then suffered a myocardial infarction (heart attack). After discussion with a Cardiologist a clinical decision was taken to delay surgery until next day;
3. Patient admitted 7th December, but was unable to have surgery until 9th December due to full list of hip fractures scheduled on 8th (the patient was discharged in March, which is why this patient is reported in the March Best Practice Tariff figures);
4. Four hip fracture patients were admitted overnight on 13th March, but only three patients could be treated within 36 hours. One patient had surgery at 43 hours 43 minutes due to theatre capacity.

Recovery plan, including expected date performance will be restored:

- Continued daily monitoring of trauma waiting times and escalation within the division to identify additional theatre capacity when required;
- Hip Fracture Clinical Lead has introduced a daily ‘Golden Case’ protocol for simple hip fracture surgery (i.e. a Dynamic Hip Screw fixation or

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a hemi-arthroplasty at the start of every trauma list). This started during week of 31st March.

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Q6. EXCEPTION REPORT: Percentage of patients spending at least 90% of their time on a stroke unit	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

This is calculated as the proportion of patients who were admitted with a stroke where the patient was accommodated on a stroke unit for at least 90% of their inpatient stay for stroke care. The target is 80% of patients admitted with a stroke.

Performance in the period, including reasons for the exception:

The performance for this month was 79.5% against the 80% standard, with the target being met for 35 out of 44 patients. There was no bed available on the Acute Stroke Unit at the time of referral for the 9 patients for whom we did not meet the target.

Recovery plan, including expected date performance will be restored:

- The Standard Operating Procedure (SOP) for the Stroke Pathway has been revised to emphasise the correct flow of stroke patients to Acute Stroke Unit and more importantly the requirement to maintain a vacant stroke bed at all times. The only exception to the requirement for maintaining an empty stroke bed would be the need to admit a patient to the unit to avoid a 12-hour trolley wait in the Emergency Department;
- The topic of stroke beds is now included on the agenda for daily Patient Flow Meetings, and from these an action plan to create and maintain a vacant bed on the Acute Stroke Unit is agreed.

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Q7. EXCEPTION REPORT: High Risk Transient Ischaemic Attack (TIA) starting treatment in 24 Hours	RESPONSIBLE DIRECTOR: Medical Director

Description of how the target is measured:

High Risk patients are those with an ABCD (Age, Blood, Clinical features, Duration of symptoms) score of 4 or above. Treatments (Aspirin, statin, control of blood pressure, referral for carotid intervention) should be commenced and relevant investigations (e.g. blood tests, electrocardiogram, brain scan) completed within the 24 hour window. The 24-hour window starts at first contact with any health professional. The denominator comprises patients who attend as outpatients, not those who are admitted to hospital.

Performance during the period, including reasons for exception:

March's performance figures are still awaiting clinical validation. The figures below are therefore as reported last month.

Performance against the 60% standard was 45.5% in February, with six out of 11 high risk patients failing to be treated within the 24-hour target. These are identified high risk patients and are part of a larger volume of other lower risk patients who need to be seen within 7 days. The reason for not being able to treat these patients within 24-hours is as follows:

- 2 patients - MRI scan slot could not be organised in time
- 1 patient – the outpatient clinic was full
- 1 patient - refused an earlier appointment
- 1 patient - was referred to North Bristol Trust first, declined this option was then referred to Bristol Royal Infirmary, but outside 24 hours
- 1 patient – was seen at the weekend by the Stroke Clinical Nurse Specialist, and an MRI scan was performed within 24 hours, but the clinic appointment was at 27 hours

Recovery plan, including expected date performance will be restored:

- A review of Stroke pathway is underway to map the current and future state;
- TIA is not currently part of the pathway review, but has been added as a sub-group to the Stroke pathway work;
- Access to a MRI scan within an appropriate timescale has been a cause of some of the recent breaches of the TIA standard, and the option to use the countdown clock on ICE (diagnostics order communications system) is being progressed to support an improvement in compliance. The Division of Medicine has been working closely with the Division of Diagnostics & Therapies to facilitate this change;
- Consultant availability also had a negative impact on clinic slot availability in the period; actions continue to be taken to mitigate the impact,

where possible.

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Q8-10. EXCEPTION REPORT: Dementia- Stage 1 - Find Stage 2 - Assess & Investigate Stage 3 - Referral on to GP	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Green rating 90% or above / Amber rating 80% - 89% / Red rating below 80%

The National Dementia CQUIN, "Find, Assess and investigate, Refer (FAIR)" occurs in three parts:

1. **Find**
   The case finding of at least 90% of all patients aged 75 years and over following emergency admission to hospital, using the dementia case finding question and identification of all those with delirium and dementia. This has to be completed within 72 hours of admission
2. **Assess and Investigate**
   The diagnostic assessment and investigation of at least 90% of those patients who have been assessed as at-risk of dementia from the case finding question and/or presence of delirium.
3. **Refer**
   The referral of at least 90% of clinically appropriate cases to General Practitioner to alert that an assessment has raised the possibility of the presence of dementia

The CQUIN payment for 2014/15 has identified milestones for achievement for each quarter. As a provider we need to achieve 90% or more for each element of the indicator for each quarter taken as a whole with a weighting of 25% for each quarter.

Performance in the period, including reasons for the exception:

Stage 1- Find – status RED

Performance in March for Stage 1 was 46.9%, a marginal improvement from February which was 45.3%.

Divisional performance

Medicine 50.5%; Surgery Head & Neck 39%; Specialised Services 34.3%.

Stage 2 – Assessment and Investigation – status RED

Performance in March for stage 2 was 66.7% against a target 90%. This is a deterioration from February (78%).

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Divisional performance

Medicine 66%; Surgery Head & Neck 66.7%; Specialised Services 100%.

Stage 3 – Referral on to GP – status RED

Performance in March for Stage 3 was 52.4% compared with 38.5% in February, demonstrating an improvement over the last month.

Divisional performance

Medicine 50%, Surgery Head & Neck 100%; Specialised Services 100%.

Recovery plan, including expected date performance will be restored:

The following steps are currently being actioned to improve compliance;

- Discussions have taken place with IM&T to develop an electronic solution to capture data at the point of admission. Work is ongoing to ensure specifications of the system meet requirements. The system that will be utilised will be the e-handover system as it has the capability to flag, prompt, record and monitor all the required data at the point of admission, as well as populating the electronic discharge summary to ensure referral on to the patient's GP. Due to the development requirements this will not be in place prior to Autumn 2014;
- Discussions with the coding department have taken place as to whether they may assist with the data capture required for this CQUIN. However, this was not an option that we could pursue;
- The FAIR process to date has been addressed in its entirety. We have now focused our attention to stage 1 (Case finding), as stage 1 has to be completed to enable progress onto stage 2. Over the last few weeks focus has shifted to the admissions units where 73% of the patients who are 75 years and over are admitted. Utilising existing resources, which are limited, clinical visits are being made to;
    - Identify and flag those patients who are 75 years and over
    - Ensuring the specific electronic discharge summary is opened at the point of admission
    - Prompting clinical teams to complete the screening and record in the patients notes and the electronic discharge summary
    - Where screening has not been undertaken, this is being completed and recorded appropriately
- A successful bid has been made to the Clinical Commissioning Group (CCG) to fund a fixed-term dementia project post. The post-holder will focus on the admission areas to provide training and advice to ensure the multidisciplinary team are aware and able to undertake the required screening and assessments. This will provide a visible presence in the areas to support a sustained improvement and ensure this is fully embedded in practice in the longer term. It is anticipated, if recruited to via a secondment, that this post will be filled by July 2014;
- The new revised admission documentation includes the Dementia case finding question and is currently being trialled across the Divisions prior to wider roll out;

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- A care plan has been developed and will be piloted on the older adult care wards later this month. The care plan prompts completion of the necessary screening process and multidisciplinary communication at board rounds as to the required follow-up. It is anticipated that the care plan will be rolled-out across the Trust in June and audited from July 2014;

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Q11. EXCEPTION REPORT: Patient Experience: Kindness and understanding on postnatal wards	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

As part of the Trust's monthly maternity survey, women are asked whether they were treated with kindness and understanding on the postnatal wards at St Michael's Hospital. This survey is carried out by post and so there is a time delay in receiving the results: this exception report relates to women who were cared for during February 2014.

The question wording and scoring methodology are taken from the Care Quality Commission's national survey programme. This example, derived from the February 2014 data, shows how the result is calculated as a weighting across all of the response options to the question:

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Yes, definitely – 68%
Yes, to some extent – 26%
No – 6%

Score = 68 + (26 x 0.5) = 81

Improvement of the score on this question was one of the Trust's Quality ambitions for 2013/14. The aim is to increase the score to at least 85/100. The score for February 2014 was 81/100, which attracted a red-rating in the Quality Dashboard.

Performance in the period, including reasons for the exception:

Performance against this patient experience indicator had been at or exceeding the improvement target until August 2013. This was also reflected in the Trust's performance in the 2013 national maternity survey, where University Hospitals Bristol was classed as being better than the national average on this measure. The score then entered a period of decline between September and November 2013, which reflected significant changes to postnatal care (e.g. a reconfiguration of the postnatal wards and a relatively large number of new midwives recruited into post). These service changes were based in part on feedback from service-users and it is expected will have a positive effect on patient experience in the future. However, they did result in a period of transition for the service. As these service improvements have become embedded, the scores picked-up again during December (85) and January (91). It is therefore disappointing and concerning that the February score has again dipped. Nevertheless, the overall quarter 4 (January and February) result is 87/100, compared to 83/100 for Quarter 3, and so the broad trajectory is upward/positive.

Recovery plan, including expected date performance will be restored:

A number of actions are planned or have been undertaken in relation to improving the experience of women on postnatal wards:

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- The latest survey results will be shared with staff in maternity services for consideration and discussion. In doing this it will be acknowledged that good progress had been made and that the majority of women report a positive experience;
- A consultant-level “patient experience lead” for postnatal care has been identified and has become a champion for this element of quality;
- In order to gain further insight into the survey results, the trends in the data will be considered alongside operational information such as how busy the wards were and which staff were on duty;
- The Trust’s Patient Experience Lead (engagement and involvement) will run a workshop with newly recruited midwives, focussing on how their role impacts on patient experience. This will replicate a number of earlier staff workshops in maternity services, which correlated with a positive increase in the survey scores;
- Maternity Assistants will devote part of a forthcoming study day to an exploration of their role in relation to patient experience/kindness and understanding. This will ensure that this important group of staff are fully engaged in efforts to improve the postnatal ward experience;
- A project will be carried out with service-users specifically in relation to their experiences of the discharge process on postnatal wards. This will identify service improvement opportunities, and will also inform ways of ensuring that future service-users understand the discharge process (e.g. how long discharge may take, what it involves, and why the various elements of the process need to be done);
- A project with staff and service-users will be carried out to better understand experiences of the whole maternity pathway. One important aspect of this project will be to test women’s experiences of moving from one-to-one care (before and during birth), to a ward environment where this intensive care/support is not present. An understanding of these issues will help to ensure that future service-users can be given a clear understanding/expectation of care provision at different points in the pathway.

QUALITY

Q12. EXCEPTION REPORT: Percentage of complaints per patient attendance in the month	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complaints received by the Trust and either managed by a formal or informal resolution process in agreement with the complainant, as a percentage of the number of patient attendances within the month. This excludes concerns raised and immediately dealt with by front-line staff, which are recorded within each Division. A green rating on the dashboard = <0.21%

Performance in the period, including reasons for the exception:

In March 2014, complaints received represented 0.28% of clinical activity (approximately one in every 350 patient episodes of care). This compares to 0.23% in February, prior to which performance had been green-rated for eight of the nine previous months. The level of complaints received in March as a percentage of activity equates to 164 complaints, 89 of which are being progressed through formal resolution.

The Division of Surgery Head & Neck received 65 complaints in March 2014, the highest monthly total since April 2013. Twenty-two of these complaints related to care at Bristol Eye Hospital (14 in February), 13 of which were about outpatient services. The majority of these complaints (13) related to cancelled or delayed appointments or operations. A further 12 complaints related to Trauma and Orthopaedics (8 in February), with almost half (6) also being in respect of cancelled or delayed appointments or operations.

The Division of Medicine received 29 complaints in March 2014 (23 in February), its highest monthly total for over a year. Six of these complaints were about the Emergency Department (3 in February), three of which related to staff attitude and communication. No other discernible trends were noted apart from three complaints each being recorded for Dermatology and Ward 11.

The Division of Specialised Services received 23 complaints in March 2014 (12 in February), representing 0.31% of activity. Within this total, 10 complaints were received by the Bristol Haematology & Oncology Centre (7 of these concerned outpatient care and were in respect of clinical care and delayed appointments) and 13 by the Bristol Heart Institute (shared between outpatients, Cardiac Intensive Care Unit and Wards 51, 52 and 53: 3 of these complaints were about cancelled or delayed operations and the remainder consisted of complaints about clinical care and staff attitude/communication).

The Division of Women's & Children's Services received 23 complaints (14 in February), although overall performance remained green-rated at 0.19% of activity. Sixteen of these complaints related to Bristol Royal Hospital for Children and seven were for St Michael's Hospital. There were no discernible themes or trends noted, with the complaints shared between the Children's Emergency Department, Gynaecology Outpatients and Wards 30, 31, 32, 35 and 78. The complaints for this Division related to cancelled or delayed appointments or operations (5), clinical care (5) and attitude/communication (4). There were no specific areas/departments identified which would indicate a pattern/trend.

QUALITY

Recovery plan, including expected date performance will be restored:

The increase in complaints (and potential causes) has been brought to the attention of Divisions and will be discussed by Heads of Nursing at the Trust's Patient Experience Group meeting on 16th April.

QUALITY

Q13. EXCEPTION REPORT: Number and percentage of complaints resolved within Local Resolution Plan timescale	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complaints which are resolved within the timescale originally agreed (or subsequently renegotiated) with the complainant. The target for the percentage to be resolved within the formal timescale is 98% each month.

Performance in the period, including reasons for the exception:

In March 2014, 47 responses out of the 53 which had been due in that month were posted to the complainant by the date agreed (88.7%). This represents a small deterioration on the 92.0% reported for February 2014.

Six breaches were recorded in total for March, three of which were attributable to the Division of Women's & Children's Services. The other three breaches were caused by delays during the Executive sign-off process.

The Divisions of Surgery, Head & Neck, Medicine, Specialised Services, Diagnostics & Therapies and Facilities & Estates recorded zero breached deadlines in March.

(It should be noted that if a response breaches a deadline because significant amendments are necessary, this is attributed as a divisional breach, even if the Division met the initial response deadline.)

Recovery plan, including expected date performance will be restored:

Each breached deadline is validated by the Patient Support & Complaints Team and the relevant Divisional Complaints Co-ordinator: as well as being a validation of the breach (data quality check), this also ensures that the Division can look at how the delay could have been avoided and therefore how they will learn from this for the future.

Performance is discussed and monitored at the Patient Experience Group, chaired by the Chief Nurse.

All written responses must be received by the Patient Support & Complaints Team four working days before the response is due with the complainant: this is to allow time for the response to be checked prior to Executive sign-off.

QUALITY

Q14. EXCEPTION REPORT: Number of complainants dissatisfied with response	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate. The target set for this indicator is nil.

Performance in the period, including reasons for the exception:

In March 2014, five complainants told us that they were dissatisfied with our response to their complaint; this is a slight increase on the three cases received in February 2014. The five cases related to complaints in the following Divisions:

- Division of Medicine – two cases
- Division of Surgery, Head & Neck – two cases
- Division of Diagnostics & Therapies – one case

The Patient Support & Complaints Team has reviewed these complaints and returned them to the relevant Divisions for further investigation and response to the outstanding concerns.

In the cases from Medicine, one complainant disputed the information contained in the original response and one complainant was unhappy with the explanation given and wanted a personal apology from the consultant involved.

In the Surgery Head & Neck cases, one complainant felt that not all of the issues raised had been addressed and one complainant was unhappy that the issues raised had not been resolved as he had still not received an appointment as promised.

In the case from Diagnostics & Therapies, the complainant did not feel that all of the issues raised had been addressed.

Recovery plan, including expected date performance will be restored:

- A system has now been implemented to formally verify details of all dissatisfied cases with the Division. This ensures data accuracy and requires the Division to consider whether anything could have been done differently when the initial response was written – for purposes of future learning
- The corporate Patient Support & Complaints Team continues to monitor response letters to ensure that all aspects of a complaint have been fully addressed; amendments are requested from Divisions if necessary.
- There is also rigorous checking of response letters by the Chief Nurse, to ensure responses are complete and adequate before being sent to the

complainant.

1.5 SUPPORTING INFORMATION

1.5.1 QUALITY ACHIEVEMENTS

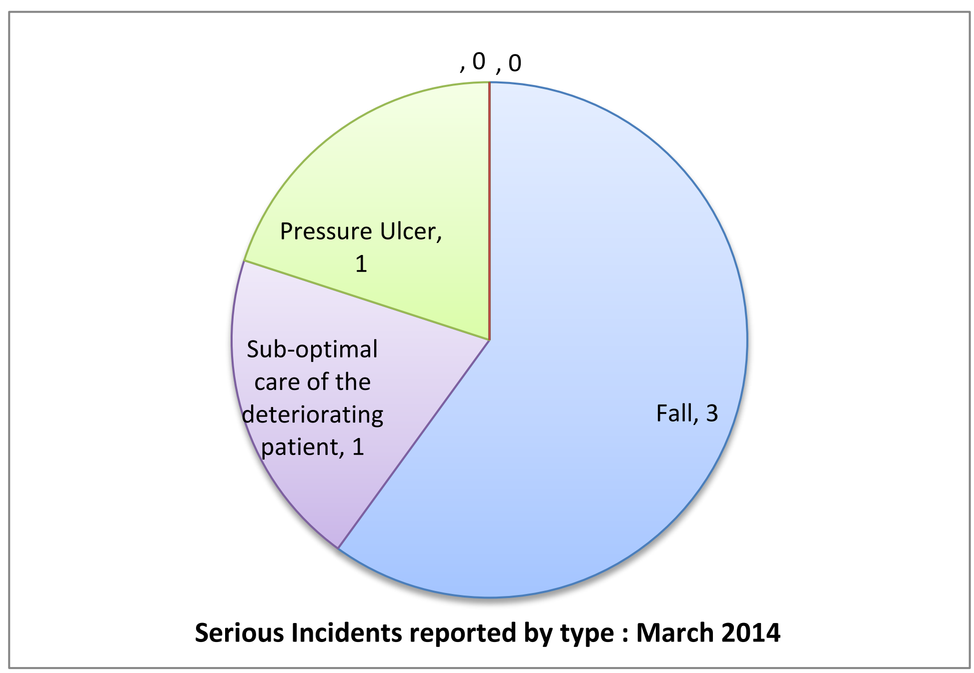
This month's quality achievements are from the Division of **Diagnostics & Therapies**.

- The Division has fully achieved its CQUINs for 2013/14:
    - Nutrition & Dietetics Nutritional Assessments (screened adult inpatients to have a dietetic review);
    - Missed Doses of critical medication: this measure is to reduce the incidence of medication errors causing significant harm to patients by focussing upon the most frequently reported medication incident, omitted doses. This has been highlighted by NHS England and the Care Quality Commission as a priority;
    - Medication Reconciliation "getting the medicines right": medicines reconciliation ensures patients are on the correct medicines within one day of being admitted to hospital which helps to reduce medication errors and associated harm to patients;
- Melanie Watson, a biomedical scientist and Learning and Development Lead in Laboratory Medicine, has won Ambassador of the Year at the 2014 Healthcare Science Awards held on 31 March 2014. Mel is an active STEM (Science, Technology, Engineering and Mathematics Network) ambassador with many years' experience of inspiring young people with interactive blood cell and maths workshops for promotion of Life Science careers;
- The Trust's Medical Equipment Management Organisation (MEMO) has recently won a three-year contract based on quality and price (commenced on 1st April 2014) with North Bristol NHS Trust/Carillion for medical gas work in the new hospital at Southmead;
- Pharmacy successfully replaced its dispensing robot during quarter 4 and during that time continued to achieve its 90% To Take Away (TTA) discharge medication turn-around time target.

QUALITY

1.5.2 SERIOUS INCIDENT THEMES

The quality dashboard shows that five serious incidents were reported in March 2014, all of these were reported within the 48-hour timescale. The themes of serious incidents reported in March are shown below.



Date of Incident	SI Number	Division	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
09/03/2014	2014 8060	Medicine	Yes	Open	Grade 1 Sub-optimal care of the deteriorating patient.	Major	Investigation underway
17/03/2014	2014 8976	Medicine	Yes	Open	Grade 1 Unwitnessed fall resulting in fracture.	Major	Investigation underway

QUALITY							
28/03/2014	2014 10447	Surgery Head & Neck	Yes	Open	Grade 1 Patient fall resulting in fracture.	Major	Investigation underway
29/03/2014	2014 10500	Medicine	Yes	Open	Grade 1 Patient fall resulting in fracture.	Major	Investigation underway
30/03/2014	2014 10539	Medicine	Yes	Open	Grade 1 Grade 3 Pressure Ulcer	Moderate	Investigation underway

WORKFORCE

2.1 SUMMARY

The Trust has selected a range of key workforce indicators. The indicator below target this month is bank and agency usage.

Achieving (1)	**Underachieving (2)**
- Appraisal compliance - compared with target	- Workforce numbers– compared with budget - Sickness absence - compared with target
Failing (1)	**Not reported/scored (1)**
- Bank and agency usage - compared with target	- Turnover (no target)

2.2 EXCEPTION REPORTS

An exception report is provided for the RED-rated indicators, which in March 2014 was as follows:

- Bank and agency usage – red rated against target

WORKFORCE

W1. EXCEPTION REPORT: Bank and Agency compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Bank and agency usage in Full Time Equivalents (FTE) compared with targets set by Divisions for 2013/14.

Performance in the period, including reasons for the exception:

During March, bank usage reduced by 7.9%, compared to the previous month, but agency increased by 1.3%. Use of bank and agency staff reduced from 410 FTE in February to 386 FTE in March. Overall variance from target reduced from 45.9% to 39.3% during the last month; a graph showing variance is shown in the Supporting Information section. Nursing agency reduced by 20.4% (9.6 FTE), and nursing bank reduced by 10.4% (22.8 FTE).

Bank and Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Facilities & Estates)	Facilities & Estates
Actual March 2013	413.6	15.1	142.4	43.9	86.5	64.9	30.2	30.7
Actual March 2014	**385.8**	**10.8**	**121.1**	**50.8**	**71.3**	**54.2**	**34.9**	**42.8**
Target March 2014	234.2	20.0	45.0	22.3	57.6	58.5	11.5	19.4
	39.3%	-84.6%	62.9%	56.1%	19.2%	-8.1%	67.0%	54.8%

Reasons for the exception:

- Trust-wide, just over 35% of bank and agency usage was due to workload and clinical needs, extra capacity and increased administrative workload;
- 13% of usage was due to sickness absence compared with 16% last month;
- Usage to cover vacancies reduced to 21.4%, compared with 23% last month. Within Facilities & Estates use to cover vacancies has continued to reduce, at only 40.7% compared with 53% last month;
- Nursing assistant one to one care reduced further this month, from 8% down to 5.6%.

Recovery plan, including progress and expected date performance will be restored:

WORKFORCE

<u>Recruitment and Retention</u>

The two key areas of focus for recruitment and retention to address bank and agency usage are nursing and midwifery and facilities:

Nursing

- 31.7 FTE nursing staff (registered and unregistered) started in March, but vacancies increased due to additional funded establishment in Intensive Care Unit and Ward 62. In addition, funded establishment was added to Children`s Theatres in advance of the Specialist Paediatric transfers. A further 29.44 FTE will commence employment during April, and 13.76 FTE have start dates between May and August 2014;
- Plans for newly qualified nurse graduate recruitment are underway with the recruitment taking place throughout April. A cohort assessment centre approach is being developed for adult nursing which will improve the effectiveness of recruitment and selection. By the end of March 2014, the Trust had received 116 applications from student nurses due to graduate this summer. These comprised of students from the University West of England and other universities.

Facilities

- There were 9 new substantive ancillary recruits with start dates during March. Work continues to convert the applications for the vacancies in the Bristol Children`s Hospital, as part of the Specialist Paediatrics transfer, into appointment following the press advertising campaign and open days in January/February 2014. Twenty-nine Domestic Assistants are needed for this, of which 22 have already been appointed, with the remainder being interviewed during April. All efforts are being made to ensure candidates are ready to start by 7 May 2014 to ensure minimal reliance on bank and agency when services transfer from North Bristol NHS Trust;
- The targeted campaign for Domestic Assistants to join the Bank continued during March to develop a robust pool of bank Domestic Assistants to support the reduction in agency usage and spend.

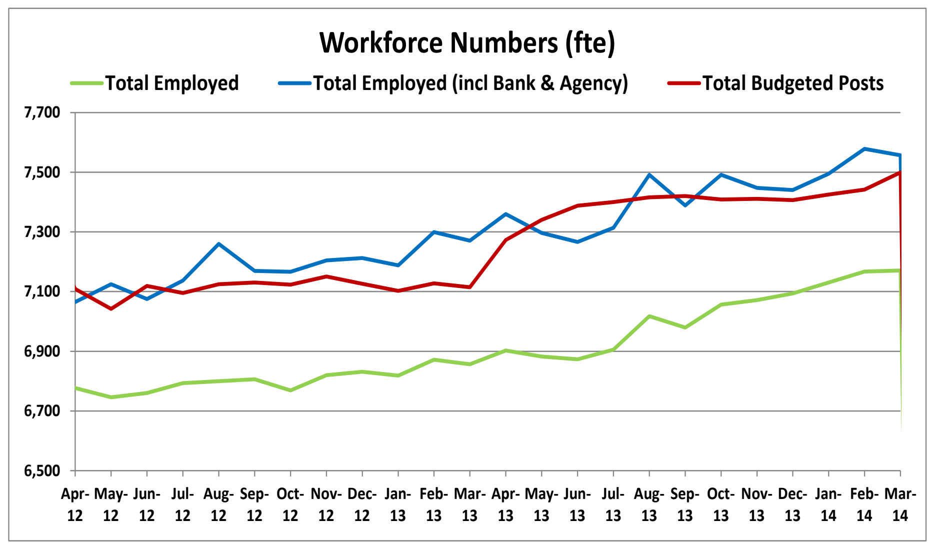
<u>Nursing Assistant One to One</u>

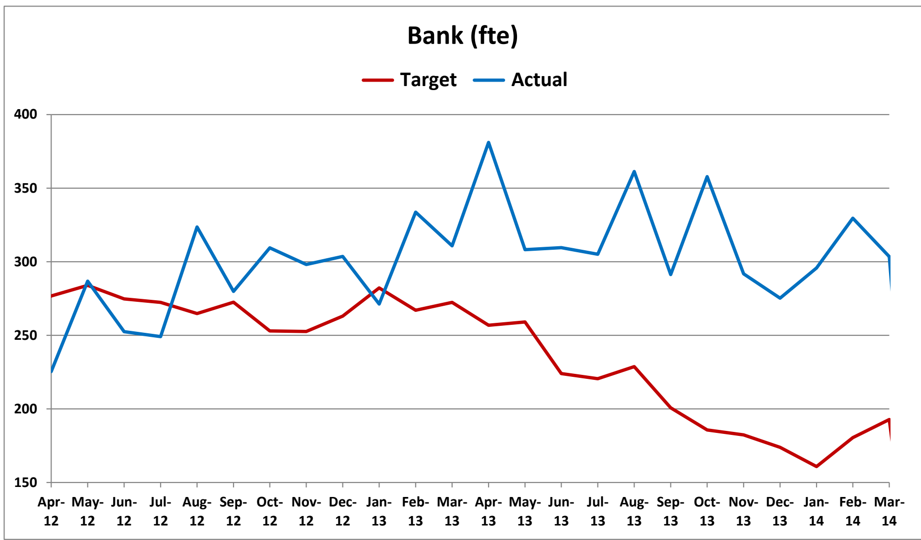
- The framework and protocol to support the use of nursing assistant one to ones which will form part of the Enhanced Therapeutic Observation Strategy is still being developed by the Division of Medicine, and is expected to be complete by the end of April. Further work is required to clarify assessment criteria, training requirements and University Hospitals Bristol staffing model.

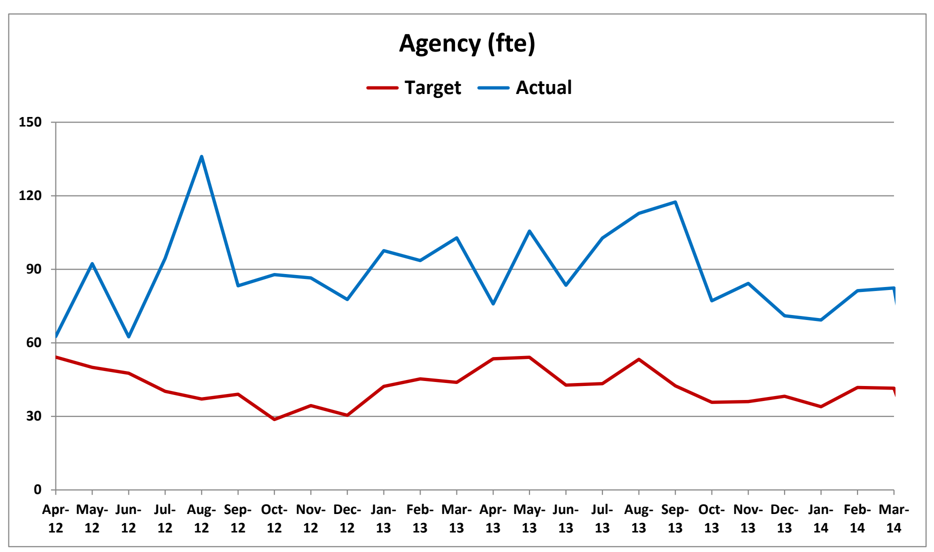
2.3 SUPPORTING INFORMATION

2.3.1 Performance against key workforce standards

This section provides an outline of the Trust's performance against workforce indicators for workforce numbers, bank and agency usage, with an additional chart to show how the variance against target for agency usage has reduced. There are also graphs to show nursing agency and vacancy rates, sickness rates, and the top five causes of sickness.






Agency (fte)
Target
Actual
150
120
90
60
30
0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
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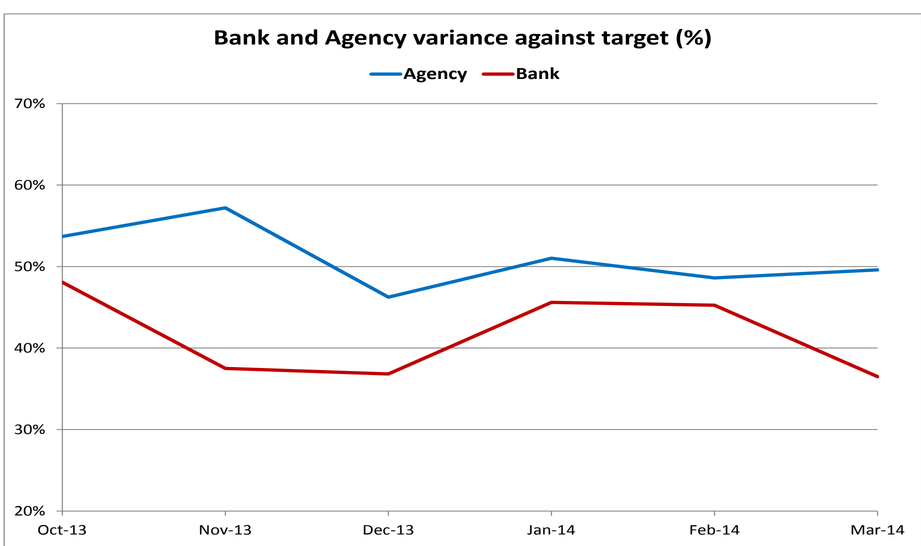
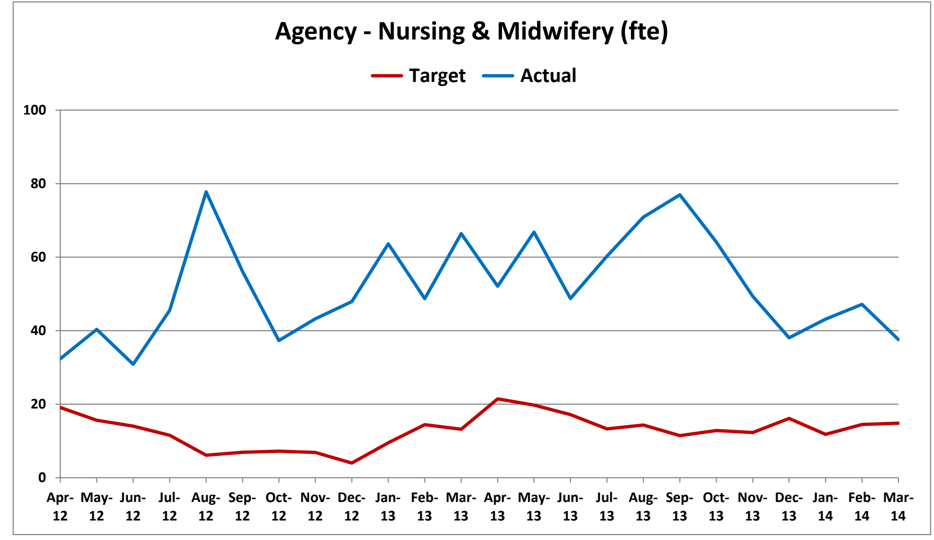
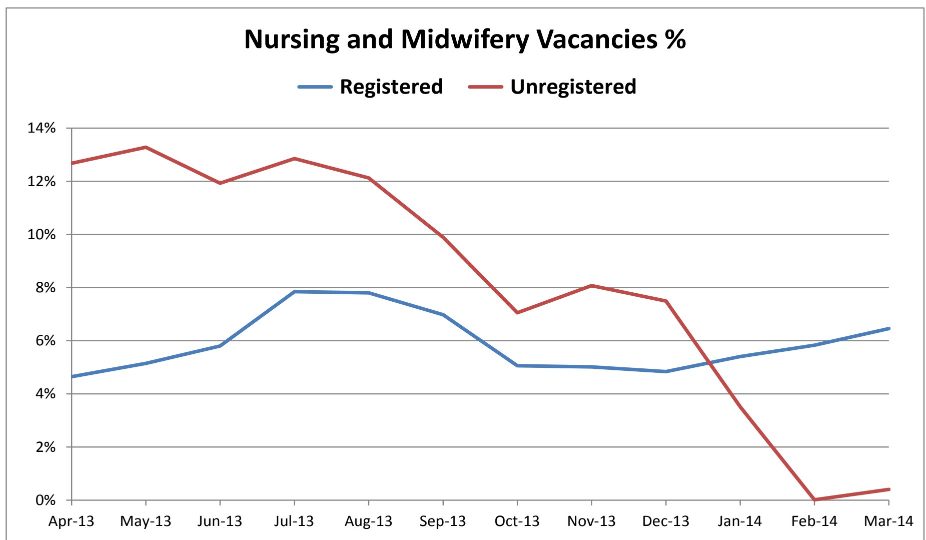
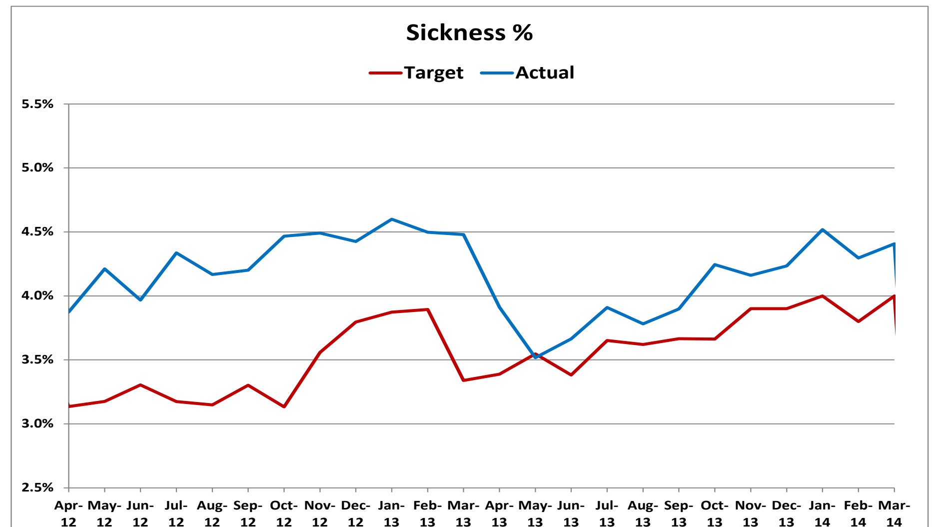
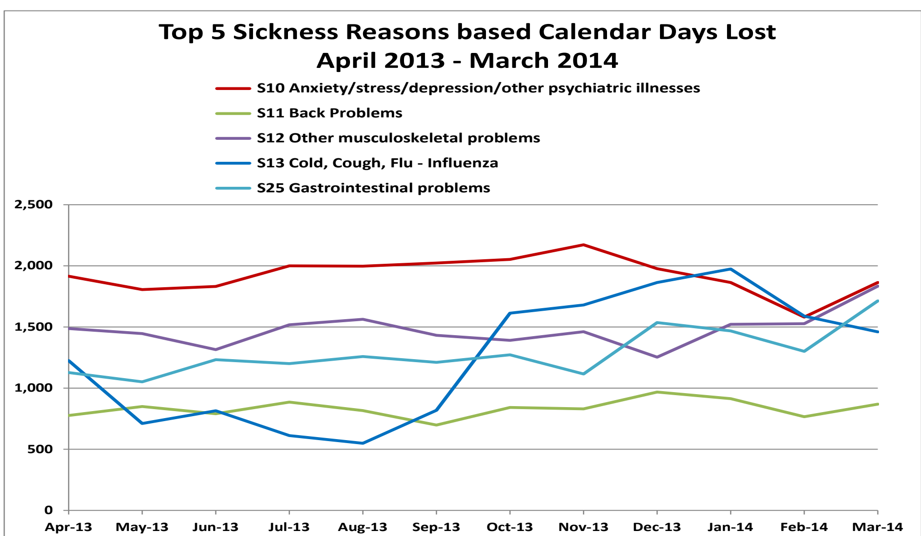
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Bank and Agency variance against target (%)
Agency
Bank
70%
60%
50%
40%
30%
20%
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Agency - Nursing & Midwifery (fte)
Target
Actual
100
80
60
40
20
0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Nursing and Midwifery Vacancies %
Registered
Unregistered
14%
12%
10%
8%
6%
4%
2%
0%
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Sickness %
Target
Actual
5.5%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14


Top 5 Sickness Reasons based Calendar Days Lost
April 2013 - March 2014
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
2,500
2,000
1,500
1,000
500
0
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14

2.3.3 Changes in the period

Performance is monitored for workforce costs, workforce numbers, bank and agency usage, turnover, sickness and appraisal percentage. The following dashboard shows key workforce information indicators RAG (Red, Amber, Green) rated for the month of March. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Numbers	A ↓	Workforce numbers reduced by 0.3% compared with February 2014. This month, workforce numbers were 0.8% above budgeted FTE. This compares with February 2014, which was 1.8% above budgeted establishment.	See summary and supporting information
Bank/ Agency	R ↓	Agency increased by 1.3% (1.1 FTE) and bank reduced by 7.9% (26.1 FTE) in March 2014 compared with the previous month.	See summary, supporting information and exception report.
Turnover	↓	Rolling turnover (with exclusions) reduced to 10.9% compared to 11.1% last month.	See summary
Sickness	A ↑	Sickness increased by 0.1 percentage points to 4.4%, 0.4 percentage points above the monthly target across the Trust. This compares with February 2014, which was 0.5 percentage points above the monthly target. The target increased by 0.2%. Divisional rates were: Diagnostics & Therapies 2.6%, Medicine 5.1%, Specialised Services 3.5%, Surgery Head & Neck 4.5%, Women`s & Children`s 4.2%, Trust Services 4.4%, and Facilities & Estates 7%.	See summary, supporting information
Appraisal	G ↓	Trust-wide appraisal rates for all staff were 85.9%. All Divisions except Women's & Children's and Facilities & Estates achieved the stretch target of 85% which was introduced in April 2012. Divisional rates were: Diagnostics & Therapies 88.1%, Medicine 87.3%, Specialised Services 85.6%, Surgery Head & Neck 87.6%, Women's & Children's 83.3%, Trust Services 88.1%, and Facilities & Estates 81.8%.	See summary and supporting information

[1] Note: RAG (Red, Amber, Green) rating reflects whether the indicator has achieved the target. The direction of the arrow shows the change from last month. The colour of the arrow reflects whether actual this month is better in relation to the target (green) or further from the target than last month (red). Sickness and bank and agency targets are set by Divisions, and appraisal is a Trust wide target.

WORKFORCE

2.3.4 Monthly forecast and overview

Measure	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	March 14 Planned
Budgeted Posts (FTE)	7114.5	7272.5	7340.6	7387.6	7399.9	7415.6	7420.3	7408.3	7411.1	7406.4	7424.8	7442.0	7502.3	7347.6
Total Employed (FTE)	6856.9	6902.7	6882.4	6872.9	6905.5	7017.4	6979.7	7056.7	7071.7	7093.7	7130.2	7167.3	7170.6	7123.1
Bank (FTE) Admin & Clerical	71.2	83.3	65.8	71.7	75.1	95.3	67.1	80.0	63.9	58.4	59.0	67.4	64.9	43.0
Bank (FTE) Ancillary Staff	19.4	25.3	21.6	27.3	29.8	37.6	27.4	36.7	27.0	25.6	30.7	35.2	34.6	9.8
Bank (FTE) Nursing & Midwifery	205.4	257.6	209.0	200.2	189.6	217.1	188.6	232.2	194.5	184.2	197.0	220.2	197.4	133.8
Agency (FTE) Admin & Clerical	11.7	9.8	17.8	11.3	18.2	19.9	27.3	12.2	14.8	17.4	13.5	27.1	25.7	7.1
Agency (FTE) Ancillary Staff	17.8	7.6	17.2	13.7	12.2	10.5	-0.5	-10.0	10.7	10.5	3.7	0.0	8.3	8.6
Agency (FTE) Nursing & Midwifery	66.4	52.1	66.8	48.7	60.3	70.9	76.9	64.1	49.4	38.1	43.1	47.2	37.5	14.8
Overtime	86.1	79.5	57.0	59.3	62.1	71.1	96.1	67.7	55.8	58.2	60.1	54.7	83.7	
Sickness absence[1] Rate (%)	4.5%	3.9%	3.5%	3.7%	3.9%	3.8%	3.9%	4.2%	4.2%	4.2%	4.5%	4.3%	4.4%	4.0%
Appraisal (%)	85.2%	87.3%	86.1%	86.1%	85.9%	86.1%	85.5%	86.1%	87.3%	88.8%	88.5%	87.9%	85.9%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.3%	18.6%	18.6%	18.7%	15.9%	18.7%	18.5%	18.4%	18.3%	18.3%	17.9%	18.0%	17.7%	
Rolling Average Turnover[3] (with exclusions) (%)	11.4%	11.5%	11.5%	11.6%	11.7%	11.7%	11.6%	11.5%	11.5%	11.6%	11.2%	11.1%	10.9%	
Vacancy[4] Rate (%)	3.6%	5.1%	6.2%	7.0%	6.7%	5.4%	5.9%	4.7%	4.6%	4.2%	4.0%	3.7%	4.4%	

1. Sickness absence is expressed as a percentage of total whole time equivalent staff in post.
2. Turnover measures the number of leavers expressed as a percentage of the average number of staff in post in the period. Turnover (all reasons) excludes bank, locum and honorary staff.
3. Turnover (with exclusions) excludes bank, locum, honorary and fixed term staff together with junior doctors.
4. Vacancy measures the number of vacant posts as a percentage of the budgeted establishment.

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of March 2014**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 4)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (15)	**Underachieving (1)**
- 31-day diagnosis to treatment cancer standard - *subsequent drug* - 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* - 31-day diagnosis to treatment cancer standard - *subsequent surgery* - 62-day referral to treatment cancer standard – *screening referred* - 2-week wait urgent GP referral cancer standard - Referral to Treatment Time for admitted patients - Referral to Treatment Time for incomplete pathways - 6-week wait for key diagnostic tests - Genito-Urinary Medicine (GUM) 48-hour access - A&E Left without being seen rate - A&E Time to Treatment - A&E Unplanned re-attendance - A&E Time to Initial Assessment - Reperfusion times (door to balloon time of 90 minutes) - Infant health – breastfeeding rate	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved*
Failing (6)	**Not reported/scored (0)**
- A&E Maximum waiting time (4-hours) - Referral to Treatment Time for non-admitted patients - 62-day referral to treatment cancer standard – *GP referred* - 31-day diagnosis to treatment cancer standard - *first treatment* - Last-minute cancelled (LMC) operations + 28-day readmission following LMC	

*Please note: Performance for the cancer standards is reported by all trusts in the country two months in arrears. The current cancer performance figures shown include the draft figures for March. Indicators are shown as being **failed** where the required standard is not achieved for the quarter to date. Indicators are shown as being **underachieved** if there has been a failure to achieve the national target in the current month, but the quarter is currently being achieved, or where a local standard is not being met.*

3.2 ACCESS DASHBOARD

	Target	Thresholds Green	Thresholds Red	Previous YTD	Year to date (YTD)	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.8%	96.6%	97.6%	96.1%	97.1%	96.6%	95.7%	97.2%	95.0%	96.3%	98.0%	95.4%	98.0%	Cancer standards report two months in arrears	96.9%	96.5%	96.4%	96.8%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.9%	96.9%	98.1%	98.2%	97.6%	99.4%	96.5%	94.3%	96.9%	99.5%	97.6%	94.9%	92.3%		98.0%	96.7%	98.0%	94.1%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.8%	99.8%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	99.2%	100.0%		99.7%	100.0%	99.7%	99.6%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	95.2%	95.1%	83.8%	100.0%	97.2%	96.1%	95.2%	89.3%	100.0%	93.5%	95.0%	92.9%	97.3%		94.2%	94.2%	96.9%	94.6%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	98.6%	97.6%	98.9%	98.9%	98.2%	97.8%	98.1%	97.1%	97.1%	97.6%	99.0%	92.2%	99.5%		98.7%	97.7%	97.8%	95.7%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	84.5%	80.7%	83.1%	78.5%	85.7%	76.6%	77.9%	82.7%	85.6%	83.1%	85.2%	73.9%	77.9%		81.7%	78.9%	84.6%	76.0%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	88.9%	93.7%	96.3%	89.3%	91.2%	95.3%	100.0%	93.9%	91.8%	84.2%	97.6%	98.0%	94.9%		92.1%	96.6%	90.5%	96.6%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	91.8%	89.0%	100.0%	100.0%	100.0%	94.3%	88.2%	100.0%	86.7%	84.2%	93.1%	79.3%	75.6%		100.0%	94.2%	88.3%	77.1%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	92.4%	92.7%	93.5%	93.2%	94.4%	93.0%	92.8%	92.2%	92.9%	91.6%	92.1%	92.8%	92.4%	90.5%	93.7%	92.7%	92.3%	92.0%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	95.7%	93.1%	95.8%	95.7%	95.7%	92.5%	91.5%	91.3%	92.4%	91.3%	94.0%	92.0%	92.7%	93.1%	95.7%	91.8%	92.5%	92.6%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.2%	92.5%	92.3%	92.2%	92.8%	92.2%	92.3%	92.6%	92.9%	93.1%	92.2%	92.6%	92.4%	93.1%	92.5%	92.4%	92.7%	92.7%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	93.8%	93.7%	91.1%	95.4%	96.0%	93.8%	95.6%	97.1%	95.1%	95.4%	90.8%	91.6%	90.1%	92.1%	94.1%	95.4%	93.7%	91.3%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	57	15	53	39	14	14	13	12	13	13	14	12	24	15	38	13	13	14
	A&E Time to treatment decision (median) - in minutes	60	60	53	52	57	51	51	54	47	49	53	53	53	46	55	54	53	50	53	51
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	2.6%	1.6%	0.7%	0.7%	0.7%	0.6%	0.7%	0.6%	2.3%	2.2%	3.0%	2.8%	2.5%	2.4%	0.7%	0.6%	2.5%	2.5%
	A&E Left without being seen	5%	5%	1.9%	1.8%	1.8%	1.4%	1.4%	1.8%	1.7%	1.8%	2.2%	2.1%	2.1%	2.0%	1.8%	1.7%	1.5%	1.7%	2.1%	1.8%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.13%	1.02%	1.65%	0.96%	0.82%	1.15%	0.85%	0.72%	0.65%	0.96%	1.02%	1.18%	1.44%	0.92%	1.14%	0.91%	0.85%	1.17%
	28 Day Readmissions	95%	85%	91.1%	89.6%	89.6%	81.3%	89.5%	88.9%	88.4%	93.6%	95.0%	95.0%	92.6%	93.6%	88.6%	89.7%	86.0%	90.1%	94.0%	90.3%
	6-week wait for key diagnostics	99%	99%	89.7%	98.6%	97.9%	98.0%	98.4%	97.7%	98.2%	98.5%	98.9%	99.5%	98.8%	98.0%	99.2%	99.2%	98.1%	98.1%	99.1%	98.8%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	83.1%	82.4%	87.9%	66.7%	87.8%	89.7%	84.4%	65.0%	86.2%	91.2%	81.6%	77.5%	82.9%		81.3%	81.5%	88.9%	80.0%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	92.4%	92.9%	93.9%	87.9%	95.1%	96.6%	90.6%	95.0%	96.6%	97.1%	89.5%	90.0%	91.4%		92.5%	93.8%	96.8%	90.7%
	Infant Health - Mothers Initiating Breastfeeding	76.3%	74.5%	80.6%	81.6%	81.6%	80.8%	85.0%	82.4%	81.5%	78.9%	81.6%	79.1%	82.3%	80.4%	84.4%	81.4%	82.4%	80.9%	81.0%	82.1%

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2013/14 has been applied in the Red, Amber, Green ratings.
Infant Health breast feeding rates have a GREEN threshold of being above 2011/12 performance, and a RED threshold of the national average that year.
The standard for Primary PCI 150 Call to Balloon Time only applies to direct admissions - the local target is shown as the GREEN threshold and the national target as the RED.
All **CANCER STANDARDS** are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter. The figures shown are those reported as part of the National Cancer Waiting Times data-set. They do not reflect any breach reallocation for late referrals, which is only allowable under Monitor's Compliance Framework.

Please note: The last-minute Cancelled Operations figures reported in February 2014 have been amended in light of a data refresh carried-out following an upgrade to Medway Patient Administration System (PAS), which affected the figures in the month.

3.3 CHANGES IN THE PERIOD

Performance against the following national standards changed significantly compared with the last reported period:

- 31-day diagnosis to treatment cancer standard – *subsequent surgery* ↑ (up from 92.9% in January to 97.3% in February) – forecast to be met for the quarter as a whole
- 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* ↑ (up from 92.2% in January to 99.5% in February) – forecast to be met for the quarter as a whole
- A&E Time to Initial Assessment within 15 minutes ↓ (down from 24 minutes in February to 15 minutes in March)

Please note the above performance figures only show the final reported position and do not show the draft March performance against the cancer standards, although additional information is noted where the draft figures have been validated.

3.4 EXCEPTION REPORTS

Exception reports are provided for the six RED rated performance indicators.

1) Last-minute cancellations
2) 28-day readmission following a last-minute cancellation
3) 62-day referral to treatment cancer standard – GP referred
4) 31-day diagnosis to treatment cancer standard - first treatment
5) Referral to Treatment Time (RTT) Non-admitted pathways standard
6) A&E 4-hour maximum wait

ACCESS STANDARDS

A1–A2. EXCEPTION REPORT: Last-minute cancellation + 28-day readmission following a last-minute cancellation	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

1) The number of patients whose operation was cancelled at last minute for non clinical reasons, as a percentage of all admissions.

This standard remains part of the NHS Constitution.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

There were 52 last-minute cancellations (LMCs) of surgery in March (0.92% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in March were as follows:

- 23% (12 cancellations) were due to an emergency patient being prioritised on the day
- 21% (11 cancellations) were due to no Intensive Therapy Unit/High Dependency Unit beds being available to admit a patient to
- 17% (9 cancellations) were due to the morning theatre list running over and/or another patient being more clinically complicated in theatres than expected
- 12% (6 cancellations) surgeon being ill/unavailable
- 8% (4 cancellations) were due to no ward bed being available to admit a patient to
- 19% (10 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging

Of the 52 cancellations, 18 were day-cases and 34 were inpatients (35% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to no critical care beds being available and emergency patients needing to take priority, which is more likely to impact inpatient than day-case procedures.

In contrast to the last two months, ward bed availability was not the single highest cause of cancellations this month. If there had been no cancellations due to the lack of a ward bed, performance would have been 0.84% against the 0.8% national standard.

In March, 89.7% of patients cancelled in the previous month were readmitted within 28 days of the cancellation, which is below the 95% national standard. There were 8 breaches of standard in the month. Three of these patients were due for readmission to the Bristol Children's Hospital, and were not re-admitted within the target 28 days due to pressures on beds and more urgent patients needing to take priority. Four of the remaining cases were due for re-admission to the Bristol Royal Infirmary. These could not have their operation re-scheduled within 28 days because of the need to operate on cancer cases. The final patient was for re-admission to South Bristol Community Hospital and was not rebooked in time due to an administrative error.

Recovery plan, including expected date performance will be restored:

The following actions continue to be taken to reduce last-minute cancellations and support achievement of the 0.8% standard (*please note: actions completed in previous months have been removed from the following list*):

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability (see A&E 4-hour Exception Report – A6);
- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing); patient list now also being reviewed at the weekly or fortnightly Referral to Treatment Time (RTT) meetings with Divisions;
- Monthly validation of all potential LMCs re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days, and that we understand the reasons for cancellations (ongoing);
- Outputs of the weekly scheduling meeting are reviewed by Surgery, Head & Neck team, to be clear on the accountability for making sure theatre lists are appropriately booked (i.e. will not over-run), and the necessary equipment/staffing are available (ongoing);
- Weekly reviews of future week's operating lists continue, to ensure the demand for critical care beds is spread as evenly as possible across the week; daily reviews of current demand for critical care beds, and flexible critical care bed-usage across Divisions to minimise cancellations (ongoing);
- Daily e-mails circulated of all on-the-day cancellations within the Bristol Royal Infirmary by the nominated Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing);
- In addition to the opening of the twentieth ITU bed, a further review of critical care capacity is being undertaken, as part of the development of the Operating Model, which is being led by the Senior Leadership Team.

Progress against the recovery plan:

The 0.8% national last-minute cancelled operations standard was not achieved in March. This was due to a combination of reasons and mainly reflected emergency pressures on beds (both ward and critical care) and theatres. However, performance was significantly better than the same period last year (0.92% March 2014 vs. 1.18% March 2013).

The 95% 28-day readmission standard was not achieved in the month. Along with the opening of the additional critical care bed at the end of February, improvements in patient flow seen during the first half of April should reduce levels of last-minute cancelled operations and improve performance against the 28-day readmission standard during quarter 1. Further improvements in performance against these standards are expected as an outcome of the implementation of the Operating Model led by the Senior Leadership Team.

ACCESS STANDARDS

A3-A4. EXCEPTION REPORT: • 62-day referral to treatment for GP referred patients • 31-day diagnosis to first definitive treatment	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

62-day referral to treatment for GP referred patients
The number of patients with confirmed cancers treated within 62 days of referral, as a percentage all cancer patients treated during the period under that standard. There are separate targets for GP and screening referred patients.

31-day diagnosis to treatment (first definitive)
The number of patients diagnosed with a cancer treated within 31 days of the decision to treat (i.e. treatment plan agreed with the patient), as a percentage all cancer patients treated during the period under that standard.

Monitor measurement period: All cancer standards are measured Quarterly (weighted 1.0 in the Risk Assessment framework)

Performance during the period, including reasons for exceptions:

62-day GP referred

Performance in quarter 4 is still subject to final validation but is expected to be confirmed at 76% against the 85% standard. Breach analysis has confirmed the reasons for the breaches to be as follows:

Breach reasons	Average Q4 breaches per month	
Late referral	5.2	31%
Medical deferral/Clinical complexity	3.8	23%
Patient choice	1.2	7%
Histology delay	0.3	2%
Outpatient delay	1.2	7%
Delayed admitted diagnostic	1.5	9%
Admin delay/pathway planning issue	1.0	6%
Delayed pathway other provider	1.0	6%
Elective cancellation	0.5	3%
Insufficient capacity	0.8	5%

Two-thirds of the breaches (67%) were due to primarily unavoidable reasons, including late referral, medical deferral, patient choice and delayed pathways at other providers.

ACCESS STANDARDS

The transfer of breast and urology services to North Bristol Trust has left the Trust with a challenging group of pathways to meet the 62-day GP standard. This is because breast cancers are relatively easy to treat within 62-day of referral because the diagnostic pathways are simple and patients are usually fit enough to proceed to treatment without further intervention. In quarter 3 2013/14 the 85% standard was only achieved for breast and skin cancers at a national level. The Trust is now the only acute provider in the country that provides neither breast nor urology cancer services.

An improvement working group was established in October 2013, focusing primarily on the 62-day cancer pathways. Improvements in performance at a tumour-site level have been realised between quarter 2 and quarter 3, This is especially evident when comparing the Trust's performance against the national average reported for the same quarter. However, the volume and proportion of unavoidable breaches has increased significantly, meaning that further improvements now have to be made to offset these additional breaches that are largely outside of the Trust's control.

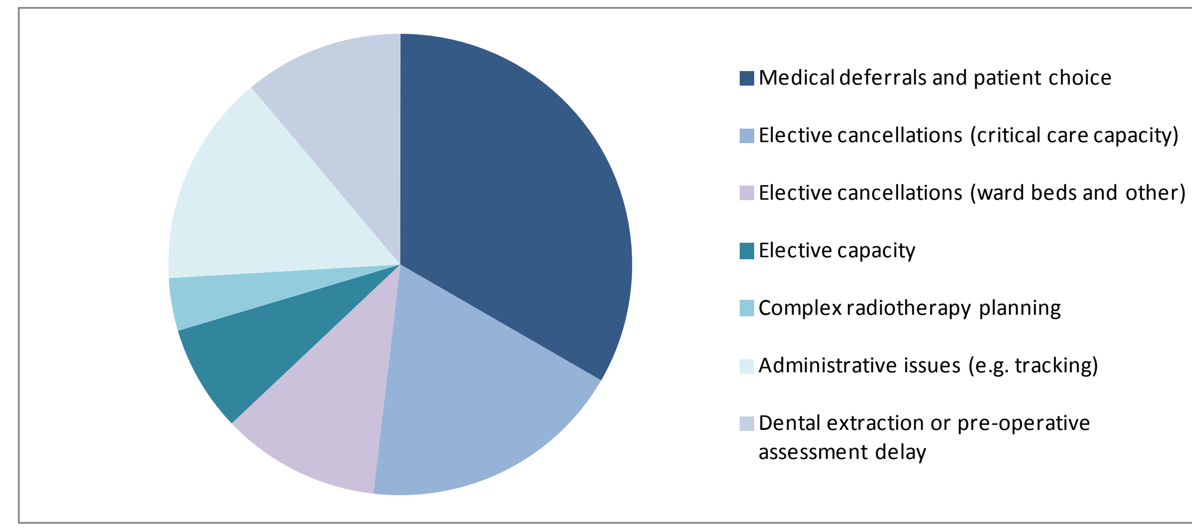
Tumour site	Quarter 2 2013/14		Quarter 3 2013/14	
	UH Bristol	National average	UH Bristol	National average
Brain/Central Nervous System	N/A	N/A	100	83.9
Breast	100	97.4	100	97
Gynaecological	88.5	82.7	93.5	83.6
Haematological	72.2	83.1	87.5	81.8
Head & Neck	69.6	74.5	83	76.8
Lower Gastrointestinal	61.5	78.8	81.5	78.7
Lung	79.8	79	75.8	77.8
Other	0	74.3	60	79.3
Sarcoma	66.7	76.2	100	78.1
Skin	97.6	97.3	100	95.8
Upper Gastrointestinal	78.9	78.9	68.6	79.1
Urological	0	83.4	66.7	81.5
All Cancers	**78.9**	**86.7**	**84.6**	**85.6**

The improvement work on the high volume tumour sites is ongoing. The focus of this work is informed by monthly breach reviews, and also structured telephone-based interviews which have been carried-out with better performing equivalent providers, to identify good practice from elsewhere. Whilst the telephone interviews provided assurance that there were no obvious differences in the diagnostic or treatment pathways that other providers had in place to treat cancer patients, disappointingly few pathway improvement opportunities were identified through these discussions.

31-day first definitive

Draft performance for quarter 4 is currently 95.9% and just below the 96% standard. For this reason achievement of the standard is considered to be high risk. However, these figures are subject to final validation prior to national reporting at the beginning of May. It is highly unusual for the Trust

to experience problems in achieving the 31-day first definitive standard. Analysis of the breach reasons for the quarter shows that 33% of the breaches were due to medical deferrals. But there was also a high proportion of breaches due to elective cancellations, mainly due to the lack of a critical care bed, but also ward bed availability. Increasing emergency and non-elective demand for critical care beds over 2013/14 increased bed occupancy (86.3% in quarter 2 to 91.7% for quarter 4 to date) and has resulted in a smaller proportion of the critical care bed-base being available to admit elective patients to. As a consequence, there were a higher levels of cancellations of elective surgery for this reason.



Recovery plan, including expected date performance will be restored:

A fortnightly cancer steering group has been established, to take forward the further improvement priorities which have identified from the most recent breach analysis and learning from other providers. The key actions are as follows:

<u>62-day GP referred actions:</u>

- Implement new management for tertiary thoracic surgery referrals (impact from Q4 onwards)
- Reduce maximum wait for 2-week wait step to 7 days for 90% of patients (July onwards)
- Further improvements in histology turn-around times to be expected with recruitment later in 2014/15
- Enact new approach to escalation of pathway delays from April onwards, involving the Divisional Management teams
- Establish 2.5 additional ENT theatre sessions per week from October 2014 onwards, to reduce the majority of panendoscopy delays
- Reduction in cancellations already seen following opening of twentieth critical care bed (**Action complete**)
- Implement new approach to critical care cancellations and booking of cases to minimise impact of residual cancellations
- Establish additional thoracic and hepato-billiary theatre sessions from October 2014, when Vascular service moves to North Bristol

Trust
- Schedule additional activity in December, when activity levels are low and breaches can result in quarter 4

31-day first definitive actions:
- Implement pathway improvements to thoracic, following practice of best performing providers
- Reduction in cancellations already seen following opening of twentieth critical care bed (**Action complete**) Critical Care Review to establish next steps
- Implement new approach to critical care cancellations and booking of cases to minimise impact of residual cancellations
- Establish additional thoracic and hepato-billiary theatre sessions from October 2014, when Vascular service moves to North Bristol Trust
- Enact new approach to escalation of pathway delays from April onwards, involving the Divisional Management teams
- Introduce escalation process for cancer patients being managed via pre-op (full impact Q3)
- Establish additional capacity to reduce dental extraction delays (full impact Q3)

Progress against the recovery plan:

62-day GP

The 85% standard was achieved in quarter 3 with breach reallocation to late referring providers. However, the high volumes of breaches for unavoidable reasons has resulted in the 85% standard failing to be achieved in quarter 4. The following improvement trajectory has been agreed, on the basis of the actions identified and expected impact of these actions. Progress with achieving this trajectory will be reported to the Board on a monthly basis.

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Q3	Jan-15	Feb-15	Mar-15	Q4
Trajectory	75.7%	80.5%	65.0%	75.3%	79.9%	82.1%	81.8%	81.3%	86.4%	85.1%	84.1%	85.3%	84.8%	85.4%	87.0%	85.8%
Actual																

31-day first definitive

It is still to be confirmed whether the 31-day first definitive treatment standard was achieved in quarter 4. However, due to the dip in performance in the quarter, plans have been developed to reduce the likelihood of each identified cause of breach of the 31-day standard. The following trajectory has been agreed and progress with achieving this trajectory will be reported to the Board on a monthly basis.

	Apr-14	May-14	Jun -14	Q1	Jul -14	Aug -14	Sep -14	Q2	Oct -14	Nov-14	Dec -14	Q3	Jan -15	Feb -15	Mar-15	Q4
Trajectory	95.9%	96.4%	96.7%	96.3%	96.8%	96.7%	96.8%	96.7%	97.2%	97.2%	96.7%	97.0%	97.2%	96.9%	97.2%	97.1%
Actual																

ACCESS STANDARDS

A5. EXCEPTION REPORT: Referral to Treatment Time (RTT) non-admitted pathways standard	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients treated or discharged within 18 weeks of referral, as a percentage of all patients treated or discharged in the month. The Non-admitted target of 95% relates to those patients not requiring an admission as part of their treatment.

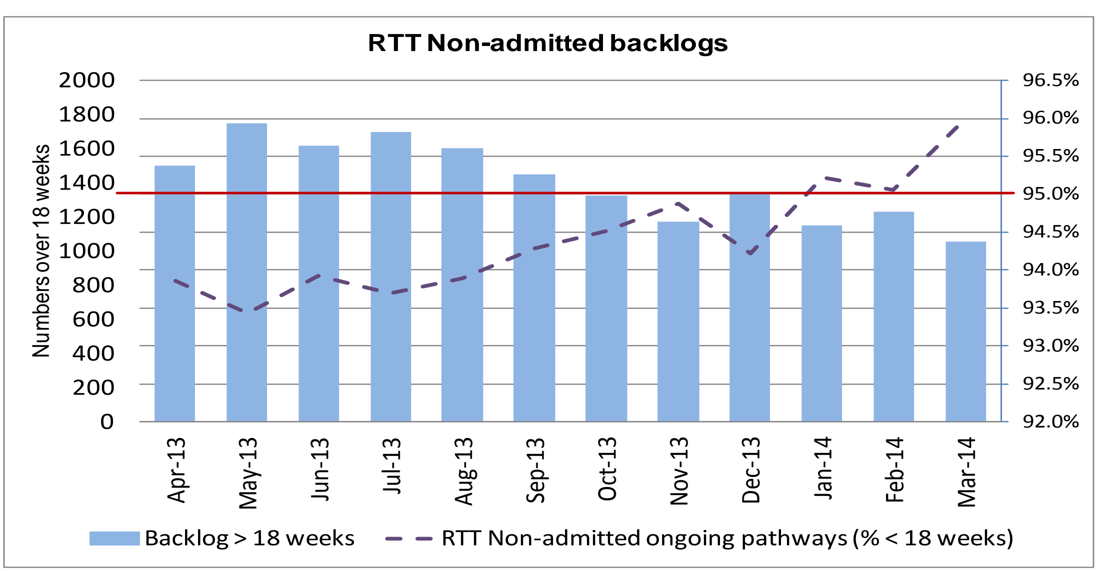
Performance is assessed by Monitor at an aggregated Trust level.

Monitor measurement period: Monthly achievement required but quarterly monitoring

Performance during the period, including reasons for exceptions:

Performance in March was 93.1%, which is an improvement on the February position of 92.7%, but 1.9% below the 95% national standard. The failure to achieve the RTT Non-Admitted standard was forecast following the Head & Neck service transfer from North Bristol Trust, due to the number of patients already waiting over 18-week for their first outpatient appointment, at the point of transfer. The forecast failure was flagged to Monitor in the Annual Plan, and re-stated as part of the quarter 2 declaration of compliance. In combination with increases in referrals from GPs, which has resulted in waits for first outpatient appointments lengthening, this led to the Trust flag the RTT Non-admitted standard being at risk of being failed in quarter 4, as part of the Trust's quarter 3 declaration to Monitor.

Graph 1 – RTT Non-admitted backlogs versus the percentage of patients on ongoing pathways waiting under 18 weeks.



Good progress has been made in reducing the backlogs of over 18-week waiters. As a result, the percentage of patients on a non-admitted ongoing pathway that are waiting under 18 weeks at each month-end has been above 95% for the whole of quarter 4, and reached 96% in March. However, this has not yet translated into achievement of the 95% standard for clocks stopped in the month.

ACCESS STANDARDS

The analysis of the breaches confirms that the main reasons for the failure to achieve the 95% standard in March were:

- Additional patients that had waited over 18 weeks from referral being seen for first outpatient appointments within the adult Ear, Nose & Throat and Oral Surgery services following transfer of the waiting list from North Bristol Trust; this is partly due to the volume and length of waits at the time of transfer, but also increases in referral volumes beyond that expected as part of the transfer
- Additional patients being seen for their first outpatient appointment to reduce the waiting times in other dental specialties (included in the RTT speciality 'Other') where waiting times have increased
- Lengthening outpatient waiting times for first appointments in a range of specialties, following increasing volumes of referrals, especially from GPs

Table 1: Performance against the RTT Non-admitted standard at a national RTT specialty level

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
CARDIOLOGY	108	15	123	87.8%
CARDIOTHORACIC SURGERY	8	2	10	80.0%
DERMATOLOGY	431	12	443	97.3%
E.N.T.	550	81	631	87.2%
GENERAL MEDICINE	270	9	279	96.8%
GERIATIRC MEDICINE	52	0	52	100.0%
GYNAECOLOGY	342	16	358	95.5%
NEUROLOGY	78	0	78	100.0%
OPHTHALMOLOGY	958	23	981	97.7%
ORAL SURGERY	398	30	428	93.0%
OTHER	3573	320	3893	91.8%
RHEUMATOLOGY	116	4	120	96.7%
THORACIC MEDICINE	241	10	251	96.0%
TRAUMA & ORTHOPAEDICS	113	16	129	87.6%
TOTAL	**7238**	**538**	**7776**	**93.1%**

Recovery plan, including expected date performance will be restored:

- To improve performance for non-admitted Referral to Treatment (RTT) pathways, a three phase project plan has been developed that focuses on immediate actions required to bring performance back in line as well as more medium / longer term sustainability improvements. The plan is to run an initial short term working group to focus on immediate improvements then continue with some more medium and long term improvements over the next 6-12 months. The first phase of this plan was **completed** at the end of March;

ACCESS STANDARDS

- A weekly working group has been established to develop the recovery plan for reducing waiting times for first outpatient appointments. This group has been meeting weekly through February and March and has developed the activity and waiting list trajectories for reducing outpatient waiting times throughout 2014/15. Weekly monitoring of activity against the plan is now taking place to ensure any deviation from plan is identified early so that mitigating actions can be taken;
- A monthly RTT Steering Group has also been set-up to oversee the progress of the working group as well as to provide a more strategic oversight of RTT performance. The first monthly Steering Group was held on 27th February 2014. This group is responsible for ensuring all the milestones of the project are met as well as overseeing risks, reviewing benchmarking information, providing cross divisional oversight and recognising / promoting best practice;
- To provide external assurance that our recovery plan is 'fit for purpose', we have asked the national Elective Care Intensive Support Team (IST) to undertake a review of our action plan to ensure it is robust as well as to share best practice from other organisations. This is scheduled for the week commencing the 21st April.

Progress against the recovery plan:

Weekly activity plans are now in place to further reduce the number of patients waiting over 18 weeks. The modelling which has been undertaken of the impact of shortening first outpatient waits forecasts achievement of the 95% standard from October 2014, as shown in the trajectory below. Each monthly report to the Board will track performance against this trajectory.

Non-admitted Trajectory	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Patients above target outpatient wait	2,940	2,483	1,998	1,454	844	505	364	207	98	98	0	0	0
Forecast performance against RTT Non-admitted standard	93.1%	93.4%	93.7%	94.1%	94.5%	94.7%	94.8%	95.0%	95.0%	95.0%	95.1%	95.1%	95.1%
Actual performance against the RTT Non-admitted standard	93.1%												

ACCESS STANDARDS

A6. EXCEPTION REPORT: A&E maximum wait 4 hours	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

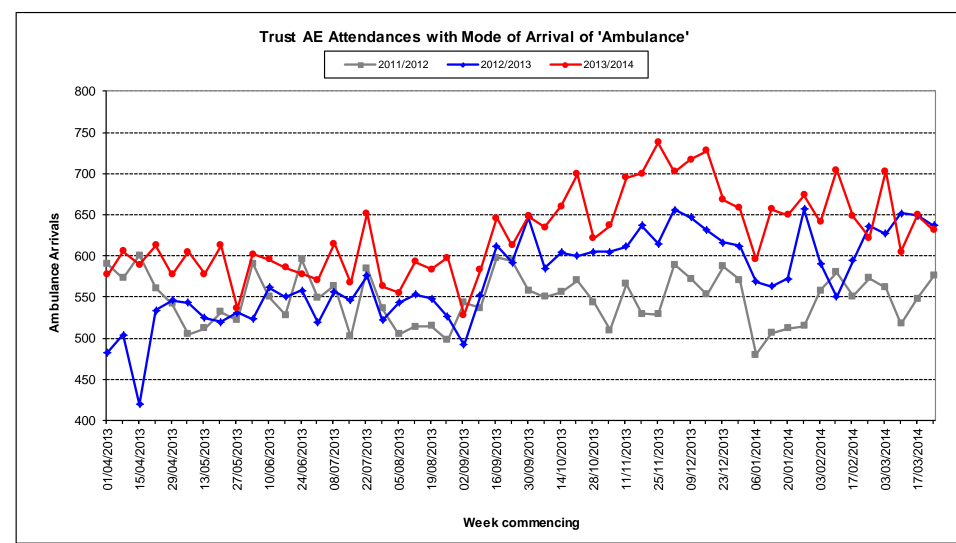
The number of patients admitted, discharged or transferred within 4 hours of arrival in the Trust's Bristol Royal Infirmary (BRI), Bristol Children's Hospital and Bristol Eye Hospitals, as a percentage of all patients seen. The local Walk in Centre attendances are no longer included in the performance figures.

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

Trust-level performance in March was 92.1%, and below the 95% standard. Performance against the 4-hour standard at the Bristol Children's Hospital was above the 95% standard at 95.2%, which was 0.3% above February's performance. However, performance within the BRI remained below the 95% standard at 88.1%, although was 2.8% above February's performance. The Bristol Eye Hospital achieved 100% against the 95% national standard.

Table 1 – Number of ambulance arrivals into the Trust by month over the last three years.



Ambulance arrivals into the Trust remain high and average 9% higher than the same period last year. However, there has not been an associated increase in emergency admissions into the BRI, which is thought in part to be due to the work of the BRI Ambulatory Care Unit.

Between November 2013 and January 2014 the Trust experienced an 8% increase in the level of emergency admissions for patients aged 75 years and over relative to the same period last year. Age is a good indicator of the level of acuity of emergency patients being admitted. Older patients also typically have more complex discharge planning needs, with a greater proportion needing care packages or placements in residential/nursing homes, meaning they are more likely to have a delayed discharge. There was an increase in both delayed discharges and patients staying over 14 days in the period, although levels have reduced following the Breaking the Cycle Together initiative.

On a positive note, length of stay for those patients aged 75 years and over has improved significantly relative to the same period last year, but has been more than offset by the impact of increasing numbers of older people. In December and January this additional pressure on beds coincided with

a number of wards being closed due to norovirus. Additional escalation bed capacity was opened during quarter 4, but we also saw a consequent rise in bed occupancy and patients having to be managed as outliers from their intended specialty ward. Despite this, performance against the ward-level indicators of quality remains good and generally improving.

Recovery plan, including expected date performance will be restored:

The Senior Leadership Team is overseeing the delivery of the 2014/15 Operating Model. This covers a programme of seven projects which are targeting improvements in patient flow, one of which, 'Breaking the Cycle Together', has already been implemented. Details of the remaining six projects are provided in the table below. Key milestones for the achievement of the objectives of the Operating Model programme of work will be defined before the end of April.

Project	Project Aims	Progress on delivery
Integrated discharge hub and supporting discharge processes	To co-locate staff from the three key Organisations responsible for managing patients with complex care needs; Bristol City Council, Bristol Community Health and University Hospitals Bristol; to improve efficiency of discharge processes; improve communication, reduce duplication and create an integrated discharge policy and process.	Area for co-location of teams identified, conversion costs being assessed. Joint workshop to develop integrated processes, taking learnings from Breaking the Cycle Together, planned for later in April 2014.
Out of hospital solution	To commission further out of hospital transitional care beds to reduce the number of bed days consumed by 'Green to Go' (delayed discharge) patients, thereby reducing Length of Stay (LOS) and bed occupancy to improve patient flow.	Potential beds identified. Proposal prepared for the Better Care Fund programme board to agree funding arrangements (completed). Criteria and Standard Operating Procedures for Discharge team are under development (April 2014).
Early Supported Discharge	Effective early supported discharge pathways in place for patients which are provided by either a community partner or UH Bristol, or a combination of both which leads to better patient outcomes, better patient experience and a reduced LOS	Success models exist locally (e.g. Stroke). Currently prioritising areas which will benefit most from the approach and scoping the right work (ongoing).
Trust wide review of Critical	The project is still being scoped but will address issues of	Long term capacity review planned alongside short

Care	flow and capacity in adult critical care facilities.	term interventions to improve flow between critical care and other areas (is in planning stage).
Weekend discharge – diagnostic and solution	To understand the issues needed to even out patient flow across the seven days of the week and increase the number of discharges that take place at the weekend.	Valuable evidence gathered during Breaking the Cycle Together being evaluated now to better understand root causes (in progress, April 2014).
Protected Beds	To develop an operating model that will support elective and urgent tertiary activity to proceed unhindered by periods of high demand for acute medical care through the Emergency Department. This will ensure that all our patient flows are supported, both planned and unplanned care.	Team is developing a planning and bed management tool to allow us to manage protected beds with high occupancy. Aim to commence pilot operating at end April 2014.

Progress against the recovery plan:

Performance against the 4-hour standard improved significantly following Breaking the Cycle Together, with the BRI achieving 95.6% for the week, compared with an average of 90.2% for the two weeks leading up to the initiative. As of the 17th April, Trust-level performance is 94.7% for the month to date.

Key milestones for the achievement of the aims of the Operating Model programme of work will be defined before the end of April. This will further inform the improvement trajectory for sustainable achievement of the 95% national standard, which is currently under development. At present, achievement of the national standard is considered at risk in quarter 1 and quarter 4 of 2014/15. This is primarily due to uncertainty over the scale of the emergency admissions that will transfer to the Trust following the closure of Frenchay Emergency Department in May 2014, relative to those assumed in the plan, and the ongoing pressures of increasing numbers of ambulance arrivals in conjunction with the increasing ago-profile of patients admitted to the Trust each winter.

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

8. Infection Control Quarterly Report

Purpose

To update the Board on the activities of Infection Prevention and Control.

Abstract

- *Clostridium difficile* target exceeded by two cases however the Trust ten cases below for the same period last year.
- Two MRSA bacteraemia cases attributed to the Trust.
- The Trust two cases below its MSSA target for 2013/14.
- Antibiotic prescribing compliance at 90%
- Antibiotic App now available for adult services.
- Line infections reducing.
- Areas falling below 95% cleaning standards are audited weekly until they achieve the standard for four consecutive weeks.

Recommendations

The Trust Board is recommended to receive this report by the Chief Nurse

Executive Report Sponsor or Other Author

- Sponsor – Chief Nurse
- Other Author – Dr Richard Brindle Director of Infection Prevention and Control. Joanna Hamilton-Davies. Senior Infection Prevention and Control Nurse/Deputy DIPC.

Appendices

- None.

INFECTION PREVENTION AND CONTROL QUARTERLY REPORT (January-March 2014)

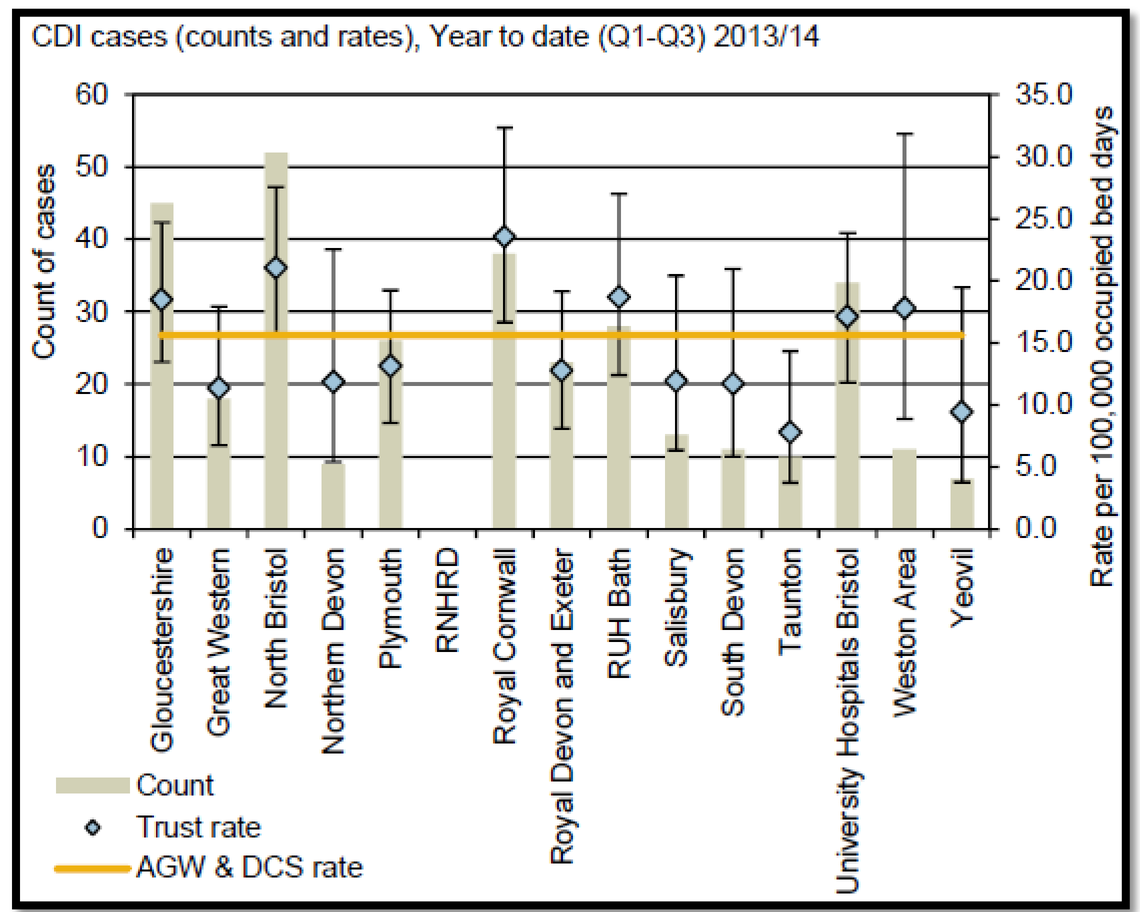
REPORT PRODUCED BY DIRECTOR INFECTION PREVENTION AND CONTROL AND THE SENIOR INFECTION CONTROL NURSE/DEPUTY DIPC

Clostridium difficile:

	JANUARY	FEBRUARY	MARCH
Target	3	3	3
Actual	0	2	2

- The final quarter total was 4 cases of *Clostridium difficile.* This was against a target of 9. Although exceeding the Trust target for 2013/14, the Trust is 10 cases below the number for 2012/13 and below the limit for 2013/14. The Trust continues its year on year reduction. Management of patients includes:
- The patient is visited by the DIPC or Infection Control Doctor, Infection control nurse and pharmacist and management assessed within one working day of receiving the positive result.
- Timelines are undertaken for each case to investigate if there were any common themes or if further actions need to be implemented.
- A meeting to discuss any issues is held with the matron for the area, the ward sister/charge nurse, Infection Prevention and Control Nurse and the DIPC/Infection Control Doctor.
- Patients with active disease continue to be nursed and managed on the cohort ward.
- The antibiotic guideline smartphone application (App) is now available in the adult areas.
- As part of the action plan a trial commenced in December using an Adenosine Triphosphate (ATP) machine, to ensure the standard of cleaning. The company have not produced any results and so the trial will commence with a new company. This action will be added onto the infection control annual programme.

Comparative data – Figure 1



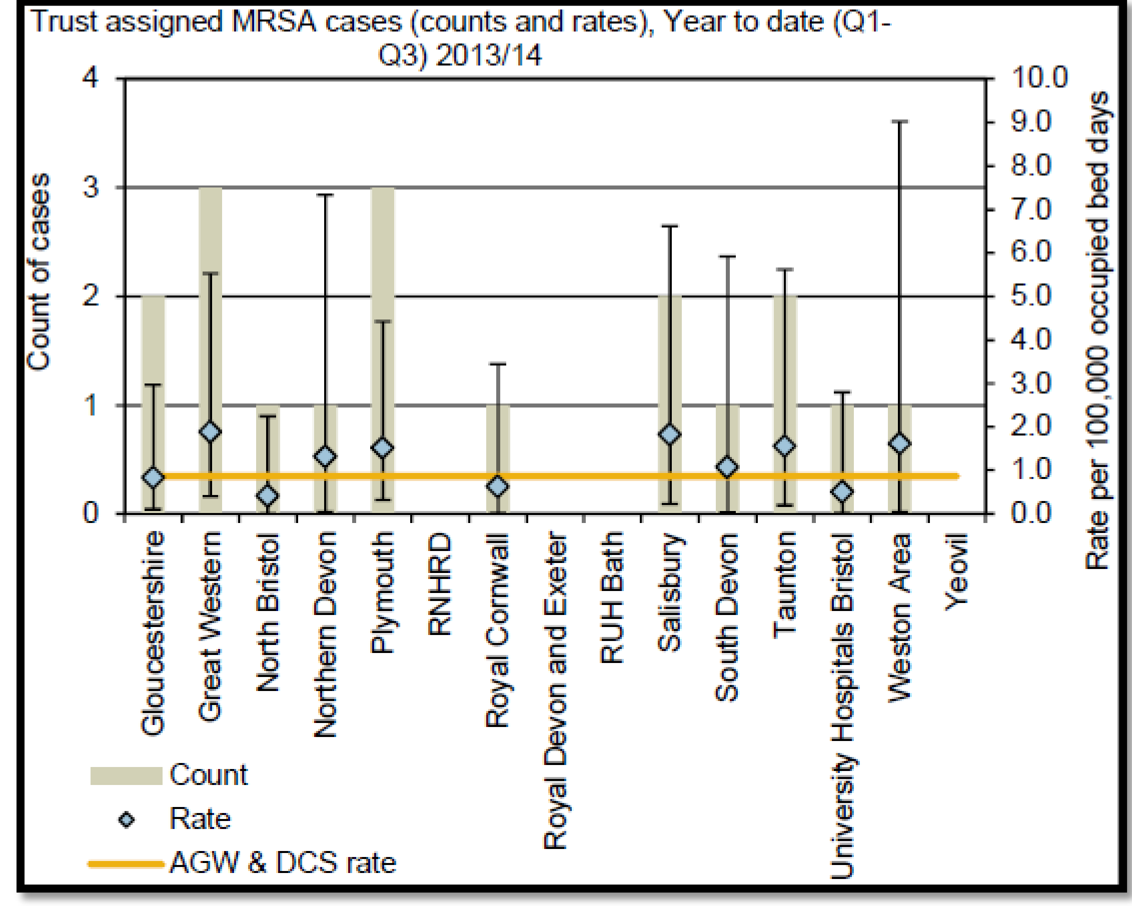
The data is published one quarter in arrears. No deaths caused by *Clostridium difficile* on part one of the death certificates for this quarter.

MRSA BACTERAEMIA

January	February	March
0	1	0

There has been one MRSA bacteraemia attributed to the Trust this quarter. This was a contaminant. This makes a total of two for the year. There were no deaths attributed to MRSA during this quarter.

Comparative data – Figure 2



MSSA

	January	February	March
Target	3	2	2
Actual	1	2	2

- The total for this quarter is 5 against a target of 7. There are no financial penalties associated with this target. The total number for the year was 27 MSSA post bacteraemia against a target of 29. The actions for MSSA are the same as MRSA.

Ecoli

	January	February	March
Post 48hrs	12	6	3
Pre 48hrs	14	16	16

- There is no national or Trust targets for E coli bacteraemia. Numbers are recorded on the Public Health England data base.

GRE/VRE

January	February	March
0	3	3

- There is no national or Trust targets for GRE/VRE bacteraemia. Numbers are recorded on the Public Health England data base.

Outbreaks and untoward incidents: Norovirus

NOROVIRUS

2013/2014 April - March

Graph 1. No. Wards/Areas Closed and Part Closed by Division

TRUST 16				
MDC	SHN	SPS	W00	C00
15	1	0	0	0

Table 1. No. Whole Wards Closed in Period

TRUST 32				
MDC	SHN	SPS	W00	C00
12	6	4	0	10

Table 2. No. Ward Bays Part Closed in Period

TRUST 524				
MDC	SHN	SPS	W00	C00
426	47	9	0	42

Table 4. No. Beddays Lost in Period

Graph 2. **Cumulative** Closures and Part Closures in Whole Trust

Graph 3. **Cumulative** Patient and Staff Affected

TRUST 273				
MDC	SHN	SPS	W00	C00
219	31	9	0	14

Table 3. Total Affected in Period

TRUST 40				
MDC	SHN	SPS	W00	C00
23	5	3	0	9

Table 5. No. Areas Deep Cleaned in Period?

TRUST 101				
MDC	SHN	SPS	W00	C00
89	8	2	0	2

Table 6. No. Positive Cases in Period

Incident investigation themes

MDR TB. The close down meeting took place on the 30th January. A letter to patients to invite them to annual screening for ten years is being developed by Dr Sarah Mungall. A process is being devised to recall these patients annually.

Infection Control Training Compliance:

January	February	March
82%	81%	82%

IV Access coordinator update

Since being in post Jody Coram has been working towards a sustainable programme to reduce our line infection rates. To date we have reported 25 line infections, 18 in the first quarter and 7 in the second, this is a significant reduction and brings the estimated cost to the Trust down from £101,178 to £44,158. Audits looking at the practice of Aseptic Non Touch Technique (ANTT) and cannula documentation have been completed. Results have been shared with the Heads of Nursing and will be presented at Infection Control Group. The catheter related sepsis protocol has been developed and is being rolled out across the Trust.

Antibiotic Prescribing Compliance

Antimicrobial Stewardship Reviews: Trustwide

Chart axis: 0% to 100% in 10% steps. Months shown: Apr-10 to Mar-14. The chart has the annotation "App introduced".

Legend: % Not to Guideline, % No Stop/Review, % No Indication, Compliance Target, % Overall Compliance, % Prescribers Legible

Innovation/activity linked to patient improvement
A patient contacted the team with regards to the MRSA discharge letter that is sent to patients and their GP's, if they have a positive result and they have left the hospital. This resulted in the letter being changed to ensure more clarification of what patients should do if they have concerns with their results.

Surgical Site Infection Surveillance (SSIS)
Surgical Site Surveillance has commenced in Cardiac at the Children's hospital.

Audit
An audit has been completed looking at the completion of documentation of the new peripheral cannula documentation. Results to be fed back to Heads of Nursing and ICG. Date to be confirmed.

Infection Control/Equipment and Environmental audits are ongoing throughout the Trust. Reports are sent to the areas and action plans are requested with four weeks.

An audit has been completed to ascertain the level of understanding staff have with regards to ANTT and to look at practice. Results to be fed back to Heads of Nursing and ICG. Date to be confirmed.

Infection Control Staffing
The Infection Prevention and Control Team have one member of staff on maternity leave. A year fixed term contract has been agreed and the post holder will commence in post at the end of April/.

Trustwide Infection Control Safety Audits

Individual Ward results are fed back to Ward Sisters and Heads of Nursing, to ensure areas that fall below 95% take appropriate action. These safety audits are the new format for Saving Lives – these audits are undertaken on a monthly basis on the same day as the Safety Thermometer audits.

Jan 2014

1	2	3	4	5	6	7	8	9	10	11	12	13
51%	96%	83%	97%	100%	96%	98%	75%	39%	86%	96%	99%	100%

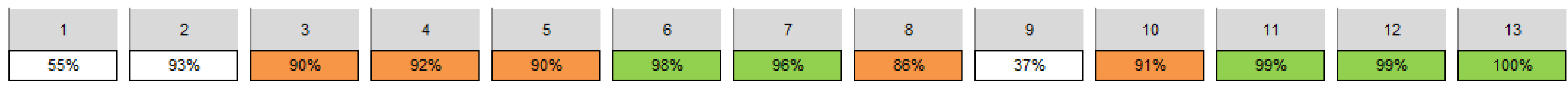
Key
1 - PVC/CVC In situ; **2** - Microclave bung with external line attached; **3** - Completed time & date indicated on dressing; **4** - PVC in under 72hrs; **5** - CVC replaced as per Trust policy; **6** - VIP/PIPA score "0"; **7** - PVC/CVC still required;
8 - Infusion line has date and time label clearly attached; **9** - Urinary catheter needed; **10** - Aseptic technique documented; **11** - Catheter secured appropriately; **12** - Drainage bag positioned correctly; **13** - PPE donned for catheter manipulation

Feb 2014

1	2	3	4	5	6	7	8	9	10	11	12	13
48%	95%	87%	97%	91%	97%	95%	78%	39%	88%	100%	99%	100%

Key
1 - PVC/CVC In situ; **2** - Microclave bung with external line attached; **3** - Completed time & date indicated on dressing; **4** - PVC in under 72hrs; **5** - CVC replaced as per Trust policy; **6** - VIP/PIPA score "0"; **7** - PVC/CVC still required;
8 - Infusion line has date and time label clearly attached; **9** - Urinary catheter needed; **10** - Aseptic technique documented; **11** - Catheter secured appropriately; **12** - Drainage bag positioned correctly; **13** - PPE donned for catheter manipulation

Mar 2014



1	2	3	4	5	6	7	8	9	10	11	12	13
55%	93%	90%	92%	90%	98%	96%	86%	37%	91%	99%	99%	100%

Key
1 - PVC/CVC In situ; **2** - Microclave bung with external line attached; **3** - Completed time & date indicated on dressing; **4** - PVC in under 72hrs; **5** - CVC replaced as per Trust policy; **6** - VIP/PIPA score "0"; **7** - PVC/CVC still required;
8 - Infusion line has date and time label clearly attached; **9** - Urinary catheter needed; **10** - Aseptic technique documented; **11** - Catheter secured appropriately; **12** - Drainage bag positioned correctly; **13** - PPE donned for catheter manipulation

Decontamination

Sterile Services: Annual Accreditation Audit – 2014 visit
Annual accreditation audit took place early March. 6 major and 13 minor corrective actions were received. Action plan is being drawn up to address issues raised. 6 monthly audit reviews scheduled for Sept 14.

CSSD air handling unit and ventilation poor compliance
Dampners on pressure stabilisers are now connected to power and the system is “live”.
AHU is to be replaced as part of CSSD refurbishment scheme – it will be necessary for CSSD to close during the extensive works required. Work is being undertaken to identify temporary premises from which CSSD can work – anticipated this will not occur until Autumn 2015.

CSSD refurbishment plans and CSP
Commencement of 7 new washers began 24th February. 4 washers to date have been installed and are being used. 3 more will be installed by end of April 2014

CSSD Dashboard
CSSD dashboard continues to be updated on a monthly basis and is to be found on the decontamination workspace.

Tray wrap breach continues to remain low – only 2 reported for Feb 14. Department continues to swap sets into containers – 60% of containers purchased are now in use.

Appraisal compliance for the department: Jan – 96%, Feb – 98%,

CSSD has recruited 4 new members of staff to support the additional CSP work that moves to the Trust in May.

The department has unfortunately experienced high levels of sickness during the winter. Staff have been covering the gaps with overtime so service delivery has not been affected.

CSSD Kingsdown: Clean Steam Installation
Part of the CSSD refurbishment programme scheduled to occur 15-16.

Automatic Endoscopic Reprocessors at SBCH – poor water results
SBCH continue to experience mycobacteria in the final rinse water. UHB is in discussions with Puricore (machine manufacturers re corrective actions). The internal tanks have been removed and undergone high level disinfection process of 90 º as heat is known to be an effective killer of the bacteria. Tanks are now back in the machines and water samples will be taken early April. High level chlorination of the machines on a monthly basis continues to be performed. CFPP guidance states that if mycobacteria is found in the rinse water the machines should be taken out of use. UHB convened a meeting of key personnel to discuss the situation and following discussion with the Trust microbiologists, manufacturers of the equipment, and completion of a risk assessment it was agreed that UGI and LGI endoscopy would continue to be delivered at SBCH. The microbiologists have made it clear that though there has been mycobacteria in the rinse water the risk of harm to patients is negligible

In addition to the mycobacteria the machines are also reporting high Total Viable Counts (TVC) on the final rinse water on a weekly basis. This can be attributed to the department's frequent inability to daily disinfect the machines due to consistent unreliability issues and frequent breakdowns.

In light of the continuing presence of mycobacteria and high TVC results both UHB and NBT microbiologists have advised that Flexible Cystoscopy is discontinued at SBCH until the machines are clear of mycobacteria and control on the TVC's is regularly achieved.

A meeting is being scheduled for April between UHB and Puricore to discuss the ongoing issues that are being experienced with these machines.

Annual and quarterly testing and validation of Trust wide decontamination equipment.
All Trust decontamination equipment held either on site or in the community remains compliant with annual and quarterly testing regimes.

Decontamination Equipment: Capital Monies
Tender for RO plant for QDU is being undertaken – decision re supplier due early April.
Capital monies have been granted for:

- RO plant replacement BDH
- AER replacement QDU
- Additional AER ENT OPD
- 3 x Endoscope HEPA filtered drying cabinets QDU

These schemes will begin to be progressed in April.

Decontamination equipment: AER in the new children's theatres in the new build
Site visits for a new AER in the new ward block are being undertaken – anticipated a decision re manufacturer of choice will be made in May.

Decontamination Facility – level C, SMH.
These works are now complete

BRCH level 8 RO water plant
Purite continue to work closely with the Trust to solve the issues that have been occurring with this machine. No major service interruptions have been experienced since the New Year but plant modifications are still required.

BDH RO plant
This machine has remained in good working order since Christmas. Following the award of capital monies the plant can now be replaced in the new financial year.

High Bacterial Water Results – BHI and HGT
New pipe work and new mini-therm RO water plant has been installed in HGT - with success. Water bacterial counts are now regularly within acceptable limits.

BHI continued to regularly report high TVC levels on the RO plant – following discussion with the manufacturer new pipe work and a mini-therm RO water plant has been installed in BHI. Water results have now returned to within acceptable limits. Samples are taken on a weekly basis as per CFPP0106 guidance.

Automatic reprocessors for radiology ultrasound probes
D&T are in the process of procuring two automatic reprocessors – anticipated these will be in use by early summer.

Low Temperature Steriliser
In order to sterilise some of the new equipment being purchased for CSP CSSD will be purchasing a Low Temperature Steriliser – anticipated this will be installed early June 2014.

Facilities/Estates Cleaning Results

Risk Category	Area	Jan	Feb	Mar
VERY HIGH				
	B.R.I	96	95	95
	B.R.C.H	94	95	96
	S.M.H	93	93	95
	B.H.O.C	97	97	98
	B.E.H	94	96	98
	S.B.C.H	98	99	96
		572	576	578
	Total Average	95	96	96
HIGH				
	B.R.I	93	92	93
	B.R.C.H	94	95	95
	S.M.H	92	94	96
	B.H.O.C	99	98	99
	B.D.H	95	94	96
	B.E.H	95	96	96
	C.H.C	98	98	97
	S.B.C.H	94	96	96
		759	762	768
	Total Average	95	95	96
SIGNIFICANT				
	B.R.I	90	89	85
	B.R.C.H	91	95	97
	S.M.H	91	91	92
	B.H.O.C	93	94	100
	B.D.H	87	93	100
	B.E.H	93	95	98
	C.H.C	96	94	97
	S.B.C.H	97	96	94
		737	745	763
	Total Average	92	93	95

Risk Category	Area	Jan	Feb	Mar
LOW				
	B.R.I			
	B.R.C.H			
	S.M.H			
	B.H.O.C			
	B.D.H			
	B.E.H			
	C.H.C			
	S.B.C.H			
	Total Average			

	Jan	Feb	Mar
TRUST SCORE	94	94	96

Key	
	>95%<100%
	>80%<94%
	<80%

Any area falling below 95%, an action plan is put in place to raise standards up to an appropriate level. Weekly audits are undertaken until the area has achieved 95% for 4 consecutive weeks. Audits revert to monthly once this standard has been achieved. PLACE visits are in progress at this time.

New Documents/Publications

- NICE quality standard 61 – Infection Prevention and Control
- *Clostridium difficile* infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation

Hygiene code and Care Quality Commission outcome 8 compliance:

Compliant	Minor concerns	Moderate concerns
50	**2**	**3**

Infection Control Programme 2013/14 Action Progress (RAG rated):

Green	Amber	Red
35	**5**	**2**

The red outcomes regarding the Infection control programme are due to the company not providing the ATP results for cleaning and having to look for another company.
Also we were unable to run an infection control activities week due to workload and staffing at the time. We will roll over this activity to the 2014/15 annual programme.

Infection Prevention and Control related risks:

Low	Moderate
2	**1**

There were minor concerns relating to Outcome 8 after the recent unannounced CQC visit. Action plan was instigated and has been completed, led by Women's and Children's Division.

Dr Richard Brindle. Consultant Microbiologist/Director of Infection Prevention and Control.

Joanna Hamilton-Davies. Senior Infection Control Nurse/Deputy DIPC.

April 2014

NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting,
to be held on 28 April 2014 at 10:30am
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

9. Transforming Care Report

Purpose

The purpose of this report is to update Trust Board on the renewal of the Transforming Care programme for the new financial year.

Abstract

The report sets out the focus areas for each pillar, the supporting project work to be carried forward, and the next steps.

Recommendations

The Trust Board is recommended to receive this report by the Chief Operating Officer

Executive Report Sponsor or Other Author

- Sponsor – Chief Operating Officer
- Other Author – Simon Chamberlain, Director of Transformation

Appendices

Transforming Care Update to Trust Board

April 2014

The purpose of this report is to update Trust Board on the renewal of the Transforming Care programme for the new financial year. The report sets out the focus areas for each pillar, the supporting project work to be carried forward, and the next steps.

1. Transformation Board began the financial year by undertaking a review of its priorities and the portfolio of projects being taken forward under the programme. Its aim was to ensure that the programme focusses on the transformational interventions needed, and does not overlap with "Business as Usual" improvement.

The purpose of Transforming Care remains unchanged - to drive the Trust towards its vision. It does this through two methods: Through a portfolio of transformational change projects, and by supporting the organisation to deliver change.

2. Trust Board has heard separately about the success of the Breaking the Cycle together project. Transformation Board recognised the success of the approach used in planning and delivery of the Breaking the Cycle Together project, and wants to see this approach used as a model for work moving forward. Each project to be taken forward must have:

- Clear specific objectives
- Fixed duration (ideally 3 months approx.)
- Executive ownership and clear leadership
- A focussed, energetic team
- A clear narrative to engage staff in the change

3. Transformation Board reviewed each pillar in turn in order to identify the step change which our transformation work must provide, and the projects we should drive forward. The intention was to identify the few key projects in each area, mindful of our capacity to deliver complex projects. The conclusions for each pillar were as follows:

Pillar 1: Delivering Best Care

The step change required:

- We must become recognised for being caring and compassionate and for communication with patients, families and carers
- The quality of care we provide, already highly regarded, must be consistently excellent

The projects we propose to take forward:

- A programme to support our teams in improving “Customer Care”
- Establish consistent senior medical review across 7 days
- Further extend the use of Enhanced Recovery techniques across surgical specialties

Pillar **2: Improve patient flow:**

The step change required:

- We must be resilient to seasonal demands without impact on quality of care and performance, and without disruption to planned care
- We must keep our “Green to Go list consistently low, giving improved flow and reduced length of stay
- We must make a step improvement in theatre productivity and patient experience

The projects we propose to take forward

- Our programme of Operating Model projects. These projects include :
    - Discharge processes (including working with community partners)
    - Protected Beds model for planned care patients
    - Additional out of hospital capacity for patients ready to leave hospital
    - Follow up work to our Breaking the Cycle Together week
    - A programme focussed on resilience in our Children’s Hospital.
- A focussed Theatre Transformation project

Pillar 3: Deliver Best value

The step change required:

- We must identify further savings opportunities across services, which are consistent with service development and build on existing productivity programmes

The projects we propose to take forward:

- Work with clinical teams to better understand and address services with high reference costs

Pillar 4: Renewing our Hospitals

The step change required:

- We must further improve the quality of the clinical environment (to be taken forward through the ‘Phase 5’ capital programme
- We must realise the full benefits of technology adoption, from both existing and future IT projects

The projects we propose to take forward:

- Support the roll out of the Electronic Data Management programme with a transformational programme to ensure the full benefits of the technology are realised

Pillar 5: Building capability

The step change required:

- We must deliver a step change in staff satisfaction and engagement leading to a better staff experience

The projects we propose to take forward:

- Our staff experience programme
- Our leadership development programme

Pillar 6: Leading in Partnership

The step change required:

- We must make system wide pathway improvements to support patients with complex discharge requirements, aligned with work supporting the Better Care Fund
- We must promote innovation (to be taken forward through existing work with AHSN and CLARHC)

The projects we propose to take forward:

- Joint working with Bristol Community Health and Bristol City Council Social Care teams (under our Operating Model discharge processes work)

4. Next steps: Work is now underway to mobilise these projects under the leadership of the relevant Executive Leads and supported by the Transformation Team. For each project we will develop a project summary, setting out specific aims and objectives, key milestones, KPIs and targets. We are also developing an overall resource plan to prioritise the deployment of the Transformation Team resources against these projects.

NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

10. National Institute for Health Research Clinical Research Network: West of England.

Purpose

This document is the 2014/2015 plan for the Clinical Research Network West of England.

Abstract

University Hospitals Bristol NHS Foundation Trust hosts the Clinical Research Network West of England on behalf of nine member organisations. As host, the Trust is accountable for the delivery of the contract to support research delivery in the West of England. The Clinical Research Network West of England has been formed by merging seven local topic research networks to form one of 15 locality research networks. The attached documents detail the planned financial spend for 2014/2015 (agreed by the Research Network Partnership Group) and a working annual plan for delivery of research studies. Delivery against the plan will be monitored by the National Institute for Health Research National Coordinating Centre and reported to this Board quarterly.

Recommendations

The Trust Board is recommended to receive this report by the Medical Director

Executive Report Sponsor or Other Author

- Sponsor – Medical Director
- Other Author – Dr Mary Perkins, Chief Operating Officer, Clinical Research Network: West of England; Dr Steve Falk, Clinical Director, Clinical Research Network: West of England

Appendices

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Clinical Research Network
West of England

Annual Plan

Financial and Operational

Dr Mary Perkins, Chief Operating Officer
Dr Steve Falk, Clinical Director

Delivering research to make patients, and the NHS, better

Table of Contents

Introduction **3**
Background and Governance **3**

Annual Plan 2014-15 .... **Appendix 1**
Annual Financial Plan 2014-15 .... **Appendix 2**
Leadership and Management Structure 2014-15 .... **Appendix 3**

Introduction

In 2013, University Hospitals Bristol NHS Foundation Trust successfully bid to host and become the administrative centre for the new National Institute for Health Research (NIHR) Clinical Research Network for the West of England. There are just fifteen NHS Trusts or Foundation Trusts in the country appointed to run a local branch of the NIHR Clinical Research Network and UH Bristol has been awarded a five year contract to take responsibility for distributing over £13million of funding per year to support clinical research across the whole area.

Background and Governance

The National Institute for Health Research Clinical Research Network (NIHR CRN) is responsible for the delivery of NIHR portfolio studies including supporting grant applications, study set-up and delivery for non-commercial and commercial research in the NHS.

Previously this service was configured nationally as topic research networks each with a separate coordinating centre, under an overall coordinating centre. The topic networks represented the following areas:

- Cancer (two networks in the CRN: West of England area)
- Dementia and Neurodegenerative Disease (DeNDRoN)
- Diabetes (no coverage in CRN: West of England currently)
- Medicines for Children (MCRN)
- Mental Health
- Stroke (no coverage in CRN: West of England currently)

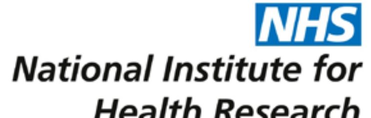
All networks delivered research studies in 'their' topic areas. In addition, the Primary Care research network supports research delivery in primary care settings and the Comprehensive Research Network supported studies in 24 additional speciality areas, and provided research management and governance for research and managed the service support budget for research.

There were 102 local networks nationally hosted by 70 NHS Trusts. There are now 15 local branches of one National Network hosted by 15 NHS Trusts or Foundation Trusts.

We have appointed Dr Steve Falk as Clinical Director and Dr Mary Perkins as Chief Operating Officer for the CRN: West of England. Robert Woolley as CEO of the host Trust is the Accountable Officer and Dr Sean O'Kelly, Medical Director is the lead executive.

The local branch is governed by an executive group led by the Medical Director reporting into a Partnership Group which has the CEOs of nine partner Trusts as voting members and other attendees. The list of members of the partnership group is detailed in Section 2 (Page 17) of the attached annual plan. There are two operational groups, the clinical leaders group and the operational management group to implement agreed strategies and plans. The annual plan and annual financial plan will be agreed with the partnership group in addition to this scrutiny from the UH Bristol Board.

Annual Plan 2014-15

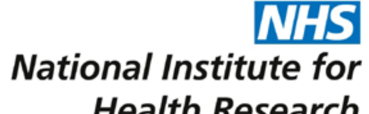


NIHR Clinical Research Network: West of England

Annual Plan 2014/15

Host Organisation	**University Hospitals Bristol NHS Foundation Trust**
Partner Organisations – **Members of the Partnership Group**	1. 2gether NHS Foundation Trust 2. Avon And Wiltshire Mental Health Partnership NHS Trust 3. Gloucestershire Hospitals NHS Foundation Trust 4. Great Western Hospitals NHS Foundation Trust 5. North Bristol NHS Trust 6. Royal National Hospital For Rheumatic Diseases NHS Foundation Trust 7. Royal United Hospital Bath NHS Trust 8. Weston Area Health NHS Trust
Other Affiliated Organisations identified (eg CCGs/Social enterprises)	1. NHS Bath and North East Somerset CCG 2. NHS Bristol CCG 3. NHS Gloucester CCG 4. NHS North Somerset CCG 5. NHS South Gloucestershire CCG 6. NHS Swindon CCG 7. NHS Wiltshire CCG 8. Bristol Community Health 9. North Somerset Community Partnership 10. SeQol (Swindon) 11. Sirona Care & Health (Bath and North East Somerset and South Gloucestershire) 12. Gloucestershire Care Services NHS Trust

Historic LRNs	South West (DeNDRoN) West (MHRN) Three Counties (NCRN) Western (CCRN) South West (MCRN) Avon, Somerset, Wiltshire (NCRN) South West (PCRN)



Host Organisation Accountable Officer for the LCRN (Chief Executive Officer)		
Name	Mr Robert Woolley	*Contact Details* *Email* Robert.Woolley@UHBristol.nhs.uk *Tel* 0117 342 3720
Nominated Executive Director for the LCRN		
Name	Dr Sean O'Kelly	*Contact Details* Email sean.o'kelly@uhbristol.nhs.uk Tel 0117 3423640
LCRN Clinical Director		
Name	Dr Stephen Falk	*Contact Details* Email: Stephen.falk@uhbristol.nhs.uk Tel 0117 3421375
LCRN Chief Operating Officer		
Name	Dr Mary Perkins	*Contact Details* Email mary.perkins@nihr.ac.uk Tel 0117 3421375

Transition Facilitation Lead for the LCRN		
Transition Facilitation Lead	Dr Althea Allison Senior Manager, West Midlands (North) CLRN and Local Transition Facilitation Lead (West of England)	*Contact Details* West Midlands (North) CLRN Room 7.11 Innovation Centre 2 Keele University Science Park Keele Staffordshire ST5 5NH *Tel* 0845 602 6772 ext: 1840 *Mobile* 07515190310 *Email* althea.allison@northstaffs.nhs.uk

Please briefly outline the process of engagement/consultation with LCRN Partners, existing local CRN Network Leadership and other stakeholders regarding the submitted LCRN Annual Plan 2014-15:

- Partnership Group aware of the need for an annual plan and will discuss in detail at next face to face meeting in June 2014. All members circulated plan in advance of submission.
- West of England AHSN fully engaged in agenda – Host CEO sits on WEAHSN Board; Chief Operating Officer as a member of the Senior Management Team. WEAHSN MD attends partnership group.
- All local research networks involved in producing the annual plan.
- Researchers and research offices included in consultation around leadership and management structures.
- LCRN Divisional Leads appointed and engaged.
- Members have agreed local recruitment targets.
- Engagement event for members planned for May 1st to agree direction of travel and priorities for 2014/15.
- Engagement event for researchers planned for May 22nd to agree: strategy; process for appointing specialty leads and member leads for workstreams.
- Launch event for all stakeholders, to include progress against plan to be held jointly with West of England AHSN on October 16th 2014.

Confirmation of approval by the Host Organisation Board			
Name		*Email* *Tel*	
Role			
Signature		**Date**	**MEETING ON APRIL 28th 2014**
Contact for any communication regarding the LCRN Annual Plan			
Name	Dr Mary Perkins	*Email mary.perkins@nihr.ac.uk* *Tel 0117 3421375*	
Role	Chief Operating Officer		
Date	7. 04. 14		

Section A: Review of 2013-14 Performance: CRN: West of England

Western Comprehensive Local Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
• Engaged Board, NHS CEO chair fully engaged partners in local primary care, secondary care NHS and academic landscape. • Coherent and stable Core Team. • Weighted Recruitment for new geographical footprint has increased 8% year on year. • RM&G metrics improved year on year, 80% of governance reviews within target. • UH Bristol top Large Trust for Recruiting to time and target with (79.6%) of non-commercial studies. • Across Network, improvement in commercial studies recruiting to time and target from 45% - 67%. • Nurses from WCLRN developed and piloted a joint initiative with Peninsula and Hampshire and IOW 'Clinical Research Essentials in Research Nurse Training • WCLRN nurses engaged with the University of the West of England raising the profile of clinical research with pre-registration adult-branch student nurses. • All research staff GCP trained and CSP conversant • Single sign off in primary care achieved • Successful implementation of EDGE into secondary care provider trusts • Joint PPI initiative with University of the West of England, the WEAHSN, the CLAHRC *West* is continuing – setting an ambitious and innovative PCPIE agenda	• Reduced footprint results in a threat to the current commercial portfolio: • Dermatology (↓100%) • Renal (↓90%) • Mental Health (↓ 75) • Cardiovascular(↓69%) • Musculoskeletal (↓69%) • Mitigation: maintain current strong relationships with neighbouring CRNs, increase focus on these areas in remaining partners, setting targets and providing support • Results in a decrease in allocation of funds (due to relative underperformance compared to other networks • Mitigation: understand our areas of strength and underperformance; address inequities in funding; think differently about staffing models • Lack of clinical leadership for non-medics • Risks: decreased engagement of non-medical research staff • Mitigaition: creation of consultant nurse post (research delivery) to provide clinical leadership, drive standards and share the passion for research	• Successful evolution to new structure building a strong leadership and management team growing the best ways of working. • Understanding our portfolio and performance and developing non-medical strengths • Develop novel non-pharma related studies in partner organisations • Grow a new generation of researchers into research leaders to change the culture in partner organisations • Ensure a flexible and motivated research workforce • Building the evidence base for best practice in recruitment by the establishment of a consultant nurse (research delivery) post. • Excellent staff in partner trusts in the areas of training and education have built strong approaches to apprenticeships. CRN West of England to explore the potential for an apprenticeship programme for research officers.

South West Medicines for Children Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
• Global first recruits for two industry sponsored paediatric rheumatology clinical trials (MCRN234 and MCRN235) at Bristol Royal Hospital for Children. (These studies both recruited their first patient within 30 days of the study opening to recruitment, and proceeded to recruit to time and to target.) • Workforce Development: The MCRN South West Senior Research Nurses, as part of the national MCRN Workforce Development working group, have revised the MCRN SW Paediatric Communication & Consent Course for roll out across England (course originally delivered by MCRN South West Co-Director, Prof. Margaret Fletcher through the University of the West of England for UKCRN). • MCRN South West Senior Research Nurses have undertaken training to become NIHR Clinical Research Network Paediatric GCP facilitators. • Increased recruitment to non-commercial trials: The number of participants recruited to "Children's"* studies in the first half of 2013-14 exceeded the number recruited in the whole of 2012-13. • The MCRN Coordinating Centre mid-year report indicates that for 2013-14 (Quarter 1-2): • Recruitment to MCRN portfolio studies at secondary care sites was higher in the South West than in any other MCRN Local Research Network outside London and the South East**. • MCRN South West met and exceeded the requirement for NIHR High Level Objective 2 (increasing the proportion of studies in the NIHR Clinical Research Network Portfolio delivering to recruitment target and time to 80%).	• Staffing and recouping costs for industry sponsored studies recruiting children with rare conditions: 12 / 17 currently active MCRN portfolio industry sponsored studies (in set up, open to recruitment or in follow up) have recruitment site targets of 1-2 and only one study has a target > 5. • The MCRN South West core team is supplemented by paediatric research nurses funded full time from study income to support these studies. The future of these posts is therefore completely dependent on costs of industry activity being fully recouped. • Contracts need careful negotiation to ensure adequate recompense for set-up and screening for difficult to recruit studies. • The current ABF model would appear to disadvantage rare diseases studies or low recruiting studies. Consideration must be given to balancing the portfolio to allow for such studies to take place	• Integration of the MCRN and CLRN paediatric (non-medicines) portfolios and Cancer brings the opportunity to provide a single point of contact for paediatricians and other clinicians who treat children with NIHR CRN. A priority is to communicate this change to the clinical paediatric community. • Develop the hub and spoke model of service provision within the south west

South West Dementias and Neurogenerative Diseases Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
• Impact of disease registers on recruitment. RESPOND – SW DeNDRoN supported Dr Emily Henderson in reaching her recruitment target of 130 participants in 6 months for the ReSPonD trial. The trial also used the PRO-DeNDRoN Parkinson's disease regional register to assist with identifying participants. This is a good example of Network delivery best practice and considering the broader work we are doing with registers, it is a good example of how they can make a real impact. • PPI. The Patient Advisory Panel One had its 1year anniversary in 2013. This is a virtual group providing the opportunity for patients and carers to give their comments on studies that were in the design stages or proposals for research funding. We received 10 requests from researchers this year and 15 other research related requests. Members of this group also presented at the Dept of Health "Year of action on dementia awareness" regional conference attended by the Secretary of State/Minister for Health on 24/04/13. • ENRICH (Enabling research in care homes). This project aims to increase the amount of research from its current levels in order to improve the quality of life and quality of care for people with dementia and their families. The project approach has been generic, so although borne from a background in dementias and neurodegenerative diseases, this approach benefits all care home residents. The project started in the south west in May 2013. It was piloted in Bristol and Bath. Recruitment of care homes to ENRICH began in July 2013 and the pilot phase was concluded at the end of September 2013 with 17 care homes signed up (target was 16). As of January 2014, there are currently 21 care homes signed up to the project.	• Lack of identified funding to continue the registers: • Mitigation: open registers to all NIHR portfolio studies. Support through existing admin staff • Lack of available portfolio	• Grow working relationships between large mental health providers and neurology service • Grow CIs in Parkinson's disease to facilitate portfolio study development • Grow the Bristol Dementia health integration team programme of applied research I dementia including register of patients

South West Primary Care Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
• Highest recruiting primary care network nationally • In 2013/2014 46.1% of practices were registered as research capable. It is anticipated that a target of 45% is achievable in 2014/2015 • A number of pharmacists are research active within the NIHR CRN West of England, and it is anticipated that securing the services of one to be a Pharmacy Champion will be achieved in 2014/2015	• Reduction in recruitment in primary care in 2013/14 due to reduction in portfolio: • Mitigation: work with academic school of primary care to facilitate portfolio adoption • Incorrect mapping of south Wiltshire practices will lead to inaccurate reports. • Mitigation: local work arounds whilst central team address this issue.	• Performance manage the primary care funding scheme to grow new practices

West Mental Health Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
• Commercial success. West Hub have grown their commercial portfolio and number of recruits considerably recruiting 10 patients across the Hub in 2012-13 to 163 in 2013-14 to date, this makes West Hub the highest recruiter to commercial studies this year to date in the MHRN. Within the WE area there were 4 patients recruited to commercial studies in 2012-13 and 84 to date in 2013-14. 66 of these were within AWP and 18 in Somerset Partnership Trust. Somerset is currently within the Western CLRN region but will move into Peninsula on 1st April. Roche Patterns study which recruited ahead of time and above target including the first global patient by CI Jonathan Evans of AWP (also MHRN Hub Lead) first commercial study). The Hub also recruited ahead of time and above target in the Lilly ADPSYC study within AWP. The target for this study was 57 demonstrating they can also deliver volume of study participants in a commercial mental health setting. • Successful recruitment to time and target to Refocus study in 2Gether NHS Foundation Trust. 2Gether recruited to time and target on the Refocus trial in 2013-14 therefore meeting their contractual obligations as one of three funded sites. • Increase in size and stability of delivery team within AWP and 2Gether NHS Trusts. Both trusts have expanded the size of their delivery teams and the majority of them are on permanent contracts. This should increase staff stability in both trusts reducing the risk of high staff turnover. These staff have been appointed on a range of bands to provide opportunities for career progression and also complement the longer term core MHRN staff well enabling appropriate resource allocation to a range of studies.	• Adult Community Mental Health Services in Bristol currently out to tender. There is a risk that current provider will not win the tender to continue to provide these services, if this happens it is unknown whether the new provider will be research active or be willing to be engaged in research activity. Given that the majority of current recruitment comes from the current provider's community MH services this could have a serious impact on their potential to recruit.	• Continue to build on previous commercial success. This would include increasing the size of the commercial portfolio in AWP and securing a first commercial study within 2Gether. 2Gether are due to open a dedicated Clinical Trials Unit in 2014-15 and so this is an ideal opportunity to start to build a commercial mental health portfolio. • Ensure all providers are research active by contractual obligation • Increase the portfolio size and recruitment figures within Gloucestershire. There is also potential to recruit within other settings such as primary care where recruitment figures tend to be higher than in the specialist MH settings. • Engaging Any Qualified Provider (AQP) organisations with mental health research. Increasingly mental health services are being awarded to non-NHS organisations and it is important to start engaging these organisations in research, to ensure a wide and varied portfolio of research and that

		patients within these settings have the opportunity to take part regardless of service provider.

South West Stroke Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
• Recruits from non-traditional settings (eg care homes & community hospitals • Has introduced research naïve staff to research studies • Has exceeded recruitment targets year on year • SW stroke conference has attracted over 300 delegates annually • PCPIE group conducts 'exit' questionnaires with study participants which illustrate positive experience	• Reduction in portfolio, and roll out of new studies is slow.	• Developing links with cardiovascular colleagues. • Ability to work with novel anti-coagulants as a result of new relationships • Non-medical Principal Investigators

3 Counties and Avon, Somerset and Wiltshire Cancer Research Network

Achievements	Challenges/Risks/Mitigating Actions for CRN: West of England	Priorities and Opportunities for CRN: West of England
1. Portfolio recruitment remains consistent with over 10% of patients by cancer incidence (as provided by the NCRN) recruited to a randomised control study. 2. Information Management: As of the 1st April 2013 all teams across ASWCRN and 3 Counties 'went live' with their use of the EDGE local portfolio management system. The EDGE system has evolved and is being used across the network in a variety of ways. Most notably the successful use of the network to use EDGE to record recruitment activity has resulted in the ability to improve activity reporting at a network level and assist in pro-active management of the portfolio. 3. Resource Infrastructure: Teams across the CRN continue to pro-actively review their skill mix and resources to ensure they continuously improve their structures in order to adequately reflect the changing challenges of the cancer portfolio of studies.	1. Engaging with established clinical groups: The replacement of the cancer service network with a strategic clinical network has presented the Cancer research networks with several challenges over the past 12 months in terms of adjusting to new ways of working and increasing efforts to ensure appropriate engagement within key clinical groups. Moving forward further changes to disease specific network groups within the South West will present a challenge to the network as it will need to ensure appropriate engagement of clinical stakeholders in order to ensure delivery of research activity and stakeholder understanding of the LCRN. 2. Supporting the Cancer Service Peer Review process: Within the CRN a centralised approach to ensuring local site specific groups and MDTs were compliant to the national cancer peer review process was adopted. This process was agreed between the CRN research team, local researchers, cancer managers and the local clinical teams. Within the newly established LCRNs a key discussion will need to take place to	1. Information Management: With the consistent use of a local portfolio management system across the LCRNs the opportunities for improving data is incredibly exciting. 2. Cross-network Portfolio: A key opportunity for the network in the next 12 months is in part due to the new structures and the roll out of a network wide portfolio management system. The CRN has worked hard to promote a culture of both inter and intra network referrals promoting the concept that the portfolio of trials should be seen as a network portfolio and should reflect the patient population and requirements. 3. Collaboration across the wider LCRN (ie. between 3 Counties and ASWCS: Key workstreams such as business intelligence, PCPIE and workforce development will benefit over the next 12 months from a more 'jointed-up' approach at an LCRN level and it is anticipated that 'cancer network researchers' both locally and centrally can share learning and ideas with researchers from other disease areas

	amend processes, agree responsibilities and determine the supporting mechanism to ensure Peer Review compliance and appropriate reviews of research activity take place. These reviews alongside supporting the local peer review compliance will support clinical engagement in delivering studies to time and target. 3. Delivering for Industry: For a large network the CRN has a relatively low level of activity in the NIHR commercial portfolio and despite efforts to improve engagement and activity this is an area for focus and improvement moving forward.	which will be mutually beneficial.

1. Progress and Plans against the LCRN Development and Improvement Objective

POF Area	POF requirement	POF Ref	Information Required	RAG** status	Commentary In this column please add brief comments if the RAG rating is Red or Amber
LCRN Governance	Host Organisation sign-off of LCRN Governance Arrangements	3.4	Provide RAG status and commentary if applicable	Green	
	Nominated Executive Director identified	3.6, 3.7	Provide RAG status and commentary if applicable	Green	
	Scheme of delegation and Host Board controls and assurances established	3.8	Provide RAG status and commentary if applicable	Amber	In Development, for agreement with Host Board, Q1 2014
	Assurance Framework & Risk Management System developed	3.12	Provide RAG status and commentary if applicable	Amber	In Development, for agreement with Host Board, Q1 2014
	Business continuity arrangements are in place for the LCRN in the event of a pandemic or other emergency	3.14	Provide RAG status and commentary if applicable	Green	
	Plans in place for inclusion of LCRN activity in the local internal audit programme of work	3.16	Provide RAG status and commentary if applicable	Green	
	Implement and maintain a documented LCRN escalation process	3.17	Provide RAG status and commentary if applicable	Amber	For agreement with Partnership Group Q1 2014 - adopting established WCLRN processes as interim approach
	LCRN Partnership Group	3.19 - 3.29	Provide a copy of the Terms of Reference for the Group	Green	
Leadership Team	Appointment of LCRN Leadership Team, including as a minimum; the nominated executive director; the LCRN Clinical Director; and LCRN Chief Operating Officer	4.1	Provide RAG status and commentary if applicable	Green	
Management arrangements	Research Delivery Cross-Cutting Team	5.25 - 5.29	Provide RAG status and commentary if applicable	Amber	Team in place, Cross Divisional Manager to be appointed 08/0514
	LCRN Support Team	5.30, 5.31	Provide RAG status and commentary if applicable	Green	
	Operational Management Group	5.38 - 5.40	Provide confirmation the Group has been established in accordance with the provided Terms of Reference	Amber	Interim Group in place. Members also involved in this Group. Research Delivery Manager appointment process 12/05/14
Research Delivery	All LCRN organisations adhere to specified national systems, Standard Operating Procedures and operating manuals in respect of research delivery. The Host Organisation ensures that the LCRN management team provides excellent study performance management in order that all NIHR CRN Portfolio studies recruit to agreed timelines and targets	6.1- 6.19	Provide confirmation the LCRN has an engagement and communication strategy in place for stakeholders involved in the research delivery and governance pathway	Amber	In Draft. For agreement with partnership group Q1 2014. Stakeholder events planned for 22/05/14 & Launch of Network on 16/10/14
			Provide a brief outline of local plans for implementation, delivery and oversight of research management and governance services by the LCRN	Amber	• Cross Divisional Manager (8b) to be appointed 8/05/14 with responsibility for RM&G. Performance Management of all studies weekly with actions if not on time or target. LCRN:West of England will support all stages of the research delivery pathway in line with attributing the costs of health and social care research (AcoRD) by creating experts in the use of the Activity and Costings Attribution Template (ACAT) across the region. • Feasibility advice and support and site identification will be provided by divisional Research Delivery Managers. • Use of Coordinated System for gaining NHS Permission will continue in accordance with national CRN processes and guidance. Major review of RM&G arrangements in the West of England Area will commence in Q1 2014 to identify fastest route to single sign off and most efficient and effective use of resources for management and governance of research. This review will be led by member organisations with support from core CRN staff. • Provision of arrangements to enable NHS and non-NHS staff to

					conduct research activities at CRN: West of England organisations and across the NHS. • Provision of regulatory and governance advice to relevant stakeholders will continue during the review. Continued provision of Coordinated Service to support research study set-up an delivery and resolution of delivery barriers.
Patient, Carer and Public Involvement and Engagement (PCPIE)	Promotion of research opportunities in line with the NHS Constitution for England, including informing patients about research conducted within the LCRN and actively involving and engaging patients, carers and the public in research	8.1- 8.6	Provide confirmation that a PCPIE workplan is in place	Green	CRN West of England is working in partnership with the West of England Academic Health Science Network, the University of the West of England and the CLAHRCWest to develop and deliver innovative approaches to PCPIE for our area. Between the four organisations we are funding a PPI manager who will act as lead for the organisations (Hildegard Dumper), a research fellow and administrative support. The workplan is being developed for agreement in Q1 2014.
Workforce Development	Workforce development plan developed in partnership with relevant stakeholders and other local learning providers	10.1- 10.9	Provide confirmation that a workforce development plan is in place	Amber	New post of Nurse Consultant (research delivery) will lead on workforce development for the CRN: West of England. this post holder will be able to access the considerable expertise that already exists amongst current topic network staff and provide the much needed leadership for this work area. Training needs analyses from 2013-14 continue to be inpmented furhter plans in development for agreement in Q1 2014.
Corporate Support Services	Provision of management processes or support services identified as necessary within the Host Organisation to enable effective running of the LCRN	11.1, 11.2	Provide confirmation all specified Corporate Support Services are in place	Green	
Information Systems	Appropriate, reliable and well maintained information systems and services are in place and fully operational	13.1 – 13.18	Confirm LPMS systems are in place as required	Amber	Systems are in place across the area, however we wish to transfer all researchers to the same system. this work will commence in Q1, however some challenges are evident to the adoption of the preferred system in primary care.
			Confirm arrangements are in place for provision of an LCRN Service Desk function and provide contact details	Green	
Communications	Dedicated communications function and delivery plans in place, and budget line identified	14.1	Confirm a dedicated communications function is in place	Green	
		14.2	Confirm a communications work programme is in place	Green	
		14.3	Confirm the LCRN is operating in compliance with brand guidelines	Green	
Information Governance	Promote and enable good Information Governance (IG) relating to all areas of LCRN activity	15.1-15.8	Provide baseline (2013) IG toolkit score for the LCRN Host Organisation and confirmation of attainment of Level 2 or above on all requirements or any exceptions that arise from or impact on LCRN-funded activities	Green	Level 2 or above achieved. Baseline 85%
			Confirm a process is in place for timely reporting to the CRN Coordinating Centre of all information governance incidents arising from LCRN-funded activities	Green	

**** RAG status – guidance for LCRN self-assessment**

Colour	Meaning
(Green)	Arrangements in place
(Amber)	Arrangements not yet in place but plans developed and on schedule
(Red)	Plans not agreed/implementation significantly delayed/behind schedule

2. Details of key groups and lead individuals

POF Area	Information Required	POF Ref	Name	Job title	Organisation	Clinical Profession
LCRN Governance	Provide the name, job title and organisation of the LCRN Partnership Group Chair	3.25	Mr Iain Tulley	Chief Executive	Avon and Wiltshire Partnership NHS Trust	
	Provide a list of members (name, job title and organisation) of the LCRN Partnership Group	3.29	Mr Shaun Clee	Chief Executive	2Gether NHS Foundation Trust	
			Dr Simon Douglass	Accountable Officer	Bath and North East Somerset CCG	
			Ms Jill Shepherd	Accountable Officer	Bristol CCG	
			Dr Steve Falk	Clinical Director	NIHR Clinical Research Network: West of England/University Hospitals Bristol NHS Foundation Trust	
			Dr Mary Perkins	Chief Operating Officer	NIHR Clinical Research Network: West of England/University Hospitals Bristol NHS Foundation Trust	
			Mr Paul Jennings	Chief Executive	Gloucestershire Care Services	
			Ms Mary Hutton	Accountable Officer	Gloucestershire CCG	
			Mr Frank Harsent	Chief Executive	Gloucestershire Hospitals NHS Foundation Trust	
			Ms Nerissa Vaughan	Chief Executive	Great Western Hospitals NHS Foundation Trust	
			Ms Andrea Young	Chief Executive	North Bristol NHS Trust	
			Dr Mary Backhouse	Accountable Officer	North Somerset CCG	
			Mr James Scott	Chief Executive	Royal United Hospital Bath NHS Trust	
			Ms Jane Gibbs	Accountable Officer	South Gloucestershire CCG	
			Mr Tony Ranzetta	Accountable Officer	Swindon CCG	
			Mr Robert Woolley	Chief Executive	University Hospitals Bristol NHS Foundation Trust	
			Ms Deborah Evans	Managing Director	West of England AHSN	
			Mr Nick Wood	Chief Executive	Weston Area Health NHS Trust	
			Ms Deborah Fielding	Accountable Officer	Wiltshire CCG	
Management arrangements	Provide a list of names of local Clinical Research Specialty Leads and their clinical profession	5.7-5.16	Prof. Hugh Barr (D1)			MD – Gastroenterology
			Claire Fullbrook-Scanlon (D2)			RGN – Stroke
			Prof. Adam Finn (D3)			MD – Paediatrics
			TBA (D4)			TBA – May 2 2014
			Dr. Tony Crockett (D5)			MD – GP
			Dr. David Collins (D6)			MD – Rheumatology
	Provide the name and email address of the individual appointed as LCRN Research Delivery Manager[1] for Division 1	5.17-5.24	Selection Process 12/05/14			
	Provide the name and email address of the individual appointed as LCRN Research Delivery Manager for Division 2		Selection Process 12/05/14			
	Provide the name and email address of the individual appointed as LCRN Research Delivery Manager for Division 3		Selection Process 12/05/14			
	Provide the name and email address of the individual		Selection Process 12/05/14			

[1] Note: LCRNs are not required to appoint six separate individuals to the 6 Divisional Research Delivery Manager posts

	appointed as LCRN Research Delivery Manager for Division 4					
	Provide the name and email address of the individual appointed as LCRN Research Delivery Manager for Division 5		Selection Process 12/05/14			
	Provide the name and email address of the individual appointed as LCRN Research Delivery Manager for Division 6		Selection Process 12/05/14			
	Provide details of the membership of the LCRN Executive Group	5.36	Dr Steve Falk stephen.falk@uhbristol.nhs.uk	Clinical Director	NIHR Clinical Research Network: West of England/University Hospitals Bristol NHS Foundation Trust	
			Dr Mary Perkins mary.perkins@nihr.ac.uk	Chief Operating Officer	NIHR Clinical Research Network: West of England/ University Hospitals Bristol NHS Foundation Trust	
			Dr. David Collins david.collins@gwh.nhs.uk	Clinical Research Specialty Lead (D6)	Great Western Hospitals NHS Foundation Trust/NIHR Clinical Research Network: West of England	
			Selection Process 08/05/14	Consultant Nurse	NIHR Clinical Research Network: West of England/ University Hospitals Bristol NHS Foundation Trust	
			Prof. Adam Finn adam.finn@bristol.ac.uk	Clinical Research Specialty Lead (D3)	University of Bristol/ NIHR Clinical Research Network: West of England	
			Dr. Sean O'Kelly sean.o'kelly@uhbristol.nhs.uk	Medical Director	University Hospitals Bristol NHS Foundation Trust	
			Selection Process 08/05/14	Cross Divisional Manager	NIHR Clinical Research Network: West of England/ University Hospitals Bristol NHS Foundation Trust	
			Selection Process 08/05/14	Senior Research Delivery Manager	NIHR Clinical Research Network: West of England/ University Hospitals Bristol NHS Foundation Trust	

	Provide details of the membership of the Clinical Research Leadership Group	5.37	Prof. Hugh Barr hugh.barr@glos.nhs.uk	Clinical Research Specialty Lead (D1)	Gloucestershire Hospitals NHS Foundation Trust/ NIHR Clinical Research Network: West of England	MD – Gastroenterology
			Claire Fullbrook-Scanlon claire.fullbrook-scanlon@nhs.net	Clinical Research Specialty Lead (D2)	Royal United Hospital Bath NHS Trust/NIHR Clinical Research Network: West of England	RGN – Stroke
			Prof. Adam Finn adam.finn@bristol.ac.uk	Clinical Research Specialty Lead (D3)	University of Bristol/NIHR Clinical Research Network: West of England	MD – Paediatrics
			TBA – selection process 02/05/14	Clinical Research Specialty Lead (D4)	TBA/NIHR Clinical Research Network: West of England	TBA
			Dr. Tony Crockett tony.crockett@nhs.net	Clinical Research Specialty Lead (D5)	NIHR Clinical Research Network: West of England	MD – GP
			Dr. David Collins david.collins@gwh.nhs.uk	Clinical Research Specialty Lead (D6)	Great Western Hospitals NHS Foundation Trust/NIHR Clinical Research Network: West of England	MD – Rheumatology
			Dr Steve Falk stephen.falk@uhbristol.nhs.uk	Clinical Director	NIHR Clinical Research Network: West of England/University Hospitals Bristol NHS Foundation Trust	MD – Oncology
			TBA – selection process 08/05/14	Consultant Nurse (Research Delivery)	NIHR Clinical Research Network: West of England/ University Hospitals Bristol NHS Foundation Trust	RGN/RSCN
			Dr Mary Perkins mary.perkins@nihr.ac.uk	Chief Operating Officer	NIHR Clinical Research Network: West of England/ University Hospitals Bristol NHS Foundation Trust	n/a
Research Delivery	Provide the name and email address of the appointed Industry Operations Manager	5.25	(Sarah.leaver@uhbristol.nhs.uk – mat leave) covered by martine.cross@uhbristol.nhs.uk			
PCPIE	Provide the name of the senior leader with identified responsibility for PCPIE within the LCRN	8.6	Hildegard Dumper hildegard.dumper@weahsn.nhs.uk			
Continuous Improvement (CI)	Provide the name and email address of the senior leader with identified responsibility for continuous improvement within the LCRN	9.5	Dr Mary Perkins mary.perkins@nihr.ac.uk			
Workforce Development	Provide the name and email address of the senior leader with identified responsibility for LCRN workforce development	10.4	TBA – consultant nurse (research delivery) Selection process 08/05/14			
Information Systems	Provide the name and email address of the identified lead for the Business Intelligence function	13.2	Mike Lacey mike.lacey@uhbristol.nhs.uk			
Information Governance (IG)	Provide the name and email address of the individual with specialist IG knowledge identified to respond to IG queries relating to LCRN-funded activities	15.7	Mike Lacey mike.lacey@uhbristol.nhs.uk			

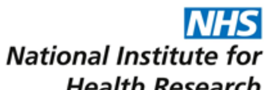
3. LCRN plans and goals in support of NIHR CRN High Level Objectives

Objective		Measure	CRN Target	LCRN Goal/Target	LCRN actions/activities for 2014-15	Timescale
1	Increase the number of participants recruited into NIHR CRN Portfolio studies	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	650,000	Enter the overall LCRN goal for 2014-15 recruitment 21,469 (includes 778 into HSR)	To raise the profile of research within all partners to understand the importance of research in the care of patients. All staff to be able to act as ambassadors for research and explain the benefits for patients, the public and society. – ACTION by workforce development team/comms team.	PLANS AGREED Q1. Implementation Q2-4
					All CRN West of England funded staff and wider staff groups to understand their own individual responsibilities in increasing recruitment into trials. All staff plans to include individual objectives, with clear actions and milestone – action by Nurse Consultant (Research Delivery) and RDMs.	
					All Divisions to have clear SMART Objectives around recruitment, implementation plans actions and milestones	
					• All workstreams to have a SMART objective identifying their role in increasing recruitment, an implementation plan with milestones and deadlines, baseline measures & agreed KPIs: Action by COO • COMMS: to include celebrating and challenging; raising awareness; reach and use of new media; spreading the message of the benefits of research. Clear messaging about benefit to tomorrows patients and improved experience of today's patients • PCPIE: to include empowering our patients to expect inclusion in trials; support the roll out of 'opt-out' for Trusts and practices; raise the profile and benefits of research; support patient ambassadors in collaboration with NIHR and NHS England research and implementation strategies. • INFORMATION: to ensure timely accurate data and reports, working with researchers and members to agree best ways of reporting and displaying data • CONTINUOUS IMPROVEMENT: to challenge process and perceptions, supporting the other workstreams to identify the process and perception improvements that can be made to increase performance. Agree, baseline and measure local Key Performance Indicators. • RM&G: to support a review of processes to ensure a supportive environment for researchers and industry so that studies set-up quickly and efficiently in the West of England • WORKFORCE DEVELOPMENT: Encourage new and younger principal investigators, including those from non-medical professions to ensure a growing vibrant community of researchers. Ensure all our staff understand their own roles and that of the network and agree their own roles in meeting the objectives.	
					Appoint Consultant Nurse (research delivery) to drive performance, support and reorganise and invigorate staff and share the passion for caring for patients through research.	
					• Consultant Nurse (research delivery) to support staff to identify and resolve all barriers – both real and perceived to recruitment into studies • Consultant Nurse (research delivery) to contribute to the evidence base around best practices in recruitment.	
					West of England CRN to work with local acknowledged academic experts in recruitment issues to translate findings from methodological trials around recruitment practices into local practice. West of England AHSN to support this work.	
					Work with local academic research leads to understand our areas of academic strength and ensure research protocols support best practices in recruitment	
					Work as a network to understand what the balance of studies in our portfolio should be and support researchers and member organisations to achieve that balance	
					Ensure Goal setting is achievable and agreed jointly with MOs. Monitor study recruitment monthly, mentor Trusts/ action plan for recruitment.	
					Share and learn from other CLRNs	

Objective		Measure		CRN Target	LCRN Goal/Target	LCRN actions/activities for 2014-15	Timescale
2	Increase the proportion of studies in the NIHR CRN Portfolio delivering to recruitment target and time	A:	Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed Network sites	80%	65%	Ensure all staff understand that recruiting to time and target supports patients by enabling more patients to participate in trials; improves our reputation and creates an environment in which the West of England is recognised as a good area to place commercial contract studies	Part of WFD plan – Q1
						Continued focus on feasibility to ensure achievable targets are set – including training and mentoring naïve staff, liaising with Clinical Research Speciality Leads to confirm targets, continued development of feasibility tools.	WFD – Q1
						Continued distribution of commercial RAG reports to CRN: West of England R&D depts. and to CRN: West of England Clinical Research Specialty Leads to monitor recruitment to time and target. Information team to ensure reports are helpful and timely	Q1 plan Q2 review
						Continued distribution of commercial bimonthly study updates to study teams and facilitation of established teleconferences between network study teams to share best practice	ongoing
						Industry working group expanded to include representation from research nurses and support departments to further share best practice	Q1
						Industry Operations Manager to act as a single point of contact for issue escalation for Life Sciences Industry partners	ongoing
						Industry Operations Manager to work closely with the Research Delivery Managers to design and implement appropriate risk management processes including contingency planning, project plans, risk analysis and innovative strategies	ongoing
		B:	Proportion of non-commercial studies achieving or surpassing their recruitment target during their planned recruitment period	80%	65%	• Build closer relationships with CTUs and liaise/share intelligence on regular basis. • Work with acknowledged local academic experts on best practice for recruitment and translate that evidence into local practice.	Ongoing Q2/3
						• Ensure study costings are accurately attributed throughout duration of research delivery pathway by reference to AcoRD guidance and through use of the Attribution of Costings and Activities Template (ACAT). • Accurate risk assessments of the deliverability of NIHR Portfolio studies to ensure feasibility at site. • Use of monthly RAG reports for benchmarking against partner organisations within the CLRN and to monitor progress. • Individualised RAG reports for studies rated Black or Red with exception reporting required for monitoring and addressing blocks to recruitment by action planning in conjunction with Specialty Group Leads/Divisional Leads and divisional Research Delivery Managers. • Proactive targeted interventions for specific clinical research studies to maintain performance during transition. • Participation in performance management calls with the national CRN Coordinating Centre Division staff and other LCRNs.	Ongoing
3	Increase the number of commercial contract studies delivered through the NIHR CRN	A:	Number of new commercial contract studies entering the NIHR CRN Portfolio	600	n/a	Assist researchers in communicating the benefits of studies being within the NIHR portfolio.	
		B:	Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II–IV studies	75%	n/a	Industry Operations Manager to act as the single point of contact to industry partners to explain the eligibility and feasibility process and highlight the benefits of inclusion on the NIHR Portfolio.	Ongoing

4	Reduce the time taken for NIHR studies to achieve NHS Permission through CSP	Proportion of studies obtaining NHS Permission at all sites within 40 calendar days (from receipt of a valid complete application by NIHR CRN)	80%	n/a	• Major review of provision of RM&G services across the network commencing in Q1 to achieve single sign off across member organisations and efficient, effective use of RM&G resources. • Support for the HRA review • Provision of single point of contact for CSP during the research and development NHS Permissions process.	Q1/2 Ongoing Q1
					Maintain performance of RM&G staff completing study-wide and local governance reviews by providing monthly RAG reports to all partner organisations and requesting feedback on CRN performance.	Ongoing
					Weekly study tracker provided to partner organisations to act as Visual Management Tool to monitor progress of studies through the NHS Permission process. Format and data to be agreed with members.	Q1
					Maintain competencies of RM&G staff by delivering ad-hoc CSP training and CSP Proportionate and Pragmatic training in key regulatory areas.	Ongoing
5	Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies	A: Proportion of commercial contract studies achieving first participant recruited within 30 calendar days of NHS Permission being issued or First Network Site Initiation Visit, at confirmed Network sites	80%	80%	• Share best practice through CRN: West of England industry working group and merge topic and comprehensive ways of working. Run the Commercial Masterclass to ensure study teams are prepared to recruit first patient within given timeframe. The latter aimed at naïve commercial investigators. • Ensure all partners comply with NIHR costing template and standard contract	To achieve 80% target by March 2015
					Revisit WCLRN Delivery of the Life Sciences Agenda to merge ways of working for all topic and comprehensive staff– Essential CLRN Checklist for areas of best practice.	To achieve 80% target by March 2015
		B: Proportion of non-commercial studies achieving first participant recruited within 30 calendar days of NHS Permission being issued	80%	80%	Use of monthly RAG reports for benchmarking against partner organisations within the CLRN and to monitor progress. Format and data to be agreed with members	Reports agreed Q1 then ongoing
					• Exception reporting for red and black RAG rated studies to identify and address blocks to recruitment particularly of first patient into study to pre-empt future recruitment issues. • Share best practice between member organisations and include methods of sharing in Workforce Development plans • Share best practice regionally and nationally to merge ways of working from topic and comprehensive networks	

6	Increase NHS participation in NIHR CRN Portfolio Studies	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	99%	99%	Weekly notification of portfolio studies available to partner organisations and Specialty Group leads to maintain activity levels.	
					Maintain 100% engagement and ensure any decreased levels of engagement are swiftly addressed	
		B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	70%	70%	Scoping of CRN: West of England member organisations for opportunities for growth of commercial portfolio.	March 2015
					• Continued roll out of Commercial Masterclass, aimed at naïve investigators who want to become involved in commercial research and possible mentoring schemes. Help new PIs to understand the benefits of working with industry: i.e. good support, training, access to regulatory training, close monitoring. • Continue to address negative perceptions of industry research through positive messages at engagement events; ambassadors for commercial research amongst PCPIE group.	Ongoing
					• Further development of commercial research activity in primary care utilising hub-spoke methodology in the North of Bristol • Support re-invigoration of the BARONET practices in Bath and Wiltshire	Ongoing
					Implementation of mutual agreement of costs and contracts for all commercial studies in CRN: West of England	Q3
					• Industry Operations Manager to promote the CRN: West of England to commercial partners • Share learning with commercial leads in each member organisation/group of practices	Q2 Q2/3 ongoing
		C: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	25%	25%	Maintain current high levels of GMPs recruiting into NIHR CRN studies	ongoing
					Start succession planning for current GP champions	Q2/3
7	Increase the number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	13,500	As per LCRN goal for 2014-15 recruitment for Dementias and Neurodegeneration (DeNDRoN)		



4. LCRN recruitment goals for CRN Specialties

Specialty	LCRN goal (participants to be recruited in 2014-15)
Ageing	52
Anaesthesia, Perioperative Medicine and Pain Management	34
Cancer	2539
Cardiovascular Disease	1423
Children	1332
Critical Care	92
Dementias and Neurodegeneration (DeNDRoN)	396
Dermatology	110
Diabetes	743
Ear, Nose and Throat (ENT)	0
Gastroenterology	317
Genetics	218
Haematology	205
Health Services Research	778
Hepatology	33
Infectious Diseases and Microbiology	1208
Injuries and Emergencies	742
Mental Health	1110
Metabolic and Endocrine Disorders	83
Musculoskeletal	1403
Neurological Disorders	26
Ophthalmology	489
Oral and Dental	60
Primary Care	6506
Renal Disorders	265
Reproductive Health and Childbirth	884
Respiratory Disorders	82
Stroke	204
Surgery	125

5. LCRN plans against the NIHR CRN Specialty Objectives

Unless stated otherwise, the following are national targets for 2014-15.

Specialty	Ref.	Objective	Measure	Target	LCRN actions to achieve objective(s)
Ageing	1	Increase the opportunities for patients to participate in NIHR CRN Portfolio studies	Establish mechanisms by which the age profile of NIHR CRN Portfolio study participants can be recorded	See note[2]	Appoint new lead build on the back of dementia portfolio.
Anaesthesia, Perioperative Medicine and Pain Management	1	Increase the number of Anaesthesia, Perioperative Medicine and Pain Management commercial contract studies on the NIHR CRN Portfolio	Number of new Anaesthesia, Perioperative Medicine and Pain Management commercial contract studies entered onto the NIHR CRN Portfolio	4	Potential for growth linking in with hospice at Gloucester. Currently have 2 commercial studies open at present at CRN: West of England sites – 1 at NBT and 1 in primary care.
	2	Establish links with the Royal College of Anaesthetists' Specialist Registrar networks to support recruitment into NIHR CRN Portfolio studies	Number of LCRNs where Specialist Registrar networks are recruiting into NIHR CRN Portfolio studies	4	
Cancer	1	Maintain a minimum level of participation in interventional Cancer studies on the NIHR CRN Portfolio	Recruitment to interventional Cancer studies as a proportion of LCRN cancer incidence	7.5%	1) In 2012/13 CRN: West of England recruited 9.6% of cancer patients into interventional studies and similar levels are expected for 2013/14 and 2014/15. The CRN: West of England is noted as the second highest LCRN in terms of achieving against this metric. 2) In 2012/13 CRN: West of England recruited 24% of cancer patients into a portfolio study. Recruitment is expected to be at similar levels in 2013/14 and 2014/15 and the network is expecting to be one of the top performing network's in terms of this metric. 3) The portfolio of cancer studies available in the CRN: West of England compliments the patient population and serves the full range of cancer types. 4) Shared care arrangements are in place for paediatric oncology patients – 5) All appropriate cancer care providers in the network are recruiting into NIHR CRN portfolio. 6) All research teams are aware of the importance of offering appropriate patients the opportunity to enter cancer studies. It would, however, be expected that research is only offered to the proportion of patients for which an available trial is open. Feedback from the cancer patient experience survey will be collated for the CRN: West of England and discussed with local teams as appropriate.
	2	Increase recruitment into Cancer studies on the NIHR CRN Portfolio overall	Recruitment to Cancer studies as a proportion of LCRN cancer incidence	20%	
	3	NIHR CRN Portfolio of Cancer studies serves the full range of cancer types in adults and children	Proportion of adult and child cancer types on the NIHR CRN Portfolio	100%	
	4	Cancer patients across England can participate in Cancer studies on the NIHR CRN Portfolio	Shared care arrangements between NHS providers within LCRN geographies	See note[3]	
	5	Increase the proportion of NHS cancer care providers recruiting into NIHR CRN Portfolio Cancer studies	Percentage of NHS cancer care providers recruiting into Cancer studies on the NIHR CRN Portfolio	100%	
	6	Increase the proportion of cancer patients offered participation in research	Percentage of patients reporting being offered participation in research through National Cancer Patient Experience Survey	> 32%	
Cardiovascular Disease	1	Increase the number of Cardiovascular Disease commercial contract studies on the NIHR CRN Portfolio	Number of new Cardiovascular Disease commercial contract studies entered onto the NIHR CRN Portfolio	42	Link in with BRU at UH Bristol to expand commercial and Portfolio work, also opportunities in primary care, Gloucester and RUH Bath. We have 6 commercial studies open at present.
	2	Increase access for patients to Cardiovascular Disease studies	Number of LCRNs contributing to multi-centre studies in the 6 Cardiovascular Disease sub-specialties	15	
Children	1	Increase the number of Children's commercial contract studies within the NIHR CRN Portfolio in each LCRN	Number of Children's commercial contract studies on the NIHR CRN Portfolio	10%	• Maintain focus on timely & detailed return of site intelligence & site identification documentation to optimise site selection likelihood. • Continue to support clinical teams with study set up, to facilitate timely opening of commercial studies. • Explore how/ whether existing models of MCRN support for commercial trials need adapting to the new LCRN models of working.
	2	All relevant sites that provide services to children are involved in research	Proportion of relevant sites recruiting to Children's studies on the NIHR CRN portfolio	95%	• Facilitate and encourage ongoing participation in CRN Children's studies at all acute trusts with full paediatric departments. • Scope out whether there are other children's healthcare settings which can contribute to NIHR studies.

[2] Qualitative objective to be assessed by a descriptive text from each LCRN.

Specialty	Ref.	Objective	Measure	Target	LCRN actions to achieve objective(s)
	3	Recruitment of children to NIHR CRN Portfolio studies is undertaken by individuals with appropriate paediatric training and experience, or who are appropriately	Proportion of staff consenting children to NIHR CRN Portfolio studies who are paediatric trained and/or experienced, or who are appropriately supervised	100%	• Identify any studies on the LCRN portfolio where this is not the case. • Engage senior leadership for the Children's specialty as necessary to enter into dialogue with PIs/Cis around changing the status quo for any studies where children aren't being recruited by appropriate paediatric trained and /or experienced staff. • Allocate LCRN resource as necessary to support consent by appropriate staff.
Critical Care	1	Increase the number of intensive care units participating in research	Proportion of intensive care units recruiting into studies on the NIHR CRN Portfolio	80%	Currently working well, potential growth of 10% increase in the number of studies.
Dementias and Neurodegeneration (DeNDRoN)	1	Implement arrangements for local use of the "Join Dementia Research system to support study recruitment	A: Proportion of NHS Trusts which provide dementia services, which have put in place generic arrangements for access to medical records, with consent, for the "Join Dementia Research" system users	50%	Objective 1 actions: • Provide project management support to contribute to national RAFT programme and implement local delivery of "Join Dementia Research" system • Suitably resource all "Join Dementia Research" system related activities and identify an implementation lead • Using local intelligence identify current and projected studies that would benefit from a register approach • Gain researcher agreement to recruit from "Join Dementia Research" system and support them with information • Target "Join Dementia Research" system information to key PIs and trust R&D depts • Implement governance policies and recruitment processes defined by "Join Dementia Research" system to support implementation • Communicate key study requirements to the researcher community • Oversee studies using "Join Dementia Research" system at study launch • Identify changes required for ways of working and use continuous improvement model to agree new processes with stakeholders • In conjunction with R&D departments and RDM, agree and implement local training plan for research support staff • Incorporate training in induction for new staff • Proactively engage with RC Psych MSNAP services to agree ways to promote research participation and "Join Dementia Research" system to their patients as standard practice • Contact memory services, provide "Join Dementia Research" system information and encourage its use • Provide support where appropriate to NHS dementia services to access and make use of the implementation and communications toolkit • Suitably resource and maintain financial and operational support for the use of the existing regional disease specific registers for neurodegenerative diseases and dementing conditions, to recruit people to Parkinson's disease (Pro-DeNDRoN) and motor neurone disease (Moto-DeNDRoN) studies Objective 2 actions: • Identify staff to attend CRN rater training programme • Provide financial support (cost of training £450 plus travel and accommodation) for minimum of 6 DeNDRoN delivery staff to attend national psychometric and global rater training in 14/15 • Identify / appoint lead research nurse(s) (or other allied health professional(s) / clinical trials officer(s) to provide professional leadership • Include time and budget to facilitate attendance at monthly teleconferences and bi-annual meetings
Dementias and Neurodegeneration (DeNDRoN)			B: Proportion of LCRN staff working on Dementias and Neurodegeneration (DeNDRoN) studies trained to use the "Join Dementia Research" system	60%	
	2	Increase the global and psychometric rating skills and capacity of LCRN staff supporting Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	A: Percentage of research sites covered by at least 2 trained raters who are registered on the national rater database	80%	
			B: Proportion of LCRN staff who support Dementias and Neurodegeneration (DeNDRoN) studies who have successfully completed rater training and joined the national rater database	35%	
	3	Improve access to research for people living in care homes	Proportion of registered care homes participating in NIHR CRN Portfolio studies	20%	
	4	Increase clinical leadership capacity and engagement in each of the main disease areas in the Dementias and Neurodegeneration (DeNDRoN) specialty	Number of LCRNs with local clinical leads in each of the main disease areas (dementias, Parkinson's disease, Huntington's disease and motor neurone disease)	15	

Specialty	Ref.	Objective	Measure	Target	LCRN actions to achieve objective(s)
					Objective 3 actions: • Provide project management support to contribute to national programme and implement local delivery of ENRICH • Identify ENRICH lead to participate in national monthly ENRICH Delivery Team meetings • Develop and implement an engagement strategy to raise awareness • Provide continued research support to proactively engage with care home owners, managers and other forums to assist with growth of local and national research ready network Objective 4 actions: • Identify senior leader in LCRN to take overall responsibility in delivering the dementia plan • Identify and appoint clinical research lead in each of the 4 disease areas (dementia, HD, MND, PD) • Include time and costs for post holders to attend monthly teleconferences and national bi-annual meetings
Dermatology	1	Increase the opportunities for patients to participate in Dermatology studies on the NIHR CRN Portfolio	A: Proportion of health care providers of dermatology services recruiting into Dermatology studies	50%	Build on effective South West working and increase the number of studies by 10%
			B: Number of 'wounds' treatment centres recruiting into wounds trials	30	
Diabetes	1	Achieve a minimum level of participation in diabetes studies	Proportion of people with diabetes (prevalence rates) recruited into Diabetes studies on the NIHR CRN Portfolio	0.5%	Re-engage with local clinicians, appoint new specialty lead: 1) Review recruitment arrangements for TrialNet Natural History and TCells studies in Bath and Weston super Mare to maximise recruitment. 2) Provide local Administration within Division 2 to support sending out study invite letters to patients registered on the ADDRESS-2 database. Open ADDRESS-2 in Bath. 3) Support Primary Care providers to open diabetes commercial contract and non-commercial trials. 4) Open 2 adult diabetes studies in Swindon. 5) Ensure all Address-2 sites have robust referral systems for newly diagnosed Type 1 diabetes patients in place.
	2	Increase the number of newly diagnosed people with type 1 diabetes in research	Proportion of patients identified via ADDRESS 2 recruited into Diabetes studies on the NIHR CRN Portfolio	5%	
	3	Increase the proportion of NHS providers recruiting into Diabetes studies on the NIHR CRN Portfolio	A: Proportion of primary care providers recruiting participants into Diabetes studies on the NIHR CRN Portfolio	4%	
			B: Proportion of secondary care providers recruiting participants into Diabetes studies on the NIHR CRN Portfolio	83%	
	4	Improve the referral systems in place for newly diagnosed people with type 1 diabetes	Proportion of secondary care trusts with referral systems in place for newly diagnosed people with type 1 diabetes	80%	
Ear, Nose and Throat (ENT)	1	Increase the number of ENT commercial contract studies on the NIHR CRN Portfolio	Number of new ENT commercial contract studies entered onto the NIHR CRN Portfolio	2	No commercial studies at present. Potential to explore growth with North Bristol NHS Foundation Trust. (NBT)
Gastroenterology	1	Increase the proportion of patients recruited into Gastroenterology studies on the NIHR CRN Portfolio	Number of participants (per 100,000 population), recruited into Gastroenterology studies on the NIHR CRN Portfolio	10	We have 3 commercial studies open at present at Gloucester and UH Bristol. Potential to grow Portfolio at NBT.
	2	Increase the number of NHS Trusts actively participating in Gastroenterology studies on the NIHR CRN Portfolio	A: Proportion of NHS Trusts participating in Gastroenterology studies on the NIHR CRN Portfolio	90%	
			B: Proportion of NHS Trusts participating in Gastroenterology commercial contract studies on the NIHR CRN Portfolio	35%	
Genetics	1	Increase access for patients with rare diseases to participate in Genetics studies in the NIHR CRN Portfolio	Number of LCRNs participating in multi-centre genetics studies through the NIHR UK Rare Genetic Disease Research Consortium	14	Establish novel ways of working with Genetics Staff: Agree governance processes for genetics studies.
Haematology	1	Increase the participation of NHS organisations in	A: Number of open Haematology studies in each LCRN	4	Link in with cancer portfolio

Specialty	Ref.	Objective	Measure	Target	LCRN actions to achieve objective(s)
		Haematology studies on the NIHR CRN Portfolio	B: Number of open Haematology commercial contract studies in each LCRN	1	Baseline and measure
	2	Increase the involvement of haemophilia centres in supporting Haematology studies on the NIHR CRN Portfolio	A: Proportion of haemophilia centres recruiting patients into Haematology studies on the NIHR CRN Portfolio (comprehensive care)	90%	
			B: Proportion of haemophilia centres recruiting patients into Haematology studies on the NIHR CRN Portfolio (large centres)	50%	
Hepatology	1	Increase access for patients to Hepatology studies on the NIHR CRN Portfolio	Number of LCRNs contributing to a multi-centre study in all of the six major study areas (viral hepatitis, NAFLD, autoimmune liver disease, metabolic liver disease).	15	Enthusiastic local researchers, room for considerable expansion of activity.
Infectious Diseases and Microbiology	1	Increase awareness of the Infectious Diseases and Microbiology specialty through the identification of a local champion	Number of LCRNs with an identified clinical local champion for infectious disease public health emergencies	15	• Previous WCLRN Lead active • Local CI-driven Portfolio. • Encourage participation in studies led from outside the LCRN • Identify clinical local champion • Identify and participate in antimicrobial resistance research studies; identify any local barriers to participation and address
	2	Increase access for patients to Infectious Diseases and Microbiology studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into antimicrobial resistance research studies on the NIHR CRN Portfolio	15	
Injuries and Emergencies	1	All NHS major trauma centres to support recruitment into NIHR CRN Portfolio studies	Proportion of NHS major trauma centres recruiting participants into NIHR CRN Portfolio studies	100%	• Strong local leadership and activity. • Grow and nurture new Clinical Lead.
	2	Increase the number of NHS emergency departments supporting recruitment into NIHR CRN Portfolio studies	Proportion of NHS emergency departments recruiting into NIHR CRN Portfolio studies	30%	
Mental Health	1	Increase the number of principal investigators supporting Mental Health commercial contract studies	Number of principal investigators working on open Mental Health commercial contract studies on the NIHR CRN Portfolio	95	• Conjoin mental health trust provision. Both our mental health Trusts participate in NIHR studies. Support needed for expansion in both trusts. • To be added to workforce development plan • Support third sector providers. • Ensure new providers are research active by contractual obligations.
	2	Maintain the skills and capacity of staff supporting Mental Health Portfolio studies in frequently used Mental Health study eligibility assessments (e.g. PANSS)	Number of staff trained in frequently used Mental Health study eligibility assessments	139	
Metabolic and Endocrine Disorders	1	Support patient access to Metabolic and Endocrine Disorders studies on the NIHR CRN Portfolio	Number of LCRNs supporting established studies of rare diseases in metabolic and endocrine disorders	15	• Discuss with local clinicians and appoint new lead. • Cross-fertilisation and growth with Diabetes
	2	Increase the number of Metabolic and Endocrine Disorders studies on the NIHR CRN Portfolio	Number of new Metabolic and Endocrine Disorders studies on rare diseases entering the NIHR CRN Portfolio	4	
Musculoskeletal	1	Increase the opportunities for patients to participate in Musculoskeletal studies on the NIHR CRN Portfolio	Proportion of Musculoskeletal service providers recruiting into NIHR CRN Portfolio studies	75%	We have 3 commercial studies at present at CRN: West of England sites, potential for growth at the Min, NBT and Great Western. Enhance non-medical input e.g. AHPs
	2	Increase the number of Musculoskeletal commercial contract studies on the NIHR CRN Portfolio	Number of new Musculoskeletal commercial contract studies entered on to the NIHR CRN Portfolio	30	
Neurological Disorders	1	Increase the number of NHS Trusts recruiting into Neurological Disorders studies on the NIHR CRN Portfolio	Number of previously inactive NHS Trusts which now are recruiting into Neurological Disorders studies on the NIHR CRN Portfolio	15	• 1 commercial study open at present at Gloucester and NBT – potential to explore further studies at these sites. • Service provision complex with difficulty of recruitment of new consultant staff. • Facilitate new members of staff to become research active.
	2	Increase the number of principal investigators supporting Neurological Disorders commercial contract studies	Number of principal investigators working on open Neurological Disorders commercial contract studies on the NIHR CRN Portfolio	58	
Ophthalmology	1	Increase the number of Ophthalmology commercial contract studies on the NIHR CRN Portfolio	Number of new Ophthalmology commercial contract studies entered onto the NIHR CRN Portfolio	4	• Region does very well for commercial studies at UH Bristol and Gloucester, with potential for growth at Great Western, Swindon. Provide mentorship and support from Gloucester. • Build on success of Bristol partnership and culture towards a research prioritised clinical service.
	2	Increase the number of NHS Trusts participating in Ophthalmology research	Number of NHS Trusts recruiting patients into Ophthalmology studies on the NIHR CRN Portfolio	100	

Specialty	Ref.	Objective	Measure	Target	LCRN actions to achieve objective(s)
Oral and Dental	1	Increase the opportunities for patients to participate in NIHR CRN Portfolio studies	Number of Oral and Dental studies on the NIHR CRN portfolio recruiting in each LCRN	1	• No commercial studies at present – potential to explore at dental hospital at UH Bristol and to link in with university departments for growth. Establish pharmacy champion role, modelled on successful GP champion role. • Share best practice and culture change with geographically adjacent Ophthalmology service.
	2	Increase the number of Oral and Dental commercial contract studies on the NIHR CRN Portfolio	Number of open Oral and Dental commercial contract studies on the NIHR CRN Portfolio	2	
	3	Offer a balanced portfolio of studies to practitioners and participants	A: Proportion of Oral and Dental studies on the NIHR CRN Portfolio recruiting from a primary care setting	20%	
			B Proportion of participants recruited from a primary care setting into Oral and Dental studies on the NIHR CRN Portfolio	50%	
Primary Care	1	Increase the opportunities for patients to participate in NIHR CRN Portfolio studies	A: Proportion of GP sites registered as research capable[3]	35%	• In 2013/2014 46.1% of practices were registered as research capable. • A number of pharmacists are research active within the NIHR CRN West of England, and it is anticipated that securing the services of one to be a Pharmacy Champion will be achieved in 2014/2015
			B: Proportion of GP sites within any individual CCG registered as research capable	5%	
	2	Improve research engagement with community pharmacy	Number of LCRNs with a community pharmacy Research Champion	15	
Renal Disorders	1	Increase the proportion of Renal Disorders commercial contract studies on the NIHR CRN Portfolio	Proportion of commercial contract studies in relation to the total number of Renal Disorders studies on the NIHR CRN Portfolio	20%	3 commercial studies open at present, continue growth at NBT and also explore Bath RUH and Gloucester. Appoint new lead and build on new renal Health Integration Team
	2	Improve the promotion of research to patients with Renal Disorders	Proportion of renal units actively promoting research to patients	50%	
Reproductive Health and Childbirth	1	Increase the number of Reproductive Health and Childbirth commercial contract studies on the NIHR CRN Portfolio	Number of Reproductive Health and Childbirth commercial contract studies on the NIHR CRN Portfolio	4	1 commercial study at present at UH Bristol and scope for growth at Gloucester and NBT. Potential identified midwifery champion at the RUH Bath (Sara Burnard)
	2	Increase engagement and awareness of the Reproductive Health and Childbirth Specialty	Number of LCRNs with an identified midwifery champion to increase engagement and awareness	15	
Respiratory Disorders	1	Increase access for patients to participate in Respiratory Disorders studies on the NIHR CRN Portfolio	Number of LCRNs recruiting participants into studies in the Respiratory Disorders main disease areas of asthma, COPD and pneumonia	15	Focus on non-pleural disease, focus on improving recruitment in UH Bristol and Great Western
	2	Increase the number of participants recruited into COPD and Asthma studies on the NIHR CRN Portfolio	Percentage of COPD and Asthma participants recruited into Respiratory Disorders studies on the NIHR CRN Portfolio	10%	
Stroke	1	Increase the proportion of patients recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	Number of patients (per 100,000 population) recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	8	Capitalise on already effective functioning both service and research network. Appointment of a non-medical lead for stroke to explore. For commercial studies, engaged teams at RUH Bath and keen team at UH Bristol who are wanting to take on more commercial stroke studies 1. Ensure recruitment to RCTs is maintained according to prediction in already active sites and prioritise opening stroke RCTs in North Bristol Trust. 2. Review new Stoke commercial Contract and medical technical studies and proactively encourage EOIs from sites where recruitment is feasible.
	2	Increase the number of commercial Stroke studies on the NIHR CRN Portfolio	A: Number of new commercial contract Stroke studies on the NIHR CRN Portfolio	5	
			B: Number of new medical technical studies in Stroke on the NIHR CRN Portfolio	2	
	3	Increase the proportion of NHS Trusts, providing acute Stroke care, recruiting to Stroke studies on the NIHR CRN Portfolio	Proportion of NHS Trusts, providing acute Stroke care, recruiting participants into Stroke studies on the NIHR CRN Portfolio	80%	All NHS Trusts in network providing acute Stroke Care are recruiting. Continue these levels of engagement.

[3] Registered Research Capable Sites are those sites working with the LCRN which have the capacity and capability to support NIHR CRN activities.

Specialty	Ref.	Objective	Measure	Target	LCRN actions to achieve objective(s)
	4	Increase activity in NIHR CRN Hyperacute Stroke Research Centres	A: Number of patients recruited to hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN Hyperacute Stroke Research Centre (HSRC)	50	None in the LCRN geography
			B: Number of patients recruited to complex hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN HSRC	15	No hyper-acute unit in our geography.
			C: Number of HSRCs recruiting to Stroke commercial contract studies on the NIHR CRN Portfolio	8	
Surgery	1	Increase the number of NHS Trusts supporting Surgery studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting patients into Surgery studies on the NIHR CRN Portfolio	75%	• Surgical Trials Unit opened at UH Bristol, therefore strong infrastructure to grow portfolio studies. • Continue to build relationships with academic surgery units at the University of Bristol • Recruit to ISOS
	2	Increase the proportion of surgery patients recruited into Surgery studies on the NIHR CRN Portfolio	Number of participants (per 100,000 surgical admissions) recruited into Surgery studies on the NIHR CRN Portfolio	50	As above

Annual Financial Plan 2014-15

Clinical Research Network: West of England

2014/15 Financial Allocations

Organisation	2013/14 Delivery Allocation	Topics - 2013/14 Delivery Allocation	Delivery Allocation (2013/14 Trust value plus Topic commitments, reduced by 1.5%)	Research Mgt Allocation (2013/14 value reduced by 7%)	2014/15 Element of Infrastructure Devt 2	2014/15 Element of May 2013 Additional Funding	Leadership & Management Funding	Admin Team	Other	Hosting	Total	Value Equal to:
Partners												
Avon & Wiltshire Mental Health Partnership NHS Trust	401,243	115,465	508,957	37,227							546,184	Topic: DeNDRoN & MHRN
Gloucestershire R&D Consortium (Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire PCT	996,684	289,673	1,267,061	102,609							1,369,670	Topic: Three Counties NCRN & DeNRDoN
Great Western Hospitals NHS Foundation Trust	505,110	187,408	682,130	46,975							729,106	Topic: Thames Valley NCRN
North Bristol NHS Trust	1,878,922	110,498	1,959,579	149,265		22,139					2,130,983	Topic: ASW NCRN & DeNDRoN & DRN
Royal National Hospital For Rheumatic Diseases NHS Foundation Trust	395,297		339,367	61,889							401,256	
Royal United Hospital Bath NHS Trust	688,817	65,216	742,722	42,451		18,885					804,058	Topic: ASW CRN
University Hospitals Bristol NHS Foundation Trust	3,008,568	422,913	3,380,009	299,925	31,780	1,538	516,706	364,000			4,593,957	Topic: MCRN & ASW CRN
Weston Area Health NHS Trust	312,768	65,189	372,288	38,039							410,327	Topic: ASW CRN
Total	**8,187,408**	**1,256,362**	**9,252,114**	**778,379**	**31,780**	**42,562**	**516,706**	**364,000**	**0**	**0**	**10,985,541**	
Primary Care												
Block Delivery	487,151		487,151								487,151	74.5% of 2013/14 forecast annual spend
Primary Care Incentive Scheme (PCIS) Level 1 & 2	230,578		230,578								230,578	74.5% of 2013/14 forecast annual spend
Sessional PCIS	313,264		313,264								313,264	74.5% of 2013/14 forecast annual spend
Clinical Sessions and Research Officer posts (PCRN)	222,774		222,774								222,774	74.5% of 2013/14 forecast annual spend
Total	**1,253,765**	**0**	**1,253,765**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,253,765**	
Other												
Excess Staff Costs									150,000		150,000	
6 Clinical Leads									159,600		159,600	6 Consultants @ 2 PA
Local Priority Groups Leads									98,970		98,970	2013/14 allocation
Honorarium Chair									2,030		2,030	2013/14 allocation
Avon Primary Care Research Collaborative (APCRC)				87,844							87,844	
Pan Bath & Swindon Primary Care Research Consortium (PBSPCRC)				70,423							70,423	
University of Bristol		99,380	97,890								97,890	Topic: MHRN
Total	**0**	**99,380**	**97,890**	**158,267**	**0**	**0**	**0**	**0**	**410,600**	**0**	**666,757**	
Hosting - University Hospitals Bristol NHS Foundation Trust												
Host Support (Finance, HR, Comms)										156,600	156,600	
Whitefriars rent, rates, service charge										43,001	43,001	
Edge										80,000	80,000	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**279,601**	**279,601**	
Grand Total	**9,441,174**	**1,355,742**	**10,603,769**	**936,647**	**31,780**	**42,562**	**516,706**	**364,000**	**410,600**	**279,601**	**13,185,665**	
% of Overall Total			**80.4%**	**7.1%**	**0.2%**	**0.3%**	**3.9%**	**2.8%**	**3.1%**	**2.1%**	**100.0%**	

2014/15 Funding **13,205,000**

(Surplus)/Shortfall **(19,335)**

Clinical Research Network: West of England

2014/15 Annual Financial Plan

The CRN:WoE 2014/15 Annual Financial Plan presents a breakeven position, which includes an unallocated value of £214k; this is expected to be required to fund the salaries of the current Topic Specific managers and admin staff employed by the host and other partner organisations until the conclusion of the Leadership & Management consultation and the subsequent Administration consultation, as well as, additional primary care costs anticipated during 2014/15.

With regards to primary care-related activity, the CRN:WoE expects to make payments directly to GP surgeries, nursing homes, hospices, community health organisations and charities.

Primary care represents a financial risk to the CRN because 1) service support costs (SSCs) awarded are often not claimed in the anticipated financial period, and, 2) payments are made in relation to actual activity undertaken throughout the year, in contrast to the allocations made to partner organisations which are not activity adjusted in year.

Once the Division 5 Research Divisional Manager is in post there are plans to revisit the primary care funding model in order to bring about a more stable funding model but this may well not impact until 2015/16. Therefore, during 2014/15, recruitment to primary care trials, claims against awarded SSCs and future approval of SSCs will need to be monitored and reviewed regularly to ensure that the primary care allocation is not exceeded.

The current Activity Based Funding model also presents a financial risk to those organisations recruiting into rare disease studies. These studies obviously recruit very low volumes but have a disproportionate cost implication which is not recognised by the current study bands of 1 to 3. The Topic Specific Research Network allocations for Medicines for Children and Mental Health appear to have addressed this in the past, however, the 2014/15 central allocation no longer allows for these rare, low recruiting, resource intensive studies.

Leadership & Management Structure 2014-15

Clinical Research Network
West of England

NIHR Clinical Research Network: West of England Organisational Change. Final Leadership and Management Structure.

Approved by Partnership Group

04/04/2014

Authors:
Dr Mary Perkins Chief Operating Officer; West of England CRN
Dr Steve Falk Clinical Director; West of England CRN

NIHR CRN West of England, Whitefriars, Lewins Mead, Bristol, BS1 2NT

Version	Author	Changes	Date
DRAFT 0.1	M Perkins/S Falk		27 March 2014
FINAL 0.1	M Perkins/S Falk	Selection process clarified	04 April 2014

Circulation: Partnership Group; Divisional Research Leads; Topic Research Management Staff; HR partners, Staff Side.

This change project is required to bring together seven existing NIHR Clinical Research Networks to form a single unified Clinical Research Network for the West of England .
Version FINAL 1 0 April 04 2014.

NIHR Clinical Research Network Organisational Change

1. Introduction

This document details the proposed final structure for the leadership and management of the West of England CRN. This structure is subject to agreement from the partnership group.

This document should be read in conjunction with the consultation paper circulated in January and attached to this paper as an appendix.

The consultation was circulated to:

- Affected Topic Staff
- Divisional Research Leads for the West of England CRN
- The Partnership Group of the West of England CRN
- The R&D departments of the Member Oganisations of the West of England CRN
- Via research staff to Topic Coordinating Centres and Assistant Director for topic Research Networks.
- Unions

Feedback was received from all of the individuals affected (n = 10) and from Topic Coordinating Centres (Mental Health and Primary Care), Divisional Research Leads, researchers and staff side (RCN regional representative).

Many thanks to all who took the time to respond. The feedback was incredibly helpful and has helped inform our thinking for the final structure. The affected staff should be commended for the mature and helpful way in which they have responded to this consultation. At a time of great uncertainty for them as individuals, they have remained focussed on their current positions, supporting topic staff and provided constructive feedback to inform our thinking. Thank you.

2. Major Points from the Feedback:

1. Primary Care is different – it is a location, not a disease and will feed into and be fed from, all of the other divisions.
2. Research Management and Governance will not become the responsibility of The Health Regulatory Agency for at least 12-18 months and will therefore remain a responsibility of the core team.
3. The current structure is too lean and will not allow for any CRN staff to undertake national duties on behalf of all of the CRNs nor provide adequate support to researchers and the Chief Operating Officer.

4. The current structure does not allow for career progression for Research Managers.

5. The Consultant Nurse post is poorly understood and is felt to be a luxury at a time of constraint.

6. All network managers and topic researchers expressed concern about the ability to continue with business as usual at a time of change and all wished to maintain their current management structure and staff.

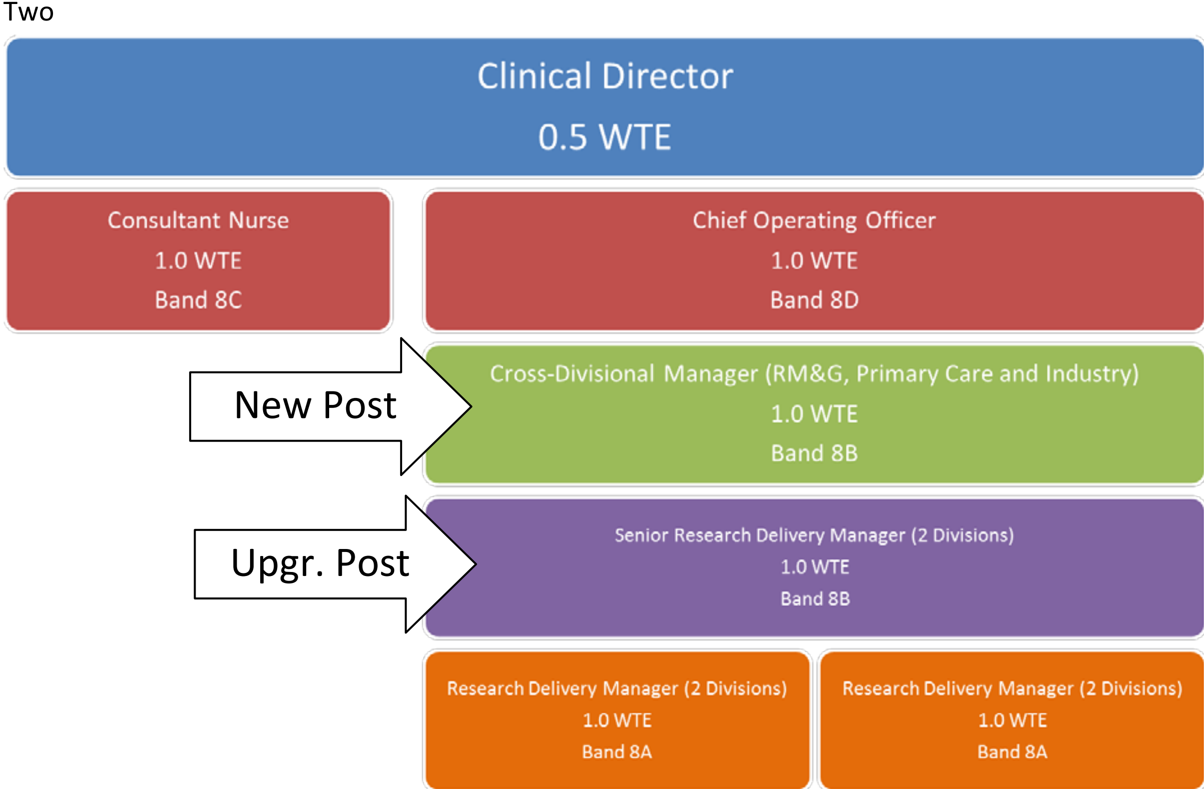
7. We have been questioned on why the Industry Manager post is not part of the consultation.

8. There were several comments that we were doing things very differently from the rest of the networks across the country.

Response to Feedback

The chart below illustrates the suggested final structure for the West of England CRN Leadership and Management Team

Two



Changes – shown by arrows:

One new 8b post has been added to the structure – this is to take account of the national legislative support for research - we had anticipated the Health Research Authority to assume overall responsibilitiy for Research governance, we now have been told that this is unlikely for the next 12-18 months.

One of the 8a Research Delivery Manager posts has been upgraded to an 8b to provide expert leadership for the other Research Delivery Managers. This is to free up time for the COO and to provide for career progression for the RDMs

Changes and anticipated benefits.

1. Primary care is taken out of the Divisional Structure and will now be part of the remit of the new post of Cross Divisional Manager. This allows for a cross-portfolio approach for Primary Care and also reduces the burden on the RDM with responsibility for Division Five. The Cross Divisional Manager will also take responsibility for RM&G, Business Intelligence and Industry. This senior post is banded at 8b. This addresses points 1,2,3&4.
2. One Research Delivery Manager job description has been rewritten to reflect a new role of Senior Research Delivery Manager. As well as providing exemplar management for two of the Divisions, this post will also formally take on line management of the other two research delivery managers. This post has also been banded at an 8b. this addresses points 3,4 &6.
3. The consultant nurse post is a part of the clinical leadership for the CRN. This post will support research delivery staff in the member organisations, helping to address skill mix gaps, supporting workforce development for all research professionals and producing evidence to support different ways of addressing the ways of recruiting and caring for patients in research. Clinical leadership is largely provided at present by medical staff. We felt it was important to address this gap. Previous posts in the comprehensive network of lead research nurses at Band 8a have not impacted on the behaviours and structures within individual organisations. Therefore, we agreed to create a senior nursing post to address both this lack of support and also able to provide primary evidence for different ways of working. This post has attracted considerable interest with many other networks seeking the job description and rationale. It is good to be innovative at times of constraint and we appear to be leading the way on non-medical clinical leadership. This addresses point 5.
4. The industry manager post is not a part of the consultation because the job description and banding are not changing. The current incumbent is on maternity leave and will resume that position on her return. This addresses point 7.
5. We are drawing up a different structure from most other networks. The final structure is similar to that of Wessex and The Peninsula – our nearest neighbours. Like us, these two networks are small, both in terms of the portfolio delivered and the number of members. It should be remembered that the larger networks support up to 29 member organisations with a budget of nearly £30 million. We support nine member organisations and our budget is £13.2 million. We are also punching below our weight in terms of recruitment and we therefore lost part of our expected budget. All money spent on management and leadership is money taken out of the member organisations for delivery. We believe this proposed structure allows us to answer the concerns raised by the proposed draft structure without impacting too harshly on our members. This answers point 8 and point 6. We believe in lean management, and also recognise that there comes a point at which clinical staff become inefficient if not supported adequately by leadership and management.

Selection Process for the New Posts

To allow individuals who are ring fenced against more than one post to apply for all posts for which they are suitable, the appointments will take place in the following order:

1. Nurse Consultant Post will be appointed to first
2. The Cross Divisional Manager Post and the Senior Research Delivery Manager Post will be appointed second
3. The Research Delivery Managers Posts will be appointed to last.

Financial Implications of the changes

The addition of the 8B Cross Divisional Manager Post and the uplift from 8A to 8B for the Senior Research Delivery Manager Post results in an **additional cost of £89,000** per annum. This takes our total Leadership and Management costs to £605,282 (maximum allowable under NIHR finance rules, £782,383) If we were to fund this in year from core funds, the increased cost of the CRN Management and Leadership would result in a decrease of 1% in delivery allocations to partner organisations.

On 24th March 2014 John Sitzia, Chief Operating Officer of the National CRN announced at the COO/CD Induction that £11.8 million Research Capability Funding (RCF) will be available nationally for the Clinical Research Networks. The West of England CRN has been awarded £625,000 for 2014/2015.

We propose to **not** decrease partner allocations in this transition year and support the structure from RCF. It is important in a transition year to work with partners to ensure a balanced position without relying on RCF funding from April 2015.

Actions Required from Partnership Group

Partners are asked to agree the uplift in funding to support the proposed structure. Agreement should be emailed to:
Mary.Perkins@nihr.ac.uk

We would like to circulate this final structure to affected staff on Friday April 4th latest.

Option B

If the partnership group do not approve these changes to structure, we will circulate and appoint to the original structure – this however could mean that we are unable to deliver on the necessary transition work **and** maintain recruitment into trials. If we do not maintain recruitment, we will see a further drop in our funding in 2015/16. In addition, the work done during consultation and the resulting change in thinking would not be reflected in changes to a structure and staff would be further demoralised.

END.

Clinical Research Network
West of England

NIHR Clinical Research Network: West of England
Organisational Change
Consultation paper

This paper is an appendix to:

NIHR Clinical Research Network: West of England Organisational Change Final Leadership and Management Structure. March 27th 2014.

Version	Author	Changes	Date
DRAFT 0.1	M Perkins	First Draft	February 2014
FINAL 0.1	M Perkins	Updated to correct factual errors	March 27 2014

This change project is required to bring together seven existing NIHR Clinical Research Networks to form a single unified Clinical Research Network for the West of England. Version FINAL 27 March 2014 M Perkins.

NIHR Clinical Research Network Organisational Change

1. Introduction

1.1 This change is required to bring together seven existing NIHR Clinical Research Networks to form a single unified Clinical Research Network for the West of England.

1.2 The National Institute for Health Research Clinical Research Network (NIHR CRN) is responsible for the delivery of NIHR portfolio studies including supporting grant applications, study set-up and delivery for non-commercial and commercial research in the NHS. Currently this service is configured nationally as topic research networks each with a separate coordinating centre, under an overall coordinating centre. The topic networks represent the following areas:

- Cancer (two networks in the CRN: West of England area)
- Dementia and Neurodegenerative Disease (DeNDRoN)
- Diabetes (no coverage in CRN: West of England currently)
- Medicines for Children (MCRN)
- Mental Health
- Stroke (no coverage in CRN: West of England currently)

All networks deliver research studies in 'their' topic areas. In addition, the Primary Care research network supports research delivery in primary care settings and the Comprehensive Research Network supports studies in 24 additional speciality areas, provides research management and governance for research and manages the service support budget for research.

There are currently 102 local networks nationally hosted by 70 NHS Trusts.

1.3 In 2012 the NIHR CRN announced an intention to re-structure the current clinical research networks; this transition process will bring together all existing networks to form one network operating from 15 geographically based Local Clinical Research Networks (LCRN), with an associated reduction in the number of NHS host Trusts.

1.4 As part of this transition, organisations from across England were invited to apply to become hosts for the new combined networks. In September 2013, University Hospitals Bristol NHS Foundation Trust was selected as the host for the NIHR CRN: West of England. This role makes UH Bristol the contract holder for the West of England with a requirement to work with all organisations providing NHS care to support and enhance research delivery for NHS patients.

1.5 This new structure necessitates a change in management and governance arrangements as the individual clinical research networks cease to exist as single entities. Organisational change is required to provide the management structure in a combined network.

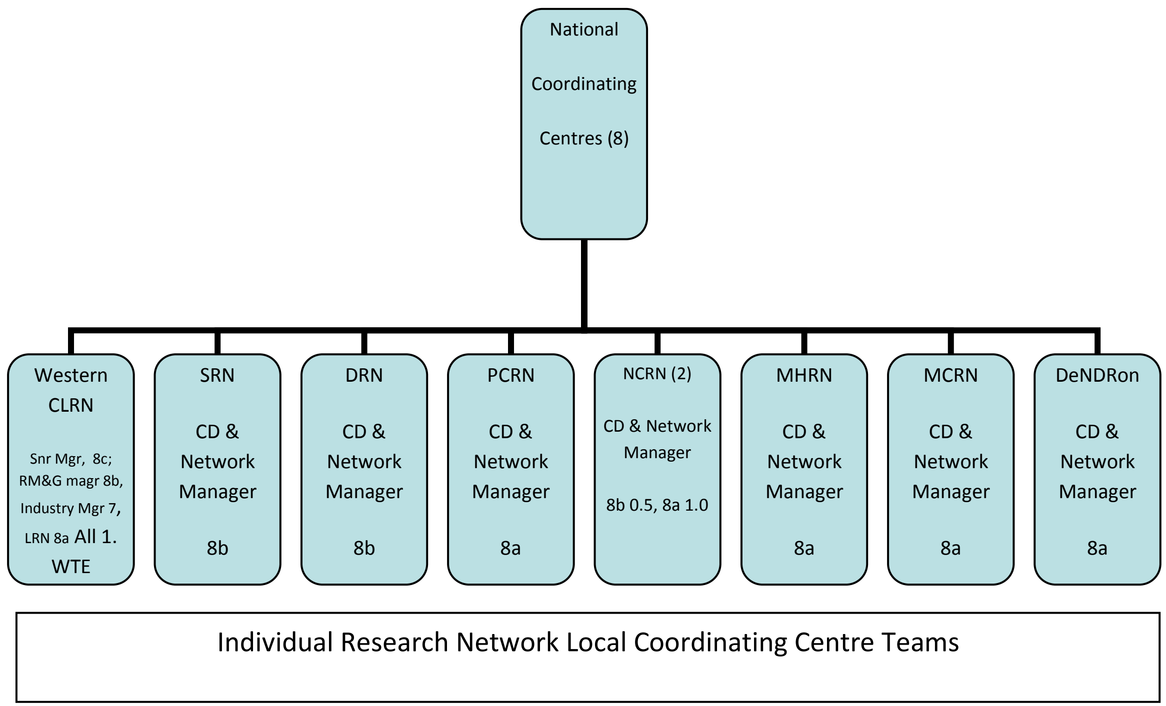
1.6 The identified benefits of this change are:

- Improved efficiencies across the clinical research network
- Provision of transparent, consistent governance and clear accountability
- More flexible and responsive research delivery
- Provision of a platform to share best practice in research delivery and improve learning opportunities and career development

2. Existing Structures

2.1 The wider South West is currently covered by all existing research networks (all areas of England currently have CLRN and PCRN coverage, not all areas have coverage from existing topic networks. Some of these networks are shared with the Peninsula and the Midlands.

Figure 1: Current South West structure



Areas of responsibility and current hosting arrangements are set out in Table 1 below:

Table 1: Areas of Responsibility and current hosting arrangements

Network	Host	Area of Responsibility	Local Coordinating Centre Base	Manager's Employer
Western CLRN	UH Bristol	Gloucester, Bristol, Bath, Swindon, Somerset, Dorset, Wiltshire, South Gloucester and North Somerset	Bristol	UH Bristol
SRN	RDE	Gloucester, Somerset, Dorset, Devon, Cornwall and the Isles of Scilly (with support for the north)	Exeter	RDE
DRN	RDE	Gloucester, Somerset, Dorset, Devon, Cornwall and the Isles of Scilly(with support for the north)	Exeter	RDE
PCRN	BCCG	Gloucester, Bristol, Bath, Swindon, Somerset, Dorset, Wiltshire, South Gloucester and North Somerset	Bristol	BCCG
NCRN	UH Bristol Gloucester	As above, + parts of Midlands and Thames Valley	Bristol Gloucester	UH Bristol Gloucester
MHRN	University of Bristol	Gloucester, Bristol, Bath, Swindon, Somerset, Dorset, Wiltshire, South Gloucester and North Somerset	Bristol	University of Bristol
MCRN	UH Bristol	Gloucester, Bristol, Bath, Swindon, Somerset, Dorset, Wiltshire, Devon Cornwall, Isles of Scilly, South Gloucester and North Somerset	Bristol	UH Bristol
DeNDRoN	AWP	Gloucester, Bristol, Bath, Swindon, Somerset, Dorset, Wiltshire, South Gloucester and North Somerset	Bristol	AWP

2.2 The revised network boundary for the CRN: West of England has been mapped to the geographical boundaries of the West of England Academic Health Science Network: Gloucester, Bristol, Wiltshire (but not Salisbury), Bath, Swindon, North Somerset & South Gloucester.

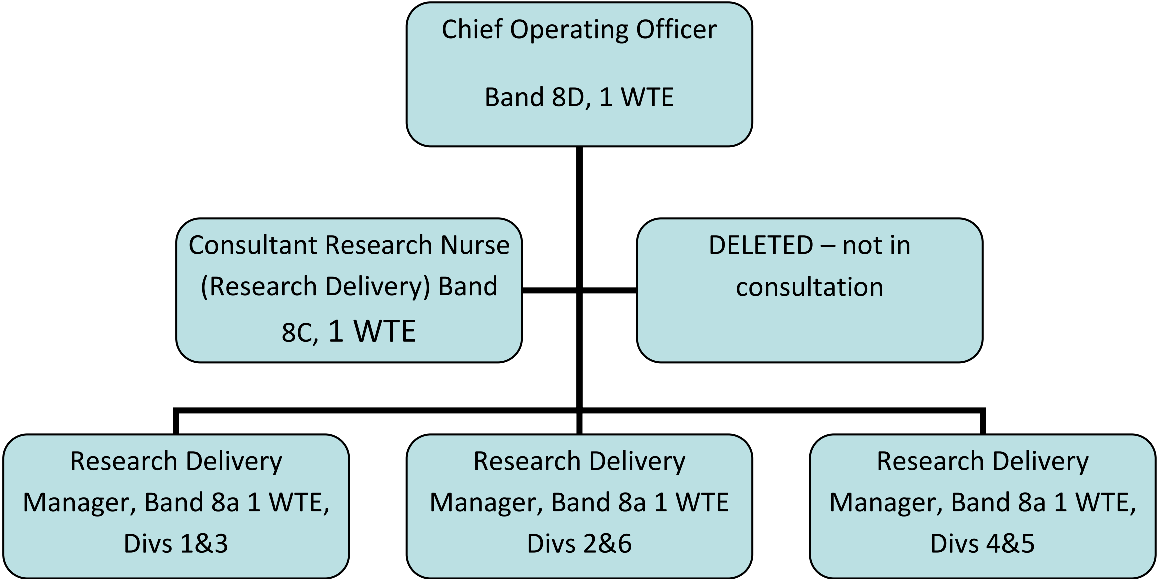
2.3 The existing Exeter based network management teams will be part of the new NIHR CRN: South West Peninsula management change process which will be led from Exeter. It is therefore out of scope for this consultation. This applies to the Stroke Research Network and the Diabetes Research Network.

3. Proposed Change

3.1 There are seven Band 8 Network Managers currently employed in the CRN West of England area. It is proposed these specific roles will not exist in the new structure. There are an additional 2 Band 8 roles: Lead Research Management and Governance Manager (RM&G

Manager) & Lead Research Nurse – it is proposed these specific roles will also cease to exist in the new structure. It is proposed that the roles of Research Divisional Managers (3 WTE) and Cross Divisional, Consultant Nurse (research delivery – 1 WTE) are created, as detailed in the figure below:

Figure 2: Proposed New Structure



3.2 Other administrative roles within the networks will still exist in the new structure. Some will remain focussed on cross divisional support or will change to become either cross divisional, or divisionally focussed. This paper concentrates on the Network Managers described above and the structures beneath them are currently out of scope. For clarity, the NIHR have also mandated an industry manager role. The Western CLRN already has this post in the old structure and this post will move to the new structure. Therefore this post is declared out of scope for this consultation. It is however shown within structures so that it is understood that this post will continue.

3.3 As shown in Table 1, there are currently seven clinical research networks within the CRN: West of England area of responsibility (two Cancer networks, one comprehensive, one Medicines for Children, One Primary Care, One mental Health and one Dementia and neurodegenerative diseases). All have local senior management teams and other central posts to support research delivery. Each local network has its own governance structure and manages research delivery and finances associated with this on an individual basis.

3.4 The CRN: West of England will work as one organisation with a revised governance structure and one income stream. Tasks that are not specialty specific, for example, business intelligence and communications will be managed as cross divisional activity. Existing network research management roles will no longer be required, and whilst the configuration of the operational team is the responsibility of the Chief Operating Officer, a

number of roles have been mandated nationally within the proposed contract: the Chief Operating Officer, Research Delivery Managers, Industry Operations Manager and Cross Divisional Manager.

3.5 In the first instance, the staff most affected by the change are the existing Research Network Managers as shown in figure one as it is proposed their roles do not exist in the new structure and will therefore cease on 31st March 2014.

3.4 It is proposed the roles below this level of the structure will not change in the first instance; staff will continue to undertake their roles in support of delivery of the NIHR portfolio. The next financial year is considered to be the transition year and once it is better understood how the network will work operationally as a single entity, a review of staff below the level of Research Delivery Managers will be undertaken. It is expected, but cannot be guaranteed that although some roles may change focus, the number of staff will remain the same.

3.5 This proposed change therefore affects current research network managers only, with the proposed new organisational structure shown in figure 2.

3.6 Feedback should be addressed to Dr Mary Perkins, Chief Operating Officer, in writing via email or post. All feedback, including feedback during 1-2-1's will be collated and considered at the end of the 30 day consultation period.

4. Selection criteria and method

The proposed process of avoiding all possible redundancies will be as follows: Wherever possible "at risk" staff will be slotted into posts in any revised structure, and competitive interviews between staff will be kept to a minimum, only taking place where there are two or more potential applicants for a post, or where the duties of the new post are substantially different from those of the old post. [see "slotting in", "ringfencing" and "open competition" details below.]

All organisations within the network will seek to offer suitable alternative employment in order to avoid redundancies in accordance with the Redeployment Policies. This addresses the issues of suitable alternative employment, trial periods, retraining and protection of earnings and other conditions of service. The HR lead for UH Bristol will work with the HR leads at partner organisations to ensure that staff are considered equally.

Alternative employment will be sought during the period of an individual's statutory notice and for not less than one month

The method of calculating the redundancy payment will be in line with the provisions detailed in the Agenda for Change Terms and Conditions of Service handbook (s. 16)

Selection Criteria

This proposed change relates to the structure of the research networks and proposed change may result in changes to roles/posts and there may be a resulting need for selection processes to roles in Research Delivery Managers and Consultant Nurse (Research Delivery)

The proposed method of selection will need to be agreed as part of the consultation period. The factors to be considered may include all or any of the following:

Skills/Qualifications
Experience
Length of service (this will never be considered as a sole criteria)
Experience

Care will be taken in applying all of these criteria to avoid unlawful discrimination. The selection criteria including any weighting of specific criteria will be discussed during consultation with staff and trade unions.

Method of Selection

Slotting in

'Slotting in' is the process of transferring an employee from an existing position to a position in the new structure without going through the redeployment process or having a selection interview. This only happens when the position in the new structure is substantially similar to the employees existing role and no other employee who is affected by the change could make the same claim.

Substantially similar means:

- Location - a location within reasonable travelling distance
- Qualifications - professional qualifications/registration and competencies, where appropriate, required to do the job
- Equivalent grade / level within the organisation
- Equivalent hours and shifts unless both parties agree to vary this
- Equivalent complexity - taking into account responsibility/budgets/supervisory responsibilities
- Person Specification - Individual meets the criteria or could have training to meet criteria
- Job Description - account should be taken of the similarities and differences between the old and the new roles and should have a substantial overlap.

Ring Fencing

Ring fencing is the term given to a process where there is an identifiable group of employees to be considered for substantially similar roles and where there are fewer posts than employees. This group of staff are then 'ring fenced' so that only they can apply for those vacant posts. Ring fencing can also apply where there are more posts than employees, but 'slotting in' is not guaranteed as a number of people may

choose the same post.

This process should be used if there is a restructuring of work and there is more than one individual and there are roles that are substantially similar. In this instance, 'slotting in' cannot happen, as there is a choice for employees and there may be competition. Ringfencing allows a group of staff who are 'at risk', to compete for the available positions without allowing anyone else within the Trust or (partner organisations) to apply.

Staff within the 'ring fence' will be invited to apply for available posts, and assessment will take place through the usual Trust recruitment procedure, i.e. formal application, interview, references. It should be noted that assessment must be made against the appropriate person specification.

If, as a result of this process, a member of staff is moved into a post on a lower substantive band, protection of earnings will be applicable in line with the current Trust's pay protection arrangements.

The use of a preference form (attached) allows the opportunity for employees to express their preferences for ring fenced posts.

Open Competition

New positions that are not substantially similar to any role in the existing structure will be open for employees to apply. Staff affected by change and 'at risk' of redundancy, will be given priority status i.e. be considered before other applicants in applying for vacancies, other than candidates with priority status for health reasons will be granted the same priority status.

Staff will be invited to apply for available posts, and assessment will take place through the usual Trust recruitment procedure, i.e. formal application, interview, references. Assessment must be made against the appropriate person specification.

5. Executive Approval

5.1 The NIHR CRN is a national organisation that contracts NHS Trusts to provide a service to support research delivery and it is this external organisation that has driven this change. UH Bristol submitted a bid to be the host led by Mr Robert Woolley to host the new CLRN. The host trust board is therefore aware of the requirement for this change.

5.2 The LCRN COO is the responsible senior manager for designing and implementing the revised way of working.

5.3 The partnership group will be asked to minute approval to the changes.

6. Proposed Timescales

The LCRN becomes operational on April 1st 2014. Every effort will be made to complete this process by the end of May 2014.

The implementation and consultation plan is described in Table 2

Table 2: implementation and consultation plan

	Actions	**Timescale**	**Responsible**
1	Informal discussions with topic managers	January 2014	COO
2	Discussions with Transitional Oversight Group	January 2014	COO
3	Informal discussions with staff side	January 2014	COO
4	Agreement from Partnership Group for structure	21 02 14	COO
5	Completion of consultation papers	21 02 14	COO/HR
6	Group consultation launch (sharing of new structure with affected staff)	24 02 14	COO/HR/staff side
7	Set-up 1:1 consultation meetings	03 03 14 – end of consultation	COO/HR/staff side
8	End of consultation	24 03 14	COO/HR/staff side
9	Formal consultation review and collation of feedback	24 03 14 (for one week)	COO/CD/HR
10	Issue final consultation outcome via email and personal letters	04 April 2014	COO/CD/HR/staff side
11			
12	Individual circumstances agreed and next steps discussed with individuals	04 04 14 – as needed for each affected individual	COO/HR/employer

Contacts and support:

Dr Mary Perkins, LCRN West of England Chief Operating Officer. Suite 4b Whitefriars, Lewins Mead, BS1 2NT Tel 0117 342 1379, m: 07854 802 881 email mary.perkins@nihr.ac.uk

Lisa Balmforth, UH Bristol HR Business Partner. Tel 0117 342 3750, email lisa.balmforth@uhbristol.nhs.uk

Avon Partnership Occupational Health Service. Tel 0117 342 3400 (for counselling and support)

Union support: unions@uhbristol.nhs.uk 0117 3420824

	Bristol CCG	Avon & Wilts MHP	University of Bristol	Gloucestershire Hospitals
HR Contact	Judith Champion	Laura McGoldrick	Dorieke Van Den Brom	Julie Hapeshi
Job Title	Senior HR Business Partner	Employee Relations Specialist	Human Resources Officer	Associate Director R&D/Deputy Director SW RDS
Contact Email	judith.champion@swcsu.nhs.uk	l.mcgoldrick@nhs.net	Dorieke.van-den-Brom@bristol.ac.uk	Julie.Hapeshi@glos.nhs.uk
Contact Tel. No.	0117 9002205	07775 025812	0117 33 16814	0300 4225460
Working Days		Mondays (am), Tuesdays (9-5), Wednesdays (am) and Thursdays (9-5)	Monday to Thursday	

Glossary of terms:

CRN	Clinical Research Network
DeNDRoN	Dementia and Neurodegenerative Disease
LCRN	Local Clinical Research Network
LRN	Lead Research Nurse
MCRN	Medicines for Children Research Network
NIHR	National Institute for Health Research

All terms relating to processes within the consultation policy can be found in the UH Bristol Management of Change Toolkit, available on request or from HR Web on the UH Bristol intranet. A copy will be circulated with this paper.

Clinical Research Network
West of England

Whitefriars
Lewins Mead
Bristol, BS1 2NT
Tel: 0117 342 1375
Email: mary.perkins@nihr.ac.uk
Web: www.crn.nihr.ac.uk/westengland

Cover Sheet for a Report for the Public Trust Board Meeting, to be held on 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11 – Research & Innovation Strategy Progress Report
Purpose
The Director of Research will give an oral report to update the Board on research activity within the Trust. Data will be presented on recruitment activity into National Institute for Health Research portfolio trials, which determines future funding, and performance against the Department of Health benchmark relating to the time to setup and open trials.
Abstract
Recommendations
The Trust Board is recommended to receive this report by the Medical Director for review.
Executive Report Sponsor
Medical Director, Sean O'Kelly
Other Author
Appendices
Research & Innovation Q4 (2013/14) performance report.

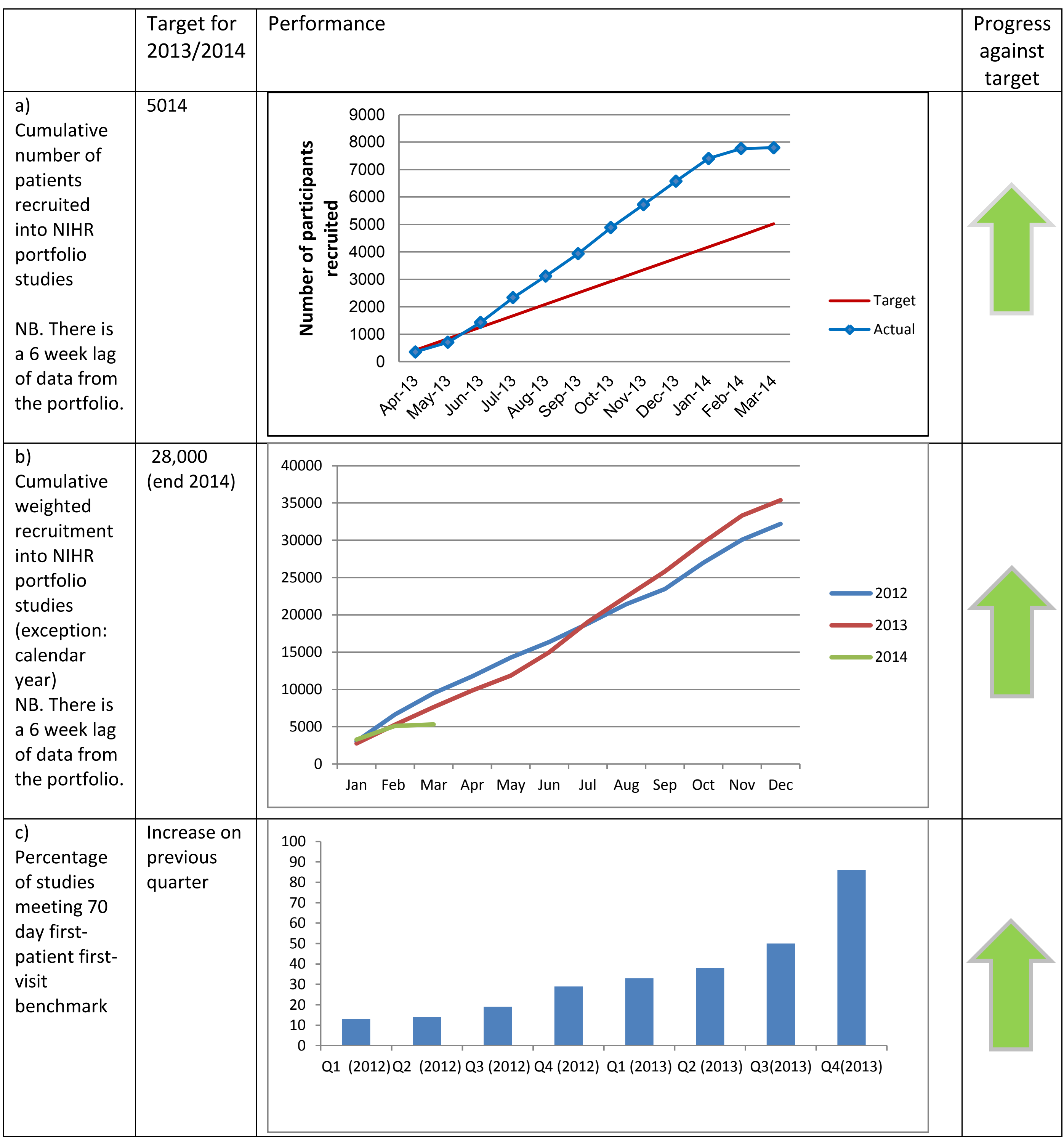
Previous Meetings

Executive Team	Trust Management Executive	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other

Despite an increase in weighted recruitment in the previous calendar year (2013), UH Bristol will be receiving a cut in the delivery funding allocated by the new West of England Research Network. This is not due to UH Bristol's performance in delivering trials but instead due to a cut in the overall funding provided to the Network. As a consequence and due to a higher number of interventional trials with long patient follow ups currently active on the UH Bristol research portfolio, the weighted recruitment target set for 2014 (calendar year) is a realistic 28,000. We have however seen a 27.4% increase in our Research Capability Funding awarded this year.

The NIHR have adjusted the way they measure our performance on achieving the 70 day benchmark to exclude from their analysis delays which were caused by the Sponsor and delays which were caused by neither the Trust nor the Sponsor. This change was made effective from Q4 2013/14 and has been reflected in the marked improvement in our Q4 performance against the benchmark (graph c).

Recruitment Indicators:



	Target for 2013/2014	Performance	Progress against target
a) Cumulative number of patients recruited into NIHR portfolio studies NB. There is a 6 week lag of data from the portfolio.	5014		
b) Cumulative weighted recruitment into NIHR portfolio studies (exception: calendar year) NB. There is a 6 week lag of data from the portfolio.	28,000 (end 2014)		
c) Percentage of studies meeting 70 day first-patient first-visit benchmark	Increase on previous quarter		

d) Our performance of meeting the 70 day first patient first visit benchmark *in comparison to other Trusts* (reported to the Barometer)	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	NIHR PID report- Quarter 3 2013/2014 52% Q1(13/14) 52% Q2(13/14) 52% Q3(13/14)	
e)Percentage of commercial studies recruiting to time and target	Increase on previous quarter	Percentage (0–50): Q1 (13/14), Q2 (13/14), Q3 (13/14), Q4 (13/14)	

Grants Indicators:

	Target		
f) Number of Grants submitted	No target	Number of grants (0–20): 2011/12, 2012/13, 2013/14	N/A
g) Total value of Grants awarded in year	No target	£ Million (0–4.5): 2011/12, 2012/13, 2013/14	N/A

UH Bristol R&I Q4 2013-14

Key:

NIHR	National Institute of Health Research - created by DoH in 2006 to implement the R&D strategy: 'Best Research for Best Health'
Portfolio	The NIHR's list of adopted studies. Studies that are funded through major funders (NIHR, Research Councils, Charities etc) via peer reviewed open national competition are eligible for inclusion on the NIHR Portfolio. Other studies are also adopted on a case by case basis. Funding from CLRNs is provided to support NIHR portfolio adopted studies. Some Commercial research is also adopted but no funding is provided via the CLRNs. UH Bristol falls under the WCLRN who provides funding for delivery of our portfolio studies.
Weighted recruitment	There are 3 different bands of study within the NIHR portfolio- Band 1, 2 and 3. This banding represents the complexities of a study. Patients recruited into a band 1 study are weighted lower than those recruited into a band 2 (observational) study which in turn is weighted lower than those recruited into a band 3 study (interventional). The ratio for the weighting is 1:3:14. The weighted recruitment provides an indicator of the monetary value of our research portfolio and influences the delivery funding supplied by the WCLRN at the end of the year.
70 day benchmark	This benchmark has been set by the NIHR and is 70 days from receipt of a valid research application into Research and Innovation to first patient recruited (consented) by the research team. Our target for approval of each study is 30 days thus allowing 40 days for the research teams to recruit.
Internal delay	Where the 70 day benchmark is not met we are required to supply reasons for this. Some factors influencing whether this benchmark is met is out of our control for example; external sponsors causing delays. However some reasons for not meeting this benchmark is a delay caused by UH Bristol and is thus an 'internal delay'.
Time to target	When an approval application is received into Research & Innovation a target number of patients to be recruited is provided as well as duration of the study. The NIHR requires us to submit quarterly data on whether our commercial studies are meeting their recruitment target and within the timescales of the research study.
Commercial studies	Commercial studies - Research funded AND sponsored (i.e. contracted) by commercial companies e.g. pharmaceutical company; medical device company
Non-commercial studies	Non-commercial - All other research. Funded by a non-commercial organisation such as the NIHR, a research council or charity or local funding. Also includes studies funded by a grant from a commercial company but sponsored by a non-commercial organisation.
R&D approval	Any project that is to be delivered within an NHS trust must be approved by that trusts R&D department before it can start recruiting patients. R&D approval is a process to confirm that a study can be delivered safely and successfully at UH Bristol
RCF	Research capability funding - funding provided by the NIHR for use in developing new grant applications and/or plugging the gaps of NIHR Investigators' salaries in-between grants
WCLRN	WCLRN - One of 25 Comprehensive Local Research Networks (CLRNs) as part of a national research network infrastructure. All NHS organisations in Avon, Gloucester, Wiltshire, Dorset and Somerset are members of the Western CLRN.

'High Quality Patient Care Through Research and Innovation'

Research and Innovation
http://www.uhbristol.nhs.uk/research-innovation
University Hospitals Bristol NHS Foundation Trust
Level 3 Education and Research Centre
Upper Maudlin Street
Bristol BS2 8AE
Tel: 0117 342 0233
Fax: 0117 342 0239
e-mail: research@uhbristol.nhs.uk

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

R&I Key activities

Mission

To undertake world-class translational and applied health services research and innovation in collaboration with our regional partners, that generates significant health gain and improvements in the delivery of our clinical services

- **Initiating research**
  - Increase grant funding awarded to UHBristol to lead high quality relevant research
  - Improve and build on patient, public and carer input to all aspects of our research
  - Set up research more quickly by improving systems and processes (costings, contracts etc)
- **Delivering research**
  - Improve the quality of information and understanding clinical divisions have about research activity
  - Share best practice across the divisions for setting up and staffing research, maintaining a workforce with the skills and support to develop and deliver high quality research that is of direct patient benefit
  - Make best use of existing IT systems to increase recruitment to research
- **Disseminating and evaluating research**
  - Collect and share information about outcomes and impacts of research
  - Showcase experiences of patients taking part in research

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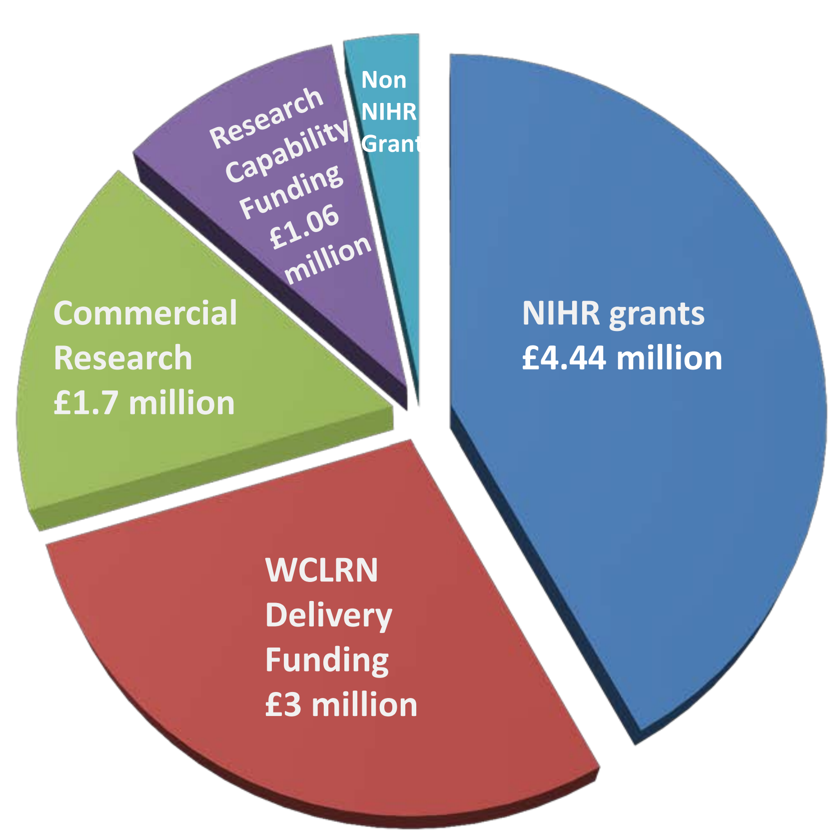
http://www.uhbristol.nhs.uk/research-innovation/research-and-innovation-department-at-uh-bristol/

Research funding at UH Bristol
All income 2013/14

- **Delivery funding from the Western Comprehensive Local Research Network (WCLRN)**
- **National Institute for Health Research (NIHR) Grants**
- **Research Capability Funding (RCF)**
- **Commercial Research**
- Non-NIHR Grants (charities, commercial grants)
- Also some income from grants held in other institutions



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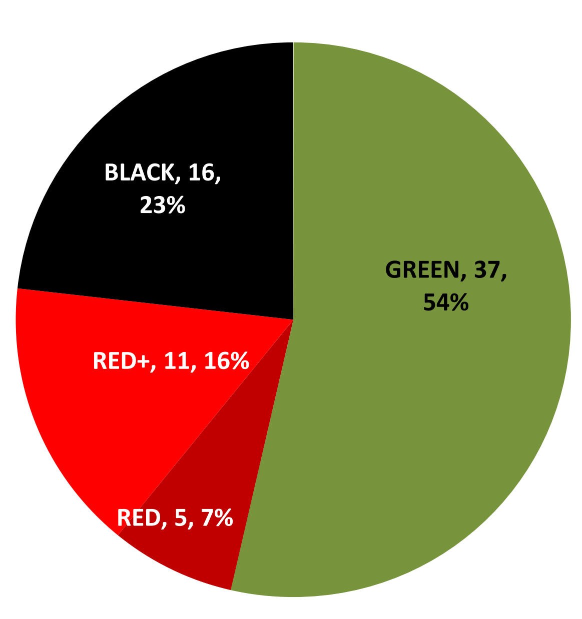
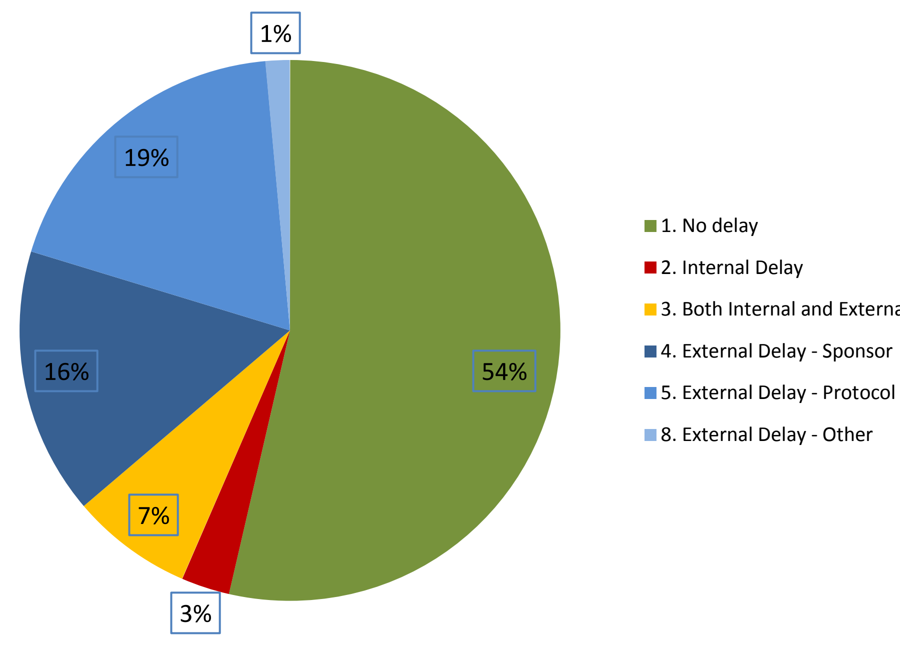
Measuring our performance: initiating research

Percentage of clinical trials meeting 70 day benchmark between 01/01/2013 and 31/12/2013



Reasons for studies not meeting the 70d target (n=49)



BLACK	Yet to Recruit - > 70 Days since valid application
RED+	Recruited - > 100 days since valid application
RED	Recruited - < 100 and > 70 days since valid application
GREEN	Recruited - < 70 days since valid application

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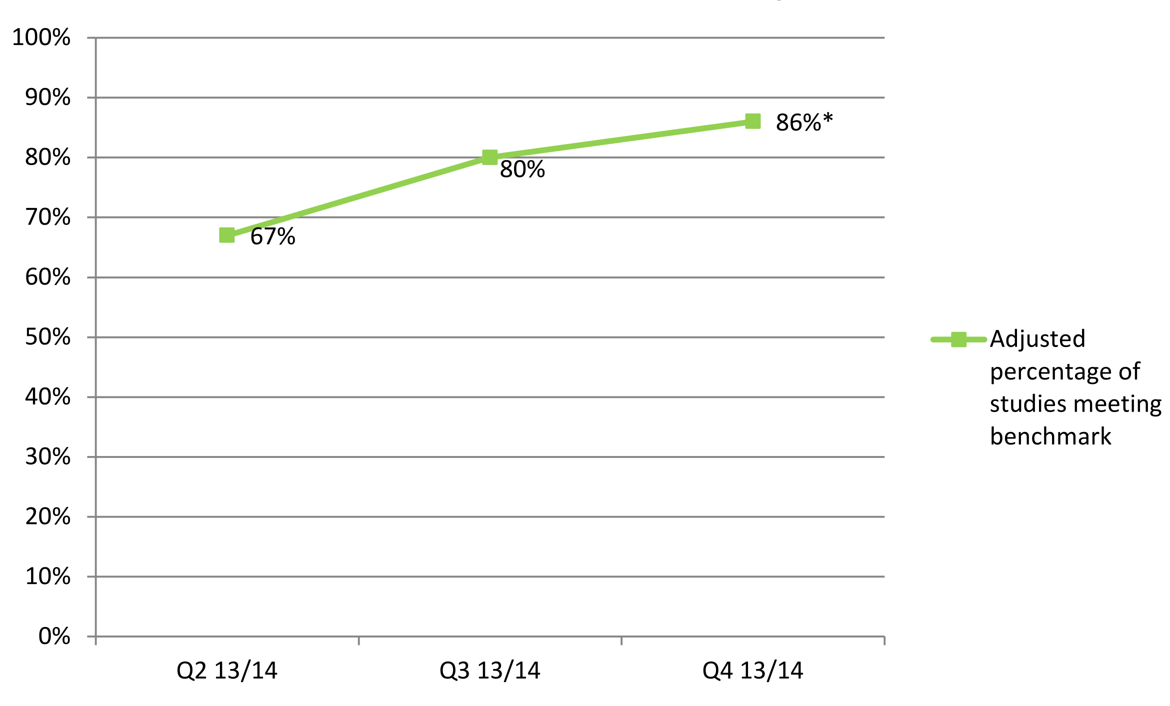
Time from a valid research application to recruiting the first patient

Adjusted performance: initiating research



Adjusted figure excludes:

- Delays which were caused wholly by the Sponsor
- Delays caused neither by the Trust nor Sponsor

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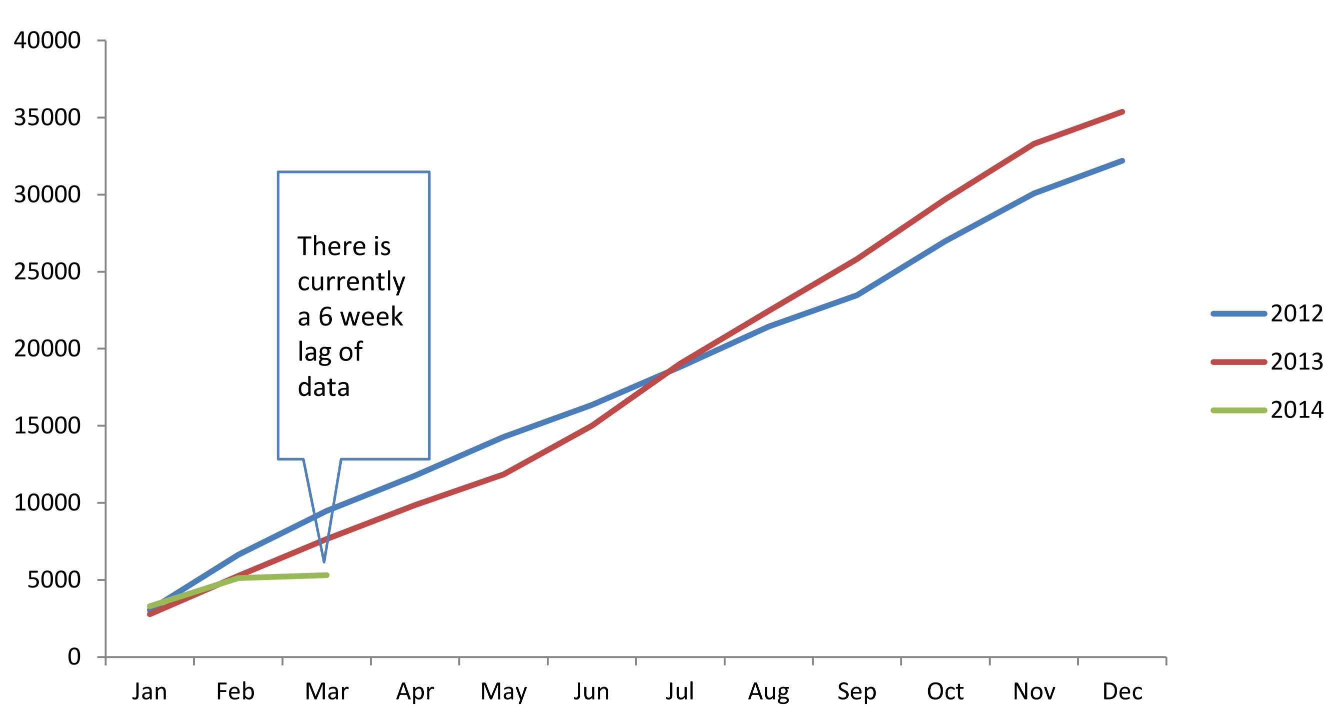
***Note**: final Q4 13/14 value may vary once NIHR has assessed which studies should be included

Measuring our performance: recruitment



*excludes recruitment to commercial studies

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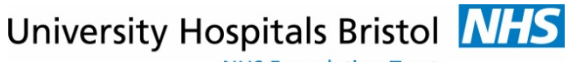
Our hospitals.

Weighted recruitment drives delivery income. UH Bristol is apportioned the largest share of the WCLRN allocation. But the WCLRN national allocation dropped by £1.7mill in 2013. All allocations are dependent on performance.



Research funding at UH Bristol:
2014/15 and ahead

Confirmed activity driven income due 14/15:

- Research Capability Funding (RCF) **£1.3m**
  - *Return to 12/13 levels*

- Delivery and Research Management and Governance funding from the Clinical Research Network: West of England **£3.6m**
  - *Cut of £70k; increased activity but smaller pot of money available due to poor performance of network as a whole*
  - *Expect strong focus by network on delivering value for money ("more for less")*
    - *Possibility of in-year reduction in delivery funding*
    - *Need increased clinical engagement across the Divisions to deliver this*
  - *Cut in delivery income of at least £400k expected in 15/16 as protected topic funding is lost after transition year.*
    - *Review model of delivery of paediatric research in context of whole trust over the next year to accommodate cut in funding*

Developments in 2014/15: Regional Agenda

Synergistic and closer working by BHP, CLAHRC*west* and WEAHSN allow us to:

- Focus on further integration of early-stage “bench to bedside” translational studies across both Universities and acute trusts
  - Scale up the pace of alignment in infrastructure, investment priorities and governance
  - Directly feeds into building capacity towards BRC/BRU bids in 2016
- Focus on the commissioning of HITs and building critical mass in our priority areas e.g. cancer and cardiology
- Consider using BHP as a vehicle for big-system change/redesign to better deliver evidence-based clinical services

Thank you

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Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

12. Estates Strategy Update

Purpose

The purpose of this report is to provide the Board with an update on progress and next steps in the development of the Trust's estate strategy and asset management plans, and to seek its approval for the approached described.

Abstract

Further to the presentation of the emerging estate priorities work to the January 2014 meeting of the Board, work has continued to develop the final estate strategy and evaluate options for land considered surplus to current requirements.

The attached paper sets out the emerging proposals, intended next steps and associated timescales.

Recommendations

The Trust Board is recommended to receive this report and confirm their approval for the approach described.

Executive Report Sponsor or Other Author

- Sponsor – Director of Strategic Development and Deputy Chief Executive

Appendices

- Appendix 1 – Estates Strategy Update
- Appendix 2 – DRAFT Master Site Control Plan

ESTATE STRATEGY DEVELOPMENT

1. Introduction

This paper provides an update on the first phase of the Estate Strategy work and describes the outcome of the initial site master planning exercise undertaken. The purpose of this master planning work has been to ascertain whether the approved Trust estate priorities can be accommodated on the land to the east and west of Marlborough Hill, or whether there is a requirement for the Old Building site to remain in clinical use in order to address these needs.

2. Background

The prevailing estate strategy (2010-2015) will be delivered through the current strategic development programme which will conclude in March 2016 when Phase IV of the BRI Redevelopment is concluded. This updated strategy will consider the site development requirements to 2020 and beyond and notably determine the future plan for the Old Building.

The following objectives for the Strategy were confirmed by the Board in January and will shape the final asset management proposals contained within the Strategy.

Strategic Estate Objectives

- Address known estate priorities
- Rationalise the estate whilst promoting operational and clinical efficiency
- Develop maximum flexibility for the estate to address unknown future priorities
- Minimise current and future backlog maintenance
- Deliver a contribution to the Trust's financial health
- Align commercial development of surplus land in a way which benefits the Trust
- Develop partnering solutions for the Trust which helps diversify risk and promote strategic partnering opportunities in areas that support the Trust's core mission

Through previous work the scope of the strategy has been defined and the following strategic estate priorities were also agreed by the Trust Board in January 2014. These have subsequently been further specified to inform the brief for the site master planning exercise.

Estate Priorities

- Improved patient access achieved through on-site, multi-storey car parking provision with associated rationalisation of existing provision and enhanced drop off and site circulation.

- Replacement of THQ and Estates & Facilities accommodation arising from rationalisation of land north of Upper Maudlin Street to accommodate multi-storey parking.

- Re-provision of soon to be obsolete, parent accommodation and required expansion to accommodate impact of specialist paediatric transfer.

- Re-provision of services displaced by any future NICU cots expansion.

- Retained space requirement for an additional 24 bed ward or other clinical accommodation such as care home.
- Retained space for further expansion of Trust research offer
- Retained space for displaced services in a scenario where disposal of Central Health Clinic and/or Tyndalls park is deemed desirable.

Following further benefits and economic evaluation of other priorities, the following have now been removed from scope

- On-site nursery provision – offsite solution considered more appropriate.
- Repatriation of all leased office accommodation – research related elements only to be repatriated.
- Work to evaluate the costs and benefits of re-providing on-site staff accommodation lost to site rationalisation remains underway but is expected to demonstrate no case for on-site re-provision

3. Site Master Planning

Through external consultants, Capita, the services of AWW have been retained to undertake an initial site master plan exercise to deliver the brief as described above within the context of expected planning requirements and constraints.

Their initial findings are shown on the drawing at appendix 1.

This plan demonstrates how all the Trust's estates priorities set out above can be accommodated in the land to the east and west of Marlborough Hill. The consequences of this exercise are that the options for evaluation of the future plans for the Old Building site are broadened in scope.

With this context confirmed, it is proposed that the following options for the Old Building Site be developed to Outline Business Case (OBC) with the aim of presenting the OBC for consideration by the Board in September 2014 (or sooner if work can be concluded earlier).

This timeline is driven by the requirement to declare the building surplus to current clinical requirements in March 2015 if the Trust wishes to limit the on-going revenue liabilities associated with capital charging and running costs from April 2016, which is the earliest date this can be achieved by. This approach to revenue cost reduction is a key planning assumption within the current Long Term Financial Plan.

The net capital receipt (after necessary works) is no longer sufficiently large to become a determining factor in the decision to retain or dispose of the site, unlike the revenue considerations.

The following options are proposed to be developed at OBC

Option 1 – secure building and retain site for future, unknown, use

Option 2 – demolish and retain site for future, unknown, use

Option 3 – market disposal

Option 4 – dispose or lease to strategic partner i.e. Trust determines future use and may or may not be a co-tenant / partner subject to final scheme selected.

Alongside the work to develop the OBC for the Old Building, it is intended to commence work on the case for Phase 1 of the land north of Upper Maudlin Street. This will enable the patient and the revenue benefits, associated with the car park, to be realised as soon as practical. All other estates priorities assumed to be developed on this land can be accommodated as part of a Phase 2 scheme which will follow – currently the only known time imperative associated with Phase 2 is the requirement to have replaced parent accommodation by 2022.

4. Next Steps

The following steps and provisional milestones to conclude the Strategy work are

- Final Estate Strategy presented to Board June 2014
- OBC for Old Building presented to Board September 2014
- OBC and FBC for Phase 1 of Marlborough Hill developed (car park / THQ) – date to be confirmed
- FBC for Old Building presented to Board January 2015
- Board Declaration that Old Building is surplus to requirement March 2015 if FBC concludes option 3 or 4 are to be pursued.

UHB Estate Rationalisation

March 2014

Proposed Building Boundaries

Dove Street

Dove Street South

Radio Pharmacy

Area for VIE plant access

Access to Car Park

Car Park

Surplus 1000m^2

Estates/ MEMO 1660m^2

Car Park 9 storeys Approx 1200 parking spaces

Trust HQ

Malborough Hill

24 Bed ward - 1400m^2
Area displaced by NICU - 400m^2
Parent Accommodation - 1000m^2

Car Park / Service area

Surplus Displaced Services 1000m^2

Eugene Street removed

Cottage Place

Alfred Parade

Dighton Street

Marlborough Street

N

Site Plan

Dove Street
Dove Street South
Radio Pharmacy
Area for VIE plant access
Access to Car Park
Car Park
Surplus 1000m²
Car Park 9 storeys Approx 1200 parking spaces
Trust HQ
Malborough Hill
Estates/ MEMO 1660m²
24 Bed ward - 1400m²
Area displaced by NICU - 400m²
Parent Accommodation - 1000m²
Cottage Place
Car Park / Service area
Surplus Displaced Services 1000m²
Eugene Street removed
Dighton Street
Alfred Parade
Marlborough Street
N

View 1

24 Bed ward - 1400m^2
Area displaced by NICU - 400m^2
Parent Accommodation - 1000m^2

Estates & MEMO
1660m^2

Existing
Pharmacy

Surplus Displaced
Services
2-3 storeys, 1000m^2

Surplus development
2-3 storeys
1000m^2

Car Park
9 storeys
Approx 1200

Trust HQ
3 storeys,
Approx 3250m^2

View 2

24 Bed ward
1400m^2
Area displaced by NICU - 400m^2
Parent Accommodation - 1000m^2

Estates & MEMO
1660m^2

Surplus Displaced
Services
2-3 storeys, 1000m^2

Existing
Pharmacy

Surplus development
2-3 storeys
1000m^2

Car Park
9 storeys
Approx 1200
parking spaces

Trust HQ
3 storeys,
Approx 3250m^2

View 3

24 Bed ward
1400m^2
Area displaced by NICU - 400m^2
Parent Accommodation- 1000m^2

Estates & MEMO
1660m^2

Surplus Displaced Services
2-3 storeys, 1000m^2

Car Park
9 storeys
Approx 1200 parking spaces

Existing Pharmacy

Trust HQ
3 storeys,
Approx 3250m^2

Surplus development
4 storeys
1000m^2

Car Park entrance

Removal of Eugene Street

Street View from Dighton Street Junction

Car Park
9 storeys
Approx 1200
parking spaces

**Cover Sheet for a Report for a Public Trust Board Meeting,
to be held on 28 April 2014 at 10:30am
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**

13. Action Plan in Response to the Care Quality Commission Inspection of Dementia Care (Action 262).

Purpose

To brief the Board regarding actions being taken by the Trust in response to the Care Quality Commission's inspection of dementia care on 22 January 2014.

Abstract

The CQC's judgement was that the Trust was non-compliant with Outcome 4 (care and welfare of people who use services), resulting in 'minor impact' on patients. The CQC noted a range of good practice in the care of patients with dementia, but also found that practice was inconsistent. The majority of actions agreed by the Trust are due to be implemented by the end of June 2014.

Recommendations

The Trust Board is recommended to receive this report by the Chief Nurse.

Executive Report Sponsor or Other Author

Sponsor – Chief Nurse

Appendices

- CQC Inspection Report, 22 January 2014
- Action plan dated 24 March 2014

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RA7
Our reference	INS1-1168223611
Location name	University Hospitals Bristol Main Site
Provider name	University Hospitals Bristol NHS Foundation Trust

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met:
	Care for people with dementia was not always planned and delivered in ways which met their individual needs and ensured their welfare and safety.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

We will ensure that caring for people with dementia is planned and delivered in ways which meet their individual needs and ensures their welfare and safety through the following actions:

We will develop and implement a specific care plan for dementia, to enable staff to deliver person centred care. This will include:

- The use of the "This is me" document to inform staff about people's needs, preferences, likes, dislikes and interests
- The use of the visual identification system (forget me not)
- The use of the ABC Behaviour chart to reflect individual support needs of people with behavioural and psychological symptoms of dementia.
- Assessment of capacity to make informed decisions
- The use of the Abbey Pain Assessment Tool
- Assessment of nutrition and hydration needs, including the use of red jug lids and drinking glasses
- Carer support

We will ensure that all patients who are 75 years and over who are admitted as an emergency are screened for a possible dementia by:

- Developing an electronic system routinely used by both doctors and nurses to prompt and capture the required screening, assessments and investigations (e-handover) by autumn 2014.

- Recruiting a fixed term Dementia Project Nurse to focus on all admission areas (Emergency Department, Medical Assessment Unit, Older Persons Assessment Unit and Surgical and Trauma Assessment Unit) to provide advice and ensure best practice at the point of admission.

We will minimise unnecessary non clinical moves at night through:

- Trust-wide awareness of the revised Transfer Policy
- Use of the Reverse Triage system – identifying those patients who should not be moved between the hours of 8pm and 8am unless for clinical reasons.

We have developed and will implement an "Enhanced Observation" policy which will set out the Trust's framework for providing enhanced observation of vulnerable patients within ward settings. It will ensure a consistent approach across the whole organisation, and support our statutory duties as set out in the NHS Constitution.

- Training will be provided to staff to support the implementation of the policy.

Who is responsible for the action?	Natalie Godfrey, Julie Dovey, Helen Morgan

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

Monthly ward-based audits (in addition to the annual dementia audit and monthly CQUIN dementia audit) will commence in July 2014 to monitor compliance against the use of the patient-centred care plan and inform actions necessary to improve and sustain improvements.

- Audit results will be reported to Divisions on an individual ward basis. Divisions will develop actions to address gaps and report into the Trust Dementia Implementation Steering group. The audits will include all aspects of the person-centred care plan.

- The electronic system that prompts and captures dementia screening and subsequent assessments and investigations will enable real time reporting progress, which will be in place by autumn 2014.

- Staff training records will provide documentary evidence that staff have participated in training on the use of the person centred care plan

- The trust-wide transfer audit will be repeated on a six monthly basis (achieved 100% in October 2013) and is planned for April 2014. Any incidents where patients are moved for non-clinical reasons out of hours will be followed up by the Lead Nurse for Dementia / Dementia Project Nurse to identify and remedy causative factors.

What resources (if any) are needed to implement the change(s) and are these resources available?

- IM&T resources are available to develop electronic system to prompt and capture the required screening, assessments and investigations. Available to implement from autumn 2014.

• Funding for a fixed term Dementia Project Nurse post has been confirmed from the CCG

Date actions will be completed:	End of June 2014 Autumn 2014 for Electronic System

How will people who use the service(s) be affected by you not meeting this regulation until this date?
We have already begun to implement a number of the actions identified. We do not anticipate any detrimental effect upon the people using our services whilst these actions are being implemented

Completed by: (please print name(s) in full)	Natalie Godfrey and Helen Morgan
Position(s):	Lead Nurse for Dementia and Deputy Chief Nurse
Date:	24th March 2014

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

University Hospitals Bristol Main Site

Bristol Royal Infirmary, Upper Maudlin Street,
Bristol, BS2 8HW

Date of Inspection:	22 January 2014	Date of Publication: March 2014

We inspected the following standards as part of this inspection. This is what we found:

Standard		Outcome
Care and welfare of people who use services	✗	Action needed
Cooperating with other providers	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	University Hospitals Bristol NHS Foundation Trust
Overview of the service	'University Hospitals Bristol Main Site' is a location of the University Hospitals Bristol NHS Foundation Trust. A range of acute and specialist services are provided from the location. The location's hospitals include the Bristol Royal Infirmary, the Bristol Royal Hospital for Children, St Michael's Hospital, the Bristol Eye Hospital and the University of Bristol Dental Hospital.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	5
More information about the provider	5
Our judgements for each standard inspected:	
Care and welfare of people who use services	6
Cooperating with other providers	12
Assessing and monitoring the quality of service provision	15
Information primarily for the provider:	
Action we have told the provider to take	18
About CQC Inspections	19
How we define our judgements	20
Glossary of terms we use in this report	22
Contact us	24

Summary of this inspection

Why we carried out this inspection

This inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and received feedback from people using comment cards. We reviewed information given to us by the provider and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During this inspection we looked at the care for people with dementia in the Bristol Royal Infirmary. This is an acute hospital which forms part of the Trust's location called 'University Hospitals Bristol Main Site'. We spent time in the hospital's Medical Assessment Unit (MAU), the Accident and Emergency Department (A & E) and in two wards for older people. Our findings were limited to the scope of the inspection programme and were not indicative of standards in other areas of the hospital and the location as a whole.

Patients and relatives we met with were mostly positive when talking about the staff. They commented, for example, that staff were very "very attentive" and "look after us very well". We observed examples of good practice, such as when staff interacted well with people and were able to establish a good rapport. However we also saw occasions when staff missed opportunities to engage with the individual or did so in an uninterested manner. Where procedures and guidance had been introduced to support staff, these were not being applied consistently across the hospital.

The Trust had identified a number of areas where improvements were needed in the care of people with dementia. Some key actions had been taken, such as training for staff about dementia and developing systems for ensuring that there was good communication

with other providers. However further developments were needed in order to ensure that people with dementia experienced a well planned and person centred approach to their care.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 29 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The Trust was taking steps to improve the care provided to people with dementia. However there were shortcomings in the arrangements being made for assessing the needs of people with dementia and in the planning of their care. There was a risk that people with dementia would not receive care that was safe and of good quality. Interactions between staff and patients with dementia were mostly positive although there were occasions when staff did not engage well with people.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spent time in the Medical Assessment Unit (MAU), the Accident and Emergency Department (A & E) and in two wards for older people. At the time of our visit, these wards were being brought together and designated as an Elderly Admissions Unit (EAU). We spoke individually with nine staff who in working in these areas and they told us about the care they provided to people with dementia. We talked with other staff who had specialist roles within the hospital. We met with patients and with relatives, and observed how staff supported people with dementia. The Trust provided us with information about the care of people with dementia and we looked at examples of the care records. We carried out 'pathway tracking', which is when we look at an individual's route through the service and their experience of the care being provided.

How are the needs of people with dementia assessed?

Information about people's conditions at the time of their admission was obtained from a variety of sources. In the A & E department, for example, staff said that ambulance crews provided them with important details about people's needs. We were told that this could include information about whether the person had a diagnosis of dementia. Staff on the MAU said that people admitted from care homes usually came with information about their needs. GP referral letters and feedback from relatives were also mentioned as sources of information.

This information helped to ensure that people with a diagnosis of dementia were identified

and their needs could be assessed upon admission. However, staff said that the quality of information varied, and commented that the detail received from care homes ranged from "brilliant" to "very poor". We spoke with staff who recognised the need to ensure that gaps in information were followed up as much as possible.

Staff told us about training they had received which had increased their understanding of dementia. Information provided by the Trust showed that good progress had been made in increasing the number of staff who had received some form of training in dementia. We were told, for example, that 93% of staff who had contact with adults had attended dementia awareness training. This meant that staff were aware of how the condition affected people and the importance of assessing people's individual needs.

However, we found that the arrangements made for assessing the needs of people with dementia lacked a consistent and personal approach. This was seen in our pathway tracking of four patients and in the records we saw for seven other people with dementia. Information was recorded which reflected an assessment of their medical and nursing needs, although a specific dementia screening assessment had not been undertaken. The Trust told us that their own audits of standards in dementia care had identified that improvements were needed in the screening of patients for a possible dementia.

Where a diagnosis of dementia had been confirmed, there were shortcomings in the documentation relating to the person's needs and individual circumstances. For example, the Trust had told us about a booklet called 'This is me' which was used to inform staff about people's needs, preferences, likes, dislikes and interests. Staff had spoken positively about the booklet and its purpose although we found that it was not being used consistently. In nine of the eleven records we looked at relating to people with dementia, we saw that the 'This is me' booklet had not been completed. This meant that staff did not have the information they needed to ensure that care was provided in a person centred way.

Staff we spoke with were aware of the importance of assessing pain in people with dementia who may not be able to express what they are feeling. Staff were aware of a tool that could be used to assess the level of pain in people with dementia, but also acknowledged that this was not being used consistently. We saw this was the case when we looked at people's care records; pain assessment forms were available but these had not been completed. One staff member commented "we don't ask people on the medical wards enough about their pain". Without a suitable assessment, there was a risk that people's pain would not be recognised and responded to adequately.

How is the care of people with dementia planned?

Care plans were in place which reflected a range of medical and healthcare needs. Through 'pathway tracking' we saw that plans had been written in relation to areas such mobility, pressure area care and infections. However, there was no specific care plan for dementia and people's records did not show that a dementia pathway was being followed. This meant that staff did not have the opportunity to anticipate symptoms, and to prevent them or to reduce their impact. We saw there was a lack of person centred planning because the fundamental document 'This is me' had not been completed in the majority of records we looked at.

Medical and nursing records included references to people being 'aggressive', 'agitated' or 'challenging'. However, we found that care planning did not reflect the support that people

needed with their condition of dementia. In one person's record, for example, we read that they were 'very aggressive, distressed and confused'. There was no plan in place to ensure that staff had good knowledge about this person's condition and how it affected them. Where there was guidance for staff about responding to people's behaviour, we found that this was not being consistently followed (refer to 'How is care delivered to people with dementia?'). Staff we spoke with on one ward said that if "physically aggressive" they could call security to come and help. We were told that this was a last resort because it could "aggravate the situation". In information we received from the Trust they acknowledged that 'the management of behaviours that challenge us' was an area for improvement due to the current lack of training and documentation.

The Trust told us about initiatives that had been introduced to help ensure that care was provided in a way which met the needs of people with dementia. This included use of the 'Forget me not' system, which provided a discreet way of identifying patients who have dementia and may need additional reassurance or assistance from staff. Staff we spoke with were knowledgeable and very positive about the system although we found that it was not being used consistently with people with dementia. This meant that there was risk that a person would not receive the additional support that they needed because of their dementia.

The Trust informed us of the arrangements being made for supporting people with hydration and increasing fluid intake for those people at risk. These included the use of red drinking glasses, which would be more visible to people, and red lidded jugs to identify those patients who needed encouragement or assistance to drink. When we visited the MAU and wards we found that the arrangements for using these items varied. We were told that in one area the red lidded jugs had been ordered and staff were waiting for these to arrive. We also heard that on one ward the red glasses were being used for everyone so that people with dementia "did not stand out".

Are people with dementia Involved in making decisions about their care?

For the most part, we found that staff sought to involve people with dementia in making decisions and choices about their care. We observed a number of occasions when staff asked people about their care and their individual preferences. These included occasions when people were asked how they wanted to spend their time. Staff, for example, were heard to say "would you like to have a lie down on your bed now?" and "is there anything else I can get for you". One patient commented "the nurses have been good and helped me with anything I wanted".

At lunchtime, we observed staff on one ward asking people about their meals and individual preferences. We heard, for example, "you wanted an omelette today, would you like some mashed potatoes and vegetables with it" and "how are you getting on with it, is it nice …. are you managing to chew it alright …. would you like something else". Another person with sandwiches was asked "would you like me to cut off the crusts for you".

We spoke with staff who were aware that people may be able to make decisions about some aspects of their lives, but not others. We saw some information about mental capacity in people's records. In one person's record we read that there was a concern that the person was declining to eat and drink. It was recorded that they did not have capacity to make an informed decision about their refusal to eat and drink. This showed that people's capacity was being assessed individually in relation to specific decisions about

their care and treatment. Staff told us that a plan had been discussed for how the refusal should be responded to. However, a 'best interest' meeting had not yet taken place and there was a lack of documentation about the process being followed. The records did not show that action was being taken in a timely way.

Are people with dementia provided with information about their care?

Staff we spoke with were aware of the need to take time to explain to people the care and support that was being offered. Staff were heard talking to people about their care and asking questions such as "how are you feeling". We heard doctors explaining who they were, giving clear information about treatment and checking if patients were happy and had any questions. A nurse was observed talking to one patient; they got down to the patient's level and explained what she was intending to do. The patient smiled and nodded and once the nurse had confirmed that the patient was in agreement, they drew the curtains inside the bay.

We were shown laminated cards with information in the form of pictures and symbols. Staff said that information in a visual form helped people to make their wishes and needs known. Information in people's records such as care plans was not presented in a user friendly way. This meant that they would be more dependent on staff and visitors to provide them with the information they needed about their care.

How is care delivered to people with dementia?

We received information from the Trust about a range of developments in relation to the care of people with dementia. We were told, for example, about the recruitment of dementia champions and work being undertaken to create a more dementia friendly environment. There had also been a programme of training to support staff in understanding how best to care for people with dementia. These arrangements helped to ensure that there was a better awareness of the needs of people with dementia.

Staff we spoke to recognised the benefits of these developments, but we also heard about obstacles to achieving good outcomes for people. No wards were specifically designated for the care of people with dementia and the current configuration of the wards meant that people with dementia were cared for alongside people who had no such needs. Comments from staff highlighted the challenge they faced in ensuring that the needs of people with dementia were identified and responded to effectively. We were told that ward closures were not uncommon and there were pressures relating to staffing and bed capacity. One staff member, for example, commented "they try and rush people through, sometimes not enough time is given. Patients are moved at night, everyone is in a rush and putting pressure on people".

Staff in the different areas we visited told us that on occasions patients were assessed for receiving one to one support. We heard that the response to this was varied. In one area we were told that requests for additional one to one help were "usually granted". In another area however we heard that it was more difficult to provide this extra staffing.

Arrangements were in place for reviewing care plans and monitoring people's day to day needs. One staff member, for example, commented "care plans are reviewed every seven days, nutrition charts every three days. Everyone who has dementia is on a nutrition chart". We were also told "we review the care plan every Sunday or sooner if there has

been deterioration. We write in the care log in front of the file about what care we have given".

The food and fluid charts we saw were up to date, with one exception which we brought to the attention of the ward sister. Recording in relation to people's dementia tended to describe behaviour rather than provide an evaluation of the circumstances in which it had arisen. This meant that there was a lack of good information when people's care was being reviewed.

The feedback we received and our observations of support highlighted some variation in the quality of care that people received. Patients and relatives were mostly positive in their comments about the staff and how they went about their work. Their comments, for example included "I'm comfortable here, they look after us well" and "the nurses have been good and helped me with anything I wanted". One person described the staff as "very patient with people and very understanding". However, they told us that their experience of care was adversely affected by the attitude shown by one staff member in particular. We brought this to the attention of the ward sister.

Our observations of care showed that staff were busy and combined responding to requests from patients with the carrying out of their routine checks. We saw some very positive interactions, such as when staff adopted a friendly approach and used the care task as a time to engage in conversation with the patient. However there were also missed opportunities, for example when we saw staff regularly entering one person's bay without acknowledging their presence.

When visiting another area, we were aware of one person who had been shouting and calling out throughout our time there. We discussed this with the staff present. Although some 'one to one' support had been arranged, this was not being provided in a way which was consistent with the guidance that had been produced about the person's needs. We saw that there was lack of empathy and personal interaction, and person providing the support was heard to say "you should not shout like that".

Is the privacy and dignity of people with dementia respected?

Staff were mostly observed to be supporting people in ways which respected their privacy and respect. Curtains were routinely drawn around beds so that care was provided in privacy. We also saw that staff supported people with maintaining their dignity, for example by checking that they were suitably dressed when in bed and when walking around the ward. On one occasion, after being hoisted into their side chair, a person was asked if they wanted a sheet to cover their legs, which they agreed to. Our observations showed that staff were aware of the need to be aware of people's dignity and how this could be compromised without their support. Staff in the A & E department told us that although it could be a challenge, maintaining the patient's privacy and dignity was always a priority when treatment was being provided.

Patients on the wards were being cared for in 'same sex' accommodation. We saw that female and male areas were identified by the use of pink and blue door frames. The colours did not particularly stand out from the general décor although the intention was to help patients to identify their beds.

Our observations of care and support included use of the SOFI (Short Observational Framework for Inspection) tool. The SOFI tool helps us to closely observe and record the

support that they receive and how this impacts on their wellbeing. This is particularly used in situations when people are not able to pass on their own views directly.

In one area we had observed staff engaging well with patients during the lunch meal and asking about their individual needs. We had also seen staff positioning themselves well in relation to the person and maintaining good eye contact. We undertook the SOFI in another area and the quality of engagement was more varied when people received support with their meals. One staff member had initially engaged well with the patient at their level, but later appeared distracted and then provided support with eating while standing over the person. Another staff member did not explain to the person they were supporting what they were doing and adopted a similar standing position. This was a task centred approach which lacked any personal interaction.

Cooperating with other providers Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

The Trust had procedures in place for the planning of care and the sharing of information when people moved between services. Steps were being taken to increase the effectiveness of the arrangements so that people with dementia benefited from a more coordinated approach to their care.

Reasons for our judgement

We spoke with staff in the Medical Assessment Unit (MAU), the Accident and Emergency Department (A & E) and in two wards for older people. Staff told us how they worked with others when providing care to people with dementia. We heard about the arrangements made with other providers to meet the needs of people with dementia. The Trust provided us with information about discharge procedures and how information was shared between services.

Does the provider work with others when providing care to people with dementia?

In the different areas of the hospital we visited we were told about the arrangements made for working with other departments and providers. Overall, we found that there were well some established procedures in place, with work being undertaken to develop these and to improve communication and the sharing of information.

Staff in the A & E department told us that they had seen an improvement in communication with ambulance crews. They said that better information was being passed on to them by the crews. This included statements about people's wishes and information relating to their needs when admitted to the hospital from a care home. In the MAU and in the wards we heard that information coming from care home varied greatly. We were told that phone calls were often needed to ensure that staff had the information they required, particularly when people were not able to express their own needs.

As reported under 'Care and welfare of people who use services', the records in relation to assessments and care plans did not provide evidence of good, person centred information to enable smooth transitions of care. This would also have an impact on how well information was transferred when people moved within the hospital. We were told by the Trust that work was being undertaken to reduce inter-ward moves of older people. A project group was also looking at ways of reducing the admission of older people, particularly those with dementia.

Information we received from the Trust included details of other projects and pilot schemes that were being undertaken in conjunction with other agencies. A number of these had the aim of promoting better communication between providers and a more coordinated approach to people's care. We saw, for example, that new documentation had been produced to use when people moved between hospital and care home. This meant that information would be shared in a more timely and consistent way.

Attention had also been given to the discharge procedures. There had been developments in how discharges were managed and who co-ordinated the arrangements. We received good feedback about the changes that had been made and the work undertaken by a discharge liaison team. A nurse we spoke with commented that the team were good at contacting other agencies. We were told that the involvement of the team meant that nurses' time was "freed up" and they could spend their time more efficiently.

Staff told us about their role in the discharge arrangements. Their feedback about the arrangements was positive. One staff member said that a "general assessment" was undertaken before a person left their care. We were told that, on discharge, "all information is given to the care home". Comment was also made that "we would seek consent" and if the patient had capacity they were involved in the discharge arrangements.

We met with one relative who specifically mentioned the arrangements being made for the discharge of their family member. They told us that the nurses had been "very attentive" and "were working hard to complete a fast track discharge … we have all been very involved with the plans and discussions and they have liaised with other agencies … things that we haven't even thought of. If it all works it will be great".

Are people with dementia able to obtain appropriate health and social care support?

People with dementia were assisted with obtaining a range of health and social care support from within the hospital. Staff told us about the services that were available and in people's care records we read about their contact with different healthcare professionals.

In each area we visited staff described the arrangements by which patients were seen by doctors and other health care professionals on a regular basis. We were told about meetings to discuss patients' needs. One staff member, for example, told us they had "a meeting every morning at 9am, a multidisciplinary meeting which everyone comes to - physiotherapist, occupational therapist, nurses, doctors, and pharmacist".

We were told about other specialist services that were available through the hospital. These included referrals to a psychiatric liaison team. The Trust was not able to refer patients directly to memory services but we were told that referrals were made through the patient's GP. A nurse told us "if any problems are identified with nutrition we will refer to dietician and offer snacks and sandwiches".

A member of staff was in the role of 'Falls Assistant', which meant staff made a referral to them if there was a risk that a patient might fall. It was their job to reduce the risk and we observed them engaging very positively with a person with dementia and building a good rapport. They told us that they worked as part of a team and had weekly meetings with the lead nurse for dementia. This helped to ensure that there was a coordinated approach to supporting people with dementia.

Through pathway tracking we noted that support from a social worker had been obtained and there had also been contact with professionals who had a role in relation to safeguarding adults.

Assessing and monitoring the quality of service provision

Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The quality of dementia care was being assessed and shortcomings in the service were recognised. Overall, the Trust was taking action and had plans in place to improve the service that people with dementia experienced.

Reasons for our judgement

We looked at how risks to people with dementia were managed and how their safety was promoted. Staff told us how the service was monitored and we heard about a number of new initiatives. We received information from the Trust about audits and the plans that were in place to improve the service for people with dementia.

How is the quality of dementia care monitored?

Information we received as part of this inspection showed how the Trust was working towards achieving the South West Hospital Standards in Dementia Care. The standards were designed to promote improvements in hospital care for people with dementia. The Trust had mapped these standards to the NICE (National Institute for Health and Care Excellence) Quality Standards for dementia care and undertaken a baseline assessment.

The Trust had undertaken a number of developments in relation to meeting these standards. These included training and other activities to increase staff awareness of dementia. Current developments included changes to care documentation and the creation of personalised care plans. We were told that these developments were in order to ensure that care was delivered in a way which met people's individual needs. As reported under 'Care and welfare of people who used services', these were areas where we found shortcomings and where improvements were needed.

The Trust had identified further areas for improvement and told us that an annual audit of dementia care within the hospital was undertaken. Information provided by the Trust included details of their involvement in national and trust led audits since 2012. This showed that the quality of the service was being checked and shortcomings identified.

The audits included conclusions and recommendations about the standards achieved. Following an audit in November 2012, for example, it was concluded that patients with cognitive impairment do not consistently receive 'optimal assessment and care' as set out

by national and regional guidelines. From the audit undertaken at this time, it was seen that a range of improvements and developments were needed in order to achieve the expected standards.

Audits referred to the strategies that would be needed to improve the care received by patients with dementia. The feedback we received showed that progress had been in some key areas. This had included the recruitment of 135 dementia champions from within the staff team. A clinical lead for dementia and a lead nurse for dementia had been appointed to promote good practice and to act as an 'in reach' team resource. These developments helped to ensure that the arrangements being made within the hospital were consistent with good dementia care.

Plans had been produced with actions for how improvements would be made, as identified at the last clinical audit in November 2012. Timescales were identified for the completion of actions, with a latest completion date of March 2014. An action relating to the creation of a care pathway for older people with dementia had not yet been completed. The provider may wish to note that we found that progress in some areas was limited and the rate of improvement was not being closely monitored. We were told that the next full audit was due to take place in February 2014. We saw that a data collection tool had been developed to use in this audit. The tool covered a range of areas and included questions, for example, about the screening of people for dementia and use of the 'This is me' booklet. This meant that the Trust would have the information needed in order to assess the progress that was being made.

How are the risks and benefits to people with dementia receiving care managed?

We spoke with staff who told us how risks to people with dementia were being managed. In the Accident and Emergency department, for example, a daily safety briefing took place. This provided the opportunity for staff to be updated on any concerns and risks to people. We also saw that daily notes were being audited to highlight any issues which needed to be brought to the attention of staff.

Staff we spoke with in the A & E department were aware of the vulnerability of people with dementia. They talked about their role in relation to safeguarding adults and the reporting of allegations of abuse. Staff recognised that this was particularly important as the A & E department would be where a number of people with dementia were first seen within the hospital

In other areas, we heard about the arrangements in place for monitoring risk, including the use of a monthly 'safety thermometer'. This was a means of measuring harm, for example from pressure ulcers, and the proportion of patients who were 'harm free' during the month. The data collected each month helped to identify areas for improvement. Staff told us that incident forms were being completed, for example, when risks had been identified and there were safety issues to be highlighted.

Some adaptations were being made within the environment to take account of the needs of people with dementia and to promote their wellbeing. In the A & E department, for example, staff said that a quieter area within the department would be used whenever possible. We were told that the end bays in a row of examination bays would be used for people with dementia. Staff said that these bays were next to the toilets, which helped with orientation. In a ward area, colour coding had been used around the bays to help people identify where there bed was.

We saw that some areas were available to people for social activities. The Trust told us about a 'reminiscence pod' that was available to people on one ward. This was designed to be a facility within the ward that would encourage conversation and reassure people with dementia. In another ward we saw a small area that was designated as a 'social area' for patients. This was situated in a busy area near the entrance to the ward'; a location which was not ideal for patients with dementia.

One person we spoke with commented "the only problem is the noise sometimes" when talking about their ward. Overall we found that environmental enhancements in relation to the needs of people with dementia were limited. In information received from the Trust they had identified this as an area for further consideration and development.

Are the views of people with dementia taken into account?

The Trust had a range of procedures in place for obtaining the views of patients. These included the use of surveys and comment cards. We were shown a new leaflet that had been produced, in which people with dementia, or someone in a supportive role, were invited to pass on their views. The leaflet also provided information about forthcoming events relating to the needs of people with dementia and those of their carers.

Information received from the Trust included examples of actions that had been taken in response to recent feedback and how these had been of benefit to people with dementia. They included improving the information on the wards about dementia and we saw evidence of this during the inspection. We were told that there had been good feedback about the hospital's befriending scheme and the carer liaison support service, and that these were being further developed. A staff member we spoke with felt that the befriending scheme was a good service for people with dementia.

The Trust told us about actions that had been taken following observations and peer reviews undertaken within clinical areas. These included ensuring that the principles which underpin a positive therapeutic environment for people with dementia were incorporated into refurbishment programmes. We were told that attention had also been given to visiting times, which had been extended to provide greater flexibility for patients and their relatives.

We received positive feedback about the work undertaken by the Trust's lead nurse for dementia. The Trust told us that consideration was being given to the creation of dementia clinical nurse specialist post to provide a clinical service that would complement the work undertaken by the lead nurse.

As part of this inspection we left comment cards for patients, staff and visitors to complete during the week following our visit. Two cards were completed. One person commented that there was a now a greater awareness of dementia, but "still a long way to go" and "implementation of initiatives patchy". The second person commented that the hospital was "OK" and that "people talk nicely".

This section is primarily information for the provider

✖ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care for people with dementia was not always planned and delivered in ways which met their individual needs and ensured their welfare and safety.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 29 March 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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NHS Foundation Trust

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

14. Finance Report

Purpose

To report to the Board on the Trust's financial position and related financial matters which require the Board's **review.**

Abstract

The summary income and expenditure statement shows, subject to audit, a surplus (before technical items) of £6.188m for the year ending 31st March 2014. The Trust's Continuity of Services Financial Risk Rating is 4 (actual 4.0) for the year.

The Trust is required, in completing its Annual Report and Accounts, to recognise, where appropriate, technical accounting issues. For 2013/14, there are four items i.e. donations and grants, asset impairments, reversal of asset impairments and depreciation on donated assets, which lead to the income and expenditure surplus becoming a deficit after technical items of £5.162m.

Recommendations

The Trust Board is recommended to receive this report by the Director of Finance and Information

Executive Report Sponsor or Other Author

- Sponsor – Director of Finance and Information
- Other Author – Head of Finance

Appendices

- Appendix 1 – Summary Income and Expenditure Statement
- Appendix 2 – Divisional Income and Expenditure Statement
- Appendix 3 – Monthly Analysis of Pay Expenditure
- Appendix 4 – Executive Summary
- Appendix 5 – Summary of Divisional Variances and RAG Ratings
- Appendix 6 – Financial Risk Ratings

Previous Meetings

Executive Team	Senior Leadership Team	Quality and Outcomes Committee	Finance Committee	Audit Committee	Other
			25 April 2014		

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £6.188m (before technical items) for the year ending 31 March 2014. The provisional outturn position represents a favourable variance of £0.266m against the planned surplus for the year of £5.922m.

The Trust is required, in completing its Annual Report and Accounts, to recognise, where appropriate, technical accounting issues. For 2013/14, there are four items under this heading which lead to the income and expenditure surplus becoming a deficit after technical items of £5.162m.

The position is summarised in the table below.

	Annual Plan £'000	Actual Income and Expenditure £'000
Income and Expenditure Surplus to 28 February (before Technical Items)		**5,277**
Annual Plan Surplus £5.922m x 1/12th		494
Overspending in March by Divisions		-
Incremental Drift Reserve – (£0.873m x 1/12th)		72
Trust Reserves (Balance of £7m)		223
Financing (includes depreciation and PDC Dividend) and other minor changes		122
Income and Expenditure Surplus to 31 March – before Technical Items	**5,922**	**6,188**
Technical Items		
- Donations and Grants	2,250	1,501
- Asset Impairment	(3,030)	(19,073)
- Reversal of Asset Impairments	1,886	7,073
- Depreciation on Donated Assets	(866)	(851)
Income and Expenditure Surplus / (Deficit) to 31 March – after Technical Items	**6,162**	**(5,162)**

The Trust has received donations and grants of £1.501m. This is £0.749m less than assumed in the Annual Plan. It has been agreed with the Teenage Cancer Trust that moneys anticipated to be received this year will now be paid to the Trust in 2014/15.

An estimate of £3.03m had been made to provide for the impact of impairment of the BHOC capital scheme in 2013/14. The actual impairment value as assessed by the District Valuer is £4.454m. In addition to this the District Valuer, as part of the quinquennial asset revaluation exercise has advised of the requirement for an impairment of £2.29m for the Welcome Centre. For financial planning purposes no impairment had been provided as the Welcome Centre is an income generating scheme. However, as it is in effect an extension of the Queens Building rather than a separately identifiable asset the valuation leads to there being a requirement to impair part of the capital cost. The third scheme which is subject to an impairment this year is the Centralisation of Specialist Paediatrics project. The opening of part of the new facility leads to an impairment in

2013/14 of £12.332m. The impairment has allowed for the original provision (assumed in May 2013) of £5.7m to be removed from the 2014/15 Annual Plan submission. The total adverse impact of asset impairments is £19.073m, or £16.043m more than planned. It should be noted that this technical adjustment has no adverse impact on cash.

Each year the Trust anticipates the likely change (indexation) in asset values over the coming year. In line with previous practice an assumption of 2% was made at the start of 2013/14. Changes to the index are a guide for organisations to use in those years between formal asset valuation exercises. The quinquennial review carried out to inform the 2013/14 Annual Accounts is an opportunity for a comprehensive review of the value of the land and buildings owned by the Trust. The District Valuer has advised on revaluation which results in a reversal of previous impairments to a value of £7.076m. This is a technical gain of £5.187m when compared with the Annual Plan assumption. The single biggest factor item which leads to this change is the revaluation of the BHOC at £5m.

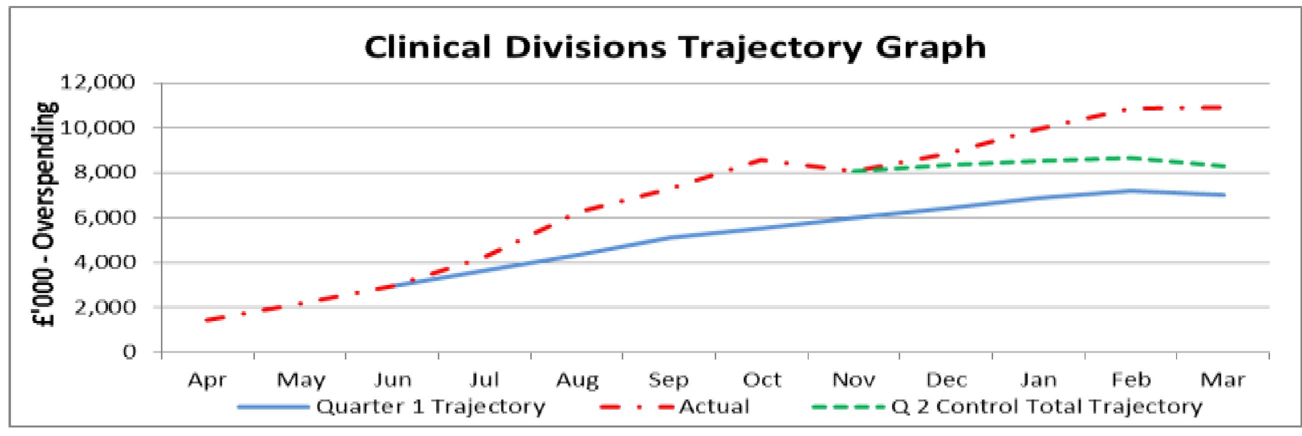
The Trust's Annual Plan included provision for depreciation on donated assets to a value of £0.866m for the year. Depreciation charges of £0.851m are marginally less than plan for the year.

The results to 31 March are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0). Further information on the financial risk rating is given in section 6 below and appendix 6.

The table below shows the Trust's income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £10.566m. Detailed information and commentary for each Division is to be considered by the Finance Committee (agenda item 5.3 refers).

Divisional Variances	Variance to 28 February	March Variances	Variance to 31 March
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(3,930)	(131)	(4,061)
Non Pay	(5,811)	(644)	(6,455)
Operating Income	310	352	662
Income from Activities	2,999	393	3,392
Sub Totals	(6,432)	(30)	(6,462)
Savings Programme	(4,134)	30	(4,104)
Totals	**(10,566)**	**-**	**(10,566)**

The trajectories from Clinical Divisions for delivery of the out-turn within the control total of £8.16m is shown below.



Pay budgets have a cumulative overspending of £4.061m – an overspending of £0.131m in the month. The principal area of concern is the overspending in Medicine, £0.153m (cumulative £2.717m). For the Trust as a whole bank, agency, overtime and waiting list initiative and other payments totalled £1.805m in March and £22.1m to date.

Non-pay budgets show an adverse variance of £6.455m for the year, a net overspending of £0.644m in the month. Significant in-month overspendings have been recorded against Diagnostic and Therapies (£0.134m), Specialised Services (£0.329m), Facilities and Estates (£0.117m) and Trust Services (£0.147m).

Operating Income budgets show a favourable variance of £0.352m for the month with a favourable position of £0.662m for the year. The underspending in March reflects improvements within Diagnostic & Therapies (£89k), Surgery, Head and Neck (£122k), Women's and Children's (43k), Facilities and Estates (£42k) and Trust HQ (£89k).

Income from Activities shows a favourable variance of £0.393m for the month leading to an over-performance of £3.392m for the year. The projected performance for clinical services activity for March is positive with higher than planned income in Diagnostic and Therapies (£68k), Medicine (£87k), Specialised Services (£78k), Surgery, Head and Neck (£103k) Women's and Children's Services (£10k) and Estates and Facilities (£31k).

The table below summarises the changes in financial performance in March for each of the Trust's management divisions.

	Cumulative Variance to 28 February Fav / (Adv)	Variance for March Fav / (Adv)	Cumulative Variance to 31 March Fav / (Adv)	Quarter 2 Control Totals Fav / (Adv)
	£'000	£'000	£'000	£'000
Diagnostic and Therapies	415	202	617	150
Medicine	(2,748)	(199)	(2,947)	(1,750)
Specialised Services	(804)	(94)	(898)	(1,000)
Surgery, Head and Neck	(6,282)	(30)	(6,312)	(4,750)
Women's and Children's	(1,441)	61	(1,380)	(1,000)
Estates and Facilities	200	(13)	187	150
Trust HQ	246	21	267	260
Trust Services	(152)	52	(100)	(220)
Totals	**(10,566)**	**-**	**(10,566)**	**(8,160)**

2. The main Divisional Budget changes in March include the following:-

	£'000
Local CEA Awards	139
CSP Transition	138
Capital to Revenue transfers	123
Energy inflation	116
European Working Time Directive	98
CSIP	92
Tribunal Costs	75
NMET	48
Legal Costs	40

3. Savings Programme

The Trust's Savings Programme for 2013/14 is £20.989m. Savings of £16.885m have been achieved over the year (80.4% of Plan) , a shortfall of £4.104m against divisional plans. The outturn for the year includes non-recurring savings of £4.425m. Income generation schemes contributed £2.116m. Reductions in pay costs of £5.95m were achieved and a further £8.819m was saved on supplies and services. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme Performance to 31 March 2014		
	Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000
Diagnostics and Therapies	1,342	2,063	721
Medicine	2,959	2,558	(401)
Specialised Services	3,261	2,700	(561)
Surgery, Head and Neck	6.893	2,516	(4,377)
Women's and Children's	2,643	2,672	29
Estates and Facilities	1,081	1,097	16
Trust HQ	1,033	1,086	53
Other Services	1,777	2,193	416
Totals	**20,989**	**16,885**	**(4,104)**

4. Income

Contract income was £0.10m higher than plan in March. Activity based contract performance at £373.66m for the year ending 31 March is £3.82m greater than plan. Contract rewards / penalties at a net income of £6.47m are £2.25m better than plan. Income of £65.49m for 'Pass through' payments is £4.38m higher than Plan.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Activity Based			
Accident & Emergency	13.27	12.86	(0.41)
Emergency Inpatients	67.60	67.58	(0.02)
Day Cases	30.32	34.39	4.07
Elective Inpatients	49.32	46.91	(2.41)
Non-Elective Inpatients	26.89	26.33	(0.56)
Excess Bed days	8.21	7.66	(0.55)
Outpatients	58.06	60.89	2.83
Bone Marrow Transplants	7.99	7.11	(0.88)
Critical Care Bed days	39.85	39.82	(0.03)
Other	68.33	70.11	1.78
Sub Totals	**369.84**	**373.66**	**3.82**
Contract Rewards / Penalties	4.22	6.47	2.25
Pass through payments	61.11	65.49	4.38
Totals	**435.17**	**445.62**	**10.45**

5. Expenditure

In total, Divisions have overspent by £10.566m for the year. The table given in section 1 (page 3) summarises the financial performance for each of the Trust's management divisions. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

Four divisions are red rated[1] for their financial performance for the year.

The **Division of Medicine** reports a cumulative adverse variance of £2.947m for the year, a net overspending of £0.199m in the month.

The Division has a significant overspending on pay headings, £0.153m in March and a cumulative overspending of £2.717m. Pay costs continue to run significantly higher than plan to maintain clinical services to unfunded capacity. Expenditure of £6.007m has been incurred in the year on bank, agency, overtime, waiting list and other payments.

Non-pay budgets have overspent by £72k in March and by £0.925m for the year. The provision of additional capacity has resulted in further cost pressures on catering, portering, mattress hire and other internal recharges.

The Division reports a favourable variance of £26k in the month on its Operating Income budgets thereby increasing the surplus for the year to £93k.

Income from Activities has an over achievement of £87k in the month leading to an over performance for the year of £1.003m.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £0.898m for the year, an adverse net movement in the month of £94k.

Pay budgets show an overspending of £0.603m for the year, an increase in the month of £35k. The overspending on budgets is the cost of covering gaps in the medical rotas and premium nursing agency costs.

Non pay budgets show an overspending for the year of £541k. The in-month deterioration of £0.329m reflects higher than planned expenditure on non-pass through consumables linked to increased in-patient activity within the BHI together with a net adverse movement on clinical supplies stock levels of £0.192m.

Operating Income budgets show a cumulative adverse variance of £3k, an underspending of £3k in March. Income from Activities shows a cumulative underspending of £0.811m, an improvement in March of £78k. Favourable income variances are recorded against Cardiac Critical Care (£0.392m), Cardiology (£0.594m) and Oncology (£0.660m). Under performance on cardiac surgery in March was £77k thereby increasing the cumulative total to £1.034m. Radiotherapy reports a positive in month performance of £24k to bring their year to date position to £0.295m favourable.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £6.312m for the year, a net overspending in the month of £30k.

Pay budgets have overspent by £8k in the month, to give a cumulative overspending of £2.014m. There has been a reduction in the rate of overspending on operational budgets. The position has been further improved with the receipt of arrears of funding secured from outside the Trust for dental staff training. The Division has incurred costs of £4.546m for the year on bank, agency, overtime and waiting list and other payments.

[1] Division has an annualised cumulative overspending greater than 1% of approved budget.

Non pay budgets are overspent by £34k in the month to give a cumulative overspending of £1.982m. The position reflects the gain from an increase (£116k) in stock values mainly in trauma and orthopaedics and Queens Day Unit. Other operational budgets including drugs and clinical supplies, have overspent by £150k in the month.

Income from Activities shows a favourable variance of £1.713m for the year – a favourable movement in March of £103k. Favourable in-month income performance was recorded for Head and Neck (£27k) and ENT (£4k) services and other specialities within the Division (£79k). A net overspending of (£11k) was incurred as income for activity by other Divisions e.g. Specialised Services and Women's and Children's was below plan.

Operating Income budgets show a favourable variance of £0.347m for the year. The improvement of £122k in the month has been achieved through increased recovery of peripheral clinic income, and securing contributions towards overhead costs for screening and research projects.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £1.380m for the year. This is a net underspending of £61k in the month.

Pay budgets are overspent by £10k in March and cumulatively by £0.197m. The overspending on pay budgets has stabilised as funding for the advance recruitment for the Centralisation of Specialist paediatric posts has been released.

Non-pay budgets show an overspending of £45k in the month and a cumulative overspending of £0.196m.

Income from Activities shows an adverse variance of £1.050m for the year, after a favourable movement of £10k in the month.

The remaining three divisions are green rated.

The **Diagnostic and Therapies Division** reports an underspending for the month of £0.202m to give a cumulative underspending to 31 March of £0.617m. The underspending in the month is made up of favourable contributions from pay £61k (vacancies), income £157k (operating and activity related) and savings budgets (£118k) budgets. This is offset by an adverse movement on non-pay headings principally laboratory medicine and radiology.

The Facilities and Estates Division reports an underspending for the year of £0.187m. The adverse movement of £13k in March reflects additional non pay costs incurred on estates, hotel and transport services.

Trust Headquarters Services report a cumulative underspending of £0.267m for the year, an improvement of £21k in the month.

6. Financial Risk Rating

The Trust's overall financial risk rating, based on results for the year ending 31 March is 4. The actual financial risk rating is 4.0 (February 3.50). The actual value for each of the metrics is given in the table below together with the bandings for each metric. Further information showing performance to date is given at Appendix 6

.

	December	January	February	March
Liquidity				
Metric Performance	(4.15)	(2.69)	(2.46)	2.71
Rating	3	3	3	4
Capital Service Capacity				
Metric Performance	2.87	2.94	2.98	3.04
Rating	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**

7. Capital Programme

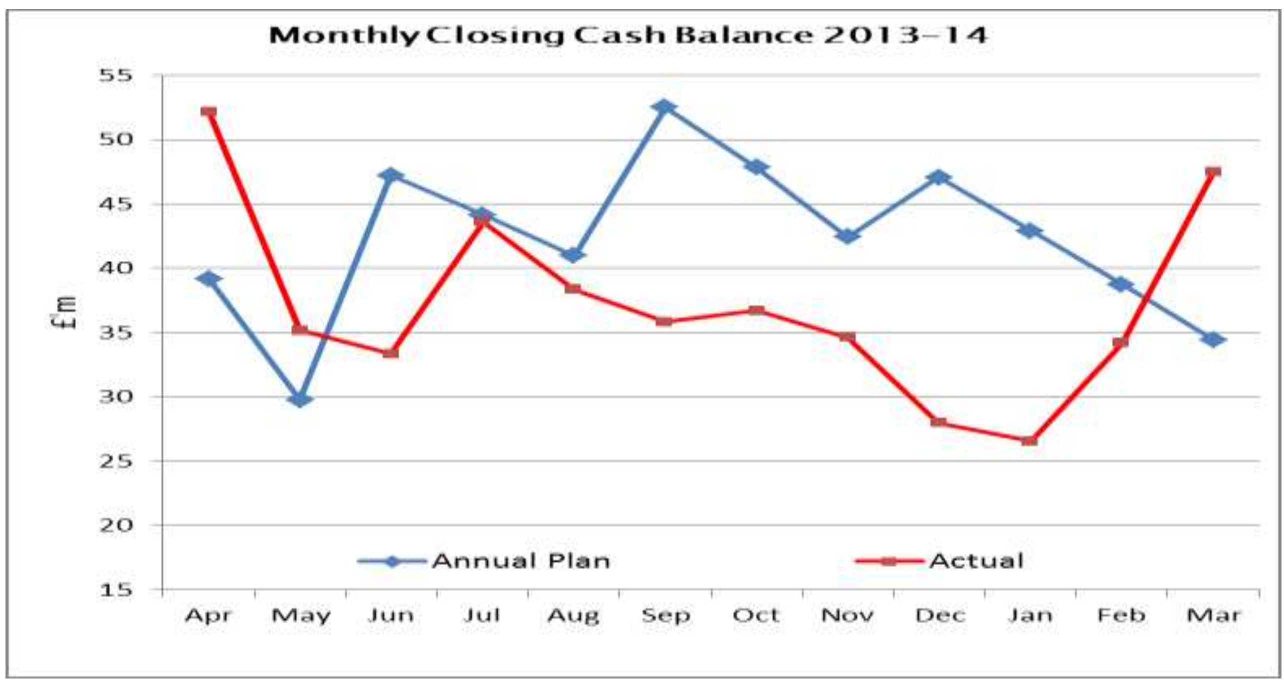
A summary of income and expenditure for the year ending 31 March is given in the table below. Expenditure for the period of £64.986m equates to 92.7% of the revised capital expenditure plan submitted to Monitor in September 2013.

	Revised Monitor Plan (Sept 2013)	**Year Ending 31 March**		
		Plan	**Actual**	**Variance Favourable / (Adverse)**
	£'000	£'000	£'000	£'000
Sources of Funding				
Public Dividend Capital	230	490	490	-
Donations	3,312	1,199	1,199	-
Retained Depreciation	17,959	17.959	17,871	(88)
Prudential Borrowing	50,000	50,000	50,000	-
Sale of Property	700	700	-	(700)
Grants / Contributions	30	75	75	-
Cash balances	(2,148)	5,026	(4,649)	(9,675)
Total Funding	**70,083**	**75,449**	**64,986**	**(10,463)**
Expenditure				
Strategic Schemes	(50,634)	(54,608)	(49,487)	5,121
Medical Equipment	(7,902)	(9,425)	(5,353)	4,072
Information Technology	(2,735)	(4,144)	(2,763)	1,381
Roll Over Schemes	(2,280)	(2,331)	(1,719)	612
Operational / Other	(6,532)	(12,379)	(5,664)	6,715
Anticipated Slippage	-	7,438	-	(7,438)
Total Expenditure	**(70,083)**	**(75,449)**	**(64,986)**	**10,463**

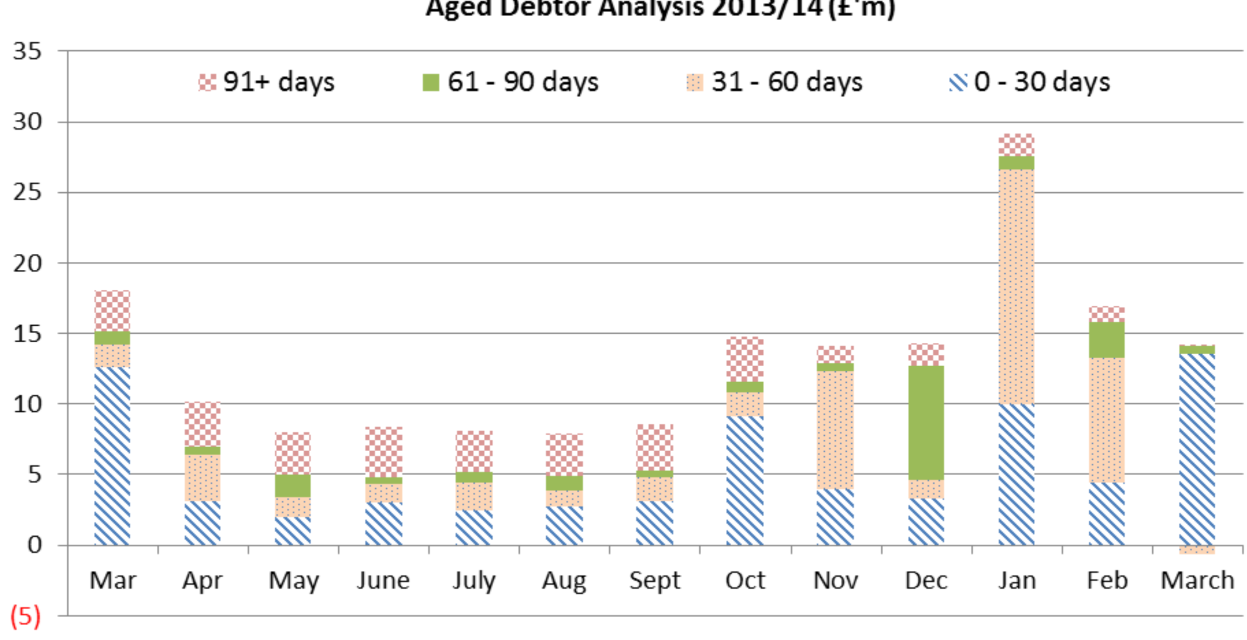
The Finance Committee is provided with further information on this under agenda item 6.

8. Statement of Financial Position (Balance Sheet) and Cashflow

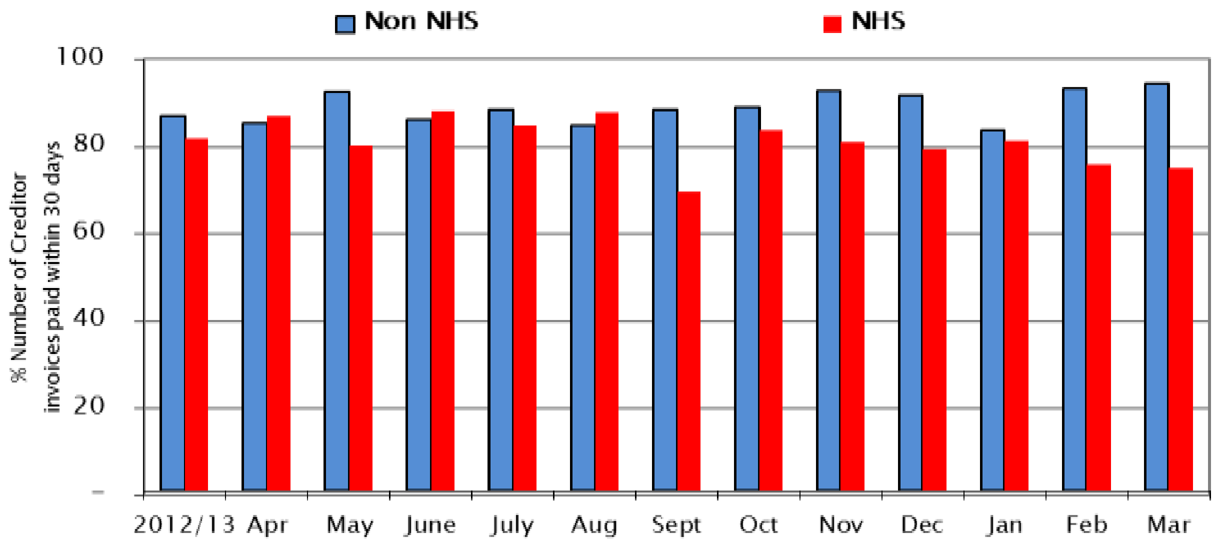
Cash - The Trust held a cash balance of £47.455m as at 31 March. The Trust drew down the final tranche (£13m) of the £70m long term loan agreement with the Foundation Trust Financing Facility in March.



Debtors - The total value of invoiced debtors has decreased by £3.319m during March to a closing balance of £13.618m. The total amount owing is equivalent to 9.2 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In March the Trust achieved 75% and 94% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors.



Attachments	*Appendix 1 – Summary Income and Expenditure Statement*
	Appendix 2 – Divisional Income and Expenditure Statement
	Appendix 3 – Monthly Analysis of Pay Expenditure 2013/14
	Appendix 4 – Executive Summary
	Appendix 5 – Summary of Divisional Monthly Variances and RAG Ratings
	Appendix 6 – Financial Risk Rating

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report March 2014 – Summary Income & Expenditure Statement

Approved Budget / Plan 2013/14	Heading	Position as at 31st March Plan	Position as at 31st March Actual	Position as at 31st March Variance Fav / (Adv)	Actual to 28th February
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
446,122	From Activities	446,122	451,287	5,165	414,554
92,729	Other Operating Income	92,729	93,429	700	84,919
538,851	**Sub totals income**	**538,851**	**544,716**	**5,865**	**499,473**
	Expenditure				
(312,726)	Staffing	(312,726)	(319,238)	(6,512)	(291,359)
(181,892)	Supplies and Services	(181,892)	(190,310)	(8,418)	(176,354)
(494,618)	**Sub totals expenditure**	**(494,618)**	**(509,548)**	**(14,930)**	**(467,713)**
(6,640)	Reserves	(6,640)	–	6,640	–
(873)	Reserves – Incremental Drift	(873)	–	873	–
36,720	**EBITDA**	**36,720**	**35,168**	**(1,552)**	**31,760**
6.81	**EBITDA Margin – %**		**6.46**		**6.36**
	Financing				
92	Reserves	92	–	(92)	–
(110)	Profit/(Loss) on Sale of Asset	(110)	(110)	–	(85)
(18,710)	Depreciation & Amortisation – Owned	(18,710)	(17,872)	838	(16,156)
50	Interest Receivable	50	145	95	132
(363)	Interest Payable on Leases	(363)	(370)	(7)	(339)
(1,954)	Interest Payable on Loans	(1,954)	(1,484)	470	(1,275)
(9,803)	PDC Dividend	(9,803)	(9,289)	514	(8,760)
5,922	**NET SURPLUS / (DEFICIT) before Technical Items**	**5,922**	**6,188**	**266**	**5,277**
	Technical Items				
2,250	Donations & Grants (PPE/Intangible Assets)	2,250	1,501	(749)	899
(3,030)	Impairments	(3,030)	(19,073)	(16,043)	(412)
1,886	Reversal of Impairments	1,886	7,073	5,187	–
(866)	Depreciation & Amortisation – Donated	(866)	(851)	15	(780)
6,162	**SURPLUS / (DEFICIT) after Technical Items**	**6,162**	**(5,162)**	**(11,324)**	**4,984**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report March 2014 – Divisional Income & Expenditure Statement

Appendix 2

Approved Budget / Plan 2013/14	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 28th February	Control Totals
			Pay	Non Pay	Operating Income	Income from Activities	CRES			
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
434,001	Service Agreements	434,003	–	109	(119)	12	–	2	–	–
(1,487)	Overheads	107	–	(331)	–	1,925	–	1,594	2,228	–
40,023	NHSE Income	40,024	–	–	–	–	–	–	–	–
472,537	**Sub Total Service Agreements**	**474,134**	**– –**	**222**	**(119)**	**1,937**	**–**	**1,596**	**2,228**	**–**
	Clinical Divisions									
(46,792)	Diagnostic & Therapies	(46,175)	187	(1,223)	154	778	721	617	415	150
(63,102)	Medicine	(66,049)	(2,717)	(925)	93	1,003	(401)	(2,947)	(2,748)	(1,750)
(72,539)	Specialised Services	(73,436)	(603)	(541)	(3)	811	(562)	(898)	(804)	(1,000)
(88,482)	Surgery Head & Neck	(94,793)	(2,014)	(1,982)	347	1,713	(4,376)	(6,312)	(6,282)	(4,750)
(95,294)	Women's & Children's	(96,674)	(197)	(196)	34	(1,050)	29	(1,380)	(1,441)	(1,000)
(366,209)	**Sub Total – Clinical Divisions**	**(377,127)**	**(5,344)**	**(4,867)**	**625**	**3,255**	**(4,589)**	**(10,920)**	**(10,860)**	**(8,350)**
	Corporate Services									
(32,879)	Facilities And Estates	(32,693)	379	(554)	100	246	16	187	200	150
(24,510)	Trust Services	(24,336)	880	(833)	(58)	129	54	172	160	260
(4,706)	Other	(4,810)	24	(296)	(5)	(238)	415	(100)	(152)	(220)
(62,095)	**Sub Totals – Corporate Services**	**(61,839)**	**1,283**	**(1,683)**	**37**	**137**	**485**	**259**	**208**	**190**
(428,304)	**Sub Total (Clinical Divisions & Corporate Services)**	**(438,966)**	**(4,061)**	**(6,550)**	**662**	**3,392**	**(4,104)**	**(10,661)**	**(10,652)**	**(8,160)**
(6,640)	Reserves	–	–	6,640	–	–	–	6,640	6,417	6,287
(873)	Reserves – Incremental Drift	–	873	–	–	–	–	873	801	873
(7,513)	**Sub Total Reserves**	**–**	**873**	**6,640**	**–**	**–**	**–**	**7,513**	**7,218**	**7,160**
36,720	**Trust Totals Unprofiled**	**35,168**	**(3,188)**	**(132)**	**543**	**5,329**	**(4,104)**	**(1,552)**	**(1,206)**	**(1,000)**
	Financing									
92	Reserves/Profiling	–	–	(92)	–	–	–	(92)	(312)	–
(110)	(Profit)/Loss on Sale of Asset	(110)	–	–	–	–	–	–	–	–
(18,710)	Depreciation & Amortisation – Owned	(17,872)	–	838	–	–	–	838	876	500
50	Interest Receivable	145	–	95	–	–	–	95	86	–
(363)	Interest Payable on Leases	(370)	–	(7)	–	–	–	(7)	(7)	–
(1,954)	Interest Payable on Loans	(1,484)	–	470	–	–	–	470	456	500
(9,803)	PDC Dividend	(9,289)	–	514	–	–	–	514	226	–
(30,890)	**Sub Total Financing**	**(28,980)**	**–**	**1,818**	**–**	**–**	**–**	**1,818**	**1,325**	**1,000**
5,922	**NET SURPLUS / (DEFICIT) before Technical Items**	**6,188**	**(3,188)**	**1,686**	**543**	**5,329**	**(4,104)**	**266**	**119**	**0**
	Technical Items									
2,250	Donations & Grants (PPE/Intangible Assets)	1,501	–	–	(749)	–	–	(749)	(1,001)	–
(3,030)	Impairments	(19,073)	–	(16,043)	–	–	–	(16,043)	–	–
1,886	Reversal of Impairments	7,073	–	5,187	–	–	–	5,187	–	–
(866)	Depreciation & Amortisation – Donated	(851)	–	15	–	–	–	15	8	–
–	Profiling Adjustment	–	–	–	–	–	–	–	700	–
240	**Sub Total Technical Items**	**(11,350)**	**–**	**(11,590)**	**(749)**	**–**	**–**	**(12,339)**	**(1,294)**	**–**
6,162	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**(5,162)**	**(3,188)**	**(9,155)**	**(206)**	**5,329**	**(4,104)**	**(11,324)**	**(174)**	**0**

Analysis of pay spend 2012/13 and 2013/14

Division		2012/13	2013/14																		2012/13
		Total	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total	Mthly Average	Mthly Average
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Women's and Children's	Pay budget	70,755	6,062	5,854	6,088	18,004	5,935	6,246	6,073	18,254	6,243	6,101	6,112	18,456	6,298	6,209	6,258	18,764	73,478	6,123	5,896
	Bank	2,042	189	125	133	446	148	199	167	514	197	122	129	448	130	148	128	406	1,813	151	170
	Agency	1,480	91	115	118	323	180	156	198	534	83	63	108	254	87	75	126	287	1,398	117	123
	Waiting List initiative	164	8	15	30	53	61	22	26	109	42	49	31	122	29	26	26	81	365	30	14
	Overtime	57	8	7	4	18	6	9	32	47	24	26	22	73	20	20	49	88	226	19	5
	Other pay	67,615	5,815	5,577	5,700	17,093	5,628	5,819	5,762	17,209	5,902	5,893	5,896	17,690	6,075	6,068	5,977	18,119	70,112	5,843	5,635
	Total Pay expenditure	71,359	6,111	5,838	5,984	17,933	6,023	6,205	6,185	18,413	6,248	6,153	6,186	18,587	6,340	6,336	6,305	18,981	73,913	6,159	5,947
	Variance Fav / (Adverse)	(604)	(49)	16	104	71	(88)	41	(112)	(159)	(5)	(52)	(74)	(131)	(42)	(128)	(46)	(216)	(435)	(36)	(50)
Medicine	Pay budget	44,264	3,736	3,707	3,620	11,063	3,693	3,695	3,656	11,044	3,767	3,648	3,651	11,066	3,647	3,639	3,692	10,978	44,151	3,679	3,689
	Bank	3,430	397	282	259	938	256	302	259	817	310	230	231	771	253	279	248	779	3,305	275	286
	Agency	1,374	224	311	223	758	252	205	225	681	179	125	120	424	159	170	162	491	2,354	196	115
	Waiting List initiative	148	12	48	8	68	13	18	14	45	4	9	8	21	0	22	(5)	17	151	13	12
	Overtime	72	9	7	7	22	6	5	45	57	18	26	14	57	20	19	22	61	197	16	6
	Other pay	41,085	3,434	3,353	3,409	10,195	3,399	3,515	3,387	10,301	3,598	3,486	3,532	10,616	3,555	3,519	3,557	10,631	41,743	3,479	3,424
	Total Pay expenditure	46,110	4,076	4,001	3,906	11,982	3,926	4,044	3,930	11,901	4,109	3,876	3,904	11,889	3,987	4,009	3,984	11,979	47,751	3,979	3,842
	Variance Fav / (Adverse)	(1,846)	(340)	(294)	(285)	(919)	(233)	(349)	(274)	(856)	(342)	(228)	(253)	(823)	(340)	(371)	(292)	(1,002)	(3,600)	(300)	(154)
Surgery Head and Neck	Pay budget	69,283	5,870	5,867	5,945	17,682	5,864	5,962	5,924	17,750	5,957	5,886	5,924	17,767	5,916	5,801	6,010	17,728	70,927	5,911	5,774
	Bank	2,247	230	159	173	562	174	201	145	520	203	128	116	447	110	86	134	330	1,859	155	187
	Agency	981	49	48	88	186	106	136	127	369	64	49	43	156	18	41	39	97	808	67	82
	Waiting List initiative	1,097	60	50	113	223	215	221	114	550	135	128	109	372	67	98	84	249	1,394	116	91
	Overtime	149	14	7	8	29	16	37	54	108	110	52	24	186	42	44	77	162	485	40	12
	Other pay	67,476	5,698	5,702	5,669	17,068	5,583	5,779	5,914	17,276	5,738	5,816	5,845	17,399	5,941	5,779	5,731	17,451	69,195	5,766	5,623
	Total Pay expenditure	71,950	6,051	5,965	6,051	18,068	6,094	6,375	6,354	18,823	6,250	6,173	6,137	18,560	6,177	6,048	6,065	18,290	73,741	6,145	5,996
	Variance Fav / (Adverse)	(2,667)	(181)	(99)	(106)	(386)	(230)	(413)	(431)	(1,074)	(293)	(287)	(213)	(793)	(261)	(246)	(55)	(562)	(2,814)	(235)	(222)
Specialised Services	Pay budget	35,888	2,967	2,958	3,166	9,091	3,073	3,061	3,072	9,206	3,054	3,061	3,071	9,186	3,067	3,103	3,064	9,234	36,718	3,060	2,991
	Bank	1,071	105	75	83	263	91	132	91	314	129	97	85	311	94	115	86	296	1,184	99	89
	Agency	1,194	82	113	147	342	166	161	152	479	200	180	162	542	205	186	127	518	1,882	157	99
	Waiting List initiative	288	42	27	29	98	18	9	26	53	49	50	34	133	100	(34)	29	95	379	32	24
	Overtime	70	12	7	6	25	8	8	22	38	28	18	14	60	11	18	30	59	182	15	6
	Other pay	34,439	2,798	2,797	2,844	8,440	2,919	2,710	2,881	8,510	2,811	2,817	2,864	8,492	2,808	2,956	2,875	8,638	34,079	2,840	2,870
	Total Pay expenditure	37,063	3,039	3,018	3,110	9,167	3,202	3,021	3,172	9,394	3,217	3,162	3,159	9,538	3,219	3,241	3,146	9,606	37,705	3,142	3,089
	Variance Fav / (Adverse)	(1,175)	(72)	(60)	56	(76)	(129)	40	(100)	(189)	(163)	(101)	(88)	(352)	(151)	(138)	(82)	(371)	(988)	(82)	(98)

Analysis of pay spend 2012/13 and 2013/14

Division		2012/13	2013/14																		2012/13
		Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Feb £'000	Mar £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average £'000
Diagnostic & Therapies	Pay budget	38,231	3,265	3,330	3,299	9,894	3,295	3,355	3,343	9,992	3,313	3,285	3,283	9,881	3,150	3,373	3,237	9,759	39,526	3,294	3,186
	Bank	398	38	27	30	96	35	32	24	91	28	17	20	65	20	18	17	54	306	26	33
	Agency	362	(17)	(1)	23	5	26	34	41	101	32	35	35	102	7	51	74	132	340	28	30
	Waiting List initiative	176	15	10	16	41	16	9	27	52	10	21	21	52	24	15	41	80	225	19	15
	Overtime	279	34	25	27	86	25	25	27	77	27	25	30	83	26	29	15	69	314	26	23
	Other pay	37,491	3,143	3,244	3,177	9,564	3,194	3,169	3,219	9,582	3,249	3,220	3,190	9,659	3,095	3,206	3,046	9,347	38,153	3,179	3,124
	Total Pay expenditure	38,706	3,213	3,306	3,273	9,792	3,295	3,270	3,339	9,904	3,347	3,317	3,297	9,961	3,172	3,318	3,192	9,682	39,339	3,278	3,225
	Variance Fav / (Adverse)	(475)	52	24	26	102	(0)	85	4	89	(34)	(33)	(14)	(80)	(23)	54	45	77	187	16	(40)
Facilities & Estates	Pay budget	18,638	1,566	1,556	1,585	4,706	1,465	1,552	1,514	4,531	1,566	1,509	1,536	4,611	1,569	1,492	1,525	4,586	18,435	1,536	1,553
	Bank	285	39	30	36	105	39	62	39	140	64	37	43	144	57	55	54	165	555	46	24
	Agency	1,174	43	28	38	109	24	29	22	75	35	21	19	74	24	19	45	88	346	29	98
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overtime	1,131	86	73	94	253	92	89	73	254	97	52	57	205	70	48	66	183	895	75	94
	Other pay	15,952	1,408	1,400	1,353	4,161	1,394	1,403	1,339	4,136	1,373	1,339	1,366	4,079	1,370	1,321	1,329	4,021	16,397	1,366	1,329
	Total Pay expenditure	18,542	1,576	1,532	1,520	4,628	1,550	1,583	1,473	4,606	1,568	1,449	1,485	4,503	1,521	1,443	1,493	4,457	18,193	1,516	1,545
	Variance Fav / (Adverse)	97	(10)	24	65	78	(85)	(31)	41	(75)	(2)	60	51	108	48	49	32	129	242	20	8
Trust Services (Including R&I and Support Services)	Pay budget	26,447	2,114	2,117	2,249	6,480	2,166	2,343	2,207	6,717	2,286	2,461	3,414	8,160	2,445	2,044	3,645	8,135	29,492	2,458	2,204
	Bank	527	75	51	45	170	60	63	56	179	65	47	44	156	48	58	70	176	680	57	44
	Agency	133	10	22	48	80	28	26	32	86	35	38	35	108	17	40	44	102	375	31	11
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overtime	185	13	10	7	30	8	6	5	19	7	6	8	20	11	14	20	45	114	9	15
	Other pay	24,361	2,011	1,947	2,071	6,029	2,048	2,157	2,016	6,221	2,073	2,231	3,168	7,472	2,250	1,893	3,560	7,703	27,425	2,285	2,030
	Total Pay expenditure	25,206	2,108	2,031	2,171	6,309	2,144	2,251	2,109	6,504	2,180	2,322	3,255	7,756	2,327	2,004	3,694	8,026	28,595	2,383	2,101
	Variance Fav / (Adverse)	1,241	6	87	78	171	23	92	98	213	106	139	159	404	119	39	(49)	109	897	75	103
Trust Total	Pay budget	303,506	25,580	25,388	25,952	76,920	25,492	26,213	25,788	77,494	26,186	25,951	26,990	79,127	26,092	25,660	27,432	79,184	312,726	26,060	25,292
	Bank	10,001	1,073	748	758	2,579	803	992	781	2,575	996	678	669	2,343	712	758	736	2,206	9,702	809	833
	Agency	6,699	482	640	683	1,805	781	747	798	2,325	628	511	521	1,660	517	581	617	1,715	7,506	625	558
	Waiting List initiative	1,873	137	150	196	483	323	279	207	809	240	257	203	700	220	127	175	522	2,514	210	156
	Overtime	1,943	174	136	153	463	162	179	259	599	311	204	169	684	199	192	277	667	2,413	201	162
	Other pay	288,419	24,308	24,017	24,224	72,549	24,165	24,552	24,518	73,235	24,744	24,802	25,863	75,409	25,095	24,742	26,074	75,911	297,103	24,759	24,035
	Total Pay expenditure	308,935	26,174	25,691	26,014	77,879	26,233	26,749	26,563	79,545	26,919	26,452	27,424	80,796	26,742	26,400	27,879	81,020	319,238	26,603	25,745
	Variance Fav / (Adverse)	(5,429)	(594)	(303)	(62)	(959)	(741)	(535)	(774)	(2,051)	(733)	(501)	(434)	(1,668)	(650)	(740)	(447)	(1,836)	(6,514)	(543)	(452)

NOTE: Other Pay includes all employer's oncosts.

NOTE: In month 12 there was a change in accounting treatment for salary sacrifice schemes Trust wide, moving it from income in the ledger to reduce pay expenditure. The cumulative impact of this for the Trust was a reduction in pay costs of £306k for the year. This value was credited in total in month 12.

Appendix 4

Key Issue	RAG	Executive Summary	Table
Financial Risk Rating	G	The Trust's overall financial risk rating under the new Risk Assessment Framework for the year ending 31st March has been calculated to be 4 (actual score 4.0, February 3.5). The improvement in March is mainly as a result of the draw down of the balance (£20m) of the £70m loan arranged with the Independent Trust Financing Facility.	Agenda Item 5.1 App 6
Service Level Agreement Income and Activity	G	A forecast has been made on the activity provided in March as the information required was not available in this month's reporting cycle. Contract income, in total, is forecast to be £0.10m higher than plan in March and £10.45m higher than Plan for the year. Activity based contract performance at £373.66m for the year is £3.82m greater than plan. Contract rewards / penalties at a net income of £6.47m are £2.25m favourable to plan. 'Pass through' payments for the year total £65.49m and are £4.38m higher than Plan. *The following information represents estimates of the activity outturn for the year.* A&E Attendances at 113,434 are 486 **higher** than planned. The average number of daily attendances is 311. Emergency activity at 35,643 is 0.7% or 233 spells **lower** than planned. Non Elective activity at 2,326 is 9.1% or 194 spells **higher** than planned. Elective activity at 14,171 is 8% or 1,233 spells **lower** than per planned. Day case activity at 52,098 is 11.7% or 5,436 spells **higher** than planned. Outpatient Procedure activity at 51,371 is 22.9% or 9,581 attendances **higher** than planned. New Outpatients activity at 151,498 is 10.8% or 14,756 attendances **higher** than planned. Follow up Outpatient activity at 296,973 is 4.8% or 13,673 attendances **higher** than planned. An income analysis by commissioner is shown at Table INC 2. Information on clinical activity by Division, specialty and patient type is provided in table INC 3.	Agenda Item 5.2 INC 1
Savings Programme	R	The 2013/14 Savings Programme totals £20.989m. Actual savings achieved for the year total £16,885m (80.4% of Plan) , a shortfall of £4.104m against divisional plans. The outturn for the year includes non-recurring savings of £4.425m. Income generation schemes contributed £2.116m. Reductions in pay costs of £5.95m were achieved and a further £8.819m was saved on supplies and services.	Agenda Item 5.4

Key Issue	RAG	Executive Summary	Table
Income and Expenditure	G	The surplus before technical items for the year is £6.188m. This represents an over performance of £0.266m when compared with the planned surplus of £5.922m. Total income of £544.716m is £5.865m higher than Plan. Expenditure at £509.548m is greater than Plan by £7.417m. Financing costs are £1.818m lower than Plan.	Agenda Item 5.3
	R	Whilst the Trust has delivered the planned income and expenditure surplus for the year it has done so with four clinical divisions being 'red-rated' i.e. each with an annualised cumulative overspending greater than 1% of approved budget. The achievement of the planned surplus has been secured with the Trust using reserves, some of which are non-recurring.	
Capital	A	Expenditure for the year was £64.986m. This equates to 92.7% of the revised capital expenditure forecast submitted to Monitor in September 2013. The outturn position is after scheme slippage of £10.210m – funding for these items will be carried forward to meet expenditure in 2014/15.	Agenda Item 6
Statement of Financial Position and Treasury Management	G	The cash balance on 31st March was £47.455m. The balance on Invoiced Debtors has decreased by £3.319m in the month to £13.618m. The invoiced debtor balance equates to 9.2 debtor days. Creditors and accrual account balances total £64.169m with £3.975m relating to deferred income. Invoiced Creditors - payment performance for the year for Non NHS invoices and NHS invoices within 30 days was 89% and 81% respectively. Payment performance by invoice value is 89% for Non NHS and 91% for NHS invoices.	Agenda Item 7 SFP 1 SFP 2 SFP 3
Financial Risk Rating	G	The Trust's overall financial risk rating under the new Risk Assessment Framework for the year ending 31st March has been calculated to be 4 (actual score 4.0, February 3.5).	Agenda Item 5.1 App 6

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

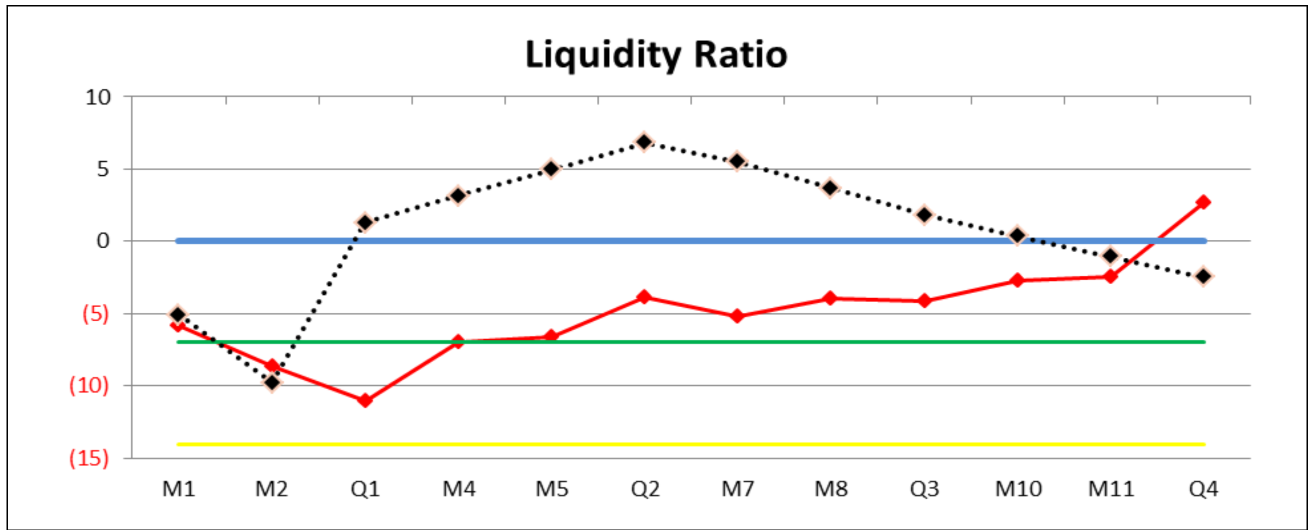
Finance Report March 2014 - Summary of Divisional Monthly Variances and RAG Rating 2013/14

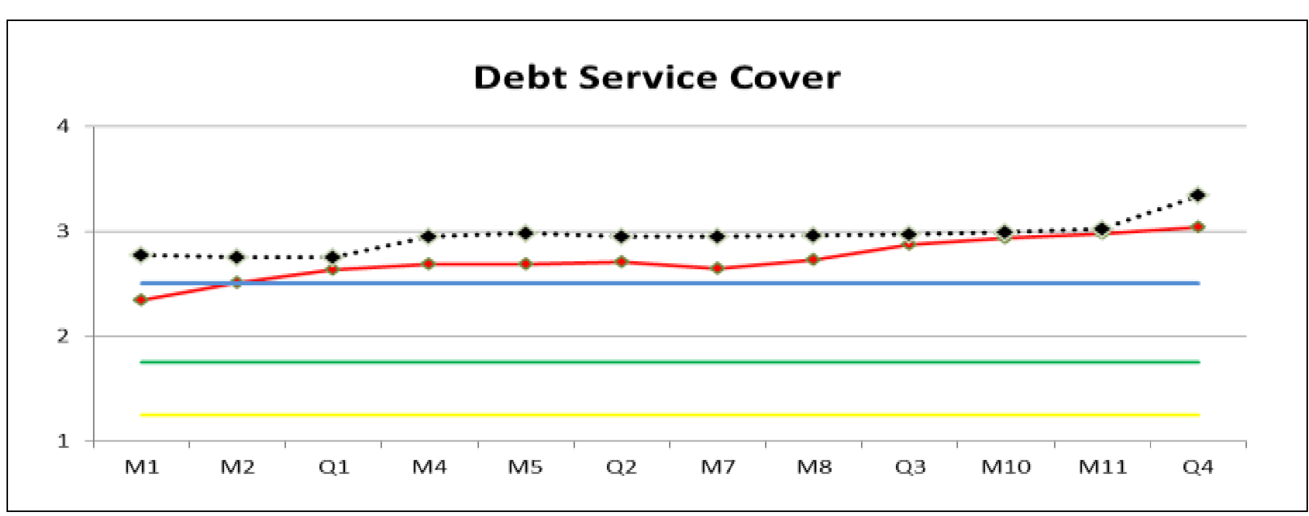
	Favourable / (Adverse) Variance												
	Apr £'000	**May** £'000	**Jun** £'000	**Jul** £'000	**Aug** £'000	**Sep** £'000	**Oct** £'000	**Nov** £'000	**Dec** £'000	**Jan** £'000	**Feb** £'000	**Mar** £'000	**Totals 2013/14** £'000
Diagnostics & Therapies	8	10	24	(3)	45	(48)	73	148	2	3	153	202	617
Medicine	(341)	(184)	(277)	16	(603)	(260)	(238)	42	(231)	(273)	(399)	(199)	(2,947)
Specialised Services	(371)	(137)	(68)	(153)	(41)	(107)	(145)	172	146	(1)	(99)	(94)	(898)
Surgery, Head & Neck	(625)	(416)	(329)	(660)	(645)	(462)	(913)	(206)	(564)	(799)	(663)	(30)	(6,312)
Women's & Children's	(100)	(16)	(144)	(465)	(744)	(163)	(89)	343	(113)	(24)	74	61	(1,380)
Estates & Facilities	(24)	(13)	5	8	30	18	32	61	9	10	64	(13)	187
Trust HQ	4	(5)	13	(12)	42	28	69	40	30	12	25	21	267

Continuity of Service Risk Rating – March 2014 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics which came into use from 1st October under the new Risk Assessment Framework. The 2013/14 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 4 (blue line)**; **FRR 3 (green line)** and **FRR 2 (yellow line)**.

	December	January	February	March
Liquidity				
Metric Performance	(4.15)	(2.69)	(2.46)	2.71
Rating	3	3	3	4
Debt Service Cover				
Metric Performance	2.87	2.94	2.98	3.04
Rating	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**





For consideration and approval by

Finance Committee	25th April 2014 – Agenda Item 8
Trust Board	28th April 2014 –

QUARTER 4 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
April 2014

1. EXECUTIVE SUMMARY

This commentary covers the results for the year ending 31st March 2014. The Trust reports an income and expenditure surplus of £6.188m (before technical items) for the year ending 31 March 2014. The provisional outturn position represents a favourable variance of £0.266m against the planned surplus for the year of £5.922m.The Trust is required, in completing its Annual Report and Accounts, to recognise, where appropriate, technical accounting issues. For 2013/14, there are four items under this heading which lead to the income and expenditure surplus becoming a deficit after technical items of £5.162m. The position can be summarised as follows:

	Annual Plan	Actual Income and Expenditure
	£'000	**£'000**
Income and Expenditure Surplus to 31 March – before Technical Items	**5,922**	**6,188**
Technical Items (further information provided in Section 9 below)		
- Donations and Grants	2,250	1,501
- Asset Impairment	(3,030)	(19,073)
- Reversal of Asset Impairments	1,886	7,073
- Depreciation on Donated Assets	(866)	(851)
Income and Expenditure Surplus / (Deficit) to 31 March – after Technical Items	**6,162**	**(5,162)**

The Continuity of Service Risk rating is 4.

	December 2013	**March 2014**
Liquidity		
Metric Performance	(4.15)	2.71
Rating	3	4
Capital Service Capacity		
Metric Performance	2.87	3.04
Rating	4	4
Overall Rating	**4**	**4**

4	**3**	**2**	**1**
0	**(7)**	**(14)**	**<(14)**
2.5	**1.75**	**1.25**	**<1.25**

2. NHS CLINICAL INCOME

The final March position on activity is not yet known, therefore the Q4 position is based on a forecast from the Month 11 actuals. Based on this, NHS Clinical income is forecast to be £2.023m higher than the Monitor Annual Plan, at £444.431m for the year. NHS Clinical income includes income from NHS commissioners and territorial bodies. The variance for the year is explained in table 1 below:

Table 1 – NHS Clinical Income – 2013/14 - Variance from Plan

	£m
Monitor Plan	442.408
Over Performance (See Table 2 Below)	2.023
2013/14 Income	444.431

Activity and Income by Worktype

Forecast Performance against the plan for the year is summarised below by worktype.

i. Elective Inpatients

Overall Elective Inpatients are £2.670m behind plan. The under-performance is across a number of specialties particularly Cardiac Surgery, Cardiology, ENT and Vascular Surgery.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £1.538m behind plan at the end of the year. The key areas of under-performance are Cardiac Surgery, Paediatric Cardiac Surgery, Oral Surgery and Paediatric Trauma & Orthopaedics.

iii. Day Cases

Day Cases are £3.805m ahead of plan for the year. The key areas of over-performance are Clinical/Medical Oncology, Cardiology, Gastroenterology, Trauma and Orthopaedics, Ophthalmology and Radiotherapy.

iv. Outpatients

Outpatient activity has under-performed by £0.225m; the major driver in the change from last quarter is the transfer of Genitourinary Medicine and Family Planning Services from NHS commissioners to Local Authorities. The underlying over-performance in Ophthalmology, CPAP/BIPAP, Clinical/Medical Oncology, Cardiology and Colorectal Surgery continue.

v. Accident and Emergency

A&E has under-performed by £0.410m against plan.

vi. Other NHS

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, PbR Excluded Drugs & Devices, Contract Penalties, CQUINs and specialised services such as Bone Marrow Transplants. This category is £3.059m ahead of plan for the year, the most significant element of this is due to PBR excluded drugs and devices.

Table 2 – NHS Clinical Income – 2013/14 - Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	49.341	46.671	(2.670)
Day Case	30.566	34.371	3.805
Non-Elective Inpatient	94.675	93.137	(1.538)
Outpatient	65.001	64.776	(0.225)
Accident & Emergency	13.266	12.856	(0.410)
Other NHS	189.560	192.619	3.059
Grand Total	442.408	444.431	2.023

Over Performance by Commissioner

During the Local Delivery Plan process the Trust agreed to reduce Service Level Agreement values for demand management schemes put forward by Commissioning Care Groups that the Trust believed were over optimistic. Because the Trust did not expect these activity reductions to materialise the clinical income budgets were not reduced, and an income budget was created for a dummy commissioner - Variable Estimates. Table 3 below shows the cumulative income variances by commissioner and how the Variable Estimates income target then adjusts this for the overall position. The latest identification rules have now been implemented and have caused a large shift in activity from Clinical Commissioning Groups to NHS England. In Quarter 4 Commissioners have also transferred commissioning responsibility for secondary care dental and screening services from CCGs to NHS England, and Family Planning and Genitourinary Medicine services from CCGs to Local Authorities. These changes are reflected in the actuals below.

Table 3 Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	(11.776)	(7)
NHS North Somerset	(1.491)	(4)
NHS South Gloucestershire	(4.960)	(17)
NHS Bath & NE Somerset	(1.890)	(18)
NHS Somerset	(1.041)	(12)
NHS Gloucestershire	(1.029)	(21)
NHS England	32.958	21
Other	(0.397)	(2)
Variable Estimates	(8.350)	(89)
Total	2.023	0.5

Non Mandatory/Non Protected Revenue

Private Patient Revenue

Private Patient Revenue has over-performed by £0.599m for the year.

Other Clinical Revenue

Other Clinical Revenue has over-performed by £3.582m for the year the outturn figure of £5.292m includes income relating to G U Medicine and Family Planning which in previous quarters was included in clinical income above. The planned income was included in clinical income also hence the large over performance here.

3. OTHER OPERATING INCOME

Overall other income is £0.432m higher than planned. Research and Development income is £0.547m higher than planned, Education and Training income is £0.345m higher than planned. Donations and grants are £0.749m lower than planned and other income was £0.301m lower than planned.

4. EXPENDITURE

Overall operating costs of £509.547m are £8.896m higher than plan. Trust pay costs are £1.347m higher than plan and non pay costs are £7.549m higher than plan.

4.1 Pay Costs

Pay costs at £319,238m for the year to date are £1.347m higher than plan. Spend on permanent staff is £1.514m higher than planned. Agency spend is £0.167m lower than planned. There is a shortfall on pay savings of £2.521m of which £1.974m relates to lower than planned savings with regards to nursing skill mix and rota change plans. There were a number of vacancies within staff groups which accounts for the balance.

4.2 Drugs

Drug costs of £59.611m are £6.953m higher than plan. This is related to NICE drugs, cancer Drug fund funded costs not in the original plan and higher than planned clinical activity.

4.3 Clinical supplies and services

Clinical supplies and services costs at £56.688m are £5.163m higher than plan mainly due to higher than planned activity volume.

4.4 Other Operating Expenses

Other costs were £4.567m lower than plan. There was a shortfall on savings programme delivery of £4.630m, this was offset by unspent planned reserves and developments in the plan of £7.513m and other underpends in this category including premises and fixed plant.

4.5 Depreciation

Depreciation charges at £18.723m were lower than the Annual Plan projection of £19.570m for the period. The reduction of £0.847m is due lower than planned capital expenditure.

4.6 Non Operating Expenses

Interest expense on non-commercial borrowings are £0.474m lower than plan. This is due to the delayed drawdown of the Trust's loan during 2013/14.

5. CAPITAL

The Trust's Capital Programme was £75.856m per the Annual Plan submission in May 2013. The Trust submitted a revised 2013/14 forecast outturn to Monitor in September 2013 of £70.083m. The table below summarises the actual expenditure for the year against the Monitor plans.

		£000's			
		Q1	**Q2**	**Q3**	**Q4**
Monitor Plan	Original submission	18,655	18,440	24,187	14,574
	Cumulative	***18,655***	***37,095***	***61,282***	***75,856***
	Resubmission – Sept	15,449	16,588	18,903	19,143
	Cumulative	***15,449***	***32,037***	***50,940***	***70,083***
Spend	Quarter spend	15,449	16,187	15,728	17,622
	Forecast spend				
	Cumulative	***15,449***	***31,636***	***47,364***	***64,986***
Actual as % plan	Original submission	82.8%	85.3%	77.2%	85.7%
	Resubmission – Sept	100%	98.7%	92.9%	92.7%

Actual expenditure at £64.986m equates to 85.7% of the original Annual Plan or 92.7% of the revised annual plan.

The table provided below shows a comparison of the Trust's Plan with actual expenditure for the year.

	Year ending 31st March 2014		
	£'000 Plan	£'000 Actual	£'000 Variance
Sources of Funding			
Public Dividend Capital	490	490	-
Donations	1,199	1,199	-
Retained Depreciation	17,959	17,871	(88)
Prudential Borrowing	50,000	50,000	-
Grants/Contributions	75	75	-
Sale of Assets	700	-	(700)
Cash balances	5,026	(4,649)	(9,675)
Total Funding	**75,449**	**64,986**	**(10,463)**
Expenditure			
Strategic Schemes	(54,608)	(49,487)	5,121
Medical Equipment	(9,425)	(5,353)	4,072
Information Technology	(4,144)	(2,763)	1,381
Roll Over Schemes	(2,331)	(1,719)	612
Operational / Other	(12,379)	(5,664)	6,715
Anticipated Slippage	7,438	-	(7,438)
Total Expenditure	**(75,449)**	**64,986**	**10,463**

6. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £388.847m at the end of March is £22.321m lower than the original plan. This mainly reflects lower than planned capital expenditure during 2013/14 and the revaluation of land and building assets by the District Valuer.

6.2 Inventories (formerly referred to as Stock)

At the end of March the value of inventories held totalled £10.934m. This is £1.894m higher than planned and is a result of additional purchases in the catheter laboratory, an increase in the value of pharmacy stocks and additional stock holdings to support the clinical service transfers from North Bristol NHS Trust from April 2013.

6.3 Current Tax Receivables

The balance of £1.938m at the end of March includes £1.043m connected with VAT recovery on the Welcome Centre scheme which will be claimed at the end of the BRI Redevelopment project. The remainder represents a claim made to the HMRC for additional VAT that is recoverable under legislation. These moneys will be received in April.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance of trade and other receivables at the end of March at £10.940m is £5.565m less than plan. Moneys owed to the Trust but not yet invoiced, are shown as accrued income and this is currently £4.617m which is £4.016m higher than the plan figure. Income due to the Trust is recognised and accrued in the relevant accounting period and sales invoices are issued in accordance with the national framework. The Trust continues seeking to reduce the amount of money owed to the Trust. The invoiced debtor balance at 31st March equates to 9.2 debtor days.

6.5 Prepayments

The prepayment balance at the end of March is £2.647m. This is mainly due to payments for maintenance contracts for servicing of equipment and is broadly in line with the plan of £2.371m.

6.6 Non Current Assets held for Sale

This item relates to the sale proceeds for the disposal of the Kingsdown Garage site. This sale has been subject to unexpected delays outside of the Trust's control but disposal of this asset is expected early in the 2014/15 financial year.

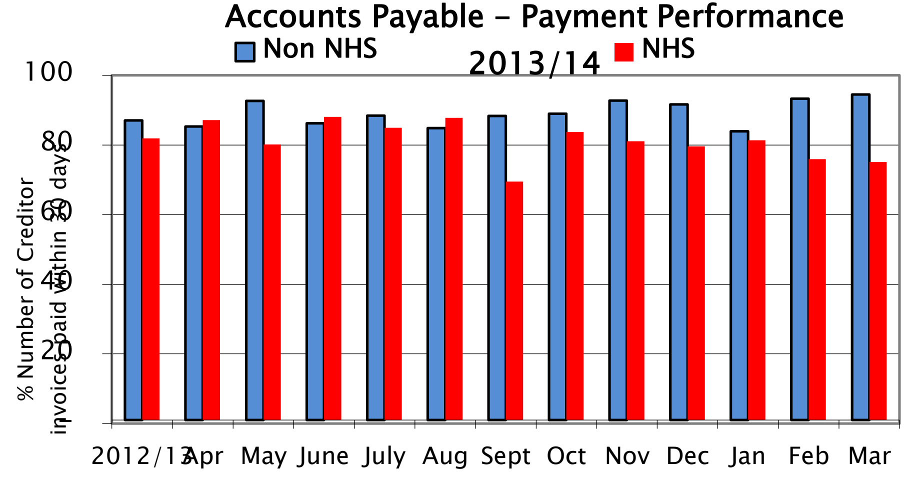
6.7 Deferred Income

Deferred income of £3.975m is £1.475m higher than the plan of £2.500m. This relates mainly to research income.

6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, other and capital creditors total £25.846m at the end of March. This is £1.800m higher than the plan projection of £24.046m. This includes capital payables which are £6.986m above plan. The non-capital variance under this heading should be considered against the corresponding higher than plan variance reported under section 6.9 below.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For 2013/14 the Trust achieved 81% (91% by value) and 89% (89% by value) compliance against the Better Payment Practice Code for NHS and Non NHS creditors respectively.



6.9 Other Financial Liabilities

The closing balance for accruals at £21.419m is £2.837m higher than the plan of £18.582m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the year end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 31st March together with comparative information taken from the Trust's Annual Plan.

Summary Statement of Financial Position

	Position as at 31st March 2014		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current assets			
Intangibles	10,122	7,065	(3,057)
Property, Plant and Equipment	401,046	381,782	(19,264)
Non current assets total	**411,168**	**388,847**	**(22,321)**
Current assets			
Inventories	9,040	10,934	1,894
Current Tax Receivables	644	1,938	1,294
Trade and Other Receivables	16,505	10,940	(5,565)
Other Financial Assets	705	4,988	4,283
Prepayments	2,371	2,647	276
Cash & Cash Equivalents	34,687	47,535	12,848
Non Current Assets held for sale	-	700	700
Current assets total	**63,952**	**79,682**	**15,730**
ASSETS TOTALS	**475,120**	**468,529**	**(6,591)**
Current Liabilities			
Loans	(260)	(260)	-
Deferred Income	(2,500)	(3,975)	(1,475)
Provisions	(237)	(171)	66
Current Tax Payables	(6,427)	(6,275)	152
Trade and Other Payables	(24,046)	(25,846)	(1,800)
Other Financial Liabilities	(19,487)	(22,257)	(2,770)
Other Liabilities	(5,410)	(5,385)	25
Current liabilities total	**(58,367)**	**(64,169)**	**(5,802)**
NET CURRENT ASSETS/(LIABILITIES)	**5,585**	**15,513**	**9,928**

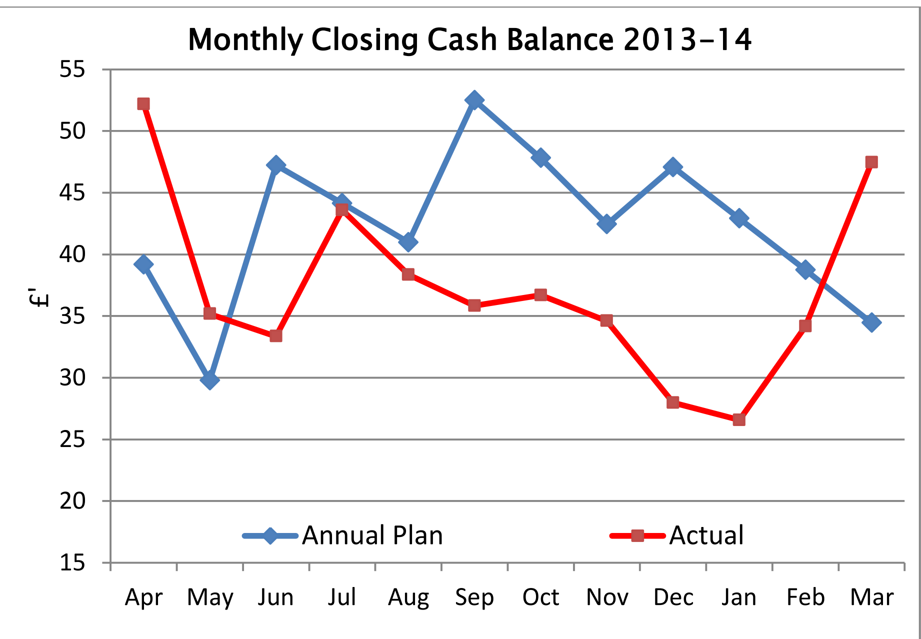
	Position as at 31st March 2014		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current liabilities			
Loans	(74,430)	(74,430)	-
Provisions	(191)	(177)	14
Finance Leases	(5,504)	(5,555)	(51)
Non current liabilities total	**(80,125)**	**(80,162)**	**(37)**
TOTAL ASSETS EMPLOYED	**336,628**	**324,198**	**(12,430)**
Taxpayers' and Others' Equity			
Public Dividend Capital	191,011	191,501	490
Retained Earnings	80,632	79,875	(757)
Revaluation Reserve	64,900	52,737	(12,163)
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**336,628**	**324,198**	**(12,430)**

7. Cash and Cash Flow

The Trust held cash balances at the end of March of £47.535m. This is £12.848m higher than the Annual Plan projection of £34.687m. This is mainly due lower than planned capital expenditure.

The balance (£50m) of the £70m Independent Trust Financing Facility (ITFF) loan has been drawn down during the year.

The graph shown below provides a comparison of actual and projected month-end cash balances for 2013/14.



8. Loan Application

The Trust submitted an application to the ITFF for a loan of £20m repayable over 15 years to support the Trust's Medium Term Capital Programme. This has recently been approved by the Independent Trust Financing Facility. The planning assumption is that this loan will be taken up in the first quarter of 2014/15.

9. Technical Accounting Issues

9.1 Donations and Grants

The Trust has received donations and grants of £1.501m. This is £0.749m less than assumed in the Annual Plan. It has been agreed with the Teenage Cancer Trust that moneys anticipated to be received this year will now be paid to the Trust in 2014/15.

9.2 Asset Impairments

An estimate of £3.03m had been made to provide for the impact of impairment of the BHOC capital scheme in 2013/14. The actual impairment value as assessed by the District Valuer is £4.454m. In addition to this the District Valuer, as part of the quinquennial asset revaluation exercise has advised of the requirement for an impairment of £2.29m for the Welcome Centre. For financial planning purposes no impairment had been provided as the Welcome Centre is an income generating scheme. However, as it is in effect an extension of the Queens Building rather than a separately identifiable asset the valuation leads to there being a requirement to impair part of the capital cost. The third scheme which is subject to an impairment this year is the Centralisation of Specialist Paediatrics project. The opening of part of the new facility leads to an impairment in 2013/14 of £12.332m. The impairment has allowed for the original provision (assumed in May 2013) of £5.7m to be removed from the 2014/15 Annual Plan submission. The total adverse impact of asset impairments is £19.073m, or £16.043m more than planned. It should be noted that this technical adjustment has no adverse impact on cash.

9.3 Reversal of Asset Impairments

Each year the Trust anticipates the likely change (indexation) in asset values over the coming year. In line with previous practice an assumption of 2% was made at the start of 2013/14. Changes to the index are a guide for organisations to use in those years between formal asset valuation exercises. The quinquennial review carried out to inform the 2013/14 Annual Accounts is an opportunity for a comprehensive review of the value of the land and buildings owned by the Trust. The District Valuer has advised on revaluation which results in a reversal of previous impairments to a value of £7.076m. This is a technical gain of £5.187m when compared with the Annual Plan assumption. The single biggest factor item which leads to this change is the revaluation of the BHOC at £5m.

9.4 Depreciation on Donated Assets

The Trust's Annual Plan included provision for depreciation on donated assets to a value of £0.866m for the year. Actual depreciation charges at £0.851m are marginally less than plan for the year.

Cover Sheet for a Report for a Public Trust Board Meeting,
to be held on 28 April 2014 at 10:30am
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

16. Teaching and Learning Annual Report

Purpose

The purpose of this Teaching and Learning Annual report is to set out the background to the provision of the education and teaching provided at UH Bristol NHS Foundation Trust; how it is governed; how it is funded and includes an overview of the education and teaching activity during 2013/14.

Abstract

The report also presents the challenges and risks for the provision of education and teaching over the coming years and the current review of the Teaching and Learning strategy will address these areas with a programme of work to minimise these and provide assurance that these will be addressed. The refreshed strategy document will be presented to the Board in July 2014 and will ensure that UH Bristol continues to provide and build upon the excellent range of education and teaching opportunities for post and undergraduate students and all staff groups across the Trust.

Recommendations

The Trust Board is recommended to receive this report by the Director of Workforce and Organisational Development

Executive Report Sponsor or Other Author

- Sponsor – Director of Workforce and Organisational Development
- Other Authors – Kay Collings, Assistant Director of Teaching and Learning, Alex Nestor, Deputy Director of Workforce and Organisational Development

Appendices

- Appendix One - Strategic Priorities from the Teaching and Learning Strategy

Teaching and Learning Annual Report

APRIL 2013 – MARCH 2014

Index

Section	Title	Page
1	Purpose	2-3
2	National and Local Context	3
3	Overview of Funding and Budget Trainings for Teaching and Learning	3-4
4	Facilities and Resources	4-5
5	Medical Postgraduate Education	5-6
6	Staff and Associates Specialists	6-7
7	Medical Induction	7
8	Medical Undergraduate Education	7-8
9	Dental Postgraduate Education	8-9
10	Dental Undergraduate Education	9
11	Pre-Registration Nursing Education	9-10
12	Pre-Registration Allied Health Professionals	10
13	Healthcare Scientists (Modernising Scientific Careers)	11-12
14	Other Trust wide Teaching and Learning	12
15	Bands 1-4 Clinical Support	12-13
16	Apprenticeship Scheme, Non-Clinical	13
17	Qualification Credit Framework, Non-Clinical	13
18	Skills for Life	13
19	Essential Training (Essential Training)	13-14
20	Transformational Leadership	14-15
21	Key Achievements and Developments in 2013/2014	15-16
22	Challenges and Risks	16-17
23	Conclusion	17
24	Appendix One - Strategic Priorities from Teaching and Learning Strategy	18

Executive Summary

This Annual Report presents a high level overview of the many aspects of the education and teaching opportunities that UH Bristol provides, how the national and local education bodies set the funding streams to support the infrastructure and delivery of this important agenda as a Teaching Trust.

The funding and delivery of a large part of this agenda is governed by the Local Delivery Agreement which the Trust agrees with Health Education South West, who monitor the achievement of key performance indicators.

The quality of medical and dental postgraduate and undergraduate education provision across the Trust is measured in a number of ways, the main feedback is provided from the trainees via an annual General Medical Council Survey. It is important that we continue to listen and respond to this feedback to ensure we remain an attractive and viable learning environment.

The Trust also supports a range of pre-registration placements for Nursing students, Allied Health Professions and Health Care Scientists, all of whom are supported in their learning by appropriately qualified and trained staff. Sustaining and building on the partnerships with the local and regional Universities we work with to deliver the placements is an integral and important part of the teaching and learning agenda. There is increasing demand to increase the number of placements and we must ensure that we maintain effective learning environments whilst continuing to provide exceptional care to our patients.

The report also provides an opportunity to describe training and education for all staff groups, whilst ensuring the importance that staff are compliant with their essential training (which has been subject to a major review). The Trust provides a wide variety of teaching and learning opportunities and these range from a number of different options of Qualification Credit Framework (previously National Vocational Qualification's) including an Essential Care programme for Nursing Assistants, Customer Service and Business Administration for Bands 1 - 4 staff. These programmes are an important to our staff to enable them to develop themselves and improve the patient experience.

In providing such a large range of education opportunities across the organisation there a number of challenges emerging, these come mainly from the externally driven changes to commissioning and funding to the internal pressures of time to release staff to attend training due to operational performance delivery. There is a focus to mitigate both external and internal risks to ensure we remain an attractive and viable learning environment.

A review of the Teaching and Learning Strategy, currently underway and will address these areas with a programme of work to minimise any risk and provide assurance that these will be addressed. The revised strategy and its priorities will ensure that UH Bristol continues to provide and build upon the excellent range of education and teaching opportunities for post and undergraduate students across the many professions and the teaching and learning opportunities for all staff groups across the Trust. The refreshed strategy document will be presented to the Board in July 2014.

Finally, during 2014/15 a review will be undertaken of the Teaching and Learning infrastructure to ensure that all service provision is aligned to enable education and teaching is best placed to deliver a high quality service. As part of this review the current governance and assurance will be integral to this programme of work.

The Board are requested to note the progress and achievements of the delivery of Teaching and Learning agenda from 2013/14 and challenges ahead for 2014/15.

1. Purpose

The purpose of this Teaching and Learning Annual report is to set out the background to the provision of the education and teaching provided at UH Bristol NHS Foundation Trust; how it is governed; how it is funded and includes an overview of the education and teaching activity during 2013/14. This report also presents some of the key achievements/developments during 2013/12 and some of the challenges and risks for the provision of education and teaching over the coming years.

The current Teaching and Learning Strategy and its strategic priorities (Appendix One) are being refreshed in line with the Trust's overall strategy and this will be presented to the Board in July.

The revised strategy will ensure that UH Bristol continues to provide and build upon the excellent range of education and teaching opportunities for post and undergraduate students across the many professions and the teaching and learning opportunities for all staff groups across the Trust.

2. National and Local Context

The Department of Health has overall responsibility for set the education and training outcomes for the system as a whole and Health Education England is responsible for ensuring a better educational experience, supported by a fair and responsive funding system.

The Department of Health's Education Outcomes Framework provides the structure for planning and commissioning education and training for healthcare. The key components of the new system are Health Education England, Local Education and Training Boards and Academic Health Science Networks.

Local Education and Training Boards are responsible for the education, training and development of the healthcare workforce in the South West. Local Education Training Boards came into being on 1st April 2013 with a responsibility for driving the quality of education and training outcomes locally to improve patient care and experience. Their role is to work with stakeholders, through membership of Local Education Training Board meetings, including providers of NHS services, clinicians and education providers, to ensure the security of supply of a caring, compassionate and skilled workforce.

West of England Academic Health Science Network form a key component of the Education Outcomes Framework and is a vibrant and diverse network of partners (providers of NHS care working with universities, industry, NHS commissioners and a wide range of other organisations) committed to equality and excellence, which will accelerate the spread of innovative, evidence based practice to improve health and care quality.

The Network covers Bath and North East Somerset Training, Bristol, Gloucestershire, North Somerset Training, South Gloucestershire, Swindon and Wiltshire and the role of the West of England Academic Health Science Network is to bring together our local NHS, universities and industry to address the many challenges currently facing health care.

3. Overview of Funding and Budget Trainings for Teaching and Learning

Health Education South West allocate education funding to Trusts annually via the Department of Health, based on the allocated number of undergraduate and postgraduate students and trainee placements within a Trust, across medicine, nursing, allied health professional and healthcare scientists. The funding is called Multi-Professional Education and Training and funds specific education and training activities and to meet strategic education and training objectives. In 2013/14 UH Bristol received £37 million to support the delivery and infrastructure of education.

In 2013/14 the Trust received the following Multi-Professional Education and Training income:

- **Medical & Dental Education Levy** - £14.7m predominantly covers junior doctors' salary, travel and removal expenses plus Postgraduate Medical Education staff, tutors and Library staff, books and journals.

- **Medical Service Increment for Teaching** - £9.9 m predominantly covers Trust infrastructure costs for the teaching and placement of medical undergraduates.

It supports the South Bristol Academy Undergraduate administration and tutors team, wards and placements for students together with facilities and resources e.g. lecture Theatre on level 9 Queens Building, Education and Research Centre and the Library.

- **Dental Service Increment for Teaching** - £9.9m predominantly covers Trust infrastructure costs for the teaching and placement of undergraduates, primarily within the Dental Hospital and Chapter House.

- **Nursing & Midwifery Education & Training** - £2.5m predominantly covers the salary support costs for staff undertaking non-medical training. It covers training (backfill) for non-medical Healthcare professionals, including Nursing, Scientists, Pharmacy Technicians and Dental Nurses, Hygienists and Therapists. Tuition fees payable to Education Providers for non-medical undergraduate students and access to learning for the existing workforce via the South West Learning4Health.

- **Continuing Professional Development-** Funding for staff continuing professional development is managed locally within the Divisions, using a small allocation of the Medical and Dental Education Levy, Medical and Dental Service Increment for Teaching.

3.1 Governance and Monitoring

Health Education South West ensures the appropriate use of the allocation of funding for education for medical, dental, nursing and allied health professionals, by monitoring the achievement of the key performance indicators set out in a four year service level agreement, the Local Delivery Agreement, approved and signed by the Chief Executive and Finance Director for the Trust. There are three monitoring methods as part of the agreement, a self-assessment report against the operational objectives set out within the Service Level Agreement and a separate report against the financial objectives, together with an annual onsite visit from the Local Education Training Board. The monitoring process was suspended last year pending a national review of the structure and funding for education by Health Education England. The next Local Education Training Board visit to review the contract is scheduled for October 2014.

Internally the allocation of funding is monitored through the quarterly Medical and Dental Education Committee where all postgraduate and undergraduate teaching is reviewed.

3.2 Department of Health Review of Education Funding

The Department of Health and Health Education England have been working closely with NHS Trusts to improve the costing of education and training in order to obtain a better understanding of the true cost of delivering undergraduate and postgraduate medical and non-medical clinical placements. The aim is to replace the transitional tariffs that are currently in place, with a more permanent set of tariffs. To inform the tariffs, there are two mandatory cost collection exercises for Trusts to complete in 2014 and this is a considerable exercise with many technical issues still to be resolved, it is has been recognised that there are some errors and omissions in the data gathered nationally. However the Trust succeeded in providing details of all of its Medical and Dental Education Levy, Nursing and Midwifery Education and Training and Service Increment for Teaching funded courses for the first data collection exercise in January 2014. Health Education England expects to have the results and subsequent funding structures available to Local Education Training Boards and Trusts by October 2014.

4. Facilities and Resources

To enable the delivery of the education and teaching priorities across the Trust the following resources are available to support the learning experience.

The Education and Research Centre

- The Education and Research Centre is a serviced multi-professional facility, accessible to all staff working within the Trust (constructed in 1991 and funded by the Above and Beyond Charities). Within it are 8 tutorial rooms, 2 computer training rooms, 3 lecture theatres and a clinical skills practical facility. Health and Safety and Resuscitation Services have dedicated teaching rooms within the Centre. The Library and Simulation training facilities are also based within the building. The Centre hosts many regional conferences and seminars and is a venue of choice for the National Foundation Programme annual poster presentations.

Library and Information Services

- The Library and Information Service provides all staff and students free access to a range of high quality evidence-based resources. The Library supports evidence-based practice, clinical governance, education, research and continuing professional development. It is monitored by Health Education South West and for the past two years has achieved 100% compliance with the national NHS Library Quality Assurance Framework.

Bristol Medical Simulation Centre

- In April 2009, the Bristol Medical Simulation Centre was transferred into UH Bristol. Prior to this, Bristol Medical Simulation Centre was operating as an independent company (Pentamed Ltd) supported by the Above and Beyond Charities, providing simulation training commercially. The first of its kind in the United Kingdom, Bristol Medical Simulation Centre opened in 1996 and has now become nationally and internationally recognised as a high class simulation training facility. Trust staff have access to the Bristol Medical Simulation Centre and courses provided, focus on Human Factors and Patient Safety training e.g. Training the Trainer courses, Instructor Master Classes and Human Factor/Team working courses, together with bespoke smaller training programmes.

  These courses are specially designed for staff and educators who wish to improve and develop their debriefing skills, discover how to use simulators as teaching tools and foster a generic approach to Teamwork and Human Factors that can be applied to virtually any clinical setting and emergency situation. Twelve Human Factors courses, tailored to specific specialty requirements have been delivered to Trust staff during 2013.

5. Medical Postgraduate Education

In 2013/14, the Postgraduate Medical Education department supported approximately 520 doctors in training, which includes 39 Foundation Year 1 and 42 Foundation Year 2 doctors. The salaries for these doctors are funded by Health Education South West, at 50% or 100% of their pay costs and funding is received into the trust via the Medical and Dental Education Levy.

The Director of Medical Education, supported by an administration team, leads an Educational Faculty within the Trust; this includes Specialty Tutors who are responsible for the quality assurance of the education delivered to the trainee doctors. The Faculty meet quarterly at the Medical and Dental Education Committee, where educational quality and governance is assured. Specialty tutors are appointed by the Director of Medical Education.

The Director of Medical Education communicates any risks within Educational Governance through the Divisional Boards and the Senior Leadership Team and is supported by the Post Graduate Medical Education Team led by a Medical Education Manager.

There are 210 Educational Supervisors supporting all doctors in training. They are required to achieve 7 modules of learning to become accredited by Severn Postgraduate Medical Education (formerly the Severn Deanery).

Currently 90% of our Educational Supervisors are accredited, one of the highest achieving Trusts within Severn Postgraduate Medical Education. They are responsible for the overall supervision and management of a trainee's learning and educational progress during placements, by supporting the trainee to plan their training and achieve agreed learning outcomes. They remain the named educational supervisor for the entire time the trainee stays in the Trust irrespective of changing clinical placements.

Doctors in training also have named Clinical Supervisors who are responsible for supervising the trainee within the clinical placement, supervising the trainee during the time in the placement and feed into the educational supervisors report. They oversee a specified trainee's clinical work for a placement in a clinical environment. Clinical Supervisors are also required to achieve 4 of the 7 training modules provided to the Educational Supervisors. They provide constructive feedback during that placement, and inform the decision about whether the trainee should progress to the next stage of their training at the end of that placement. UH Bristol delivers the 4 modules of training during the monthly Consultant Development Away Day's.

The General Medical Council hold an annual National Survey in late spring which is sent to all junior doctors. The results are sent to the Director of Medical Education who is required to respond to any immediate patient safety concerns that may have been flagged by the Junior Doctors. The final results of the survey and actions to address any concerns are presented to the Senior Leadership team. The survey results are also sent to each Educational Supervisor to address any areas of concern over the junior doctor's education/teaching experience.

UH Bristol quality assures the provision of medical education in partnership with the General Medical Council and Health Education South West. The educational experience is evaluated by coordinating information from a number of sources:

The General Medical Council survey, Specialty Quality Panels, reporting to the Medical and Dental Education Committee by specialty tutors and from the trainees themselves at the Junior Doctors Forum held every 3 months.

All registered doctors in training, including Foundation Year 1 and Foundation Year 2 doctors, are required to participate in an annual assessment process (annual review of competence progression) and from 2014 will make a declaration regarding whether they have been involved in any serious incidents or patient complaints. Trainees will revalidate approximately five years after registration with the General Medical Council and/or at the time of Completion of the Certificate of Training.

6. Staff and Associate Specialist Doctors

Staff and Associate Specialist doctors and dentists are a group of 100 permanent medical staff working in the Trust. Staff and Associate Specialist doctors and dentists are not part of a formal training programme unlike other grades of medical staff, therefore Health Education England have identified this important group as requiring specific training and developmental opportunities.

UH Bristol receives £40k per annum via the Medical and Dental Education Levy provision to fund a Staff and Associate Specialist Tutor and an administrator, who manage a local training programme, support funded development opportunities for Staff and Associate Specialist doctors and work with other Trusts to provide regional training. The Staff and Associate Specialist Doctors tutor and team are supported by the Medical Education Department and Director of Medical Education.

During 2013/14, UH Bristol supported eleven doctors to attend a degree course, Teaching and Learning for Health Professionals and Post Graduate Certification in Education. Ten Staff and Associate Specialist doctors and dentists attended national conferences relevant to their specialty, e.g.: Regenerative Therapy, Osteoporosis and the Palliative Care.

Smaller events which are tailored for the Staff and Associate Specialist doctor group include; Building and Writing a Business Case, Time and Planning Skills, Negotiating and Influencing Skills and Appraisal and Revalidation Workshops.

The Trust employs a retired consultant one day per week to support Staff and Associate Specialists and doctors in training who may require guidance and support through any decisions around career choices or difficult personal situations. This service is confidential and outside the assessment process. The role is highly evaluated locally by the doctors and increasing numbers are using this facility. (33 doctors registered for support from this service in 2013).

7. Medical Induction

All doctors in training and Staff and Associate Specialists attend a two day Corporate Induction programme on their first day of their employment with the Trust. In addition each doctor attends a local departmental induction/orientation programme, as part of the NHS Litigation Authority standards.

Prior to commencing in post all new Foundation Year 1 doctors are funded via the Medical and Dental Education Levy provision to attend a week of shadowing with the outgoing Foundation Year 1 Doctor. During this time there is detailed handover of patient care, together with processes and equipment training. During this week, the Foundation Year 2 doctors deliver a the course ‘From Scared to Prepared’, which commenced in 2006 as an innovation project at UH Bristol that subsequently was supported by Health Education England and made mandatory for all trusts in the United Kingdom.

8. **Medical Undergraduate Education**

The University of Bristol medical school has 100-150 medical students on clinical placements at UH Bristol at any one time. Medical Undergraduate education is the responsibility of the South Bristol Academy Dean supported by an administrative team and three NHS Consultant Deputy Deans and two full time Clinical Teaching Fellows. The South Bristol Academy undergraduate team has responsibility for ensuring delivery of the curriculum to the medical students during their clinical placements.

UH Bristol receives funding from Health Education South West via the Service Increment for Teaching provision based on the number of student placements and the educational infrastructure to support their learning. UH Bristol invested in two clinical teaching fellow roles during 2013/14 to ensure we continue to improve the student experience within the Trust and support the University of Bristol Medical School.

The clinical curriculum is divided into individual Units which are placements between 9-18 weeks in duration. UH Bristol staff have funded time allocation to enable them to undertake Unit Coordinator and Unit Tutor roles to support the student teaching. The South Bristol Academy Dean undertakes regular educational appraisal of these posts.

The South Bristol Academy Dean’s team, Unit Tutors and Unit Coordinators provide pastoral support for students. The South Bristol Academy Dean liaises closely with the University of Bristol Director of Student Affairs concerning students in difficulty.

Some Units also provide a mentorship scheme whereby students are linked to 2/3 volunteer junior doctors during their clinical placements. Evaluation in Medicine and Surgery placements has rated these schemes very highly.

9. Dental Postgraduate Education

Dental Postgraduate education is based in the Bristol Dental Hospital and involves dental core training and specialty registrar training.

The Trust offers training in all dental specialities with the exception of oral pathology and micro-biology. The dental postgraduate deanery (Health Education South West) is based within the Dental Hospital hosted by the University of Bristol and quality assures all training placements.

There are approximately 35 trainee dentists working at UHBristol; this includes Academic Clinical Fellows. Of these 15 are Dental Core Trainees (Senior House Officer) and 20 are Speciality Trainees. The following dental specialities currently have trainees and a Training Programme Director within the trust.

Speciality	Number of Specialty Registrars (NHS)	Number of Specialty Registrars University of Bristol / National Institute for health Research
Dental & Maxillofacial Radiology	1	
Orthodontics	5	2
Paediatric Dentistry	2	
Special Care Dentistry	3	1
Restorative Dentistry	2	1
Oral medicine	1 (+1 Locum Associate Specialist at present)	
Oral Surgery		1

Every dental trainee has a named Educational Supervisor. There are 20 dental Educational Supervisors at UH Bristol, whom are also required to achieve 7 modules of learning to become accredited by Severn Postgraduate Dental Education. Currently 90% of our Educational Supervisors are accredited. (Their roles are similar to the Medical Educational Supervisors). For Dental Core Trainees, the Educational Supervisor is required to assess the trainee's portfolio of experience and competency assessment and recommend to the South West Postgraduate Dental Education Dean that the trainee is awarded a certificate of completion of one year of core training.

Clinical Supervision for dental trainees is similar to that of medical postgraduate training described in section 7. Pastoral care and support is provided through a variety of mentoring schemes within the South West Postgraduate Dental Education department, as well as the support available for all medical and dental trainees accessed through Severn Postgraduate Medical Education Professional Support and Development programme.

All dental trainees have opportunity to provide feedback via the Trust Junior Doctors and Dentists Group. Furthermore feedback provided to the Dental Postgraduate Education team in the annual surveys of trainees is passed on where appropriate to the Trust, e.g. if concerns about standard of training, patient care or bullying is reported.

There is a General Dental Council visit scheduled for 29th and 30th April 2014. This is the first time that the General Dental Council will have visited since 2003.

10. **Dental Undergraduate Education**

There are 365 dental students working within the Bristol Dental School (Bristol Dental School, based at UH Bristol Dental Hospital). This includes 78 students in year 1, 70 in year 2, 66 in year 3, 73 in year 4 and 78 in year 5.

The School operates in accordance with the University's Education Strategy and the University's regulatory and policy framework, and within UH Bristol's Clinical Governance framework. The Bristol Dental School Programme is divided into Themes and then into Units, each of which covers a particular subject that is taught and assessed as a whole. The programme is subject to University, Faculty and School review processes. Units and Elements report to Annual Programme Review, and any major changes made to Units are approved by Dental Education Committee, Faculty Undergraduate Studies Committee and University Education Committee.

Each student must have passed every unit within the year to progress to the next. In 2012 the Bristol Dental School programme was restructured and Bristol Dental School finals revised. In 2013 – 2014, significant efforts have gone into mapping the learning outcomes of the Units and standards set for the end of unit examinations. .

When providing patient care and services, students are supervised appropriately according to the activity and the student's stage of development. Supervisors are appropriately qualified and trained. Clinical supervisors have appropriate general or specialist registration with a regulatory body

In 2013 a quality assurance process known as School Review was undertaken with an excellent report and positive feedback both on the research and teaching (undergraduate and postgraduate) that takes place within the Bristol Dental School.

Each year, the final year dental students undertake the National Student Survey. In 2013, the School achieved 92% for student satisfaction on the Bristol Dental School programme a drop of 8% from 100% in 2012. Recurrent themes suggest that students are generally positive about the staff, clinical facilities and teaching; however there were comments around the clinical experience and accessibility to library services, which are being reviewed.

11. Pre-registration Nursing Education

University of the West of England provides our local pre-registration nursing and midwifery education and on average UHBristol supports approximately 135 student nurses per week (based on a 40 week programme). For the academic year 2013/14, (starting in September 2013) UH Bristol are already averaging 141 nursing student placements per week. Following a national workforce planning meeting there has been a drive to address the current shortage of adult nurses and numbers increased in September 2013 and are due to increase again in September 2014.

Pre-registration student commissions across all professional groups

University	Pre-Registration Programmes	Commission Numbers for UH Bristol 2013- 2014
University of the West of England	Adult nursing	225
	Children's nursing	20 - 25
	Midwifery	40-45 across acute and community placements.

Health Education South West, University of the West of England and placement provider partners meet regularly to discuss Key Performance Indicators as set out in the Learning Development Agreement.

With the changing nature of healthcare and multiplicity of providers (who are not all NHS) there is an increasing demand on UHBristol to provide appropriate quality, range and numbers of clinical placements for students on a variety of commissioned courses.

In April 2013, Health Education South West introduced a Placement Tariff, via the Nursing and Midwifery Education provision, to support pre-registration nursing placements. This newer concept of placement monies following student nurses will hopefully encourage non NHS providers to participate in pre-registration placement activity in a more meaningful way.

University of the West of England share student placement feedback results annually with placement providers, which is discussed at local level with placement managers and Heads of Nursing for each Division within UH Bristol. The vast majority of students indicate that placements in UHBristol are a positive experience for them and they are developing knowledge and skills in a variety of learning environments.

Issues raised by students in practice placements are managed and resolved through partnership meetings with the Higher Education Institutions and placement providers.

UHBristol continue to maintain 100% compliance with Nursing and Midwifery Council requirement for two yearly audits of all pre-registration nursing placements.

UHBristol has recently revisited the concept and principles of Clinical Supervision for nurses across the Trust and is in the process of developing a formal position statement, guidance and resources to support further implementation of this across the organisation.

11.1 Preceptorship Programme

UHBristol provide Preceptorship support for graduate nurses, midwives and Operating Department Practitioner's new to Band 5 roles across the organisation. The Learning Education Facilitators provides direct training and support to preceptees and preceptors and refresher updates as required. They have also developed a Preceptorship Professional Development Framework Document which supports Preceptees in gathering evidence in order that they can meet the requirements for their Band 5 Foundation Gateway appraisals. This is used in conjunction with other competency framework / orientation documents that several wards use for clinical skills acquisition.

12. Pre-registration Allied Health Professions Education

UHBristol supports approximately 215 Allied Health Professional students in placements that range in length from 4 to 26 weeks depending upon the programme. All the professions have agreements in place with the respective Universities to set placement capacity for the whole academic year in advance.

Pre-registration commissions across Occupational Therapy, Physiotherapy, Diagnostic Radiography and Therapeutic

University	Pre-Registration Programmes	Commission Numbers
University of West of England	Occupational Therapy	55
	Physiotherapy	60
	Diagnostic Radiography	58
	Therapeutic Radiography BSc	30
	Therapeutic Radiography MSc	12
Plymouth	Speech and Language Therapy	To be confirmed
	Nutrition and Dietetics	To be confirmed
	Orthoptists	To be confirmed
	Orthotics	To be confirmed

Students are allocated a placement supervisor from the University and a Trust based clinical supervisor and this allows for direct communications between the student, university and placement. Student issues are discussed at these informal meetings. In addition there are also placement/supervisor meetings held annually by most of the Universities where overall programme delivery is reviewed.

At UH Bristol, students are provided with a feedback form at the end of the placement, which addresses access to resources, personal experience and quality of education. University of the West of England also hold an annual event where students can nominate outstanding placement supervisors for an award and a supervisor from UH Bristol is regularly nominated.

Allied Health Professional pre-registration programmes now include at least a module on inter-disciplinary working and learning and many modules are accessed by different professions learning alongside each other. In practise many of the therapy services are now delivered by integrated services. In UH Bristol in adult therapy services students from Occupational Therapy and Physiotherapy are supervised together and share tutorials

The clinical supervisor/ mentor role is delivered differently across the programmes and different models are in place ranging from 1 student to 1 supervisor to 4 students to 1 supervisor. Unlike nursing, there is no requirement either from Health and Care Professions Council or any of the professional colleges that Allied Health Professional supervisors require mandatory accredited qualification e.g. Facilitation of Learning and Assessment in Practise.

Many of the Allied Health Professionals work in isolation so juniors seldom have the opportunity to learn alongside a more senior practitioner. Clinical supervision allows for juniors to review and reflect on practise in a safe environment. Clinical supervision is prioritised as an activity not withstanding situations of increased pressure such as black escalation.

13. Healthcare Scientists (Modernising Scientific Careers)

Modernising Scientific Careers is an ambitious work programme designed to deliver a sustainable NHS scientific workforce equipped to meet the challenges and opportunities of the future delivery of care. The Department of Health published *Modernising Scientific Careers: The UK Way Forward* in February 2010 detailed the strategy for the education and training and career development of the NHS scientific workforce which covers over 45 healthcare scientific specialisms. It supports workforce planning by providing a flexible career pathway structure with five clearly defined roles that are applicable to all healthcare science disciplines: Assistant, Associate, Practitioner, Scientist, and Consultant Clinical Scientist.

The Trust currently employs approximately 400 healthcare scientists and has been at the forefront of delivering the new Scientist Training Programme curricula funded by Health Education South West via the Nursing and Midwifery Education provision, in a range of subjects and supporting Higher Education Institutes, in particular University of the West of England, through providing work placements for Batchelor of Science students working on the Practitioner Training Programmes.

The Trust provides the widest range of Healthcare Scientist services within the South West so it is well placed to work strategically both with Health Education Institutes and across healthcare providers regionally to train future workforce to a highly competent level.

Sharing good practice and developing a consistent approach to training and education across all Healthcare Scientist specialisms could enable UHBristol to develop specific expertise in Healthcare Scientist training and recognition as a regional training hub across all careers frameworks from Assistant/Associate to Consultant grade Scientist.

During 2013 the Healthcare Science leads have been preparing for an internal audit to be carried out by the National School of Health Care Science in 2014. They will be assessing the standards and quality of education and supervision arrangements provided to Healthcare Scientist trainees across all specialisms within the Trust

UH Bristol receives a small amount of funding via the Nursing and Midwifery Education provision to support scientific trainees in clinical placements across the Trust.

Every scientist trainee has a named educational supervisor who is known to the National School of Healthcare Scientists.

This trainer is selected and has appropriate education, experience and training to be responsible for the overall supervision and management of a trainee's planned learning and educational progress during their time in UHBristol. The educational supervisor's role is to help the trainee to plan their training and achieve agreed learning outcomes, which are recorded on a national computer system. They are responsible for the educational agreement and for bringing together all relevant evidence to form a summative judgement at the end of the training period in UH Bristol.

Currently, educational training and education for trainers training within Modernising Scientific Careers is being developed by the National School of Healthcare Scientists related to the requirements expected for an educational supervisor under Modernising Scientific Careers.

14. Other Trust wide Teaching and Learning

In addition to the education and teaching provided for specific staff groups as described above, which is funded and governed by Health Education South West, the Trust also supports other staff groups with teaching and learning opportunities. The majority of this provision is provided by internal teaching and learning trainers. This training and education is quality assured by an internal assessor and all training is governed by the Teaching and Learning Steering Group which reports into the Senior Leadership Team. Some of the key components are listed in sections 15-20 below.

15. Bands 1- 4 Clinical Support

For nursing/midwifery assistant's there is an internal educational pathway through induction, the essential care programme, and the delivery of the Qualification Credit Framework level 2 and 3 supported by an education in practice team.

Induction is a 5 day programme, which all Nursing/Midwifery Assistants attend before commencing with the Trust. It incorporates all Essential Training and covers the patient pathway through illustrating the role of the Nursing Assistant in relation to patient care and the values associated with delivering the 6 C's as described in the Francis report. In 2013; 273 Nursing/Midwifery Assistants attended Induction.

Nursing/Midwifery Assistants subsequently attend the Essential Care Programme after 8 weeks in post. The programme is run over 8 days each month, with sessions designed to consolidate skill in practice; The Essential Care programme was delivered to 125 learners in 2013.

The Trust is an accredited centre for the Qualification Credit Framework, the qualification is internally verified, and the award is quality assured and accredited by a Standards Verifier from the Awarding Body, Edexcel. During 2013 a further 62 Nursing/Midwifery Assistants were

registered for the Qualification Credit Framework Qualification, the Teaching and Learning team have the capacity for 140 learners on a rolling basis due to the nature of the qualification and learner completion dates.

16. Apprenticeship scheme: Non-Clinical

There are 35 registered apprentices undertaking one of the following Qualification Credit Framework Level 2 qualifications; Customer Service, Business Administration, Team Leading or Certificate in Healthcare Support Services.

17. Qualification Credit Framework: Non-Clinical

There are 33 Hotel Service Assistants are registered for the Qualification Credit Framework Cleaning and Support Services Level 1 or 2 or Customer Service Level 1; this is in partnership with the City of Bristol College who provides the learner support and external accreditation. During 2013 seven learners completed the level 1 Cleaning and Support Service and three have completed Level 2.

Due to further government funding becoming available a further 25 staff members will be registered for the Cleaning Qualification Credit Framework during 2014. The Trust is also working with the City of Bristol College to provide a Level 3 Qualification Credit Framework qualification in Management and Business Administration this should be forthcoming later in 2014.

18. Skills for Life

Following the recommendations of the Leitch (2006) and Fryer (2006) reports, the Trust made the Skills Pledge, with the specific intention of giving everyone the opportunity to achieve a Level 2 qualification, and giving staff the support and encouragement needed to achieve this. During the last three years over 700 staff has been assessed and 107 have passed the requisite level examination for their post. The Trust also received the Learners Direct award for excellence for work completed with Skills for Life.

In partnership with the City of Bristol College 26 staff members will go through a cohort programme undertaking the Adult Numeracy and Literacy Level 1 or 2 commencing in April 2014.

19. Essential Training

A full review of Essential Training was conducted in 2013; the review resulted in four key areas of change:

- **Governance and Rationalisation**: This included the introduction of a multi-professional core group who are accountable for validating Essential Training and governing the processes associated with the delivery of Essential Training including quality assurance and evaluation. A new matrix was developed from this along with 5 staff portfolio groups

- **Induction and Updates:** Ensuring wherever possible that learners can access Essential Training in one place at one time; this includes Induction and the creation of the consolidated three yearly update for both clinical and non-clinical staff groups.

- **Connect:** The new Teaching and Learning website enables staff to be no more than three clicks away from all relevant Essential Training information including training records.

- **Learning Management System:** A new system was procured to ensure seamless communication with ESR in order to ensure 'real-time' data and the ability to have manager and employee self-service in the future, along with a move towards a more blended approach to learning.

The four key areas of change are now focussing on driving up compliance in all areas of essential training to 90%. To support compliance additional training is planned in addition to the introduction of E-learning at the end of June 2014 to support staff accessing a blended approach to training.

20. Transformational Leadership

Transformational Leadership at UH Bristol is defined in the strategy as:

'A leadership approach that causes change in both individuals and organisations. The model creates valuable and positive change by connecting the values of the organisation with the skills and behaviours[1] of the individual creating a culture of high performance, continuous improvement, and organisational transformation.'

In order to ensure leadership development is transformational the following principles underpin the strategic priorities:

- The principles of 'Transformational Leadership' cover all staff in leadership roles including clinicians and medical staff.
- Robust governance to be in place to validate the internal leadership agenda
- Ensuring internal leadership development links to one of the three core elements of leadership and these are mutually inclusive when developing leadership solutions
- Commitment to the NHS Leadership Healthcare Model[2]
- Talent Management is used to develop solutions, define opportunities, and as the nomination pool for opportunities, with the exception of medical leaders which will be managed through the medical directors office
- Partnership working with transformation to ensure leadership development delivers organisational transformation
- Strong relationships with the Local Delivery Partnership of the National Leadership Academy in order to influence regional/national leadership agenda
- Ensuring UH Bristol is well represented on all regional leadership development programmes

The website for Leadership and Management was developed and launched at the Leadership conference in September 2013, with over 80 leaders and managers attending. The website is branded using the NHS Leadership Healthcare model as the foundation for supporting existing staff in leadership/management positions. It is also a useful resource for those employees who aspire to move into management and leadership roles as they can navigate through the various options available.

During 2013, over 530 Managers/Leaders were trained in a variety of different people management topics including supporting attendance, recruitment, teambuilding and managing change. Up to 80 clinical staff completed the two day supervisory sister programme.

The people management programme was extensively reviewed in the last half of 2013 in order to ensure we develop a continuously improved programme aligning to the new NHS leadership healthcare model. The revised programme was launched at the Leadership conference in September 2013.

The Trust has secured all of its regionally allocated places on the NHS Leadership Academy Programmes during 2013/14, this is 12 in total.

[1] The three core elements of Leadership: Values, Skills and Behaviours as endorsed by the research conducted by Professor Michael West who concluded that leadership should be underpinned by Values in order to ensure organisational success
[2] The NHS Leadership Healthcare model is the competency model used by the Trust.
http://www.leadershipacademy.nhs.uk/discover/leadershipmodel/

It has been agreed that the Quarterly Chief Executive Leadership Forum will now be integral to the overall leadership approach to ensure we continue to build capability effectively. Work will commence to develop two leadership conferences per year to support Transformational Leadership and build the connectivity of an internal leadership community.

It is proposed that the first of these conferences will take place 20th October 2014, and the second in April 2015. We will take the opportunity during the conferences to ensure the dimensions of the NHS Leadership Health care model are integrated within the development opportunities.

21. Key Achievements and Developments during 2013/14

There have been a number of key achievements during the last year; in addition work undertaken this year has led to a number of initiatives that will be rolled out over coming year. . These can be summarised as follows:

- The South Bristol Academy team have been short-listed as finalists for the 2014 Annual British Medical Journal Awards Education Team category.
- In 2014-2015 the Local Education Training Board will set mandatory Key Performance Indicators for Library's across the Southwest region, which is based on the current Key Performance Indicators set by UH Bristol, highlighted as excellent practice in the recent 2013 - 2014 Library Quality Assurance Framework.
- Academic Health Science Networks are working together with Local Education Training Boards to support funding to increase Human Factors training programmes within Simulation Centres. Severn Postgraduate Medical Education (formerly Severn Deanery) was recently successful in securing a bid for £1.5million, for the delivery of simulation training programmes in Human Factors across the South West region. UH Bristol has been nominated as a key Centre to deliver some of this training in 2014 – 2015.
- The Medical Education team will be inviting patients to contribute in educational programmes particularly around behaviours and patient centred care.
- The South West regional Staff and Associate Specialist tutors are working together to create an educational framework that addresses coaching and mentoring, ethics and law, leadership & management, teaching & learning, appraisal & revalidation and personal skills. It is hoped that this will become a national framework.
- A new 4-week course for Year 2 students is being introduced in May/June 2014, 'Learning in the Hospital Environment'. The aim of this course is for students to familiarise themselves with the Hospital Environment and to develop a culture of patient-centred care at the end of Year 2 so that they are fully prepared to engage with clinical placements as they enter Year 3.
- The Children's hospital funds a mobile simulation programme delivering simulated training at the point of care.

  The Simulation Centre is increasing its income by providing training overseas, and they will use the income to fund a more robust mobile adult simulation programme.
- The South Bristol Academy has developed two Clinical Teaching Fellow posts based at the Bristol Royal Infirmary in response to student feedback and to align South Bristol Academy with the other Academies who had already established this model. The roles have been highly evaluated by the student.
- During 2014/15 the Modernising Scientific Careers Programme will be offering apprenticeships leading to Band 2-4 posts and Higher Specialist Scientific Training to

achieve the knowledge and competences required of Consultant Healthcare Scientists through a 5 year ‘fast track’ programme for registered Clinical Scientists.

- Following a request from the Department of Health Chief Scientific Officer the Trust appointed a Lead Scientist 1st April 2014.
- During 2014/15 Dr Crawford will work to establish effective communication with the LETB and seek to maximise opportunities for the Trust to take advantage of external funding for existing and new specialist training programmes.
- The West of England Academic Health Science Network have approved two UH Bristol projects. **Dementia Health Education South West,** leading on the national project to raise awareness of dementia and ensure that foundation level training is made available to all NHS staff. UH Bristol has been working with them to develop plans for rollout of training across existing staff groups and newly qualified staff, to ensure they receive foundation level dementia training. UH Bristol compliance against this training achieved 90% in 2013. This will ensure that staff are aware of the needs of patients, their families and carers, and enable them to provide safe, dignified and compassionate care. The second project is **Developing Clinical Academics in the South West**:

The Clinical Academic Training Programme enables the development of Clinical Academics in nursing, midwifery and the allied health professions, which consists of two components, Clinical Academic Internships and Research Innovation and Improvement Capability Project. Two staff have been successful in their applications for bursaries in the categories above. Katy Buchan, a Physiotherapist awarded a bursary for the Clinical Academic Internship and Sharron Carrie, Paediatric Sister for the Research Innovation and Improvement Capability Project. These staff are being supported through these bursaries to complete a Masters qualification in an area of study that will increase the knowledge and evidence base in caring for people living with dementia, meeting the needs of frail older people and moving care closer to home.

22. Challenges and Risks

It is clear there are a number of risks emerging, these come mainly from the externally driven changes to commissioning and funding to the internal pressures of time to release staff to attend training due to operational performance delivery.

There is a focus to mitigate both external and internal risks to ensure we remain an attractive and viable learning environment.

The following external and internal challenges and risks for the education and teaching agenda over the coming year will be addressed as part of the on-going work to review the Teaching and Learning strategy. There are a number of mitigating actions and plans already in place to mitigate these risks.

- Funding and tariff changes in 2014-15 following the Department of Health review on funding.
- Managing changes in commissioning of training and a potential reduction in Local Education and Training Board funding.
- Maintaining effective learning environments whilst accommodating increased placements.
- 100% accreditation of Medical and Dental Educational Supervisors to achieve 7 modules of training.
- Training and recruiting suitable examiners for student assessments.

- In 2014-15, pathology will be moving from its current curriculum position in Year 4 to Year 3. There will effectively be twice as many students on pathology clinical placements from September 2014
- Accessing funds to pay for post-graduate Continuing Professional Development training and development for non-medical staff remains a challenge
- Making explicit the time within Allied Health Professionals' job plans for training and education
- Compliance for Essential Training if staff are not released

23. Conclusion

This report has described the high level context and background to how UH Bristol delivers against its education and teaching priorities during 2013/14.

As the report demonstrates there are a vast number of education and teaching programmes delivered across the Trust and it is imperative that we continue to ensure experience for all our students, leaners and staff is of high quality and contributes to providing exceptional care for our patients.

During 2014/15 a review will be undertaken of the Teaching and Learning infrastructure to ensure that all service provision is aligned to enable education and teaching is best placed to deliver a high quality service. As part of this review the current governance and assurance will be integral to this programme of work.

In addition to this the Teaching and Leaning Strategy along with its strategic priorities is being reviewed and the revised strategy will ensure that UH Bristol continues to provide and build upon the excellent range of education and teaching opportunities.

The report also presents the challenges and risks for the provision of education and teaching over the coming year and the review of the strategy will address these areas overall with a programme of work to minimise these and provide assurance that these will be addressed. The refreshed strategy document will be presented to the Board in July 2014.

Appendix One – Strategic Priorities from Teaching and Learning Strategy

- We will have a Teaching and Learning strategy that will work in synergy with the Clinical Services Strategy and Research and Innovation Strategy, so that they are mutually supportive, and collectively, are the key drivers to supporting the delivery of the Trust mission.
- We will provide high quality Teaching and Learning programmes to support the development of a diverse flexible workforce so we have the right people, with the right skill, in the right place at the right time through effective training needs analysis and appraisal processes enabling us to play a greater leadership role within the health system.
- We will develop transformational Leadership competencies to embrace the Trust Values, to drive our performance, and to deliver high quality patient care.
- We will create appropriate structures and a strong governance culture within the Teaching and Learning service to ensure equity of opportunity, consistency of approach, and a measurable return on investment for all activity.
- We will ensure that our service budgets are managed equitably with a fair bidding process in order to deliver the Trust's Teaching and Learning outcomes alongside our need to deliver efficiency savings. We will draw down on all available external funding to support the delivery of a multi-professional Teaching and Learning Strategy.
- We will build on our teaching hospital status and endeavour to increase our income through the marking of our Teaching and Learning services beyond the South West.
- We will fully review practices and procedures within our Teaching and Learning services and implement a flexible structure solution capable of meeting the demands of the future.
- We will ensure the Education Centre is a 'Centre of Excellence', by developing innovative Teaching methods to ensure we maximise usage of the Education Centre and our Teaching and Learning services meet the on-going needs of the workforce.
- We will further develop our partnerships with North Bristol Trust, University of Bristol, and University of the West of England, Severn Deanery and the City of Bristol College.
- We will establish wide community links and networks to improve our communication and reputation beyond our health care partners.

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

17. West of England Health Science Network Board

Purpose

This is the second quarterly report for the Boards of the member organisations of the West of England Academic Health Science network which includes the three health research active Universities, NHS Trusts and Foundation Trusts, Community Interest Companies who provide community health and social care and the seven Clinical Commissioning Groups.
A similar briefing will be circulated to a wider range of partners and stakeholders following each quarterly meeting of the Academic Health Science Network Board. This report includes a one page summary of our Business Plan for 2014/15.

Abstract

Sir Bruce Keogh, Medical Director, NHS England Visit to West of England AHSN. The Chair reported that Sir Bruce Keogh had visited the West of England Academic Health Science Network (AHSN) on 21 February. This was Sir Bruce's first visit to an AHSN and he met Board members and clinicians who are leading our work across the West of England.

Recommendations

The Trust Board is recommended to receive this report by the Chief Executive

Executive Report Sponsor or Other Author

- Sponsor – Chief Executive

Appendices

- West of England Academic Health Science Network - Plan 2014/15

Report from West of England Health Science Network Board, 05 March 2014

1. **Purpose**

This is the second quarterly report for the Boards of the member organisations of the West of England Academic Health Science network which includes the three health research active Universities, NHS Trusts and Foundation Trusts, Community Interest Companies who provide community health and social care and the seven Clinical Commissioning Groups.

A similar briefing will be circulated to a wider range of partners and stakeholders following each quarterly meeting of the Academic Health Science Network Board. This report includes a one page summary of our Business Plan for 2014/15.

Board papers will be posted on our website - http://www.weahsn.net

2. **Sir Bruce Keogh, Medical Director, NHS England Visit to West of England AHSN**

The Chair reported that Sir Bruce Keogh had visited the West of England AHSN on 21 February. This was Sir Bruce's first visit to an AHSN and he met Board members and clinicians who are leading our work across the West of England. A short film has been made of the visit www.youtube.com/watch?v=gftizLhXiwY. Member organisations are invited to use it on their websites.

3. **Progress Report and Business Plan for 2014/15**

At Sir Bruce Keogh's visit, we highlighted the key areas of focus during our first year and these are being built on within our Business Plan for 2014/15 which will come to all member organisations to confirm their support. In line with the NHS England "Licence for AHSNs", our programme is under the following headings:

Focus on Patients and Populations

- **Patient Safety Programme** – we are continuing to support Safer Care South West which is the Patient Safety programme headed by James Scott, Chief Executive, RUH Bath and Shaun Clee, Chief Executive of 2Gether Mental Health Trust. We already have a vibrant core programme in patient safety which is well supported by clinical "faculty" across the West of England and which we intend to develop to draw in all member organisations as fully as possible.

  The Mental Health programme extends across the whole of the South of England and we expect this to continue. During 2014/15, the West of England will lead a bid to establish a Patient Safety Collaborative as part of which we will pilot a Patient Safety in Primary Care programme which is currently being

developed under the leadership of North Somerset Clinical Commissioning Group, working with the BNSSSG Area Team.

- **Connecting Data for Patient Benefit** – during 2013/14, we have had discussions across the West of England about how best to connect data at individual patient level across GP practices, NHS Trusts and Social Enterprises and our local authorities. We have now agreed to support a feasibility, or proof of concept, study in each of Gloucestershire, BaNES and Swindon/Wiltshire. This will include all organisations including those who cover several health communities, such as Mental Health Trusts and the South West Ambulance Services.

  "Connecting Care", the BNSSG programme for Connecting Data for Patient Benefit is now live and is showing great potential for improving patient safety, system-wide efficiencies and more holistic management of a person's care to avoid hospital admission. During 2014/15, this programme will offer "e-Discharge" to the GP practices of all patients discharged from hospital.

Adoption of Spread and Innovation

- **Evidence into Practice** – we have now selected and are at Project Initiation stage of three schemes which will be rolled out during 2014/15. They are:
  - Preventing Cerebral Palsy in pre-term babies – women who go into labour early can be given Magnesium Sulphate which is protective against Cerebral Palsy. The strength of this evidence has been verified by the Cochrane Collaboration and will be adopted initially by Gloucestershire Hospitals, University Hospitals Bristol and North Bristol Trust.
  - Proving outcomes in hip replacement – this evidence from the National Joint Registry confirms that cemented hip replacements results in better outcomes for people who are over 70. The programme will start with presentation and discussion of the evidence by clinicians in each NHS Trust which offers hip replacements.
  - Stroke Prevention in Atrial Fibrillation. This is NICE guidance and a priority of the Cardiovascular Strategy Clinical Network in the South West. It is being addressed with advice from Dr Martin James, Clinical Lead for the Cardiovascular Network, and will be implemented jointly with the seven Clinical Commissioning Groups in the West of England.
- **Commissioning Evidence-Based Care** – this programme was launched on 29 January 2014 with a training event for commissioners on interpreting, presenting and using evidence. This event included all Clinical Commissioning Groups and was well attended and well evaluated. It is the first of a series of initiatives in which we plan to support commissioners and help them build capability and capacity for commissioning evidence-based care.

Enterprise and Translation

This programme established three themes during 2013/14 which are being strengthened in 2014/15:

- **Articulating Key Challenges for Clinicians or the NHS** – inviting companies to work in partnership with us to develop responses. The national Small Business Research Initiative programme has supported a specification we crafted with the Patient Safety Faculty around the deteriorating patient. Three

companies were selected and we will now work with them as they develop their proposals. We will use this model for a series of local West of England challenges in 2014/15.

- **Developing a 'Translator Network'** – we have over 40 people in the West of England who have a role in innovation within their Trust, Clinical Commissioning Group or Social Enterprise. We will fill in the gaps and build this network during 2014/15.
- **Mapping Health Related Companies** – we now have over 250 companies on our database and we will work with the three Local Enterprise Partnerships for Gloucestershire, Avon and Swindon/Wiltshire to offer outreach events and build on areas of strength.

4. West of England AHSN Conference 2014

Our conference this year will be on Thursday 16 October 2014 at the University of the West of England Conference Centre.

We are holding it jointly with the West of England Local Clinical Research Network.

Deborah Evans
March 2014

West of England Academic Health Science Network - Plan 2014/15

NHS ENGLAND LICENCE FOR AHSNs	WEST OF ENGLAND BUSINESS PLAN KEY THEMES	WE WILL DELIVER
Focus on needs of patients and local people	• Patient safety	• a West of England Patient Safety Collaborative, building on our successful Patient Safety Programme; • support to our Mental Health Patient Safety programme; • a pilot Primary Care Patient Safety programme.
	• Connecting data for patients benefit	• feasibility studies in Bath and North East Somerset, Gloucestershire and Swindon/Wiltshire; • 'e-Discharge' to 100+ GP practices and support live 'Connecting Care' programme in Bristol, North Somerset and South Gloucestershire.
Accelerate the adoption of innovation into practice to improve clinical outcomes and patient experiences	• Evidence into practice • Commissioning evidence-based care	• treatment to prevent cerebral palsy in pre-term babies; • improved outcomes of hip replacements for older people; • stroke prevention in people with atrial fibrillation; • 'Evidence Fellows' for CCGs with Health Education South West.
Build a culture of partnership and collaboration	**Strengthening capacity and capability for:** • adoption and spread of best practice; • service improvement science; • innovation; • patient and public involvement; • working with industry.	• master classes, seminars and Action Learning Sets; • capability in 'Translator Network'; • an Innovation Fellowship Scheme with EU partners; • a YouTube innovation channel for challenges and solutions.
Make a meaningful contribution to the West of England and UK economy	**Enterprise and Translation:** • mapping local health related companies - working with Local Enterprise Partnerships on outreach and 'Health Clusters'; • articulating clinical challenges and seeking industry partners; • streamlining procurement.	• interaction with 250+ companies through external events; • three West of England local challenge processes; • partnerships with other AHSNs on the Small Business Research Initiative; • successful working relationships with companies and clinicians to develop and evaluate innovation; • a procurement collaboration programme.

Our Values: Connecting Collaborative Catalytic Challenging

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

18. Quarterly Capital Projects Status Report

Purpose

To update the Board on the current status of the Trust's major capital development schemes.

Abstract

The purpose of this report is to update the Board on progress, issues and risks arising from the Trust's major capital developments which are governed through the Strategic Development Department and associated programme infrastructure.

The BHOC Programme is now complete and was successfully concluded.

The CSP building programme is now complete and the programme is on track for service transfer on the 6th & 7th May.

The BRI programme remains broadly on track in respect of both budget and timelines based on the revised programme reported previously, with the notable exception of a potential 2 week delay to level 9 reported by the contractor though this has yet to be agreed.

The report notes a number of programme risks that are being actively managed and mitigated where possible.

Recommendations

The Trust Board is recommended to receive this report by the Director of Strategic Development and Deputy Chief Executive.

Executive Report Sponsor or Other Author

- Sponsor – Director of Strategic Development and Deputy Chief Executive
- Other Author – Strategic Development Programme Director

Appendices

- Appendix A – Quarterly Status Report.

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Item 16 – 28th April Trust Board

1. Introduction

This status report provides a summary update for Quarter 4 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

CENTRALISATION OF SPECIALIST PAEDIATRICS		
1	**Decisions required**	None.
2	**Progress**	Build work is fully complete within the Children's Hospital with some areas already operational. The level 5 of the new ward block is on programme for handover at the end of May with interim operational work a rounds in place. Models of care and operational policies have progressed well and service simulation exercises are on-going. Patient records. data migration and appointment scheduling in hand and on track. Communication to stakeholders and parents underway. Current focus on staff orientation and induction and move arrangements. CSP and NBT Transition Board have both given approval for transfer to proceed.
3	**Budget**	A capital allocation of £31.3m is in the capital programme including a level of assumed charitable funding support and remains within budget.
4	**Programme**	On track and in budget.

5 **Risks**	**Risk**	**Mitigation Actions**
	Staff recruitment is delayed resulting in risk to patient safety and/or quality.	Robust recruitment plans for all areas and enhanced oversight by Operational Delivery Group and CSP Board of high risk areas. Contingency plans in place for areas of residual risk, signed off by CSP Board.
	Critical equipment is not available at point of transfer.	Equipment requisition process in place with appropriate escalation for delays. Contingency plans in place for any unavoidable delays.
	Accident & Emergency activity is higher than forecast with resulting risk to ED performance and service quality.	Extensive communication campaign to raise awareness of new urgent care pathway. Operational contingency developed to manage scenario of increased referrals.
	Risk of failure to agree out of hours theatre model with transferring service leads.	National benchmarking undertaken to confirm appropriateness of proposed model. Simulation exercise planned to confirm safety of proposal. Full risk assessment undertaken.

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS, GENERATORS AND QUEEN'S FAÇADE		
1	**Decisions required**	None
2	**Progress**	**BRI Phase 3** – Programme dates for all levels are now on programme. No further ambulance diversions planned. **BRI Phase 4** – Space allocation plan for Phase 4 remains robust with few minor changes. Progress has been made to resolve use of Central Health Clinic and final location for EEG service. A provisional office allocation plan will be reviewed by Project Board next month. Some Ward refurbishment work now at tender stage.. Ward closure and move programme version 18 approved by Project Board. **Air Ambulance Access / Helideck –** Complete, successful training flight. Further resilience to be developed in workforce model. **Queens Façade** – design team meetings, including the architects Nieto Sobejano, are on-going and are now working with the 2 shortlisted contractors to work towards their best and final offer (due in May 2014).
3	**Budget**	A total capital allocation of £92.3m is in the capital programme including assumed charitable funding support of £2m. Allocation of £86.6m for the phase 3 works includes funding for the helideck and site wide generators, which is now part of the target price agreement. Allocation also includes funding for facade. The scheme remains within its capital budget.
4	**Programme**	The contract generally continues to run to the revised programme following the changes to levels 3&9. The contractor has warned of a potential delay of 2 weeks to level 9 due to inclement weather, but this has yet to be agreed.

5	**Risks**	**Risk**	**Mitigation Actions**
		Activity and capacity assumptions do not materialise as planned, following recent re-fresh, due to changes in demand or length of stay assumptions.	Series of changes to the Trust Operating Model to improve flow, length of stay and delayed discharge with aim of creating excess capacity to deal with activity in excess of plan. Out of hospital bed capacity commissioned and 20 additional beds in place since 31st March.
		Current ward move sequencing plans suggests a 5-6 month period of 5 site working for Medicine.	Options paper developed by Medicine to support the earlier closure of inpatient wards within the Old Building, which requires support from SHN for temporary access to cohort area on ward 800. Position agreed.
New risk since last report		Operational impact of transferring existing Clinical Information System in ITU.	Trust wide procurement of CIS is unlikely to proceed in time for ITU transfer, alternative plan now being formulated by Equipping Lead.
		Delay in transfer out of Vascular Surgery to October 2014.	Confirmation of delayed transfer until October. Requires changes to ward moves (version 17) and workforce plan from SHN Division.

BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE (BHOC)		
1	**Decisions required**	None.
2	**Progress**	The project is now complete
3	**Budget**	The scheme final account is being assessed but no significant overspend is predicted.
4	**Programme**	Two week delay from original timeline but with no adverse impacts.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 17.04.2014

Cover Sheet for a Report for a Public Trust Board Meeting,
to be held on 28 April 2014 at 10:30am
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

19. Governor's Log of Communications

Purpose

The purpose of this report is to provide the Council of Governors with an update on all open questions on the Governors' Log of Communications.

Abstract

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Four items have been entered onto the Governors' Log of Communications since the previous Public Board meeting. These can be seen in Appendix A.

Recommendations

The Trust Board is recommended to note this report by the Chairman

Executive Report Sponsor or Other Author

- Sponsor – Chairman

Appendices

- Appendix A – Governor Log – Items since the previous meeting.

ID	Governor Name		
86	Ken Booth	Title:	On-street drop-off parking for volunteer drivers

Query **14/04/2014**

The Board will be aware that lengthy discussions with City Council officials lead by Bob Pepper, Director of Facilities and Estates, with a view to the provision of on-street patient drop-off spaces have been un-successful. With the full support of governors Lorna Watson and I have been pressing for spaces to be set aside on both Upper and Lower Maudlin streets, particularly adjacent to the BRI entrance (where there would be no obstruction to traffic) and opposite the Eye hospital entrance (where there are currently pay & display spaces).

This issue poses a serious problem for volunteer drivers in car schemes who bring the elderly and/or infirm to out-patient appointments, as well as to those of us who offer this facility to friends or neighbours on an informal basis. Parking tickets are frequently issued by over-zealous attendants, outside the BRI, which makes volunteer drivers reluctant to provide this service. Short-term (15 minute, parking ticket-free) drop-offs outside the Eye hospital are practically impossible.

Providing easy access to our hospitals should be a priority if we truly believe in our values. This must not be obstructed by red-tape and excuses put forward of council officials. I now ask our Non-Executive Directors to support a direct approach by Robert Woolley to the Mayor, with a view to solving this problem once and for all.

Response **22/04/2014**

Pending Assignment

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85 **Mo Schiller** **Title:** **Trust support for staff training**

Query **09/04/2014**

What can the trust do to support care assistants/nursing/midwifery assistants financially to allow them to undertake further training to become qualified registered nurses/.midwives/operating department assistants.

Response **10/04/2014**

Pending Assignment.

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84 **Mo Schiller** **Title:** **Process for cancelling appointments**

Query **09/04/2014**

What is the purpose of sending out 1st class letters confirming a cancellation due to black alert 3 days after the booked session is cancelled.Surely speaking with the patient verbally is adequate.

Response **10/04/2014**

Pending Assignment.

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83 **Mo Schiller** **Title:** **Productive Outpatient initiative**

Query **09/04/2014**

The Productive Out patient initiative was meant to alleviate some of the problems with appointment booking.Why is it that the telephone lines meant to be manned Monday to Friday,9-5pm do not respond to messages when staff are away from their desks.A minimum 36 hours should be adequate for a telephone response.

Response **10/04/2014**

Pending Assignment

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

20. Q4 Risk Assessment Framework Monitoring and Declaration

Purpose

The Trust is required to make its quarter 4 declaration of compliance with the 2013/14 Monitor Risk Assessment Framework by 30th April 2014. The purpose of this report is to set out the Senior Leadership Team's recommendations to the Board in support of this declaration.

Abstract

Since 1 April 2013 all NHS foundation trusts require a licence from Monitor stipulating specific conditions that they must meet to operate. Key among these are financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach to overseeing the sector under the new rules. It explains how Monitor will use the framework to assess individual NHS foundation trusts' compliance with two specific aspects of their work: the continuity of services and governance conditions in their provider licences.

The Risk Assessment Framework replaced the Compliance Framework from 01 October 2013.

The aim of a Monitor assessment under the Risk assessment framework is to show when there is:

- a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or
- poor governance at a NHS foundation trust.

These will be assessed separately using new types of risk categories set out in the Framework; each NHS foundation trust will be assigned two ratings. The role of ratings is to indicate when there is a cause for concern at a provider. It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

This report sets out the Trust's risk rating for governance and finance, as calculated using the criteria set out in the Risk Assessment Framework.

The Director of Strategic Development and Deputy Chief Executive has provided an analysis of governance risk (Appendix A).

The Director of Finance and Information has provided commentary on financial risk to the Finance Committee.

The Trust Executive confirms that it is not aware of any matters arising in the quarter requiring an exception report to Monitor which have not already been reported.

Recommendations

The Trust Board of Directors is recommended to approve a declaration as follows:

- A submission against the 'Governance Rating' reflecting the four standards failed and the further standard at risk of being failed in quarter 4, and,
- A 'Continuity of Service Risk' of 4.

Report Sponsor
Chief Executive
Appendices
Appendix A – Monitor Quarter 4 declaration against the 2013/14 Risk Assessment Framework for Governance Appendix B – Monitor Quarter 4 declaration against the 2013/14 Financial Summary for quarter-end and the year

Appendix A - Monitor Quarter 4 declaration against the 2013/14 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 4 declaration of compliance with the 2013/14 Monitor Risk Assessment Framework by 30th April 2014.

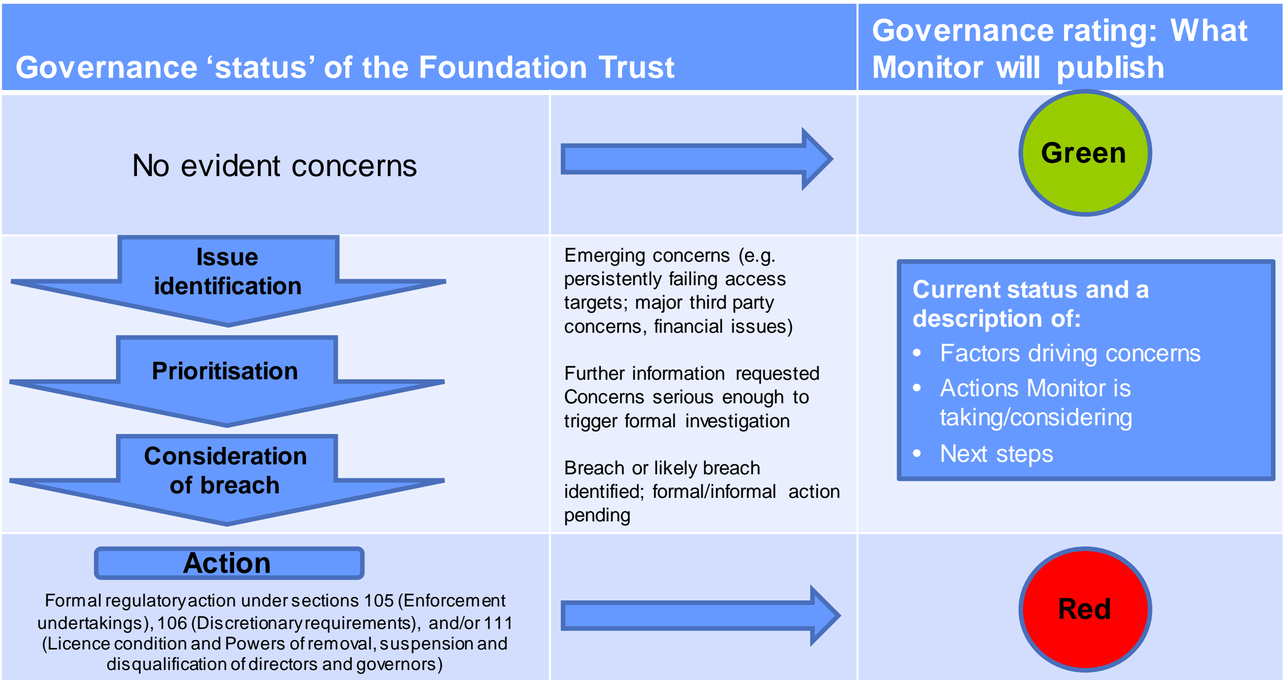
The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 4, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

In the future Monitor intends to include in its list of Governance Concerns patient and staff metrics including changes in satisfaction rates, turn-over rates, levels of temporary staffing and cost reduction plans in excess of 5%.

The resultant Governance Rating that Monitor publishes will depend on further investigations it conducts following Governance Concerns being triggered. The following shows the rationale for the application or either a GREEN or a RED rating:

Table 1 Monitor's process for determining the Governance 'status' of a Foundation Trust



Each quarterly declaration to Monitor must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to Monitor as part of the narrative that accompanies the submission.

Monitor compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent

review of its self-certification and associated processes. In the 2013/14 Monitor Annual Plan the Trust declared three standards to be at risk of failure in the year:

- A&E 4-hour maximum wait
- *Clostridium difficile* (C. diff) annual objective
- 18-week Referral to Treatment Time (RTT) non-admitted standard

2. Performance in the period

Table 2 shows the performance in quarter 4 against each of the standards in Monitor's Risk Assessment Framework. The following standards were not achieved in the quarter:

- *Clostridium difficile* (C. diff) (scores 1.0) – failed for the fourth consecutive quarter (Governance Concern triggered)
- RTT Non-admitted pathways standard (1.0) – failed for a third consecutive quarter
- A&E 4-hour standard (1.0) – failed during a three-quarter period following failure during the preceding four-quarter period (Governance Concern triggered)
- 62-day GP Cancer standard (1.0)

A fifth standard, the 31-day first definitive treatment cancer standard, is also considered to be at high risk of not being achieved when final reporting is completed at the beginning of May.

Under the rules set-out within the Risk Assessment Framework, C. diff, RTT Non-admitted and the A&E 4-hour standard would trigger Governance Concerns for repeated failures of the same standard. In addition the overall Service Performance Score of 5.0 (including the 31-day first definitive standard) would trigger a further Governance Concern.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of May and therefore the position shown in Table 2 is draft only.

3. Quarter 1 2014/15 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in Monitor's 2013/14 Risk Assessment Framework in quarter 4, along with the key risks to target achievement for quarter 1 2014/15. The mitigating actions that are being taken are also provided, along with the residual risk.

The A&E 4-hour standard was failed in quarters 1, 3 and 4 of 2013/14. The 95% standard was also failed in quarter 1 of 2012/13. The Trust has recently embarked upon its Operating Model for 2014/15, including the 'Breaking the Cycle' initiative. Although there is significant emphasis on actions to improve patient flow, recent and historical performance in quarter 1 does not provide the necessary assurance that the 95% standard will be consistently achieved in quarter 1 of 2014/15. In addition, the closure of Frenchay Hospital's Emergency Department, and the associated Emergency Flows, poses an additional risk if the transfer of activity is above that forecast.

Performance against the 62-day GP standard has been variable in 2013/14, with the standard being failed in quarter 2, and expected to be confirmed as failed in quarter 4. The 85% national standard was achieved in quarters 1 and 3 with breach reallocation to late referring providers taken into consideration. The lack of breast and urology in the Trust's portfolio of cancer services makes the achievement of the national standard significantly more challenging as breast is one of only two services nationally (the other being skin) which routinely achieves the 85% standard each quarter. The Trust has taken action to mitigate the impact of the portfolio on performance through an active programme of improvement work in quarters 3 and 4. Whilst improvements in performance have been made, as quarter 4 demonstrates, high levels of medical deferrals, clinically complex cases and patient choice, on top of late referrals, can result in significant deterioration in performance,

which is difficult to mitigate. For these reasons achievement of the 62-day GP standard is considered high risk going in to 2014/15.

It was originally agreed with the commissioners that the transfer of Head & Neck services from North Bristol Trust (NBT) at the end of March 2013 would result in a potential failure of the RTT non-admitted standard for the first two quarters of 2013/14, due to the longer than expected waiting times at the point of transfer and partial validation of pathways. Whilst the RTT Non-admitted standard was achieved in quarter 1 this year, the standard was failed each month in quarters 2, 3 and 4. Although good progress has been made in addressing the Head & Neck backlogs there continues to be a risk of failure of the Non-admitted standard as a result of the long waiting times for first outpatient appointments following an increase in GP referrals. Detailed activity plans have been developed to reduce outpatient waiting times during quarter 1 2014/15. It is currently forecast that the RTT Non-admitted standard will be failed in quarters 1 and 2 in 2014/15, although achievement of the standard may be able to be brought forward. This is dependent upon how quickly existing backlogs are treated, in addition to bringing future booked outpatient appointments.

Performance against the 31-day first definitive cancer standard was unusually low in quarter 4. The current assessment is that the standard is at high risk of being failed when final reporting is completed at the beginning of May. The main reasons for the potential failure to achieve this standard were high levels of medical deferrals, cancellations of surgery, mainly due to the lack of a critical care bed, and dental extractions delays for Head & Neck patients prior to radiotherapy. The opening of an additional Intensive Therapy Unit (ITU) bed at the end of February has reduced, but not eliminated, this cause of cancellations and resulting breaches. The implementation of the action plan arising from the review of the Head & Neck cancer pathways in quarter 3, will address the delays to dental extractions. These steps, in conjunction with an increase in thoracic surgery capacity, which was also a contributing factor to some 31-day breaches, should support recovery of the 31-day first definitive standard in quarter 1 2014/15, although the standard remains at moderate risk of being failed.

Of specific note is the de-escalation of C.diff from having a high residual risk in previous years, and having been failed in each quarter of 2013/14, to a moderate residual risk in 2014/15. It has recently been confirmed that the maximum number of cases of C. diff the Trust is expected to have during 2014/15 is 40. It is assumed Monitor will continue to apply a flat trajectory across quarters, with a maximum 25% of annual cases being reported in quarter 1, and 50, 75% and 100% in quarters 2, 3 and 4 respectively. Our outturn for 2013/14 is expected to be confirmed at 38 cases. The 2014/15 maximum number of 40 therefore represents a zero target reduction in acknowledgement of the progress made in reducing hospital acquired C. diff over the last three years. In addition, the recent guidance allows for cases to be discounted, following agreement with commissioners, if a trust can demonstrate that there has been no lapse in the quality of care provided. An example of this would be a patient becoming C. diff positive following appropriate and necessary administration of an antibiotic. Whilst the continued adoption of the flat profiling of cases in 2014/15 by Monitor poses a risk to achievement of the annual objective in quarters 1 and 2 in particular, due to the seasonal spread of cases, the ability to discount cases where there has been no failing on the part of the Trust is likely to offset this risk. Although the exact numbers are not known it is thought that the majority of the Trust's C. diff cases in 2013/14 fell into this category.

Five standards have a moderate residual risk of being failed in 2014/15. These are: the 62-day screening cancer standard, the 31-day first definitive cancer standard, the 31-day subsequent surgery cancer standard, the RTT ongoing pathways standard, and the Clostridium *difficile* (C. diff) annual objective of maximum cases. Further details of the risks to achievement of these standards are detailed in Table 2. These standards will remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

4. Recommendation

The Trust will be declaring the standards failed in quarter 4 to be, the *C. diff* objective, the RTT Non-Admitted standard, the A&E 4-hour standard and the 62-day GP cancer standard, with a further standard, the 31-day first definitive cancer standard, also considered to be at high risk of

being failed. It is recommended that the likely failure of the RTT non-admitted and 62-day GP cancer standards for a further quarter are flagged to Monitor as part of the narrative that accompanies the declaration, along with the potential failure to achieve the A&E 4-hour standard due to the ongoing risks posed by year-on-year increases in ambulance arrivals, increasing age profile of emergency admissions and the closure of Frenchay Emergency Department in quarter 1.

Table 2 Summary of performance in quarter 4 2013/14, and the risks to quarter 1 2014/15 compliance

Indicator	Score	Achieved in Q4 2013/14?	New risks to Q1 2014/15?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for admitted pathways (aggregate)	1.0	Yes – achieved each month	Yes – significant increase in backlog	- Long waits for first outpatient appointments in Adult ENT, Dermatology, Dental and some paediatric specialties. - Increasing backlogs in some admitted specialties, such as Ophthalmology, Gynaecology and some paediatric specialties.	- Additional activity being put into contracts for 2014/15 to deliver shorter stage of treatment waits which will reduce the admitted backlog - Cross Divisional approach to "breach quota" to support whole Trust achievement. - Robust monitoring and escalation to optimise the number of long waiters booked each month.	Moderate	Low
18-weeks Referral to Treatment for non-admitted pathways (aggregate)	1.0	No – not achieved in Q2, Q3 or Q4	No – continued risks from 2013/14	- Head & Neck non-admitted backlogs reducing, but still being addressed - Long waits for first outpatient appointments in Adult ENT, Dental, Dermatology and some paediatric specialties, due to a combination of high GP referrals rates and capacity constraints - Non admitted RTT performance cannot be planned/managed in the same way as admitted pathways, because	- Additional activity being put into contracts for 2014/15 to deliver shorter outpatient waits in quarter 1 as part of a recovery plan which will be monitored weekly - RTT steering group has been established to oversee the implementation of the plans to reduce outpatient and other stage of treatment waits, with a weekly RTT working group reporting into this - A revised process for offering ENT patients a choice of being	High	High

[1] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

				attendance at an outpatient appointment may, or may not, stop a patient's RTT clock - Centralisation of Specialist Paediatrics transfer in Q1 2014/15, although based upon data received from North Bristol Trust the impact is expected to not be material.	referred to the local Independent Sector Treatment Centre is being established		
18-weeks Referral to Treatment for incomplete pathways (aggregate)	1.0	Yes – achieved each month	Yes – increasing admitted backlog	- Same as for RTT admitted	- See RTT admitted and non-admitted plans - Current high level of admitted backlog should be off-set by the reduction in the non-admitted backlog in quarter 1. - Small team of temporary staff to be appointed to validate 'On hold' patients on Medway, which is likely to improve RTT Ongoing performance	High	Moderate
A&E Maximum waiting time 4 hours	1.0	No – performance in Q4 = 91.3%	Yes – Closure of Frenchay Emergency Department planned for end May 2014	- Closure of Frenchay Emergency Department, and resulting additional emergency admissions - Ambulance arrivals remain significantly higher than in previous years - Length of stay is below that of the same period last year, but the reductions have been insufficient to absorb the increases in the number of over 75 year old patients being admitted to the Trust	- Implementation of Breaking the Cycle w/c 31st March as part of the wider Operating Model for 2014/15 - BRI Discharge Lounge continues to provide some buffer to 4-hour breaches, even when operating at higher occupancy levels, as a result of improved timeliness of discharge - Learning and actions taken forward to support performance at the Bristol Children's Hospital in future years if there is another	High	High

				- Delayed discharges have reduced but over 14-day stays remain higher than optimal	spike in respiratory cases		
Cancer: 62-day wait for first treatment – GP Referred	1.0	No – achieved in Q1 and Q3 with late referral breach reallocation; not achieved in Q2 or Q4.	No	- High levels of medical deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are very difficult to mitigate) - Late tertiary referrals, which are subject to breach reallocation negotiations - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) bed related cancellations - Cancellations of surgery due to emergency pressures	- Cancer Rapid Improvement Group established in Q3, focusing on pathway redesign for high volume, lower performing, tumour sites and improving steps in the pathway for high volume causes of breaches - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work - Booked calls/visits to other providers to understand where further improvements can be made - Patients on the cancer patient tracking list continue to be actively managed and any delays escalated - 20th ITU bed now in operation - Breach reallocations to be agreed with late referring providers as necessary and where possible - See also A&E 4-hour plans	High	High
Cancer: 62-day wait for first treatment – Screening Referred		Yes	Yes – transfer of Avon Breast Screening	- Following the transfer of the Avon Breast Screening Service in 2014/15 the majority of the Breast Screening pathways will no longer be reported under this standard; breast	- All patients on shared pathways actively tracked via our Cancer Register until treated at other providers - Specialist practitioner and colonoscopy waiting times	High	Moderate

				pathways normally completed in under 62 days, although more recently performance at other providers has deteriorated - Patient choice in bowel screening pathway - Age extension to the bowel screening programme - Colorectal elective capacity not always sufficient to meet demand - Numbers of cases reported under this standard will in the future be quite low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact	remain short and continue to be closely monitored - Need for additional elective capacity for colorectal surgery continuously reviewed		
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	Yes	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU and ward beds) - Having enough surgical capacity to meet peaks in demand, especially for the hepatobiliary service - Current high rate of delays due to medical deferrals	- Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons - Review of Critical Care capacity as part of the 2014/15 Operating Model - 20th ITU bed now in operation	High	Moderate
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low

Cancer: 31-day wait for subsequent treatment - subsequent radiotherapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for first definitive treatment	0.5	To be confirmed – high risk of failure in Q4	No – continuing from Q4	- Higher volumes of breaches in quarter 4 2013/14 as a result of medical deferrals and cancellations of surgery (mainly as a result of ITU/HDU bed availability but some attributable to black escalation)	- Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons - 20th ITU bed now open - Review of Critical Care capacity as part of the 2014/15 Operating Model - Head & Neck pathway review action plan to be implemented, including work to reduce delays to dental extractions prior to radiotherapy - Continue to pro-actively manage patients on the Cancer patient tracking list	High	Moderate
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	0.5	Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	No – failed in each quarter of 2013/14	No	- Target for 2014/15 as a whole is confirmed at 40 cases (5 more than in 2013/14), which has reduced the risk of failure - Providers are allowed to appeal to exclude cases that were not as a result of a 'lapse in quality of care' from the	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application has been	High	Moderate

				contractual requirement with CCGs - Flat profiling of annual target is likely to continue to be imposed by Monitor - Bristol community is an outlier for antibiotic prescribing	implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a lapse in quality of care to be demonstrated to the commissioners.		
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	0.5	Yes	No	- No significant risks	See the standard set-out in Appendix 1, which the Trust is declaring compliance with.	Low	Low

Appendix 1 – Learning Disability Access Criteria

Criteria	Trust evidence
1. Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• The Trust has a clinical alert system which has approximately 3,000 patients registered and is managed by the learning disabilities Nurse/team. This system has proven to be an effective way of identifying known patients with learning disabilities when accessing both inpatient and outpatient services • The Trust has an informative learning disabilities internal web page which includes referral pathways and documentation tools to support assessments, implementation and reasonable adjustments. The learning disabilities risk assessment gives opportunity for staff teams to record all reasonable adjustments made against the identified needs • When individuals with learning disabilities are referred to the learning disabilities team from carers or external providers (local authority), the team is able to support pre-planned admissions and make reasonable adjustments according to identified needs. As a Trust we are able to provide multiple procedures under one general anaesthetic, bringing diverse teams together as required for treatment and/or investigations
2. Does the NHS foundation trust provide readily available and comprehensive information to patients with learning disabilities about the following criteria: – Treatment options – Complaints and procedures and – Appointments?	• The Trust has a series of \`Easy Read' leaflets. Easy Read uses pictures to support the meaning of text. It can be used by a carer/staff teams in support of the decision making process regarding treatment and care • The Trust 'Easy Read' range includes: ➢ Healthcare and treatment options ➢ Consent ➢ How to contact patient support and complaints team ➢ Going into hospital and what happens ➢ Learning disabilities liaison nurse ➢ Being discharged from hospital • The Trust has various appointment letters to support individuals individual needs
3. Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• The trust has a \`Welcome pack' which profiles the Trust providing a range of information around admission and orientation when visiting • The learning disabilities risk assessment has a section to identify the needs of family and carers to ensure reasonable adjustments are made for them as well as the individual receiving direct care

	• The learning disabilities team provide support to all carers identified for individuals accessing both inpatient and outpatient services and continues from preadmission through to discharge planning. • The Trust has a Carers' Strategy and Carer support worker to support the needs of carers
4. Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff?	• The Trust `essential training' programme including at Trust induction learning disabilities awareness training for non-clinical and clinical staff and includes medical staff • The LD nurse delivers custom made training to meet the needs of existing staff groups as required • Annual training events are hosted for link nurses to support their knowledge and skills in caring for patients with learning disabilities
5. Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• The Trust consults with Learning Disability user groups when strategies and Easy Read materials are in draft format for comments • The Trust provides annual training events whereby users groups attend and receive training around health needs, procedures and support systems available when accessing acute services
6. Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	• The Trust has a Learning Disabilities Strategy that informs the work plan for the Steering Group and sets the standards • Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives • The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care • The Learning Disability Steering Group reports to the Patient Experience Group

Appendix 2 – Draft declaration to Monitor for Quarter 4

Declaration of risks against healthcare targets and indicators for 2013-14 by University Hospitals Bristol

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Compliance Framework	Scoring under Risk Assessment Framework	Quarter 4 Actual Performance	Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	1.0	92.0%	Achieved	*Achieved each month.*
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	1.0	92.0%	Not met	*Average performance for the quarter = 92.6%*
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	1.0	92.7%	Achieved	*Achieved each month*
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	1.0	91.3%	Not met	*Performance for Q4 as a whole = 91.3%; lowest month = 90.1%*
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	1.0	1.0	75.6%	Not met	*Subject to final national reportung in May.*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	1.0	1.0	94.4%	Achieved	*Subject to final national reportung in May.*
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	1.0	94.0%	Achieved	*Subject to final national reportung in May.*
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	1.0	99.7%	Achieved	*Subject to final national reportung in May.*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	1.0	95.6%	Achieved	*Subject to final national reportung in May.*
Cancer 31 day wait from diagnosis to first treatment	96%	0.5	1.0	95.9%	Not met	*Standard may be achieved on final reporting in May, but reported at risk.*
Cancer 2 week (all cancers)	93%	0.5	1.0	97.4%	Achieved	*Subject to final national reportung in May.*
Clostridium Difficile -meeting the C.Diff objective	0	1.0	1.0	38	Not met	*3 cases above annual objective of 35; reported 4 cases in Q4 against limit of 9.*
MRSA - meeting the MRSA objective	0	1.0	N/A	N/A	Not relevant	No longer applicable under RAF
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	1.0	N/A	Achieved	

Target or Indicator	Threshold or target YTD	Scoring under Compliance Framework	Scoring under Risk Assessment Framework	Achieved/Not Met	Any comments or explanations
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	4.0	Report by Exception	No	
CQC compliance action outstanding (as at 31 Mar 2014)	N/A	special	Report by Exception	No	
CQC enforcement action within last 12 months (as at 31 Mar 2014)	N/A	special	Report by Exception	No	
CQC enforcement action (including notices) currently in effect (as at 31 Mar 2014)	N/A	4.0	Report by Exception	No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2014)	N/A	special	Report by Exception	No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 31 Mar 2014)	N/A	2.0	Report by Exception	No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	special	Report by Exception	No	

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A There are five targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 4. These are: the Clostridium difficile (C. diff) cumulative trajectory, the A&E 4-hour standard, the RTT Non-admitted pathways standard, the 62-day GP cancer standard, and the 31-day first definitive treatment cancer standard.
In 2012/13 the Trust achieved its annual C. diff objective (48 cases vs. a target of 54), but failed the cumulative quarterly trajectory in the first two quarters of the year. This was due to the strong seasonal pattern of cases which has been evidenced over a number of years. A similar seasonal pattern of cases was observed during 2013/14 but despite the significant recovery in quarter 4, the Trust ended the year on 38 cases against the limit of 35, 10 fewer cases than reported in 2012/13. Additional measures continue to be taken to reduce the incidence of C. diff infections. This includes, the introduction of a Procalcitonin test, to reduce the need for antibiotics in some high risk patients, Temocillin to reduce the risk of patients developing C. diff and a mobile phone application for facilitating correct antibiotic prescribing practice. The Trust conducted a telephone questionnaire in Q2 with ten of the top performing trusts on C. diff in the country to identify any further measures high performing trusts were taking. There were no further interventions identified that could be adopted. The Trust has held Study Days for Nursing Home Managers and GPs on Infection Control & Prevention, to try to reduce the number of C. diff cases emerging from the community. Continued in box B and C below.

B The Trust achieved the 95% 4-hour standard for four consecutive months (August through to November inclusive), following improvements made through the Trust's Patient Flow Programme. This included the opening of new Discharge Lounge, and the implementation of an Older Persons Assessment Unit. However, the system pressures reported in quarter 3 continued to impact on the Trust's ability to deliver sustained A&E 4-hour performance in quarter 4. This included ambulance arrivals continuing to be significantly above last year's levels (up 9%), and at any point in time around 50 delayed discharge patients un-necessarily occupying acute beds. Whilst the increase in ambulance arrivals has been mitigated by the BRI Ambulatory Care Unit, there has been a change in the age-profile of emergency admissions, with a further 8% rise in emergency admissions for patients aged 75 years and over, over and above that seen in the winter of 2012/13. Further reductions in length of stay could not, however, offset the scale of increase in bed requirements, and the resultant rise in bed occupancy and outliers had a negative impact on patient flow. A new programme of work has been initiated as part of the 2014/15 operational plan. This includes work with system partners in health and social care in order to facilitate discharge of patients within complex care needs, along with a number of other projects aimed at effecting improvements in patient flow. However, the changing age profile of admissions and the uncertainty over the scale of transfer of emergency work following the relocation of Frenchay Emergency Department in May, pose ongoing risks to sustainable achievement of the 95% standard. For this reason the Trust is declaring achievement of the 4-hour standard to be at risk in quarter 1.

C Due to the transfer of Head & Neck services from North Bristol NHS Trust and the associated transfer of a large number of patients with extended waits, the Trust declared in its 2013/14 Annual Plan significant risks to the Trust's achievement of the non-admitted RTT standard, with the potential risk of failure in two quarters. The 95% standard was failed in quarter 2 and quarter 3. Additional service capacity was established to address the backlogs. However, although in each month of quarter 4 greater than 95% of patients on ongoing non-admitted pathways were waiting less than 18 weeks, this has not translated into achievement of the 95% standard for clocks stopped in the month as had been forecast. The Trust has therefore implemented a plan of reduce waiting times for first outpatient appointments, which have increased following a significant increase in GP referrals. The recovery plan will run over two quarters and the Trust will therefore be declaring the RTT Non-admitted standard to be at risk during this period. The 62-day GP standard was failed in quarter 4, due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice). A programme of work on improving cancer pathways will continue into 2014/15, focusing on both further minimising internal causes of breaches, but also on working with other providers to reduce late referrals. The Board is declaring a risk against this standard in quarter 1 and 2. The 31-day first definitive treatment standard is still undergoing validation ahead of final reporting at the beginning of May. Execptional levels of medical deferrals were experienced in quarter 4, with 33% of breaches occuring for this reason. As there is uncertainty over whether the standard will be achieved for the quarter as a whole, the Trust is currently declaring the standard as not met in quarter 4.

<u>For consideration and approval by</u>

Finance Committee	25th April 2014 – Agenda Item 8
Trust Board	28th April 2014 –

QUARTER 4 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
April 2014

1. EXECUTIVE SUMMARY

This commentary covers the results for the year ending 31st March 2014. The Trust reports an income and expenditure surplus of £6.188m (before technical items) for the year ending 31 March 2014. The provisional outturn position represents a favourable variance of £0.266m against the planned surplus for the year of £5.922m.The Trust is required, in completing its Annual Report and Accounts, to recognise, where appropriate, technical accounting issues. For 2013/14, there are four items under this heading which lead to the income and expenditure surplus becoming a deficit after technical items of £5.162m. The position can be summarised as follows:

	Annual Plan	Actual Income and Expenditure
	£'000	**£'000**
Income and Expenditure Surplus to 31 March – before Technical Items	**5,922**	**6,188**
Technical Items (further information provided in Section 9 below)		
- Donations and Grants	2,250	1,501
- Asset Impairment	(3,030)	(19,073)
- Reversal of Asset Impairments	1,886	7,073
- Depreciation on Donated Assets	(866)	(851)
Income and Expenditure Surplus / (Deficit) to 31 March – after Technical Items	**6,162**	**(5,162)**

The Continuity of Service Risk rating is 4.

	December 2013	**March 2014**
Liquidity		
Metric Performance	(4.15)	2.71
Rating	3	4
Capital Service Capacity		
Metric Performance	2.87	3.04
Rating	4	4
Overall Rating	**4**	**4**

4	**3**	**2**	**1**
0	**(7)**	**(14)**	**<(14)**
2.5	**1.75**	**1.25**	**<1.25**

2. NHS CLINICAL INCOME

The final March position on activity is not yet known, therefore the Q4 position is based on a forecast from the Month 11 actuals. Based on this, NHS Clinical income is forecast to be £2.023m higher than the Monitor Annual Plan, at £444.431m for the year. NHS Clinical income includes income from NHS commissioners and territorial bodies. The variance for the year is explained in table 1 below:

Table 1 – NHS Clinical Income – 2013/14 - Variance from Plan

	£m
Monitor Plan	442.408
Over Performance (See Table 2 Below)	2.023
2013/14 Income	444.431

Activity and Income by Worktype

Forecast Performance against the plan for the year is summarised below by worktype.

i. Elective Inpatients

Overall Elective Inpatients are £2.670m behind plan. The under-performance is across a number of specialties particularly Cardiac Surgery, Cardiology, ENT and Vascular Surgery.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £1.538m behind plan at the end of the year. The key areas of under-performance are Cardiac Surgery, Paediatric Cardiac Surgery, Oral Surgery and Paediatric Trauma & Orthopaedics.

iii. Day Cases

Day Cases are £3.805m ahead of plan for the year. The key areas of over-performance are Clinical/Medical Oncology, Cardiology, Gastroenterology, Trauma and Orthopaedics, Ophthalmology and Radiotherapy.

iv. Outpatients

Outpatient activity has under-performed by £0.225m; the major driver in the change from last quarter is the transfer of Genitourinary Medicine and Family Planning Services from NHS commissioners to Local Authorities. The underlying over-performance in Ophthalmology, CPAP/BIPAP, Clinical/Medical Oncology, Cardiology and Colorectal Surgery continue.

v. Accident and Emergency

A&E has under-performed by £0.410m against plan.

vi. Other NHS

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, PbR Excluded Drugs & Devices, Contract Penalties, CQUINs and specialised services such as Bone Marrow Transplants. This category is £3.059m ahead of plan for the year, the most significant element of this is due to PBR excluded drugs and devices.

Table 2 – NHS Clinical Income – 2013/14 - Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	49.341	46.671	(2.670)
Day Case	30.566	34.371	3.805
Non-Elective Inpatient	94.675	93.137	(1.538)
Outpatient	65.001	64.776	(0.225)
Accident & Emergency	13.266	12.856	(0.410)
Other NHS	189.560	192.619	3.059
Grand Total	442.408	444.431	2.023

Over Performance by Commissioner

During the Local Delivery Plan process the Trust agreed to reduce Service Level Agreement values for demand management schemes put forward by Commissioning Care Groups that the Trust believed were over optimistic. Because the Trust did not expect these activity reductions to materialise the clinical income budgets were not reduced, and an income budget was created for a dummy commissioner - Variable Estimates. Table 3 below shows the cumulative income variances by commissioner and how the Variable Estimates income target then adjusts this for the overall position. The latest identification rules have now been implemented and have caused a large shift in activity from Clinical Commissioning Groups to NHS England. In Quarter 4 Commissioners have also transferred commissioning responsibility for secondary care dental and screening services from CCGs to NHS England, and Family Planning and Genitourinary Medicine services from CCGs to Local Authorities. These changes are reflected in the actuals below.

Table 3 Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	(11.776)	(7)
NHS North Somerset	(1.491)	(4)
NHS South Gloucestershire	(4.960)	(17)
NHS Bath & NE Somerset	(1.890)	(18)
NHS Somerset	(1.041)	(12)
NHS Gloucestershire	(1.029)	(21)
NHS England	32.958	21
Other	(0.397)	(2)
Variable Estimates	(8.350)	(89)
Total	2.023	0.5

Non Mandatory/Non Protected Revenue

Private Patient Revenue

Private Patient Revenue has over-performed by £0.599m for the year.

Other Clinical Revenue

Other Clinical Revenue has over-performed by £3.582m for the year the outturn figure of £5.292m includes income relating to G U Medicine and Family Planning which in previous quarters was included in clinical income above. The planned income was included in clinical income also hence the large over performance here.

3. OTHER OPERATING INCOME

Overall other income is £0.432m higher than planned. Research and Development income is £0.547m higher than planned, Education and Training income is £0.345m higher than planned. Donations and grants are £0.749m lower than planned and other income was £0.301m lower than planned.

4. EXPENDITURE

Overall operating costs of £509.547m are £8.896m higher than plan. Trust pay costs are £1.347m higher than plan and non pay costs are £7.549m higher than plan.

4.1 Pay Costs

Pay costs at £319,238m for the year to date are £1.347m higher than plan. Spend on permanent staff is £1.514m higher than planned. Agency spend is £0.167m lower than planned. There is a shortfall on pay savings of £2.521m of which £1.974m relates to lower than planned savings with regards to nursing skill mix and rota change plans. There were a number of vacancies within staff groups which accounts for the balance.

4.2 Drugs

Drug costs of £59.611m are £6.953m higher than plan. This is related to NICE drugs, cancer Drug fund funded costs not in the original plan and higher than planned clinical activity.

4.3 Clinical supplies and services

Clinical supplies and services costs at £56.688m are £5.163m higher than plan mainly due to higher than planned activity volume.

4.4 Other Operating Expenses

Other costs were £4.567m lower than plan. There was a shortfall on savings programme delivery of £4.630m, this was offset by unspent planned reserves and developments in the plan of £7.513m and other underpends in this category including premises and fixed plant.

4.5 Depreciation

Depreciation charges at £18.723m were lower than the Annual Plan projection of £19.570m for the period. The reduction of £0.847m is due lower than planned capital expenditure.

4.6 Non Operating Expenses

Interest expense on non-commercial borrowings are £0.474m lower than plan. This is due to the delayed drawdown of the Trust’s loan during 2013/14.

5. CAPITAL

The Trust's Capital Programme was £75.856m per the Annual Plan submission in May 2013. The Trust submitted a revised 2013/14 forecast outturn to Monitor in September 2013 of £70.083m. The table below summarises the actual expenditure for the year against the Monitor plans.

		£000's			
		Q1	**Q2**	**Q3**	**Q4**
Monitor Plan	Original submission	18,655	18,440	24,187	14,574
	Cumulative	***18,655***	***37,095***	***61,282***	***75,856***
	Resubmission – Sept	15,449	16,588	18,903	19,143
	Cumulative	***15,449***	***32,037***	***50,940***	***70,083***
Spend	Quarter spend	15,449	16,187	15,728	17,622
	Forecast spend				
	Cumulative	***15,449***	***31,636***	***47,364***	***64,986***
Actual as % plan	Original submission	82.8%	85.3%	77.2%	85.7%
	Resubmission – Sept	100%	98.7%	92.9%	92.7%

Actual expenditure at £64.986m equates to 85.7% of the original Annual Plan or 92.7% of the revised annual plan.

The table provided below shows a comparison of the Trust's Plan with actual expenditure for the year.

	Year ending 31st March 2014		
	£'000 Plan	£'000 Actual	£'000 Variance
Sources of Funding			
Public Dividend Capital	490	490	-
Donations	1,199	1,199	-
Retained Depreciation	17,959	17,871	(88)
Prudential Borrowing	50,000	50,000	-
Grants/Contributions	75	75	-
Sale of Assets	700	-	(700)
Cash balances	5,026	(4,649)	(9,675)
Total Funding	**75,449**	**64,986**	**(10,463)**
Expenditure			
Strategic Schemes	(54,608)	(49,487)	5,121
Medical Equipment	(9,425)	(5,353)	4,072
Information Technology	(4,144)	(2,763)	1,381
Roll Over Schemes	(2,331)	(1,719)	612
Operational / Other	(12,379)	(5,664)	6,715
Anticipated Slippage	7,438	-	(7,438)
Total Expenditure	**(75,449)**	**64,986**	**10,463**

6. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £388.847m at the end of March is £22.321m lower than the original plan. This mainly reflects lower than planned capital expenditure during 2013/14 and the revaluation of land and building assets by the District Valuer.

6.2 Inventories (formerly referred to as Stock)

At the end of March the value of inventories held totalled £10.934m. This is £1.894m higher than planned and is a result of additional purchases in the catheter laboratory, an increase in the value of pharmacy stocks and additional stock holdings to support the clinical service transfers from North Bristol NHS Trust from April 2013.

6.3 Current Tax Receivables

The balance of £1.938m at the end of March includes £1.043m connected with VAT recovery on the Welcome Centre scheme which will be claimed at the end of the BRI Redevelopment project. The remainder represents a claim made to the HMRC for additional VAT that is recoverable under legislation. These moneys will be received in April.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance of trade and other receivables at the end of March at £10.940m is £5.565m less than plan. Moneys owed to the Trust but not yet invoiced, are shown as accrued income and this is currently £4.617m which is £4.016m higher than the plan figure. Income due to the Trust is recognised and accrued in the relevant accounting period and sales invoices are issued in accordance with the national framework. The Trust continues seeking to reduce the amount of money owed to the Trust. The invoiced debtor balance at 31st March equates to 9.2 debtor days.

6.5 Prepayments

The prepayment balance at the end of March is £2.647m. This is mainly due to payments for maintenance contracts for servicing of equipment and is broadly in line with the plan of £2.371m.

6.6 Non Current Assets held for Sale

This item relates to the sale proceeds for the disposal of the Kingsdown Garage site. This sale has been subject to unexpected delays outside of the Trust's control but disposal of this asset is expected early in the 2014/15 financial year.

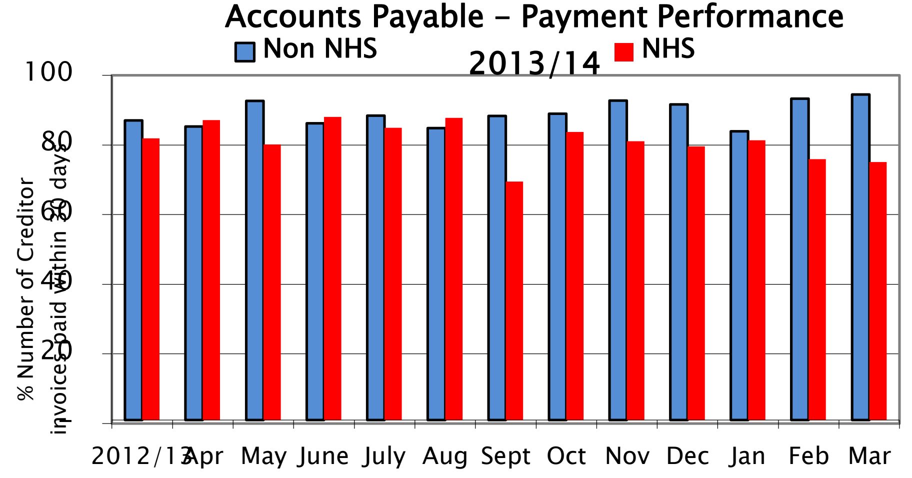
6.7 Deferred Income

Deferred income of £3.975m is £1.475m higher than the plan of £2.500m. This relates mainly to research income.

6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, other and capital creditors total £25.846m at the end of March. This is £1.800m higher than the plan projection of £24.046m. This includes capital payables which are £6.986m above plan. The non-capital variance under this heading should be considered against the corresponding higher than plan variance reported under section 6.9 below.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For 2013/14 the Trust achieved 81% (91% by value) and 89% (89% by value) compliance against the Better Payment Practice Code for NHS and Non NHS creditors respectively.



6.9 Other Financial Liabilities

The closing balance for accruals at £21.419m is £2.837m higher than the plan of £18.582m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the year end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 31st March together with comparative information taken from the Trust's Annual Plan.

Summary Statement of Financial Position

	Position as at 31st March 2014		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current assets			
Intangibles	10,122	7,065	(3,057)
Property, Plant and Equipment	401,046	381,782	(19,264)
Non current assets total	**411,168**	**388,847**	**(22,321)**
Current assets			
Inventories	9,040	10,934	1,894
Current Tax Receivables	644	1,938	1,294
Trade and Other Receivables	16,505	10,940	(5,565)
Other Financial Assets	705	4,988	4,283
Prepayments	2,371	2,647	276
Cash & Cash Equivalents	34,687	47,535	12,848
Non Current Assets held for sale	-	700	700
Current assets total	**63,952**	**79,682**	**15,730**
ASSETS TOTALS	**475,120**	**468,529**	**(6,591)**
Current Liabilities			
Loans	(260)	(260)	-
Deferred Income	(2,500)	(3,975)	(1,475)
Provisions	(237)	(171)	66
Current Tax Payables	(6,427)	(6,275)	152
Trade and Other Payables	(24,046)	(25,846)	(1,800)
Other Financial Liabilities	(19,487)	(22,257)	(2,770)
Other Liabilities	(5,410)	(5,385)	25
Current liabilities total	**(58,367)**	**(64,169)**	**(5,802)**
NET CURRENT ASSETS/(LIABILITIES)	**5,585**	**15,513**	**9,928**

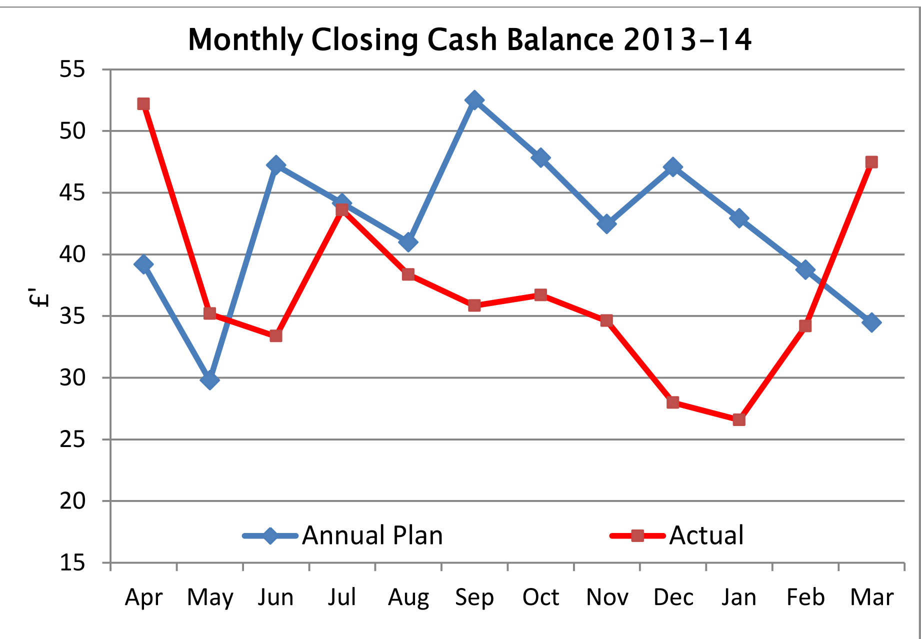
	Position as at 31st March 2014		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current liabilities			
Loans	(74,430)	(74,430)	-
Provisions	(191)	(177)	14
Finance Leases	(5,504)	(5,555)	(51)
Non current liabilities total	**(80,125)**	**(80,162)**	**(37)**
TOTAL ASSETS EMPLOYED	**336,628**	**324,198**	**(12,430)**
Taxpayers' and Others' Equity			
Public Dividend Capital	191,011	191,501	490
Retained Earnings	80,632	79,875	(757)
Revaluation Reserve	64,900	52,737	(12,163)
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**336,628**	**324,198**	**(12,430)**

7. Cash and Cash Flow

The Trust held cash balances at the end of March of £47.535m. This is £12.848m higher than the Annual Plan projection of £34.687m. This is mainly due lower than planned capital expenditure.

The balance (£50m) of the £70m Independent Trust Financing Facility (ITFF) loan has been drawn down during the year.

The graph shown below provides a comparison of actual and projected month-end cash balances for 2013/14.



8. Loan Application

The Trust submitted an application to the ITFF for a loan of £20m repayable over 15 years to support the Trust's Medium Term Capital Programme. This has recently been approved by the Independent Trust Financing Facility. The planning assumption is that this loan will be taken up in the first quarter of 2014/15.

9. Technical Accounting Issues

9.1 Donations and Grants

The Trust has received donations and grants of £1.501m. This is £0.749m less than assumed in the Annual Plan. It has been agreed with the Teenage Cancer Trust that moneys anticipated to be received this year will now be paid to the Trust in 2014/15.

9.2 Asset Impairments

An estimate of £3.03m had been made to provide for the impact of impairment of the BHOC capital scheme in 2013/14. The actual impairment value as assessed by the District Valuer is £4.454m. In addition to this the District Valuer, as part of the quinquennial asset revaluation exercise has advised of the requirement for an impairment of £2.29m for the Welcome Centre. For financial planning purposes no impairment had been provided as the Welcome Centre is an income generating scheme. However, as it is in effect an extension of the Queens Building rather than a separately identifiable asset the valuation leads to there being a requirement to impair part of the capital cost. The third scheme which is subject to an impairment this year is the Centralisation of Specialist Paediatrics project. The opening of part of the new facility leads to an impairment in 2013/14 of £12.332m. The impairment has allowed for the original provision (assumed in May 2013) of £5.7m to be removed from the 2014/15 Annual Plan submission. The total adverse impact of asset impairments is £19.073m, or £16.043m more than planned. It should be noted that this technical adjustment has no adverse impact on cash.

9.3 Reversal of Asset Impairments

Each year the Trust anticipates the likely change (indexation) in asset values over the coming year. In line with previous practice an assumption of 2% was made at the start of 2013/14. Changes to the index are a guide for organisations to use in those years between formal asset valuation exercises. The quinquennial review carried out to inform the 2013/14 Annual Accounts is an opportunity for a comprehensive review of the value of the land and buildings owned by the Trust. The District Valuer has advised on revaluation which results in a reversal of previous impairments to a value of £7.076m. This is a technical gain of £5.187m when compared with the Annual Plan assumption. The single biggest factor item which leads to this change is the revaluation of the BHOC at £5m.

9.4 Depreciation on Donated Assets

The Trust's Annual Plan included provision for depreciation on donated assets to a value of £0.866m for the year. Actual depreciation charges at £0.851m are marginally less than plan for the year.

Cover Sheet for a Report for a Public Trust Board Meeting, to be held on 28 April 2014 at 10:30am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

21. Board Assurance Framework

Purpose

To provide the Board with the quarterly update of progress against the Trust's objectives at the end of Quarter 4 and to provide assurance of the control of any associated risks to delivery.

Abstract

Context

This reporting format brings together the former Board Assurance Framework and the report on Corporate Objectives into a single monitoring and assurance framework.

The purpose of the Framework is to track progress against the Trust's stated medium term objectives and specifically tracks progress against the 2013/14 milestones which were derived as part of the 2013/14 Annual Planning programme. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

Any inherent risk rating that is high or extreme (RED rated) is also captured within the Trust's Corporate Risk Register through the reporting of the risk to achievement of any corporate objectives within the BAF.

Quarter 4 Position

There has been a slight change in Trust wide performance against the Trust's Corporate Objectives in quarter four. Five objectives remain at high risk of not being achieved for the year and are therefore RED rated, these are:

- Development of Learning and Development Centre of Excellence
- Achievement of Cash Releasing Efficiency Savings (CRES)
- Compliance with EU Working Time Directive for Medical Staff
- Compliance with all Care Quality Commission (CQC) Essential Standards
- Maintain a GREEN Monitor Governance Risk Rating (GRR)

Finally, there are 37 (41) objectives where delivery is forecast therefore with a residual rating of GREEN and 10 (7) AMBER rated objectives. Objectives that remain unmet, and are relevant to the forward priorities of the organisation, will be incorporated into the BAF for 2014/15 which is currently being developed.

NB: Figures in brackets reflect Q3 position.

Recommendations

The Board is asked to **Note** the report and associated actions to ensure all corporate objectives are met.
Executive Report Sponsor or Other Author
• Sponsor – Chief Executive • Author – Director of Strategic Development
Appendices
• Appendix A – Board Assurance Framework

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	T&L	1.1	We will develop and implement a teaching and learning Strategy that is fully integrated with all other strategies in order to support the Trust's mission.	Improved Teaching and Learning provision within the Trust. Improved recognition externally of UH Bristol as a Teaching Hospital	Strategy implemented in line with plan. Strategy reviewed and updated to reflect changes in Teaching and Learning requirement. Essential training requirements refocused and new recording system purchased and implemented. LETB implication	50% to 75% 75% to 100%	On target, working with Head of Strategic Development to refresh strategy. Essential Training review outcome went live September 2013. Action plan developed and in process of implementation to ensure compliance for all ET achieved agreed KPI.	Reduced training compliance due to staff not being released for essential training.	Amber	New training matrix reduced times spent on essential training. A plan to expedite the introduction of E-Learning is in place with the anticipated outcome being improved compliance	Essential Training Core and Steering Group HR Board. Teaching and Learning Steering Group	Amber		Dir W&OD	Teaching and Learning Group
1	R&I	1.2	We will focus on and foster our priority areas of high quality translational and applied health services research and innovation where we are, or have the potential to be world leading	Developmental research groups established and productive.	Support for NIHR grant applications in place with researchers aware of process and appropriate and agile triage system in place for support for new applications. New researchers identified when they join the trust. Researchers supported by divisional management teams to submit and deliver grants.	75% to 100%	Mechanisms in place for identifying new researchers. Support systems in place; new website in development to support researchers. Awareness of research raised in the clinical divisions; research strategy in place in D&T.	Clinical pressures prioritised, putting development and delivery of research at risk.	Green	Regular communications with divisional management teams, researchers and research delivery teams. Systems for setting up research simplified and underpinned proactively by R&I. Escalation of issues as required.	Regular review of KPIs relating to recruitment and grant submissions (monthly). Weekly review of recruitment levels. Regular oversight of performance against plan for small grants and grant development/ submission.	Green		Dir Med	Research Group
1	R&I	1.3	We will develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in clinical care	Transparency within Divisions of research funding achieved. Divisional governance structures for research in place.	Implementation in line with agreed Divisional plans. All divisions report research performance against KPIs at divisional boards. All Divisional Research Units have clear reporting lines through divisional boards.	75% to 100%	Terms of reference for divisional boards agreed, with R&I elements included. Development of R&I strategy under way in conjunction with clinical strategies. Meetings with all CCs and DDs have taken place to discuss research agenda.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir Med	Research Group
1	R&I	1.4	We will demonstrate our undertaking to improve patient health through our excellence in world-class translational and applied health services research and our culture of innovation by increasing participation in NIHR trials	Increase in the number of patients entering NIHR trials	Increase in weighted recruitment by 5% over previous year.	75% to 100%	Weighted recruitment levels have recovered and exceeded last year.	Recruitment levels and complexity of trials will not secure delivery funding at the required level.	Green	Recruitment work stream projects to maximise recruitment; engagement with research delivery staff and principal investigators; regular communications about performance to researchers.	Regular review of recruitment work stream projects (bi-weekly); KPI review monthly. Weekly review of recruitment levels.	Green		Dir Med	Research Group
1	CSS	1.5	We will consolidate and expand our specialist services portfolio through designation of target services and repatriation of work from outside the South West	An increase in income from specialised services and a greater proportion of Trust income coming from the specialist portfolio.	Ensure CSP scheme is on track to maintain designation for Paediatric Burns and secure Neurosciences designations as they are undertaken. To prepare for the commencement of the revised Paediatric Cardiac Surgery Networks from April 2014. Continue implementation plans for adult BMT and Cardiac Surgery repatriation in response to 2012/13 achievements. Successfully transfer Exeter thoracic and Basingstoke liver work. Scope and identify further opportunities for service repatriation and develops plans to secure transfers Undertake gap analysis to understand compliance of all "prescribed services" with national specialist service specifications and secure derogation as required to ensure continued commissioning of specialist services.	75% to 100%	CSP building programme two weeks behind original programme. Move planned 6th and 7th May 2014. No risk to designation and Major Trauma Designation secured. National designation process for Congenital Heart Disease now underway. Children and Young People's Engagement Event planned for 10th April on Bristol and national team visit planned for 20th May. All preparations in hand. National service specifications now operational. Initial gap analysis undertaken with all major areas of non-compliance recorded on risk registers as appropriate and proposals for commissioner investment to address areas of non-compliance now submitted as part of 2014/15 planning round.	Building programme falls behind plan or service transfer preparations are not concluded as required. Key designation standards cannot be met. Service offer is not sufficiently attractive to secure work from other areas or bed / theatre capacity is insufficient to enable transfer of new work. Trust does not secure derogation for areas where it is not compliant with specification resulting in requirement to invest to achieve compliance or risk losing service or full funding.	Green	Robust programme management and governance structure & processes around all four capital schemes. CSP Operational Delivery Group retaining oversight of compliance with designation standards through Model Of Care work streams. Work is in train to create sufficient protected capacity to support repatriation of elective surgical work. All gaps in compliance identified and plans in place to address or seek derogation.	Project Board minutes. External gateway reviews and internal audit findings. Project and corporate Risk Registers.	Green	759	Dir SD	Clinical Strategy Group and Strategic Development Scheme Project Boards.
1	CSS	1.6	We will work with our partners to ensure the optimal configuration for acute services across the City	Single strategy for acute services developed and agreed between NBT and UH Bristol and endorsed by commissioners. Reduction in the number of specialities duplicated across the City, fewer opportunities for competition between acute Trusts.	Ensure the successful implementation of the Head & Neck / ENT service transfer from NBT. Work effectively with appointed External Advisers to develop Acute Service Plan Successfully conclude Vascular Services Review and determine any further priorities for service rationalisation. Deliver all BRI and CSP annual milestones to support successful service transfer in May 2014	75% to 100%	Service transfer concluded. Work with Cooperation and Competition Directorate (CCD) concluded. BASR reports now received - insights informing Trust Strategy Re-fresh and discussions with NBT on-going regarding next steps. Vascular Services Review on track for service consolidation by end of June 2014 and derogation against national service specification from October provisionally agreed with commissioners. Recent risk to deadline identified in light of possible OFT involvement. Revised building programme, following Level 9 changes, on track with exception of BHOC which is now delayed by 6 weeks to handover in late February 2014. Welcome Centre opened on plan and very well received.	Monitor find Trust in breach of its license as a result of transfer and impose remedial actions upon Trust. Risk that work doesn't identify sufficient opportunities to contribute to a significant closure of anticipated financial gap and/or next steps not able to be agreed between partners. Agreement of model for vascular consolidation cannot be reached and/or is delayed for one or more reasons including CCD and public consultation processes. Building programme falls behind plan or service transfer preparations are not concluded as required. Key designation standards cannot be met.	Green	Robust response to CCD Stage 2 Review of transfer. Involvement of Partnership Programme Board and Healthy Futures Board in agreeing and driving next steps and subsequent progress. Effective steering group leading work and engaging wider stakeholders as required. Strong emphasis on patient benefits arising from proposed consolidation. Robust programme management and governance structure & processes around all four capital schemes.	CCD submission. Integration Project Board minutes and papers. Vascular Review Steering Group minutes and papers. Commissioner assessment of compliance with service specification. Project Board minutes. External gateway reviews and internal audit findings.	Green	759	Dir SD	Clinical Strategy Group / BRI & CSP Project Boards

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	CSS	1.7	We will undertake a feasibility study of the opportunities and models for increasing Private Patient Services and Income	Options for private patient services scoped and model for UH Bristol agreed and progressed	Implement plan to re-establish improved private patient service at UH Bristol, with a particular focus on both patients and consultants improving the offer to them.	50% to 75%	Project plan for 2013-14 signed off by TME. Phase I - Getting the Basics Right of project completed August 2013. Phase 2 - Building on Foundations - project planning is underway. PMI Contracts in place with BUPA, Aviva and Pru-Health. Service Evaluations with Divisions completed. Private patient plans included as part of Divisional OPP. Plan for PP 'front door' in progress.	Capacity constraints on beds and support functions limits opportunities to develop private practice Frustration on speed of progress results in disengagement of clinical and managerial staff	Amber	Patient Flow project to reduce LOS and occupancy rates. Identification of mixture of private market opportunities, some of which are not reliant on bed capacity. Communication Strategy to be overseen by Steering Group.	Private Patients Steering Group responsible for monitoring and ensuring the delivery of the private services project plan 2013/14.	Green		COO	Senior Leadership Team
1	CSS	1.8	Grow the non-clinical income base through exploiting greater commercial opportunities for income generation	Increase in the number of third party providers to whom UH Bristol provides its services. Increase in non-clinical income	Open Welcome Centre and commence all retail operations. Support development of emergency alliances with pharmacy industry. Develop case of need for 'Commercial Director' or similar. Identify further opportunities for commercial developments / partnerships	75% to 100%	Welcome Centre open and very well received. Partnership Agreement with Novartis finalised to support work of Bristol Eye Hospital including capital grant. Partner to develop options for Old Building site, including exploration of commercial opportunities for income generation, now retained and work in hand.	Programme delays occur that cannot be recovered elsewhere in programme. Fifth lease is not secured. No further commercially viable opportunities are identified.	Green	Robust programme management and governance structure in place. External partner secured to bring additional commercial expertise to Executive Team.	BRI Project Board minutes and Welcome Centre Steering Group minutes	Green		Dir SD	BRI Redevelopment Board
1	CES	1.9	Fully embed the Trust's values in everything we do and say and establish them as the behaviours that drive the way we do things around here.	Improvements in staff survey questions which pertain to morale and positive work place. Reduction in number of staff experiencing bullying and harassment. Achieve place in top 20% of Trusts for UH Bristol being a "good place to work".	Staff Survey remains in top 20% of Trusts - Improvements in the annual staff survey and Multi Professional Education and Training (MPET), especially relating to bullying and harassment. KPI show consistently improved staff inpatient and outpatient outcomes. Staff sickness below 3.5% for the year Loud and Clear survey results implemented with clear action plan.	50% to 75%	Over 5,000 staff now received values based training. Staff sickness is currently 4.3% at February 2014. Trust maintain one staff engagement score - above average compared to other acute NHS Trusts.	Values training now not essential therefore less staff may attend. Sickness levels increasing.	Amber	Still encouraging staff to attend values training through communications. Values training is included in induction.	Regular reporting to TME and Teaching and Learning Steering Group.	Green		Dir W&OD	Senior Leadership Team
2	CSS	2.1	We will further refine our strategic intentions and operational role in community service provision	Clear position statement on the provision of community services by UH Bristol. Direction of travel agreed for community services currently provided by UH Bristol.	Support the application of Bristol Homeopathic Hospital to become a social enterprise. Identify further opportunities for the full utilisation of SBCH. Evaluate impact of the GP Care test and learn pilot "Consultant Link".	75% to 100%	Board approved "spin out" of Homeopathic Service to social enterprise - planned go live April 2015. BHH now transferred to SBCH. Work on-going to improve theatre and outpatient utilisation and further services identified for transfer. Consultant Link evaluation very successful on non-financial parameters. Continuation of pilot in cardiology agreed for a further year.	IBP not viable and transfer to social enterprise cannot be established. Acceptable Advice & Guidance tariff for consultant link cannot be established.	Green	Divisional and Executive Director support to IBP development. Contract novation being pursued to enhance chance of agreement to transfer. Realistic and reasonable approach to tariff setting.	CSG and TME minutes and papers.	Green		Dir SD	Clinical Strategy Group
2	CSS	2.2	We will confirm our intentions with regard to major strategic opportunities that are likely to arise in the medium term including our role on the provision of services to the Weston community, our role in the running of SBCH and the organisational model through which we will work with North Bristol Trust.	Clarity regarding organisational model for acute services in Bristol. UH Bristol position in relation to SBCH and Weston formulated and agreed by Board.	Progress integration work to agreed timeline to include development of Service Plan, OBC and FBC during 2013/14 Evaluate the options for the Trusts involvement in the delivery of services to North Somerset population in response to future plans for Weston Area Healthcare Trust (WAHT) If appropriate, mobilise bid in response to any proposals relating to WAHT	25% to 50%	Trust integration not progressed. Acute Services Review concluded. Next steps now being formulated though delay incurred due to capacity constraints at NBT linked to hospital move. WHAT procurement delayed from original timeline. Discussions with potential future partners have taken place. On-going discussions with WAHT and other partners to support on-going sustainability of vulnerable services at WAHT. Additional to support to new service areas have been agreed and include maternity services, dermatology and surgery.	Risk that work doesn't identify sufficient opportunities to contribute to a significant closure of anticipated financial gap. WHAT business case is not supported by Treasury and procurement does not proceed as planned.	Amber	Involvement of Partnership Programme Board and Healthy Futures Board in agreeing and driving next steps and subsequent progress No mitigations in control of Trust around business case risk. Trust continues to develop working relationships with WHAT and support delivery of viable clinical services pending clarity over future of WAHT.	Integration Project Board , PPB and HFPB minutes and papers. CSG minutes and papers.	Amber		Dir SD	Clinical Strategy Group
2	R&I	2.3	Partnership Working – we will work with our partners in Bristol Health Partners and our regional partners to align our research and clinical strengths leading to the formation of collaborative Health Integration Teams	Academic Health Sciences Collaborations operating across health partners with demonstrable increase in research and teaching activity as a result.	Establish and start to deliver successful HIT programmes of work through Bristol Health Partners. Actively engage with AHSN structure.	75% to 100%	CLAHRC has been awarded; HITs will be supported through CLAHRC infrastructure. Key appointments are being made. Communication and reporting links established.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir Med	Bristol Health Partners Board
3	T&L	3.1	Learning and Development Centre of Excellence - We will create an Academy recognised both within and outside the Trust, that delivers high quality learning and development which is aligned with trust strategies and culture.	The trust will have a Training Academy that delivers quality assured solutions to its staff and the wider community	All training across the Trust and to external bodies is academy delivered or accredited. Income generation and activity levels delivered in line with the business plan.	50% to 75%	Strategy refresh 2013	Internal quality assurance processes and procedures have been established. External accreditation and income generation plan has yet to be developed	Red	Not applicable	Not applicable	Red		Dir W&OD	Teaching and Learning Group

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3	T&L	3.2	Skilled and flexible workforce - We will ensure that learning and career pathways are developed based on Trust priorities, are flexible and responsive to changes in service and are supported by effective development solutions	All training is based on Trust requirements, linked to required competencies and provides career development for individuals.	Career Pathways in place for all key roles, linked to the strategic workforce requirements of the Trust Pathways reviewed based on updated Trust requirements Flexible workforce linked to business priorities and operating plan.	75% to 100%	Performance management work stream is on track for delivery, along with the leadership framework.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group
3	CSS	3.3	To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care	For each of the next three years, we will seek year on year improvements in patient-reported experience of care as measured by our own robust patient surveys and national patient surveys. We will carry out robust patient surveys during 2012/13 to measure progress on these goals. Baseline data will be derived from previous surveys and the targets will be based, as a minimum, on the best Trust score nationally (as determined by the national outpatient survey). We will also seek to improve our scores for 50% of indicators in each successive National Patient Survey.	1. We will implement the second year of our Patient Experience and Involvement Strategy for 2012-2015, focussing in particular on improving the experience of care amongst maternity patients (Quality Strategy goal: to improve our scores for at least 50% of measures in the 2013 National Maternity Survey, when compared to the previous survey in 2010) 2. We will implement the NHS Friends and Family Test 3. We will seek to increase the proportion of patients who receive an explanation of medication side effects when they are discharged. 4. We will ensure patients are treated with kindness and understanding	75% to 100%	1. Strong performance in 2013 National Maternity Survey - detailed report to SLT and Board in January 2014 (60% of comparable indicators have improved compared to 2010). Current improvement activities focussing on induction of labour and women with diabetes. Reduction in reported complaints. 2. FFT implemented - very good scores (close to upper 20% threshold) and good response rates on wards and in EDs (on target to achieve >20% in Q4). FFT also implemented according to schedule in maternity services. 3. Piloting of an electronic tool developed by Pharmacy has been extended from Ward 14 to 5a, 6 and 18 (the tool provides a list of standard drugs which can be ticked according to which are being administered to the patient - the tool then provides the patient with information about common side-effects). Patient-reported scored have however been disappointing (although statistically similar to the national norm - confirmed by 2013 National Inpatient Survey scores). 4. Latest survey data (January 2014) shows score of 93.0 (green-rated)	Initial FFT implementation goal (15% minimum response rate in Q1) was not achieved, but on target to achieved second target (20% response rate in Q4).	Green	Corporate PPI team actively supporting Divisions with: ongoing FFT implementation and focus; improving patient experience in maternity services.	Monitoring by corporate PPI team, Patient Experience Group, Divisional Boards. FFT is also monitored by Trust Board.	Green		Chief Nurse	Patient Experience Group, reporting to the Clinical Quality Group
3	CSS	3.4	We will strive to eliminate all incidents of unintended harm to patients and be recognised nationally for the safety of the services we offer.	To reduce adverse events by 30% and mortality by 15% from the 2009 baseline by the end of 2014.	1. The spread of all key changes relating to the NHS South West Quality and Patient Safety Improvement Programme will have been achieved in all (breadth) work streams with at least 50% penetration (depth) into other applicable patient populations and areas 2. We will reduce medication errors. 3. We will continue to embed the use of medicines reconciliation. 4. We will improve the escalation of deteriorating patients (timely intervention, reducing cardiac arrest calls). 5. We will increase the level of harm free care (reducing pressure ulcers, falls, VTEs, catheter associated UTIs) using the new harms measure in the NHS Safety Thermometer. 6. We will reduce hospital-acquired healthcare infections 7. We will improve levels of nutritional screening and specifically 72 hour nutritional review of patients	75% to 100%	1. Achieved 15% HSMR reduction. Achieved 30% reduction in adverse event rate in 3 consecutive months but normal variation in small numbers and LOS reduction will continue to produce some points above the target. Improved overall score of 4.5 achieved in patient safety programme by November 2013 now back on trajectory. 2. Reduction in non-purposeful omitted doses of critical medication improved and back on target (1.08% against a target of 2.25%) in January, reduction in medication errors resulting in moderate or severe harm achieved. 3. Sustained improvement in medicines reconciliation in all areas where implemented. 4. Deteriorating patient: February 2013 compliance-Early Warning Score (EWS) correctly recorded 99.5%, EWS acted upon 86.5%, use of SBAR structured communication 100%. 5. Thresholds set for harm free care and no new harms using upper and lower quartile benchmarked acute teaching Trusts. Harm free care at 96.2% in February achieved the upper quartile benchmark. No new harms at 97.8% in February also above the upper quartile benchmark. 6. There were 36 cases of *C Diff* up to February (12 month target is 35). We have exceeded the target for 2013/14. One case of MRSA in May means we will not achieve the zero target for the year. 7. In February 91.8 % of inpatients received a documented 72 hour nutritional review (target 90%).	We have not achieved infection control targets. We have achieved all other aspects of the objective	Amber	Detailed recovery plans / exception reports presented to Board in respect of infection control targets.	Programme monitoring. Board quality metrics and exception reports.	Green		Chief Nurse	Patient Safety Group reporting in to the Clinical Quality Group
3	CSS	3.5	To be recognised for the excellent clinical outcomes we achieve for our patients across all areas of service.	For each of the next three years, we will seek to maintain our 'lower than expected' headline mortality ratings (HSMR and SHMI).	1. We will ensure that patients with an identified special need, including those with a Learning Disability have a risk assessment and patient-centred care plan in place. 2. We will continue to implement our Dementia action plan. 3. We ensure that 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward 4. We will achieve the best practice tariff for hip fractures 5. We will ensure that patients with diabetes have improved access to specialist diabetic support 6. We will commence a baseline review of available clinical outcomes data	75% to 100%	1. Green-rated risk assessment performance since September 2013. 2. Good progress with implementation of dementia plan; but consistently red-rated CQUIN performance in board dashboard (regular exception reports to board outlining action being taken) 3. Amber-rated performance throughout 2013/14 (two exceptions), i.e. 80%+ 4. Green-rated performance in November and February - step improvement in performance 5. Overall red-rated performance against CQUIN (Q4 data yet to be confirmed however) 6. Scoping groundwork carried out in Q4 - findings to be shared with Medical Director for consideration of next steps	Risk of failing to achieve targets.	Green	Exception reports have been received by Trust Board detailing recovery plans in months when targets for learning disabilities, dementia, stroke and hip fractures have not been achieved.	Board quality metrics and exception reports.	Green		Dir Med	Variously: Quality Intelligence Group, Clinical Effectiveness Group, Clinical Quality Group

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3		3.6	We will achieve compliance as far as is reasonably practicable with all Health & Safety regulations	We will achieve 5 - 10% improvement year on year with audit compliance across the Trust	Each Division/ area drafts and completes resultant action plan to achieve 5% increase in compliance year on year. Priority to reduce work related stress incidents.	50% to 75%	The 5 clinical divisions were subjected to annual audit in October 2013 as well as Trust services which is split into 3 specific areas, Facilities & Estates, IM&T and the remainder of Trust Services. This equates to 8 days of auditing and 8 reports, in 2013 we sustained 'blue rating' in the two Divisions/ services of Facilities & Estates and Specialised Services while 4 Divisions/ services achieved the 5% increase required. 2 of which achieved 'blue rating' namely Diagnostic & therapies and IM&T . The most recent Willis Audit shows a year on year improvement of 6%.	2 areas Medicine and Women's & Children's did not achieve the 5% increase in 2012. All areas should reach the 85% mark by 2014 but this is subject to commitment to deliver the requirements in already challenging times. Trust Services and Women's & Children's services are areas that are a cause for concern due to their departmental audit returns and the responses within them regarding completion of risk assessment for the second year running.	Amber	Health and Safety features in the Divisional Operating plans including the top five priorities identified by the Willis audit. These are part of the quarterly divisional performance review and also monitored at the quarterly Trust Health & Safety'/ Fire Safety Committee with an exception report from each Divisional Health & Safety lead. Specific issues in each area audited will be developed into a action plan which is both Trust wide issues/ themes and Divisional issues/ themes.	Minutes of performance reviews and quarterly exception reports from Health and Safety leads. Departmental audit question sets have been transferred onto a summary sheet for each Division to highlight gaps in information required by September 20th 2013	Amber	2012 and 2147	Dir W&OD	Risk Management Group
4	CSS / CES	4.1	We will play a greater role in shaping the health system in Bristol and the Southwest through our early and constructive engagement with future influencers. We will improve our reputation with our commissioners by understanding their needs better and rapidly responding to the issues they raise.	Established and productive relationships with PCT Clusters, GP Consortia and National Commissioning Board with evidence of UH Bristol leading, not reacting to, change. GPs will report improved levels of satisfaction with UH Bristol's response to their commissioning intentions and ad hoc issues (evidenced through formal market surveying)	Develop and undertake a 360 assessment of the strength of key partnerships and track our on-going reputation and profile. Develop effective working model with CCG and Local Area Team. Identify top 3 commissioners priorities for UH Bristol and develop plan to address (within any associated resource constraints)	75% to 100%	Methodology for gathering external stakeholder views being developed with aim of concluding by end of Q4. Approach to working with CCG continues to develop though impact of these relationships on Trust's priorities such as flow and timely discharge, remains limited. Positive work with Area Team on service specifications and contract for 2014/15. Initial commissioning priorities agreed (patient communications) and two workshops held in June and July - both fully subscribed to by primary care to progress joint work. Action plan arising from workshops now formulated. and further workshops planned for Q4.	Key risk to delivery is capacity within planning team to conclude work on time. No risks identified to actions agreed - risk remains that agreed ways of working do not yield benefits anticipated. Insufficient progress on agreed priorities is achieved.	Green	Clarity regarding priorities within team.	Strategic Development Team meeting work programme and minutes. Clinical Leaders forum ToRs, minutes and papers. Contract monitoring meeting agenda, papers and actions / issues tracker.	Green		Dir SD	Clinical Strategy Group and Commissioning & Planning Group.
4	CSS	4.2	We will strengthen our approach to marketing our services to both GPs and consultant referrers with a view to maintaining or growing market share in our target areas	No service losing market share except where as a response to a Trust business decision.	Continue to Issue refreshed monthly newsletter to primary care and evaluate success in year. Develop service specific marketing plans for target growth areas e.g. cardiac surgery.	75% to 100%	On-going and positive feedback secured re GP Newsletter and workshop with primary care staff on communications and service priorities took place in February 2014. First edition of external Voices published in Q4 with positive feedback. Service branding and marketing approach agreed, starting with marketing of Gamma Knife Service. Capacity constraints in some services e.g. cardiac surgery are limiting opportunities for growth.	Risk that plans do not result in retention or growth in activity.	Green	Robust approach to developing and maintaining high quality communications supported by pro-active engagement with primary and secondary care referrers.	Communication materials. Activity monitoring to confirm success of plans for growth.	Green		Dir SD	Senior Leadership Team
4	CES	4.3	Agree the nature and form of our future relationships with our major fundraising partners. Agree our priorities for charitable funding and develop cases for support in partnership with charitable leads	Fundraising target for major appeals achieved. Positive working relationships in place with all major charitable partners.	Commence public phase of major fund raising campaigns. Agree on-going governance model for Above & Beyond in light of proposed changes to NHS charity regulation Work closely with partners to develop cases of support for major donors, Trusts and foundations. Confirm specific fundraising priorities with The Grand Appeal.	75% to 100%	All major fund raising campaigns underway and on track. Cases of support developed for all major equipment / schemes and multiple applications for funds submitted to trusts and foundations with some significant one of donations secured as a result. List of additional fundraising priorities now agreed with The Grand Appeal. Very successful opening of TYA Unit and Adult BMT Unit.	Insufficient funds are raised to support pledges made by charitable partners with consequent impact on Trust's own capital programme and priorities.	Green	Pro-active and effective working with all charitable partners to support their own activities.	Project Board minutes and risk registers.	Green		Dir SD	BRI / CSP / BHOC Project Boards and Trust Management Executive
4	T&L	4.4	Leaders of the future - We will create leadership and talent pools who are equipped with the skills, knowledge and behaviours required to lead the Trust both now and in the future.	We will have leaders who are fully effective and are able to embrace and deliver change is a safe and sustainable way	Talent Matrix fully developed and linked to movements around the Trust - Succession planning at the heart of selection decisions Management and Leadership development solutions fully implemented to support the development of senior staff across the Trust in line with business requirements. Management and Leadership Training externally recognised as best in class.	75% to 100%	Leadership framework on track for delivery and we will be using the talent matrix for leadership solutions. Leadership and management framework, including CONNECT , launched September 2013, new programme in place January 2014. Update on leadership activities is being presented at SLT in April	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Teaching and Learning Group

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4	CES	4.5	We will continue to work with our media partners locally, regionally and nationally to ensure UH Bristol positions itself as a trustworthy and notable commentator on health issues and is recognised as a successful organisation, through case studies of our staff and patients in relation to Research & Innovation, Teaching & Learning and patient care.	Positive to negative media about UH Bristol increases. All proactive media about UH Bristol is balanced; the Trust is consistently featured aligned to its core values and brand through media coverage. The Trust is known for its commentators	Establish regular liaison meetings with local and regional media including BBC Promote UH Bristol regionally and nationally through nomination of best practice initiatives for regional and national awards Proactively position "good news" stories and activities in media	75% to 100%	Regular meetings established with Editor of Bristol Evening Post and Health Correspondent though personnel changes are planned for New Year and new relationships will need to be established.. Good ongoing relationships and contact with news organisations. Multiple examples of UH Bristol's pioneering work in local media. Communications team works proactively with all Bristol-based newsrooms and with other organisations to ensure coverage in a wide variety of media and management of ongoing relationships where possible. Examples of contact in March include potential national and regional pieces on childhood obesity, a story about the excellent treatment a premature child received and a documentary on a child receiving orthopaedic treatment at the children's hospital.	Adverse publicity arising from unpredicted events	Green	Positive working with local health correspondents and proactive communications management in event of adverse incidents likely to attract media attention.	Monthly communications progress to TME	Green		Dir SD	Senior Leadership Team
4	CES	4.6	The Trust embraces all appropriate methods of communication, with staff, patients, members and the wider public to involve them in the strategic developments of the Trust.	Staff survey shows improvements in staff perception of communication with respect to capital developments All KPIs being achieved to required standards. Minimal patient complaints about negative impact of construction works	Restructure communications team to reflect forward priorities and workforce requirements. Communication Strategy approved by TME and work streams for all key objectives established and effective. Pilot external issue of Voices for distribution through GP, dental and optician practices Establish staff newsletters for all major redevelopment projects and launch Simple Guide Series Launch staff listening events, and review wider engagement activities in support of reinvigoration of Transforming Care and strategy refresh.	75% to 100%	Restructure of communications team is now complete. Four new appointments made and a fifth being advertised currently. TME approved strategy in May 2013 and work stream objectives agreed and monitored monthly via TME. Simple Guide To Finance published June 2013, Simple Guide to Savings published in September and Simple Guide to Patient Experience in December. CSP and BRI redevelopment newsletters launched and very well received. Listening events took place in the summer and staff actively engaged used the Bulletin Board to air their views and respond to others. A discussion board is once again being trialled for staff to use in Breaking the Cycle Together. TME's views have been sought on the use of social media for the Trust and this will be developed in Q1 of 2013/14.	Capacity constraints in team due to delayed recruitment.	Green	Pro-active recruitment campaign, effective succession planning for key roles.	Monthly communications progress to TME	Green		Dir SD	Capital Programme Steering Group
5	ES	5.1	An Estates Strategy exists which is agreed by the Board, covering the period up to 2020. Approved Site Development Control Plan exits	Develop a 10 year Estates Strategy and secure Board approval Develop a three year rolling capital planning programme to support Estates Strategy. Develop a Site Development Control Plan	Develop plans for the implementation and funding of BRI Redevelopment Phase 4 and align these with the 3 year rolling capital programme. Approve an Operational Capital programme for the year which delivers service-driven operational requirements whilst integrating with the medium term Strategic Capital Programme and the Strategic Developments. Review year 3 of the 3 year rolling capital programme to reflect progress made and changing operational requirements. Complete development studies for the two remaining areas of the precinct for which there is no long term plan. Consider the outcome of Trust Integration review and align Estate Strategy to that outcome.	50% to 75%	Trust Board Seminars Nov & Dec 2013 undertake discussions to shape direction. Jan 2014 report to Full Trust Board to agree approach and approve preparation of a SOC or FBC. March/April 2014 completion of SOC/FBC to CPSG/TME/Trust Board. Consultants appointed to undertake options appraisal for Old Building site and area east of Marlborough Hill. Programme of work agreed to progress towards Board Seminar on 15 November where options will be presented for discussion before work stream is completed. Options for Phase 4 being prepared for summer decision. Procurement method to be agreed. The three year operational and strategic capital programme is being reviewed following the decision to add a 24 bed ward to the Terrell Street building and to accelerate the provision of the Discharge Lounge and part of the CSSD department upgrade which will deliver the additional capacity required to support paediatric neuro and burns services transferring to the Trust in early 2014. Projects within the programme will be adjusted in terms of delivery dates to match the overall availability of capital year on year. Consultants for Estate Strategy work in connection with the two areas of the precinct will be appointed at end of June (Q1) to complete exercise by end of Q2.	All stakeholders views not taken into account. A programme of enabling projects and departmental moves has been completed and approved by both SESG and CPSG. Handover dates for the Terrell Street building are now confirmed by LoR and a ward closures programme is being developed jointly between Medicine and Surgery. Work continues with the two Divisions to define the extent of both major and minor works to wards as different specialties move to new locations. A £3m budget is agreed within the overall programme and it is a low risk that this would not be sufficient.	Amber	Presentation of work and options to Board Seminar 15 November. Programme approval by SESG and CPSG has defined project scope, project-by-project budgets and an overall programme. A strict change control mechanism has been implemented. Risk registers are prepared on a project by project basis by the project group, all accountable to the BRI Redevelopment Project Board. CPSG also review spend against plan on a monthly basis.	Agreed base programme, space plan and budget with robust change control mechanism in place. BRI Redevelopment Programme Board has overall control and oversight with sub-groups with specific terms of reference.	Amber		COO	Senior Leadership Team

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5	ES	5.2	Ensure on-going compliance with all annual fire and safety audits.	Avon Fire & Rescue Service issue no Improvement Notices. Health & Safety Executive issue no improvement notices. Care Quality Commission Outcome 10 (Safety and Suitability of Premises) remains compliant. Willis Risk Management Audit shows no major unmitigated risks.	Milestones within year four of the 4 - Year Fire safety Improvement Plan implemented - 2013/14 will the programme of fire compartmentation in the Queens building implemented. Review outcomes by Division, of the 2012 Annual Willis Risk Assessment and develop and deliver action and improvement plans. Continually review evidence with regard to Outcome 10 and update as capital and backlog programmes are delivered.	75% to 100%	Project to upgrade fire compartmentation in the Queens building has been tendered and is about to start in Q2. Issues around obtaining access to clinical areas may prolong the implementation. Annual Willis Risk Action Plan being implemented. Last year obtained blue rating Capital programme projects continue to contribute to positive action towards Outcome 10 assessment. Departmental Fire Risk Assessment compliance has increased from 54% to 80%	Potential for construction project delays relating to access to clinical areas may elongate the delivery of the overall programme.	Green	Regular review meetings with users re access. Fortnightly monitoring by Estates Forum Close monitoring of Departmental and building risk assessments. Close liaison with Avon Fire and Rescue Service so they understand our issues and what we doing about them.	Executive Management Group minutes Health and Safety Group minutes F&E Divisional Risk Management Sub-Group minutes Estates Forum Action Notes.	Green	1603	COO	Service Delivery Group
5	ES	5.3	To strengthen our approach to business continuity with the aim of ensuring patient safety and minimising operational disruption during times of incident.	UH Bristol viewed as a beacon Trust in the Avon Health Emergency Response Group area. Outcome of test exercises identifies no major shortcomings in Trust arrangements	Integration of the BS25999 standard into Business Continuity Management Strategy Continual review of all Divisional and Trust Business Continuity Plans. Consolidation of learning outcomes following Business Continuity Events into future planning (Medway, Generators). Alignment with the BS25999 Business Continuity Standard ,	75% to 100%	BS25999 has been superseded by ISO 22301. A current internal audit of all trust business continuity plans will have been concluded by end of March 2014. An internal and external audit have been completed and areas for BCM improvement identified. An improvement plan has been developed and will feature in 2013/14 work plan A structured debrief process is now standard practice following any BCP incidents allowing for identification of learning outcomes and integration into future planning	Limited staff resource to enable full commitment to the process. 0.2 WTE secondment to team will cease at the end of March 2014.	Green	Additional post to support resilience was not supported as part of the OPP. Currently assessing future needs of team to improve resilience of the service.	Business continuity planning group provides progress updates to the Civil contingencies Committee	Green		COO	Civil Contingencies Committee
5	ES	5.4	Improvement trust wide satisfaction with the services provided by the Estates Function Development of KPIs and systems of feedback from Divisions to ensure improvements in responsiveness	User surveys indicate an 80% level of compliance with Service Level Agreement Key Performance Indicators User surveys show 80% return being good or excellent	Implement outcome of year end review against SLA Monthly review of patient feedback as provided through the Trusts continuous patient experience monitoring	75% to 100%	Estates SLA implemented from April 2013. First quarter reported to SDG . Second quarter report will expand the number of KPIs reported User survey being readied currently.	IT issues with hand held devices for reporting progress in real time delayed the full implementation from Q1 to Q2. Issues now resolved. Estates now require wifi coverage in the estates workshops to embed the technology. Implementation in Q3 .	Green	Estates users satisfaction survey completed Dec 2013, results to CPSG Jan 2014. Improvement in all categories. Escalated to Exec Team and priority given by IM&T to this work stream.	Divisional Board Minutes SDG minutes	Green		COO	Service Delivery Group
5	ES	5.5	Ensure estates practice contributes fully to infection control objectives	Internal and external Assurances / Audits indicate no major shortcomings in key safety related areas. All improvements to process identified through assurances and audits are fully implemented. Compliance with HTMs 1 -7 Assured regularly (at least once every 2 years) Increased percentage of single rooms available year on year.	Implement Operational Capital Programme with regard to estates projects. Implementation of the Agility web-based reporting system for maintenance reporting and tracking across all the Trust hospitals. Gain approval to and implement Service Level Agreement for Estates Services.	75% to 100%	Regular review meetings with I/C team re capital projects. Reviews of projects against four milestones are recorded in the Estates Forum notes. Compliance with ventilation HTM 03 generating additional costs in capital projects - which is being managed within budgets. Single rooms improvement will NOT be achieved in the year but will be delivered as and when the Terrell Street building is handed over in phases.	The key risk is changes in personnel where interpretation of requirements can change. Resource in I/C team to review works proposals is a risk at times of high activity.	Green	Monitored fortnightly by Estates Forum 1:1 liaison with I/C team project by project. 4-stage signoff process agreed with I/C and implemented	Executive Management Groups minutes	Green	1383	COO	Service Delivery Group
5	ES	5.6	Reduce further our carbon footprint	Carbon footprint is reduced by 5% per annum over next 3 years	Achieve annual reduction in energy consumption of 5% per annum over next three years. Implement annual milestones of three year energy strategy and Big Green Scheme. Sustainability aspect of Operating Plans to receive the same degree of review and scrutiny as other aspects of the plans.	75% to 100%	New Energy Report now produced monthly showing both volume by hospital and cost. Big Green Scheme revitalised September with a four-prong approach. Specific KPIs and targets are being finalised. Sustainability considerations a requirement of Divisional Operational Plans for this year. A programme of spend to save (both Trust funded and Department of Health funded) energy reduction schemes being implemented.	Users inadvertently increase demand for energy resource without being consciously aware of it e.g. installation of additional electrical equipment, IT equipment etc.	Green	Improved energy reporting methodology, shared with users	F&E Divisional Board minutes Monthly / quarterly finance and performance reviews SDG minutes	Green		COO	Service Delivery Group
6	T&L	6.1	Implement revised performance management processes to better align individual performance with trust goals	Performance management will fully support the achievement of Trust goals	Performance management framework implemented. Underperforming staff appropriately supported to improve. Reward and recognition scheme worked up.	75% to 100%	Linking Performance Management to Pay Progression Policy agreed for Phase 1 implementation. Phase 2 will include a review of the appraisal framework and process to be completed by October 2014	Managers not appropriately managing poor performing staff.	Green	Good relations with staff side. Additional support for managers in how to performance manage staff including refresher training.	Regular staff side communication. Numbers of managers completing appraisal and performance management training.	Green		Dir W&OD	Teaching and Learning Group

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
6	LTFP	6.2	Develop and embed a Trust wide transformation programme to ensure that the Trust maintains and wherever possible improves the quality of its services whilst reducing the cost base of those services in line with funding requirements.	The Trust achieves a balanced plan for the next three years	Re-invigorate the Transforming Care Programme through the recruitment of a new Transformation Director and the delivery of a renewed implementation group. Lead the creation and sign off of CRES plans to ensure a Trust wide balanced Operational Plan Drive the delivery of Year 3 and Transformation Plans and lead the development of any additional Transformation work streams.	75% to 100%	The Transforming Care dashboard has been developed defining clear scope, aims and success measures for trust wide projects, and giving Transformation Board renewed focus on the scope and effectiveness of the projects. Mobilised Transformation contacts for each Division and pathway improvement projects to increase engagement on Division Transformation priorities. Revised Transformation Board provides greater focus on savings programme issues and strengthened leadership of savings work streams.	Current schemes identified are not sufficient or robust enough to achieve the Trust wide savings requirement. Balance of transformation to savings not maintained Inability to identify further schemes for future years	Green	Close management of scheme development through accountability meetings, Programme Steering Group and Transformation Board. Senior Leadership Team is addressing our approach to productivity improvement linked to development of the work streams SLT approach balances actions which will deliver over at least 2 year period	Monthly and Quarterly Performance and Finance Meetings KPMG Review Programme Steering Group	Green		COO	Programme Steering Group
6	CSS	6.3	Delivery of significant improvement in outpatients by 2014.	The Outpatients function is transformed and is upper quartile nationally on a range of indicators including new to follow-up appointments, Do Not Attends and Cancelled appointments. Clinical Administration is streamlined by using technology, the new Patient Administration System is used to best effect and saved Consultant PAs have been redistributed/eliminated.	Continue to develop the central booking office. Maintain improvements in booking processes identified by the post-Medway implementation review. Achieve greater patient satisfaction as measured by reduced complaints. Deliver cost savings through improved outpatient efficiency. Increase throughput via improved productivity.	50% to 75%	Digital dictation system in implementation phase. Standards for Outpatients developed and implemented across the Trust. Review for compliance planned in Jan & Feb. Increased productivity of clinics by doing more through the same enabling FOT outpatients savings plan of £500K Appointment reminder system being implemented Q3&4 to reduce DNAs. Productivity sheets by speciality detailing slot utilisation, DNA rates, demand and capacity information completed for divisional to enable outpatients savings targets for 2014/15 to be agreed. Appointments centre in operation in Bristol Eye Hospital and Bristol Dental Hospital. Plan to move to Welcome centre Jan 2014 which will have face to face element. Changing Clinic structure to improve flow and reduce patient complaints in BEH.	Willingness of operational teams including clinicians to adopt best practice and comply with standards. Risk to cost saving as achievement may require reducing PAs & Nursing staff time. Risk that we are unable to accurately identify opportunities due to lack of slot utilisation figures from Medway	Amber	Rolling programme of specialty assessments focusing on priority areas first. Escalation to Clinical Chair & Divisional Director of required Escalation to Programme Steering Group if required Manual slot utilisation analysis while Medway development is progressed	Productive Outpatients Programme Steering Group Monthly and Quarterly Performance and Finance Meetings Programme Steering Group.	Amber	741	COO	Transformation Programme Board
6	CSS	6.4	Delivery of significant improvement in theatre productivity by 2014.	Theatre processes have been fully re-engineered and have released significant savings.	Review the productive theatre plans in light of re-worked theatre timetable.	50% to 75%	New theatre transformation programme mobilised. 5 work streams identified addressing prompt starts, scheduling, data capture and quality, non-pay (supplies) and theatre performance management. Theatre Executive focussed on project delivery	Cancellations of elective surgery due to bed capacity constraints Maintaining momentum and securing the resource needed	Amber	Patient flow project looking at reducing LOS, improving flow and bed occupancy to improve access to acute beds and flow through ICU Senior Division leadership focus on success of the theatre project Transformation Board to prioritise Transformation resource to support theatres work	Theatre Executive Divisional Board	Amber	741	COO	Transformation Programme Board
6	CSS	6.5	Delivery of improvement to upper quartile for Average Length of Stay (ALOS) and associated bed productivity by 2014.	The Trust's Average Length of Stay (ALOS) is Upper quartile for the majority of HRGs.	Deliver reduced length of stay in line with revised capacity plan (tba) to ensure Trust is in line with 2014 bed plans. Programme to look at both internal and external factors.	50% to 75%	Phase II patient flow projects have been transitioned to the Divisions. Seven further projects aimed at renewing our Operating Model have been mobilised under the leadership of SLT, following assessment of the key Planned and Unscheduled Care pathways. Projects will deliver: An integrated discharge hub (and associated processes); Rapid Procurement of Out of Hospital capacity; Expanded Early Supported Discharge capability; Actions to increase weekend discharges; A protected bed model; and delivery of the "Breaking the Cycle Together" week. Each of the projects has SLT leadership and supporting plans.	Growth in activity and demand has a negative impact on planned bed reductions Reliance on external agencies to support admission avoidance and discharges to community. Winter pressures across the health community.	Amber	Close oversight from the Senior Leadership Team Strong partnership working with external agencies Strong ownership of Divisional teams for the plans and outcomes	Senior Leadership Team will review progress twice monthly	Amber	741 1422 1704	COO	Transformation Programme Board

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
7	CSS	7.1	Develop and implement an engagement programme that ensures staff are fully involved in the work and development of the trust, are able to contribute to its further development and go the extra mile to ensure its success.	Fully engaged workforce evidenced by their participation in and awareness of transformation programme, reflected in staff survey results	Implementation continues in line with Trust priorities. Multiple significant programmes and events take place across the Trust promoting and seeking involvement in Transforming Care Evaluation commences through staff survey.	50% to 75%	Engagement paper taken to Strategic TME, outlining proposed objectives and actions. Agreement secured to carry out baseline measurement exercise across the Trust. This has been scoped and costed and is the subject of a further paper. Recommendation and action is to carry out Divisional specific surveys in addition to national survey. Working group set up with Divisional HR Business Partners and AD HR (OD) to plan and execute divisional specific engagement activities, support retention, and share best practice. Each division has an engagement plan, linked to division-specific issues. Reward/recognition framework developed, to ensure strong, positive performance management. Evaluation carried out via National Staff Survey. Local surveys/focus groups being established to strengthen and deepen evaluation tools and to inform future engagement plans. Staff Experience and Engagement Papers with action plan taken to Transformation Board.	Lack of staff and manager engagement in the process.	Amber	Engagement programme underway. Listening evens undertaken. Divisional engagement plans developed for each Division and discussed/challenged at quarterly reviews. Back to the Floor exercises planned for autumn/winter.	Staff are actively attending and contributing to engagement events.	Amber		Dir W&OD	Trust Management Executive
7	R&I	7.2	We will train, mentor and support research-active staff to deliver high quality translational and applied health services research of direct patient benefit in our priority areas of research	Increased number of staff participating in research activities with associated increase in number of approved research Pas, patients in trials and grant income.	Continue research workforce work plan to develop a skilled, high performing workforce. Develop and make available tools to allow all staff to understand and interact with the research agenda, as appropriate for their roles, leading to greater understanding within the trust of the purpose and benefits of research.	75% to 100%	Workforce work plan continuing according to plan. Research Matron has developed key links with peers and with band 7 research nurses, an important new line of communication into the divisions. Work has commenced with OD to develop tools for UH Bristol staff in leadership roles to support their research understanding and skills.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir Med	Research Group
7	CSS	7.3	Ensure continuing GMC licensing of all Medical Staff, and compliance with Responsible Officer legislation, through the development and operation of an effective and efficient Revalidation process	An effective and efficient system of Revalidation supporting the continued licencing of Medical Staff by the GMC	Operate the Trust's Revalidation system and provide Revalidation recommendations to the GMC	75% to 100%	Revalidation system working well. 74 doctors revalidated since April 2013. 2 deferrals and one non-engagement. Smooth rollout of e-portfolio system to support revalidation. Good uptake of use of this system. All appraisals will be on this system by April 2014 with the exception of a few clinical fellows using the appropriate College based system. Contract for 360 patient and colleague feedback system has been signed.	Difficulty in identifying relatively short term clinical fellow posts. These doctors remain a problem as appear at short notice on DB list and will continue to require some deferments until evidence available for a recommendation	Green	1: Have developed share drive spread sheet with Medical HR to ensure list of Clinical fellows is kept up to date. Working reasonably well.	Monitored at monthly Revalidation Group meeting	Green		Dir Med	Senior Leadership Team
7	T&L	7.4	We become an acknowledged regional leader in equality and diversity outcomes both for our patients and staff	All Trust staff (new and existing) undertake basic E&D training dealing with communication and behaviours Selected Trust staff undertake specialist training and updates Patient satisfaction levels are broadly similar across all protected characteristics Patient complaints centred on E&D issues are minimised Staff satisfaction levels are broadly similar for all protected characteristics	Year on year increase in % accessing training. Target 80% by 2014 Year on year development of trained and supported staff, competent in new legislation, new clinical issues such as dementia care etc. Rising patient satisfaction levels and reducing differentials between groups Reduction by 15% - remove Rising staff satisfaction levels and reducing differentials between groups as measured through patient and staff satisfaction surveys.	25% to 50%	Values training now include E&D aspects and needs to be accounted in % coverage returns. Difficulty in accessing complaints by protected characteristics in order to measure satisfaction levels; E&D/EDS leaflet to launch in Autumn.	Limited time on corporate induction for satisfactory Equality and Diversity Training. Trust does not monitor all its patients for protected characteristics.	Amber	HWB/ED group to discuss and acknowledge issues relating to E&D.	Regular reporting on E&D issues and workforce issues.	Amber		Dir W&OD	Equality and Diversity Steering Group ; Patient Experience Group
7	T&L	7.5	We become a national exemplar for the NHS Equality Delivery System	Implementation of the NHS Equality Delivery System	Implementation enables the Trust to make year on year improvements in reported health outcomes for those in protected groups	25% to 50%	UH Bristol working with BNSSG E&D leads to refresh EDS2 across the locality (EDL relaunched in November 2013). Trust scoping implementation of EDS2	Lack of implementation of the EDL.	Amber	HWB/E&D group to discuss and acknowledge issues relating to E&D. Need to review the Trust's EDL in light of the revised changes. Patient Experience group also being involved.	Regular reporting on equality diversity to the E&D/HWB Steering group with appropriate action as required.	Amber		Dir W&OD	Equality and Diversity Steering Group Trust Board
8	IT	8.1	Implement modern clinical information systems in the Trust	Modern clinical information systems are in use in the Trust	Phase 2 Implementation Phase 3 Design	75% to 100%		Continuing monitoring of system operation	Green	Regular monitoring in place	IM&T Committee and CSIP Committee	Green		DoF	Information Management and Technology Board
8	IT	8.2	Review and deliver fit for purpose clinical admin support processes	Fit for purpose clinical admin process in place	Agree and implement action plan arising from review	75% to 100%	Now converted into other work steams. Completed - to be reviewed 2014/15.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		DoF	Transformation Programme Board

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
8	IT	8.3	Improve our ability to manage our business through the production of robust and timely business intelligence to both head quarters and divisional staff	20% reduction in analyst time spent on routine report preparation. Improved Divisional satisfaction with information format and flow	Review staff use of QlikView Workforce, Ward Key Performance Indicators and other reports that were piloted in 2012/13, to inform changes in reporting requirements and access to reports. Develop a full suite of QlikView reports to support the Transformation agenda. Using the Divisional Analyst time freed-up by QlikView, along with the identified Corporate and Divisional information needs, develop reports that provide additional business intelligence (e.g. benchmarking data, predictive modelling/forecasting). Conduct an annual review of business intelligence and reporting needs and update QlikView reporting in line with this.	75% to 100%	Evaluation of the QlikView Workforce reports completed and presented to the Service Delivery Group (SDG) on the 2nd July. Consideration will be given to the inclusion of Essential Training compliance information once the Learning Management System has been successfully implemented. The use of QlikView to provide budgetary analysis also being scoped. QlikView now contains all Trust Key Performance Indicators. This includes transformation metrics used to monitor and provide decision support for the R3 work-stream. Monthly data briefings have been provided for R3 using QlikView reports. QlikView will be updated with any metrics required to monitor progress with implementing the Operating Mode in 2014/15. Following a review of business intelligence needs, QlikView has been used to develop Ward Performance Books, which have been rolled-out Trust-wide, and also Clinical Dashboards, which in Q4 have been made available to Surgery, Head & Neck and will be rolled-out to all Divisions in 2014/15. Benchmarking reports produced for both SLT and the Cancer Board on a quarterly basis. Benchmarking data-sets now made available to Divisional teams to support the development of the 14/15 Operating Plans.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir SD	Senior Leadership Team
8	LTFP	8.4	Develop better understanding of service profitability using Service Line Reporting	Better resource allocation in the Trust	SLR development. Use of results in informing Business Planning.	75% to 100%	2012/13 results published.	Staff turnover with two costing specialists having recently secured promotion elsewhere.	Green	Replacement commences November 2013.	Not applicable	Green		DoF	Finance Committee
9	T&L	9.1	Deliver a full Trust review of structures using the "spans and layers" approach	Structures will have appropriate spans of control and the number of layers between senior leaders and patients will be minimised	Spans and layers programme completes. Full assessment of outcomes reported and maintenance targets achieved. Further review of structures with new programme of potential changes identified	75% to 100%	Spans and layers no longer currently active as a programme.	No significant risks identified to date.	Green	Not applicable	Not applicable	Green		Dir W&OD	Senior Leadership Team
10	LTFP	10.1	Deliver minimum normalised surplus	Deliver minimum normalised surplus	Achieve full delivery of annual CRES programme (detail provided below) and positive contract settlement with CCG and NHSE commissioners.	75% to 100%	SLA signed in line with Heads of Terms. CRES Delivery (see 10.3)	LA sign off and Somerset CCG re re-admissions	Green	On-going discussions.	Oversight by operational planning core group.	Green		DoF	Finance Committee
10	LTFP	10.2	Deliver minimum cash balance	Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m.	75% to 100%	Trust remains on target to meet objective this year.	Satisfactory income and expenditure outturn.	Green	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green		DoF	Finance Committee
10	LTFP	10.3	Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements	Cost reductions commensurate with CRES target achieved	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Reviews Develop recurrent CRES plans to ensure all non-recurrent CRES is secured recurrently by Q3 2012. Deliver 13/14 CRES requirement on a normalised basis.	75% to 100%	As at month 07 80% target identified ion a risk assessed basis The Trust has a savings target for 2013/14 of £20.989m the forecast outturn delivery is £16.871m as at month 07 or 80.0% This forecast outturn has remained at roughly this figure for some time . It is imperative that new savings schemes are implemented urgently in order to improve this figure. As the present time there is little assurance that the Trust will achieve the target set for this financial year. hence the red RAG rating. Within the forecast outturn of £16.871m there remains non recurring savings identified of £3,845m.	The most significant risk to the existing plans is the risk of not being able to close beds within the Medicine Division this is valued at £635k in the savings plan and built into the current forecast outturn . Other savings plans have been robustly risk assessed however there still remains a forecast shortfall this year of £4.1m overall. The Non recurring savings within the overall forecast outturn of £16.871m is currently £3.845m.	Red	Savings Programme plans are regularly reviewed each month at Divisional and Work stream accountability meetings . This helps to ensure that the current forecast delivery is robust. Workstreams have been refreshed and are identifying additional savings through productivity in Theatres and Outpatients although it is not anticipated that this will generate additional savings in 201314 all underachieved savings will be carried forward to the next financial year.	Divisions are held to account for this both at Monthly Divisional Savings Programme Reviews and more importantly the monthly Operational and Financial reviews chaired by the COO and attended by the DOF and other Directors. Monthly reports on progress are presented to the Finance Committee Internal Audit Report.	Red	741	COO	Finance Committee
11	LTFP	11.1	Maintain Monitor Financial Risk Rating of 3 or above	Maintain Monitor Financial Risk Rating of 3 or above	Achieve EBITDA, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan	50% to 75%	Financial Risk Rating of 3 to Month 2 May 2013.	Delivery of CRES plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan.	Green	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	Green		DoF	Finance Committee

Objective	Driving Strategy	Serial Number	Strategic Objectives (3 – 5 years)	Outcome	Key Priorities for Action 2013-2014	Progress Towards Achievement of Actions %	Progress Towards Achievement Narrative	What are current risks to achieving our objectives	Risk rating (Red, Amber, Green)	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
11	T&L	11.2	Achieve Compliance with New Deal contractual requirements for junior medical and dental staff	All staff will be working appropriate hours, and taking appropriate rest breaks.	Remain compliant in audit through regular monitoring and review of shift patterns and hours worked.	75% to 100%	Monitoring of rotas continues, in close conjunction with Lead Doctors, Divisional Directors and HR Business Partners. Concerted efforts are being made to reduce the number of non-compliant rotas.	There are a small number of areas where achieving compliant rotas is challenging.	Red	Regular monitoring exercises planned in all areas. Re-monitoring exercises are undertaken where required. Communication maintained with job holders concerning hours worked. Regular meetings taking place between Lead Doctors, Divisional Directors and HR Business Partners Progress reviewed by Executive Lead at monthly Divisional finance and operational review meetings.	Monitoring of Junior Doctors hours.	Red		Dir W&OD	Senior Leadership Team
11	CSS	11.3	Maintain registration with CQC including compliance with essential standards of quality and safety	Continued compliance with all relevant CQC standards	Ensure on-going compliance with all CQC registration Outcomes	75% to 100%	The CQC carried out a responsive review of BRHC theatres on 19/11/13 - the CQC's judgement was that the Trust was non-compliant with Outcome 8 (cleanliness and infection control - primarily due to inconsistent cleaning and infection control practices in areas adjacent to paediatric theatres, i.e. corridors and storage areas) and Outcome 16 (assessing and monitoring quality of service provision - primarily because of an ineffective system for assessing risks). All actions have been completed and the Trust is currently awaiting a follow-up inspection (until which time we remain formally non-compliant). The Trust is also non-compliant with Outcome 4 (care and welfare) following a themed inspection of dementia care on 22/1/14. Action plan submitted.	By definition, the Trust has not achieved the goal of maintaining compliance with all CQC standards throughout 2013/14.	Red	Operational and Executive Leads for all Outcomes. Monitoring by CQC group, Risk Management Group. Actions in relation to 22/1/14 dementia inspection are due to be completed by the end of June 2014.	Operational and Executive Leads for all Outcomes. Monitoring by CQC group, Risk Management Group.	Red		Chief Nurse	Risk Management Group
11	CSS	11.4	Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.	Continued compliance with all relevant performance standards set as part of Monitor's performance framework (and contractual negotiations), with special reference to those three priorities set out below,	Build sustainable performance in all areas with aim of moving ambition for delivery beyond national standards where possible	75% to 100%	Delivery against 4 hour standard at a Trust level in October and November but there was a deterioration in performance in December both at the BRI and Children's hospitals. BRI has continued to struggle during Q4 with periods of black escalation. Elderly admissions unit opened in 19th June 2013. Discharge lounge opened on 16th September 2013. Improved performance for diagnostic endoscopy waiting times (99% target achieved in November)	1. Sustaining 4 hour performance during winter months 2. Backlog of ENT / OMF / Clinical Genetics non-admitted waits impacting on RTT performance 3. Cdiff performance exceeding target 4. Cancer 62 day performance at risk for Q4	Red	1. New Model of Care for 2014/15- 7 projects in development which includes both internal and external partnership working. Regular monitoring of demand to identify trends. Breaking the Cycle Together initiative planned for w/c 31st March 2014. 2. Recovery plan for outpatient first appointment waits to support improved non-admitted and admitted performance being developed. Progress will be monitored on a weekly basis to ensure trajectories delivered. 3. Regular monitoring of progress against action plan. 4. Cancer Steering Group set up to oversee improvements in 62 day and 31 day cancer waits. Escalation process for cancellations of elective activity to ensure appropriate actions taken to prevent cancellations. On-going discussions regarding breach reallocation for late referrals. Business case for 20th ITU bed approved. Review of adult critical care being progressed as part of the Operating Model work programme.	R3 Programme Steering Group Monthly and Quarterly Performance and Finance Meetings Service Delivery Group System Wide Operational Group	Red	1422 1967 1412 1383	COO	Senior Leadership Team

Cover Sheet for a Report for a Public Trust Board Meeting,
to be held on 28 April 2014 at 10:30am
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

22. Corporate Risk Register

Purpose

The Corporate Risk Register contains risks identified as having a potential impact on corporate objectives, including risks identified in and escalated up from divisions.

Risks escalated from divisions may be re-assessed and re-scored against their potential impact upon the corporate objectives.

Risks are formally approved for inclusion on and removal from the Corporate Risk Register by the Senior Leadership Team.

Abstract

New Corporate Risks:

- 2126 - Reputational Damage Arising From Adverse Media Coverage of Trust Activities
- 2479 - Performance Risk to Monitor Green Rating

Corporate Risks De-escalated to Divisional Risks

- 1383 (Trust Services) - Failure to Reduce the Incidence of Health-Care Acquired Infection
- 1412 (Trust Services) - Failure to meet Cancer Targets
- 1422 (Medicine) - Compliance of the ED with Monitor's 4-hour Wait Clinical Indicator.
- 1704 (Medicine) - Corridor Queue Outside The Emergency Department
- 2476 (Trust Services) - Operational Readiness of Helideck
- 2477 (Trust Services) - Vascular Surgery Transfer date

Risks Closed
None.

Recommendations

The Trust Board is recommended to receive this report by the Chief Executive for review.

Executive Report Sponsor or Other Author

- Sponsor – Chief Executive
- Other Author – Safeguard Systems Manager

Appendices

- Corporate Risk Register

Corporate Risk Register 22/04/2014

Number	Risk Title	Executive Lead	Risk Rating
741	Cash Releasing Efficiency Savings (CRES) Schemes	Chief Operating Officer - James Rimmer	Very High (Red)
1412	Failure to meet Cancer Targets	Chief Operating Officer - James Rimmer	Very High (Red)
1977	Lack of Capacity on NICU	Chief Operating Officer - James Rimmer	Very High (Red)
2126	Reputational Damage Arising From Adverse Media Coverage of Trust Activities	Director Of Strategic Development - Deborah Lee	Very High (Red)
2344	Achievement of Strategic Objectives	Director Of Strategic Development - Deborah Lee	Very High (Red)
2479	Performance Risk to Monitor Green Rating	Chief Operating Officer - James Rimmer	Very High (Red)

Corporate Risk Register Report

Risk Number: 741 **Status:** Action Required **Risk Title:** Cash Releasing Efficiency Savings (CRES) Schemes

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Financial	Programme Steering Group	Dean Bodill	James Rimmer	Chief Operating Officer - James Rimmer	25/06/2012	10/01/2015	16 Very High (Red)	0

BAF Reference and details of strategic objective:

10.3 - Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements

Risk Description

Risk of Plans under achieving and impacting on trust annual and planned outturn. Savings are not identified, are duplicated or double counted, slippage in delivery, activity growth consumes benefit, in year costs pressure or competing priorities eliminate gains.

This risk is also reflected in divisional risks 1912, 1420 and 1021 .

Details of Control or Assurance	Effectiveness
Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports	High
Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed	High
Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery.	Medium
Regular Reporting to the Finance Committee and Trust Board	High

Risk Number: 1412 **Status:** Action Required **Risk Title:** Failure to meet Cancer Targets

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Quality	Cancer Board	Hannah Marder	James Rimmer	Chief Operating Officer - James Rimmer	01/04/2014	12/05/2014	16 Very High (Red)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

11.4 - Maintain a "Green" Monitor Governance Risk Rating and meet all mandated and contractual performance targets.

Risk Description

Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target.

Details of Control or Assurance	Effectiveness
Weekly meetings held with all Divisions to review cancer patient tracking. Performance reviewed every two weeks at the Service Delivery Group and at the Trust Management Executive via SDG. Performance reported to Cancer Board at every meeting.	High
Choose and book - implemeted for 14 day breast and seen performance improve to 98%. needs to be sustained at this level or better	Medium
Additional ITU capacity - identified as cause of several key 62 day cancellations and addressed through additional capital investment in 2010 on interim basis and 2011 on semi permanent basis	Medium

Action Plan for Risk: 1412	***Action Number:*** 3	***Responsibility Of:*** Various	***Target date:*** 31/03/2015

Use of ongoing cancer performance target action plan to manage specific actions to improve performance e.g. pathway redesign. Actions identified via monthly breach reviews and weekly PTLs. Action plan updated fortnightly and reviewed by Service Delivery Group.

Action Plan for Risk: 1412	***Action Number:*** 4	***Responsibility Of:***	***Target date:*** 31/03/2015

Ongoing close patient level management of cancer PTL, including a weekly cross-divisional review meeting

Corporate Risk Register Report

Risk Number: 1977 **Status:** Action Required **Risk Title:** Lack of Capacity on NICU

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Patient Safety	Divisional Management Meeting W&C	Caralin Donavans	James Rimmer	Chief Operating Officer - James Rimmer	29/10/2012	29/06/2014	15 Very High (Red)	4 Low (Green)

BAF Reference and details of strategic objective:

3.3 - To be recognised by our patients and their families for the consistently high quality of the care they receive whilst in our care

Risk Description	Details of Control or Assurance	Effectiveness
Due to inadequate capacity on NICU at times of peak demand, there is a risk that neonates will need to transferred out of the region and/or the quality of care on the unit maybe compromised during these times of peak activity.Both of these risks have the potential to impact adversely on outcomes for neonates in our care, or those transferred elsewhere.	Cot Policy agreed by Trust and Network Board to prioritise last 2 intensive cots for infants requiring sub specialist care, transferring out less ill babies if necessary and possible. Consultant and senior nurse review of all possible discharge/transfer of infants 2/3 times per day minimum. Consultant advice to referring hospital when we are unable to take patients. Transfer any appropriate infant to PICU or BRCH if capacity permits. Transfer of mothers in-utero as preferable to ex-utero transfer. Any mother in who transfer presents a risk will be delivered at St Michael's and the baby stabilised and transferred out if possible. If that baby is too ill to transfer another will be transferred out in his/her place where the situation and condition allows. Good communication with parents around the need to transfer and arrangements for return should capacity allow.	Medium

Action Plan for Risk: 1977 **Action Number:** 1 **Responsibility Of:** Caralin Donavans **Target date:** 25/04/2014

Develop plans to increase number of cots, in keeping with national standards.

Corporate Risk Register Report

Risk Number: 2126 **Status:** Accepted **Risk Title:** Reputational Damage Arising From Adverse Media Coverage of Trust Activities

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Reputational	Trust Management Executive	Fiona Reid	Deborah Lee	Director Of Strategic Development - Deborah Lee	22/04/2014	27/04/2014	15 Very High (Red)	2 Low (Green)

BAF Reference and details of strategic objective:

Risk Description	Details of Control or Assurance	Effectiveness
Risk of reputational damage arising from adverse media coverage of paediatric cardiac services.	Pro-active monitoring of forthcoming inquests, robust inquest preparation including pro-active & reactive communication and media management as considered appropriate.	Medium

Action Plan for Risk: 2126 **Action Number:** 1 **Responsibility Of:** **Target date:** 30/04/2014

Identify Trust actiivties at risk of attracting adverse media and ensure proactive management and mitigation of these risks and associated supporting communications

Corporate Risk Register Report

Risk Number: 2344 **Status:** Accepted **Risk Title:** Achievement of Strategic Objectives

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Business	Trust Management Executive	Deborah Lee	Deborah Lee	Director Of Strategic Development - Deborah Lee	08/01/2014	09/05/2014	15 Very High (Red)	2 Low (Green)

BAF Reference and details of strategic objective:

Achieve Full Compliance with Health & Safety Requirements / Achievement of CRES / Compliance with EUWTD / Compliance with CQC Standards / Maintain GREEN Monitor Risk Rating

Risk Description	Details of Control or Assurance	Effectiveness
Risk of failure to achieve one or more strategic objectives within the Board Assurance Framework	Executive Director ownership and accountability for each stratgeic objective with responsibility for ensuring delivery and devloping remedial action plans where necessary	Medium

Action Plan for Risk: 2344 **Action Number:** 1 **Responsibility Of:** Deborah Lee **Target date:** 30/04/2014

Recovery plans for each high risk objectve to be developed alongside risk assessment of impact of non-achievement with approriate risk management and mitigation plans developed.

Corporate Risk Register Report

Risk Number: 2479 **Status:** Action Required **Risk Title:** Performance Risk to Monitor Green Rating

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Statutory	Trust Management Executive	Rhiannon Hills	James Rimmer	Chief Operating Officer - James Rimmer	05/03/2014	01/05/2014	16 Very High (Red)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

Risk Description	Details of Control or Assurance	Effectiveness
Prolonged failure of one of the following performance indicators, or concurrent failure of 4 or more indicators leading to loss of green status in Monitor risk rating: Referral to Treatment Time Standards Cancer Standards ED Standards Healthcare Acquired Infections	RTT Steering Group (monthly and weekly)	Medium
	Cancer Steering Group	Medium
	Project plans for new Operating Model 2014/15 being overseen via the Senior Leadership Team (SLT)	Medium
	Weekly reporing of against performance indicators and escalation to Steering Groups, Service Delivery Group and Senior Leadership Team as appropriate.	High

Action Plan for Risk: 2479 **Action Number:** 2 **Responsibility Of:** **Target date:** 30/09/2014

Monitoring of trajectories (activity and waiting list) to ensure first outpatient waiting times are reduced in line with target for end of quarter 2

Action Plan for Risk: 2479 **Action Number:** 3 **Responsibility Of:** **Target date:** 30/04/2014

Breaking the Cycle Together initiative being run w/c 31st March 2014 to help rebalance adult bed base and reaffirm standards for both UHB and partner organisations

Action Plan for Risk: 2479 **Action Number:** 4 **Responsibility Of:** **Target date:** 30/09/2014

New Operating Model for 2014/15 has identified 7 projects to be taken forward to improve flow and support delivery of the 4 hour standard, RTT and Cancer Standards, Each project has a executive and divisional lead.

Action Plan for Risk: 2479 **Action Number:** 5 **Responsibility Of:** **Target date:** 31/12/2014

See also Risk Numbers 1383 - Health Acquired Infections, 1412 Cancer Standards, 1422 4 hour performance, 1967 RTT Standards