University Hospitals Bristol NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING

Date: Wednesday 30 July 2014
Time: 14:00-15:30
Venue: Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

This meeting is held in public. We would like to request that members of the Trust and members of the public who have any questions that they would like to ask at the meeting, submit them to the address below at least 48 hours before the meeting.

Distribution

Chair:	John Savage	Chairman
Members:	All members of the Council of Governors	
In attendance:	Members of the Trust Board of Directors	
	Julie Dawes	Interim Trust Secretary
	Paul Tanner	Head of Finance
	Xanthe Whittaker	Head of Performance Improvement (deputising for Director of Strategic Development and Deputy Chief Executive)
	Sarah Murch	Membership PA/Administrator (minute taker)
	Debbie Marks	Membership Administrator
Apologies from governors:	Marc Griffiths	Appointed Governor
	Brenda Rowe	Public Governor
	Thomas Davies	Staff Governor
	John Steeds	Patient Governor
	Lorna Watson	Patient – Carer Governor
	Sue Hall	Appointed Governor
	Tony Tanner	Public Governor
	Jim Petter	Appointed Governor
Observers	Marty McAuley	Trust Secretary of South Western Ambulance Service NHS FT
	Prof Mary Watkins	Senior Independent Director & Vice-Chair of South Western Ambulance Service NHS FT
Copy for Information:	Fiona Reid	Head of Communications

Contact for apologies or any enquiries concerning this meeting should be made to: Sarah Murch, Membership PA/Administrator, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU
Telephone: 0117 34 23764 Email: Sarah.Murch@uhbristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Council of Governors meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*	*Time*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman		14:00
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		14:02
3. Minutes and Actions from the Previous Meeting To consider the minutes of the meeting of the Council of Governors on 28 April 2014 for **approval** and the status of Actions agreed.	Chairman	4	14:05
4. Election and Appointment of Governors To receive and **note** this report.	Chairman	14	14:10
5. Performance Update and Strategic Outlook a) **Chief Executive's report** – to receive and **note** a verbal update from the Chief Executive b) **University Hospitals Bristol Strategic Plan 2014-2019** – to receive and **note** this report**.** c) **Independent Auditor's Report to the Governors on the Quality Report 2013-2014** – to receive and **note** this report. d) **University Hospitals Bristol Quality Report 2013-2014** – to receive and **note** this report. e) **Achievement on Corporate Quality Objectives – Quarter 1** – to receive and **note** this report.	Chief Executive Chief Nurse	19 114 129 201	14:20
Governors' Questions			
6. Governors' Questions arising from the meeting of the Trust Board of Directors To respond to questions arising from matters of business on the agenda of the preceding meeting of the Trust Board of Directors.	Chairman		14:35
7. Governors' Log of Communications To **note** the current position of the Governors' Log of Communications.	Chairman	206	14:50
Statutory and Foundation Trust Constitutional Duties			
8. Item Withdrawn.			

Page 2 of 2 of an agenda for a Council of Governors meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*	*Time*
9. Nominations and Appointments Committee report a) To receive and **note** this report. b) To receive the recommendation of the Committee to **approve** the appointment of the Senior Independent Director.	Chairman	212	15:00
10. Governor Development Seminar report To receive and **note** this report.	Chairman	214	15:05
11. Governor Groups updates To receive and **note** the following reports: a) Annual Plan Project Focus Group b) Quality Project Focus Group c) Constitution Project Focus Group d) Staff Governors meeting e) Working Group for the forthcoming Annual Members' Meeting f) Governor Activity report	Chairman	216	15:10
12. Project Focus Groups Membership To receive as a **discussion item** a report on the future membership arrangements of Governor Project Focus Groups.	Trust Secretary	226	
13. Council of Governors Register of Interests To receive and **note** this report.	Trust Secretary	227	15:20
14. Any Other Business To **note** any other relevant matters.	Chairman		
Members' Questions			
15. Foundation Trust Members' Questions a) To **note** the proposed future arrangements for dealing with questions from Foundation Trust Members and members of the public. b) To **receive** questions from Foundation Trust members and members of the public present (notified in advance).	Chairman		15:25
Close			
16. Date of Next Meeting The **Annual Members' Meeting** will be held on Thursday 18 September 2014 in Lecture Theatre 1, Education & Research Centre, Upper Maudlin Street, Bristol, BS2 3AE. The next meeting of the **Council of Governors** will be held on Thursday 30 October 2014 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.			

University Hospitals Bristol NHS
NHS Foundation Trust

Unconfirmed Minutes for a Council of Governors meeting held on 28 April 2014 at 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Governors Present

- Sue Silvey – Lead Governor and Public Governor
- Anne Ford – Public Governor
- Clive Hamilton – Public Governor
- Mo Schiller – Public Governor
- Glyn Davies – Public Governor
- Pauline Beddoes – Public Governor
- Brenda Rowe – Public Governor
- Tony Rance – Public Governor
- Mani Chauhan – Public Governor
- Anne Skinner – Patient Governor
- Pam Yabsley – Patient Governor
- Peter Holt – Patient Governor
- Lorna Watson – Patient Governor
- Elliott Westhoff – Patient Governor
- John Steeds – Patient Governor
- Angelo Micciche – Patient Governor
- Philip Mackie – Patient Governor
- Wendy Gregory – Patient Governor
- Sue Milestone – Patient Governor
- Florene Jordan – Staff Governor
- Ben Trumper – Staff Governor
- Ian Davies – Staff Governor
- Jan Dykes – Staff Governor
- Joan Bayliss – Partnership Governor
- Jeanette Jones – Partnership Governor
- Sylvia Townsend – Appointed Governor
- Abbas Akram – Appointed Governor
- Lukon Miah – Appointed Governor
- Marc Griffiths – Appointed Governor
- Tim Peters – Appointed Governor

Board Members Present

- John Savage – Chairman
- Robert Woolley – Chief Executive
- Sean O'Kelly – Medical Director
- Carolyn Mills – Chief Nurse
- Emma Woollett – Non-executive Director
- Alison Ryan – Non-executive Director
- David Armstrong – Non-executive Director
- Iain Fairbairn – Non-executive Director
- John Moore – Non-executive Director
- Julian Dennis – Non-executive Observer
- Jill Youds – Non-executive Observer

Others Present or In Attendance

- Charlie Helps – Trust Secretary
- Paul Tanner – Head of Finance
- Rhiannon Hills – Head of Performance Delivery (deputising for James Rimmer)
- Alex Nestor – Head of Human Resources/Deputy Director of Work Force Development (deputising for Sue Donaldson)
- Sarah Murch – Membership Administrator/PA (minute taker)
- Debbie Marks – Membership Administrator
- Two members of University Hospitals Bristol NHS Foundation Trust

Item	*Action*
1. Chairman's Introduction and Apologies	

Page 2 of 9 of minutes of a Council of Governors meeting held on 28 April 2014 at 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Apologies for absence were received from: **Governors**: Pauline Beddoes, Ken Booth, Ian Davies, Peter Holt, Jim Petter, Tony Tanner. **Trust Board and Others:** Sue Donaldson, James Rimmer, Guy Orpen, Lisa Gardner. *Apologies for absence were **noted**.* The Chairman, John Savage, welcomed those present to the meeting. He extended a particular welcome to Lukon Miah and Abbas Akram, who had been appointed this month as Youth Council governors for a one-year term. Governors were also pleased as this was the first such appointment since changes to the Foundation Trust Constitution to enable Youth Council representation had come into effect. **Lead governor** John Savage thanked Sue Silvey for agreeing to remain as Lead Governor for 2014/15, with Mo Schiller as Deputy Lead Governor. Both had been elected unopposed. Phil Mackie queried this in light of the fact that both Sue Silvey and Mo Schiller had reached the end of their terms of office as governor and were currently standing for re-election. John Savage explained that if either Sue or Mo were not re-elected as governor at the end of May, there would be another Lead Governor election at that stage.	
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. Minutes and Actions from the Previous Meeting The Council of Governors considered the minutes of the meeting of the Council of Governors on 30 January 2014 and noted the status of Actions agreed. It was noted that written responses had been provided for all the items on the Action List. Tony Rance requested clarification on Item 5e – Robert Woolley's response to John Steeds' question in relation to the Centralisation of Specialist Paediatrics, in which Robert had stated that there had been a clinical aspiration for a premium level of cover which the Trust's analysis had indicated was not warranted. Robert clarified that this meant that the Trust had decided that the premium level of cover requested by certain clinical staff was not warranted. The Trust had benchmarked the activities of other specialist paediatric centres and were confident that their proposed model was a satisfactory one and was in line with other centres. By way of an update, he added that the medical staff involved had agreed to work with the Trust's proposed model subject to review after a period of time. *The Council of Governors **approved** the minutes as an accurate record of the meeting.*	
4. Chief Executive's Report and Strategic Outlook	

Governors received a verbal update from the Chief Executive, Robert Woolley, to note.

2013/14 Financial Year: Robert informed governors that the end of the 2013/14 financial year presented the Trust with a mixed picture. The Trust had delivered its financial plan, apart from some technical items, but had missed its objectives around four (and potentially five) of the key Patient Access Targets in Monitor's risk assessment framework. Monitor would undertake further investigation in May and would decide whether regulatory action should be taken as a result. Monitor had been particularly concerned about the Trust's failure to achieve the 18-week referral-to-treatment target as they believed this to be entirely within the Trust's own operational grasp. The Trust now needed to demonstrate that its recovery plans were robust and would be delivered promptly.

Quality: The Trust had been the subject of two Care Quality Commission (CQC) reviews which had found that it needed to make improvements against CQC standards: a review of the theatre department in Bristol Royal Hospital for Children last November and a recent review of dementia care in the Bristol Royal Infirmary. The Action Plans for both of those had now been approved by the Board, and the Trust was awaiting the CQC's reappraisal of the services in light of the action plans.

However, governors could take assurance from the news that the CQC's Intelligent Monitoring report (its routine monitoring analysis of all hospital providers) had placed the Trust for the second quarter running in the lowest-risk band for quality and safety of care.

Financial Outlook: Robert reported that the financial outlook was not promising. A recent survey from the Kings Fund had revealed that two out of every three finance directors in provider trusts were predicting a deficit in 2015. The government's austerity drive in relation to public services was ongoing, and as a result of its response to the independent NHS Pay Review body, UNISON and UNITE had announced their intention to ballot members about the possibility of strike action on 5 June. He undertook to keep governors and the Trust Board informed of any local developments.

Changes in the coming year: The coming year would see significant changes following North Bristol Trust's closure of Frenchay hospital and transfer of services to Southmead. The independent reconfiguration panel had supported the decision by commissioners not to build a community hospital at Frenchay in line with the original proposal, because they had decided that the need was already met by the services at Yate and Cossham.

Changes were also ongoing at the Bristol Royal Infirmary (BRI): there had been an inaugural test landing on the helipad this month and there was a very detailed plan for all the service moves that needed to take place over this financial year. Robert noted the extensive support given by charitable trustees Above and Beyond around the BRI redevelopment.

Kennedy Review: Robert advised governors that there was as yet no more news regarding the independent review by Sir Ian Kennedy into children's congenital heart services at the Trust. Terms of reference were still not yet available, and it was not known when it would start or how long it would take, though it was now understood that it would be led by Eleanor Grey QC. Robert assured governors that the Trust was undertaking appropriate steps to prepare for the review and was already anticipating the learning that was likely to be necessary. Of particular note was the need to understand

how the Trust could change in the way in which it communicated with those people whose experience of its care was not good, how the Trust managed complaints and concerns, and how it could support the staff involved.

Governors' Questions

a) Lorna Watson, Patient Governor, asked for assurance that the Communications team had appropriate plans in place to counter the negative publicity that was likely to result from the Kennedy Review. Robert responded that the Trust was alert to this risk: he was personally chairing a fortnightly meeting looking at all preparations round the review and related issues, and had also sought specialist advice. The Trust was taking proactive steps, for example, Robert had recently written a 1000-word article for the Health Service Journal which rebutted some of the negative comments that were in the public domain about the Trust and the hospital.

There being no further questions or discussion, the Chief Executive's report was noted.

Governors' Questions

5. Governors' Questions arising from the meeting of the Trust Board of Directors

Governors asked questions arising from matters of business on the agenda of the preceding meeting of the Trust Board of Directors.

a) John Steeds, Patient Governor, welcomed the news that the Trust was proceeding with plans to build a multi-storey car park, and asked why it was now affordable when it had not been in the past. Robert explained that the Trust would be asking for permission to close Eugene Street in order to build a facility for 1200 spaces. Deborah Lee, Deputy Chief Executive and Director of Strategic Development, added that affordability was due to the economy of scale that the Trust was now proposing, which the planners hitherto had been reluctant to endorse, that now allowed the Trust to approach it as a commercial scheme which would ensure that it was not a drain on Trust capital or revenue resources.

In response to a further question from Clive Hamilton, Public Governor, about when the new car park would come into use, Deborah responded that the timeline had not yet been scoped but that she would estimate that it would take at least two years. Florene Jordan, Staff Governor, thanked the Board on behalf of staff for the opportunity that they had been given to respond to the consultation on car parking. Some staff had felt that it had been the first time they had been heard on the issue.

b) In the light of the Patient Experience report discussed at the Trust Board meeting, Pam Yabsley, Patient Governor, related another case – that of an older patient who had been discharged after midnight to a nursing home, and who had died while he was being transported there. Robert expressed his deep disappointment that this had happened, and asked Pam to give him the details of the particular case so that it could be followed up. He added that the Trust had recently reinforced its expectation that patients (and particularly older patients) would not be transferred

late at night.

c) With respect to the Patient Experience report and also the CQC investigation surrounding Dementia Care, and in the light of the recent well-attended Health Matters event with a dementia focus, Wendy Gregory, Patient Governor, requested assurance that the Board was confident that the right steps were in place to deal with this issue. Robert responded that the Trust had carried out an enormous amount of work, and that significant improvements had been made, though it was not yet known whether these would keep pace with the demands. An action plan had been produced in response to the CQC findings which had been seen by the Board. The Trust had identified particular logjams in its ability to demonstrate the level of assessment that it was trying to do around older people and dementia. However, it seemed that the solutions around recording the level of assessment could take some months to come to fruition. Carolyn Mills, Chief Nurse, emphasised that it was a very challenging area and that there was always more that could be done.

Clive Hamilton, Public Governor, questioned whether schemes for enabling staff were good enough to provide the same level of care for patients with dementia as would be delivered in a nursing home. Robert responded that while the Trust provided some dementia awareness training, the emphasis was more on seeking to work with others around discharge to appropriate settings to make sure that the right follow-up care was available. The Trust was working through the Better Care Fund Programme to create a more holistic response to care for older people, and it was also liaising with charities and social enterprises, Bristol Community Health, Clinical Commissioning Groups and Social Services about changes to the health system as a whole.

d) Sue Milestone, Patient Governor, expressed concern that there were ambulances in the area that were run by private companies and did not have paramedics on board. She was particularly worried about what would happen if South Western Ambulance Service NHS Foundation Trust (SWASFT) lost its contract in the area to private companies. Deborah Lee clarified that the Trust used two levels of ambulance service: the emergency response service which was appropriately staffed by paramedics and other highly skilled practitioners, which was solely operated in the South West region by SWASFT. There was also a separate service offer – the routine Patient Transport Service that brought patients to and from hospitals, in which there was a "mixed economy of provision" – private sector, third (charitable) sector and SWASFT, and these would not typically have trained paramedics as it generally was not warranted. John Savage agreed that the Board would take Sue's concerns into account.

Wendy Gregory also enquired about the contract with SWASFT, adding that when SWAS ambulances were staffed by technicians rather than paramedics, they were unable to deliver certain medication and also unable to transport in certain ways, which made a significant difference to the condition of the patient on admission. Robert clarified that the Trust did not itself have a contract with SWASFT, as the contract was commissioned by a particular Clinical Commissioning Group on behalf of all the organisations that take services from SWASFT.

e) John Steeds enquired about the Board's plans to mitigate discontent among staff over pay rises. Robert responded that the Board would not seek to reverse out of

national contracts without significant consultation, nor was it in a position to voluntarily try to mitigate the government's response to the pay review body. He added that Sue Donaldson, Director of Workforce and Organisational Development, was looking at ways of engaging staff to demonstrate that the leadership took their concerns seriously, to find ways to encourage staff to participate and give feedback and to improve the experience of staff generally. John Savage added that the Trust was recruiting to 120% of its complement, which he believed had been a brave decision for the Board to make given the extent of savings required. *There were no further questions.*	
6. Governors' Log of Communications Governors received the current position of the Governors' Log of Communications to **note.** Sylvia Townsend, Appointed Governor, referring to Ken Booth's item on the Governors' Log about controlled parking zones for residents, suggested that a drop-off period of 30 minutes could be negotiated instead of 15 minutes. Robert responded that, while he agreed it was necessary to discuss this issue with Bristol City Council, the dialogue should at this stage be about the ability to manage drop-off in a more systematic and favourable way, rather than Governors specifying to Directors exactly how it could be done. *There being no further questions or discussion, the current position of the Governors' Log of Communications was **noted**.*	
Statutory and Foundation Trust Constitutional Duties	
7. Foundation Trust Constitution report Governors **considered** the proposed changes to the Foundation Trust Constitution. Charlie Helps, the Trust Secretary, presented the revised Foundation Trust Constitution which incorporated the requirements governors had set out in the Constitution Project Focus Group and Constitution Task and Finish Group. These were: • to make the constitution more accessible; • to make it sound and feel more like the John Lewis Partnership and Salisbury NHS Foundation Trust Constitutions; and, • to fulfil governors' requirements around changes to membership. The new draft Foundation Trust Constitution had been circulated to governors, with the proposed changes reflected in the tracked comments. Charlie explained the changes and asked for comments. Feedback was given in the following areas. **Paragraph 9**: **Patients and Carers Constituency no longer divided into classes:** Wendy Gregory wished it to be noted that she did not support the incorporation of the Carers constituency class into the Patients Constituency making one 'Patients and Carers Constituency'. She had thought that the original suggestion by governors in this regard had been to extend voting rights for the Carers' constituency class to include the patients that they cared for. She felt that it was important that the Carers constituency was retained in its own right. Charlie confirmed this section would be redrafted back to	

its original configuration as it was not legally possible to include the voting provision suggested by Wendy.

Paragraph 15.2.17: *A person may not become or continue as a Governor if he is a member of a local authority overview and scrutiny committee'* Sylvia Townsend queried this as it would apparently make her ineligible to be a governor.

[Post-meeting note: The Trust Secretary sought legal advice, and in the experience of the solicitors, this exclusion is commonly included in Foundation Trust Constitutions. The reason being that any person who is a Governor and also a member of an overview and scrutiny committee is likely to find that he/she has conflicts of interests and therefore when in the latter role is unable to robustly hold to account the Trust of which he/she is a Governor. Such conflicts of interests could be managed to some extent but the solicitors consider that it would be difficult to avoid them so that, for practical purposes, the person concerned would find it difficult to participate fully in the work of the Council of Governors and the overview and scrutiny committee equally.]

Paragraph 16.4: Charlie asked governors to consider whether they wished to include the provision for governors to appeal against the termination of a governors' term of office. It was agreed that they did wish to include this provision.

Paragraph 30.1.7: *A person may not become or continue as a Director if information revealed by a DBS check is such that it would be inappropriate for him to become or continue as a Director on the grounds that it would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.* It was agreed this would be considered should such circumstances arise.

Paragraph 30.1.10: *A person may not become or continue as a Director if he is an executive or non-executive director of another NHS Foundation Trust, or a governor, non-executive director, or chair, chief executive officer or equivalent of another Health Service Body or a body corporate whose business includes the provisions of healthcare.* It was thought that this needed to be adjusted due to the recent announcement from the Department of Health that it plans to change the law to permit multiple appointments. [**Post-meeting note**: However, it was subsequently confirmed by the advising solicitors that the announcement related to Chair roles in NHS Trusts but in any event, Foundation Trusts are permitted to provide in their constitutions for eligibility criteria for Directors and these remain current until such time as the Trust might decide to amend them. The recent announcement does not therefore impact on this draft of the Foundation Trust Constitution.]

Paragraph 45.3: Definition of Significant Transaction: Governors and Board were asked to consider the proposed change in the definition of a significant transaction from 25% of turnover to 10% of turnover. Robert Woolley commented that there was a need to align this to Monitor's new thresholds around significant material and the review of the Trust's investment policy. The Trust Secretary undertook to redraft the definition of a significant transaction to align to the Monitor Risk Assessment Framework, i.e.

45.3 A 'significant transaction ' is one which meets any of the criteria below:

45.3.1 It is an international and/or non-healthcare transaction and:

45.3.1.1 the gross assets subject to the transaction are more than 5% of the gross assets of the Trust;

45.3.1.2 the income attributable to the assets or the contract associated with the transaction is more than 5% of the income of the Trust; or 45.3.1.3 the gross capital or consideration associated with the transaction is more than 5% of the total capital of the Trust following completion; or 45.3.1.4 the effects on the total capital of the Trust resulting from the transaction are more than 5%. 45.3.2 It is a UK healthcare transaction and: 45.3.2.1 the gross assets subject to the transaction are more than 10% of the gross assets of the Trust; 45.3.2.2 the income attributable to the assets or the contract associated with the transaction is more than 10% of the income of the Trust; or 45.3.2.3 the gross capital or consideration associated with the transaction is more than 10% of the total capital of the Trust following completion; or 45.3.2.4 the effects on the total capital of the Trust resulting from the transaction are more than 10%. **Appendix E: Board/Governor Engagement Report:** Tony Rance, Public Governor, sought clarification as to the extent that governors should be engaging with their members and consulting with the public. Charlie clarified that the legislation required governors to represent the interests of the members of the Trust and the public, and noted that governors currently used the Health Matters events as opportunities to talk to their constituents. These are known as governors' surgeries and are to be formally supported by the Trust's Patient and Public Involvement team. Some governors expressed the view that the revised constitution was a much better document, and there were favourable comments about the new Code of Conduct. There was a request for consistency in the use of inclusive language with regard to gender throughout. Charlie agreed to circulate the Foundation Trust Constitution to governors following incorporation of the revisions discussed. He asked for any feedback to be sent to him in the next two weeks, after which the constitution would be distributed for broader consultation.	Trust Secretariat
8. Nominations and Appointments Committee report Governors received this report to **note**. *There being no questions or discussion, the report from the Nominations and Appointments Committee was **noted**.*	
9. Project Focus Group Meeting Accounts To receive the following meeting accounts to **note**: **a. Annual Plan Project Focus Group** Anne Ford, Governor Lead for the Annual Plan Project Focus Group, reported that there would be an extra meeting in June. She asked if she could attend this meeting even though she would no longer be a governor, as it would conclude the Annual Plan	

Page 9 of 9 of minutes of a Council of Governors meeting held on 28 April 2014 at 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

for the year. John Savage expressed appreciation for this offer. **b. Quality Project Focus Group** Clive Hamilton, Governor Lead for the Quality Project Focus Group, reported that the group had been pleased to welcome Xanthe Whittaker to the last meeting to speak on Cancer Pathways. Clive had also written a "governor review" of the performance report of the Board, which had been discussed. The next meeting would take place on 6 May and was open to all governors, and would include an update on the clinical audit team, outpatient productivity, and the Trust's Quality Report. John Steeds added that Marc Griffiths would now be writing the governor report on the Quality and Performance Report, not Tony Tanner as stated in the Meeting Report. c. **Foundation Trust Constitution Project Focus Group** Sue Silvey, Governor Lead for the Foundation Trust Constitution Project Focus Group, noted that the group would be further discussing the changes to the constitution at its next meeting. *There being no further questions or discussion, the meeting accounts were **noted**.*	
Members' Questions	
10. Foundation Trust Members' Questions To receive questions from Foundation Trust members present. *There were no questions from Foundation Trust members.*	
11. Any Other Business a) John Savage reminded governors that he had written to them all to invite them to talk to him on a one-to-one basis and he was pleased to note that some had already booked slots in his diary. b) John Savage noted that this was Charlie Helps' final meeting of the Council of Governors as Trust Secretary. He offered Charlie his sincere thanks on behalf of governors and wished him well in the next part of his career. He advised governors that an interim Trust Secretary would start on 12 May. c) Wendy Gregory asked whether Jonathan Benger, a Consultant in the BRI Emergency Department, could be approached to give a talk to governors. d) Wendy asked that the room configuration [seating arrangements for the Council of Governors meeting] be re-considered to provide a more participatory experience for governors.	Trust Secretariat
There being no further questions or comments, the Chairman thanked everyone for attending and closed the meeting.	
Date of Next Meeting: The next meeting of the Council of Governors will be held on 30 July 2014 at 13:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	

University Hospitals Bristol NHS
NHS Foundation Trust

Action Log for a Council of Governors Meeting to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Ref	Date of meeting originating action	Minute number	Description	Action by	Date to come back to Council of Governors	Date Action completed	Comments
10	28/04/2014	7	Charlie agreed to circulate the Foundation Trust Constitution to governors following incorporation of the revisions discussed. He asked for any feedback to be sent to him in the next two weeks, after which the constitution would be distributed for broader consultation.	Trust Secretariat	30/07/2014		Progress on the review of the Foundation Trust Constitution will be reported under Item 8 of the agenda.
11	28/04/2014	11c	Wendy Gregory asked whether Jonathan Benger, a Consultant in the BRI Emergency Department, could be approached to give a talk to governors.	Trust Secretariat	30/07/2014		To be incorporated either into a Governor Development Seminar (Oct 14 or Jan 15) or Health Matters Event in 2015.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 4 – Governor Elections Report

Purpose

To provide the Council of Governors with the results of governor elections, and progress in the appointment of Appointed Governors.

Report

Elected Governors: Elections to the Council of Governors of University Hospitals Bristol NHS Foundation Trust took place in May 2014. There were 14 vacancies. The governors elected were:

Public – Bristol: Bob Bennett (new), Sue Silvey, and Mo Schiller.

Public – North Somerset: Graham Briscoe (new) and Clive Hamilton.

Patient – Local: Edmund Brooks (new), Angelo Micciche and Anne Skinner.

Patient – Carer of Patients under 16: Phil Mackie and Lorna Watson.

Staff – Non-clinical Healthcare Professionals: Nick Marsh (new) and Karen Stevens (new).

Staff – Medical and Dental: Ian Davies.

Staff – Other Clinical Healthcare Professionals: Thomas Davies (new)

The terms of office of all elected governors started on 1 June 2014 and will run for three years, with the exception of Thomas Davies, whose term of office will run for two years only, as he is filling the vacancy of a governor who stepped down before their term of office ended. The full results are attached at Appendix A and Appendix B.

Appointed Governors: The following governors have been appointed or re-appointed by the Trust's partner organisations for a three-year term from June 2014-May 2017:

Bristol City Council: Bill Payne (new)

University of Bristol: Tim Peters

University of the West of England: Marc Griffiths

Avon and Wiltshire Mental Health Partnership NHS Trust: Sue Hall (new)

South Western Ambulance Service NHS Foundation Trust: Jim Petter

Joint Union Committee: Jeanette Jones

Voluntary/Community Group: vacancy

Report Sponsor or Other Author

Sponsor: Trust Secretary

Recommendations

The Council of Governors is recommended to **note** the report.

Appendices

Appendix A – UH Bristol Governor Election report 2014 – Contested Seats

Appendix B – UH Bristol Governor Election report 2014 – Uncontested Seats

ELECTORAL REFORM SERVICES

23rd May 2014

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
ELECTION TO THE COUNCIL OF GOVERNORS 2014 – REPORT OF VOTING

Our report of voting for the above election, which closed at 12 noon on Friday 23rd May 2014, is as follows:

Public: North Somerset

Number of eligible voters:		1,285
Total number of votes cast:		224
Turnout:		17.4%
Number of votes found to be invalid:		0
Blank or Spoilt	0	
No declaration form received	0	
Total number of valid votes to be counted:		224

Result (2 to elect)

BRISCOE, Graham	132	ELECTED
BURGESS, Ian Stanley	102	
HAMILTON, Clive	144	ELECTED

Public: Bristol

Number of eligible voters:		3,130
Total number of votes cast:		495
Turnout:		15.8%
Number of votes found to be invalid:		1
Blank or Spoilt	1	
No declaration form received	0	
Total number of valid votes to be counted:		494

Result (3 to elect)

BENNETT, Bob	254	ELECTED
CARE, Rae	85	
SCHILLER, Mo	253	ELECTED
SILVEY, Sue	369	ELECTED
TOWNSEND, Sylvia	135	
UPADHAYA, B.P.	124	
WALKER, Suaad	54	

Patient: Local Patient

Number of eligible voters:		3,954
Total number of votes cast:		935
Turnout:		23.6%
Number of votes found to be invalid:		5
Blank or Spoilt	5	
No declaration form received	0	
Total number of valid votes to be counted:		930

Result (3 to elect)

BEACHGOOD, Bernard Edwin 115	
BERGMANN, Alexander 299	
BROOKS, Edmund 365	ELECTED
MELENDEZ, Christine 103	
MICCICHE, Angelo.....369	ELECTED
O'NEILL-DUFF, Mick 194	
PHIPPS, Raymond 345	
SKINNER née WHITE, Anne.....755	ELECTED

Patient: Carer of Patients under 16 Years

Number of eligible voters:		533
Total number of votes cast:		17
Turnout:		3.2%
Number of votes found to be invalid:		0
Blank or Spoilt	0	
No declaration form received	0	
Total number of valid votes to be counted:		17

Result (2 to elect)

MACKIE, Philip Andrew George.....8	*ELECTED
STANTON, Shirley 7	
WATSON, Lorna 13	ELECTED

**Confirmed by re-count*

Electoral Reform Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the ballot:

a) was sent the details of the ballot and

b) if they chose to participate in the ballot, had their vote fairly and accurately recorded.

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and ERS is satisfied that these were in accordance with accepted good electoral practice.

All voting material will be stored for twelve months.

John Box
Returning Officer
On behalf of University Hospitals Bristol NHS Foundation Trust

The Election Centre, 33 Clarendon Road, London N8 0NW
Tel: 020 8365 8909 | Fax: 020 8365 8587
www.electoralreform.co.uk | enquiries@electoralreform.co.uk

ELECTORAL REFORM SERVICES

NHS

23rd April 2014

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
ELECTION TO THE COUNCIL OF GOVERNORS 2014

Further to the deadline for nominations for the above election at noon on Tuesday 8th April 2014, the following constituencies are uncontested:

Staff: Non-Clinical Healthcare Professionals 2 to elect
The following candidates are elected unopposed: Nick Marsh Karen Stevens

Staff: Medical and Dental 1 to elect
The following candidate is elected unopposed: Ian M. Davies

Staff: Other Clinical Healthcare Professionals 1 to elect
The following candidate is elected unopposed: Thomas James Davies

Elections are to take place in the following constituencies:

- Public: North Somerset
- Public: Bristol
- Patient: Local Patients
- Patient: Carers of Patients under 16 years

These will conclude in May 2014.

John Box
Returning Officer
On behalf of Berkshire Healthcare NHS Foundation Trust

The Election Centre, 33 Clarendon Road, London N8 0NW
Tel: 020 8365 8909 | Fax: 020 8365 8587
www.electoralreform.co.uk | enquiries@electoralreform.co.uk

University Hospitals Bristol NHS
NHS Foundation Trust

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

STRATEGIC PLAN 2014-19

Version 14 dated 30th June 2014

Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

Name	**Deborah Lee**
Job Title	**Deputy Chief Executive and Director of Strategic Development**
e-mail address	**deborah.lee@uhbristol.nhs.uk**
Tel. no. for contact	**0117 342 3606**
Date	**30 June 2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**John Savage**

Signature 

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	

Signature 

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	

Signature 

CONTENTS PAGE

EXECUTIVE SUMMARY

This five year strategic plan, for the period 2014-2019, sets out the Trust's forward challenges and the strategic direction and initiatives it intends to pursue, to ensure a sustainable organisation for the future. The plan builds upon the Operational Plan 2014-2016, published in March of this year, and as such should be read in conjunction with that plan.

The plan has been informed by the strategic analysis undertaken to understand the current and likely future context within which the Trust will be operating and to which any strategy must respond. This work has included both market analysis including an assessment of the threats and opportunities in the external environment alongside consideration of the Trust's current strengths and weaknesses. The response to these findings has been developed through a nine month review and refresh of the Trust's strategies for clinical, teaching and research activities and has involved Board, staff and stakeholders from across the local health economy. The Trust has informed its approach to this work by utilising Monitor's framework for assessing the robustness of strategic planning within foundation trusts.

Positively, the Trust enters the period with financial headroom to support transition towards the challenges ahead, taking forward a recurrent surplus of £14m into 2014/15. The plan describes a broadly sustainable outlook predicated upon a number of key planning assumptions, notably the assumption that the future requirement for national efficiency will not exceed 2.5% net in 2015/16 and 2% for years three to five of the plan and that tariff uplifts in this period reflect the inflationary pressures facing this sector. This includes the pressures arising from changes to pension and national insurance contributions and the costs associated with responding to the quality requirements driven by the recommendations arising from the Francis Report and similar.

The Trust has developed a methodology for assessing the sustainability of the organisation, considering the clinical, operational, workforce and financial sustainability of services and has set out the strategic and tactical responses to the issues identified that represent a risk to sustainable services within the plan; these are described both thematically in areas such as workforce but also specifically in service lines where there are specific risks to sustainable services such as specialist neonatal intensive care services.

Throughout the plan, it is noted that a sustainable future is not only predicated upon realistic funding levels and mitigation of specific service risks but it is wholly dependent upon the system, and the system partners, re-designing care pathways and services that reduce reliance on hospital based care, which in turn is expected to lead to a reduction in overall demand for services and an ability to return patients to primary and community settings as soon as their acute needs have been met. The Better Care Fund is noted to be a critical element of the system architecture if this change is to be planned, co-ordinated and implemented successfully. However, in summary the plan confirms a broadly sustainable future, noting the immediate risks to sustained operational performance in the first year of the plan which the Trust is actively managing, and which Monitor is currently reviewing.

Finally, given most failures in strategy are a failure of execution, rather than planning, development of a strategic implementation plan is in hand, which will be overseen by the Trust's Clinical Strategy Group and reported to the Trust's Senior Leadership Team.

SECTION 1 – SUMMARY AND DECLARATION OF SUSTAINABILITY

1.1 Introduction

The Trust has spent the last 6 months refreshing its strategy in the context of the challenges ahead. This approach has been led by the Board but has been supported by significant "bottom-up" input from clinical teams.

Consultation with stakeholders has been sought with mixed levels of engagement, however those that have formally responded have confirmed broad support for the direction set out i.e. to consolidate and grow our specialist offer, improve the quality of our local, non-specialist services whilst only providing in hospital that which cannot be provided outside – by us or our partners.

We have also run a number of public events to help us develop our Strategic Plans. These have focussed on helping us to understand what it is about our organisation and our services that our patients and public value, what it is that we should preserve and what it is that we should change –including specific consideration of what it is that we mean by 'hospital' and how we might need to think differently about the settings in which we deliver our care, support or advice.

We have also sought the public views via an online survey seeking their comments on a draft version of this document.

As part of the work on our 2020 strategy, we have identified what we have described as the 'future challenge'. This is relevant to both the broader 2020 strategy and the production of the Monitor Strategic Plan and it remains:

*Responding to the challenge of maintaining and developing the quality of our offer, whilst managing with fewer resources***.**

Addressing this demands three key approaches:

- Optimising the productivity and operational efficiency of our systems, processes and staff;
- Transforming the way in which we deliver care through service and workforce redesign;
- Making strategic choices that directly address the challenge.

As part of this third approach around strategic choices, we have attempted to:

- Signal new business opportunities that we might pursue;
- Identify opportunities for the development and expansion of existing services;
- Direct our discussion to the disinvestment and redesign of financially, or clinically unviable services;

- Enable cost avoidance through the strategies we execute.

Our Monitor Strategic Plan sets out the challenges we face as an organisation and as members of a community of people and organisations (the Local Health Economy (LHE)) over the next 5 years.

We have set out our position on some key strategic questions, our specific plans for the next two years, and those areas where we plan to develop – with others – longer term strategic responses to these challenges.

1.2. Declaration of sustainability

The Board declares that, on the basis of the plans and caveats as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time.	*Confirmed*

One Year Sustainability

The Trust's Operational Plan 2014-16 describes a sustainable Trust in the context of financial and clinical parameters. The key risks to sustainability set out in this period are those pertaining to operational sustainability (and associated quality impacts) and include risks to the delivery of A&E, cancer and referral to treatment time (RTT) standards and are the focus of our Operational Plan 2014-16.

Three Year Sustainability

The Board has considered its assessment of *sustainability* in the context of four domains – financial, workforce, clinical and operational sustainability. In broad terms, the Board and Senior Leadership Team assess that the Trust and its services are sustainable over the next three years.

However, in making this statement there are a number of key underpinning assumptions - set out below:

- The national efficiency requirement, delivered through tariff deflation, does not exceed 2.5% in 2015/16 and 2% per annum for the remainder of the planning period;
- The impact of the Better Care Fund does not exceed that assumed within this plan;
- There are no significant changes to activity flows in the period;
- Workforce availability remains within parameters assumed;
- The current unsustainable position on the achievement of access standards is addressed.

In addition to the above key assumptions, there are a number of known risks that we have

assumed we will eliminate or significantly mitigate as a means of ensuring the sustainability of our services and wider organisation. These are set out in the body of this plan and in summary below.

Operational Sustainability – Key Risks and Issues

The current unsustainable position on delivery of key access standards including A&E, cancer and RTT is a threat to the Trust's forward declaration and must be addressed. There are a number of strategic issues that have the potential to support or undermine this position and these include:

- The future catchment for urgent and emergency care across the wider Bristol area has the potential to be impacted by the acquisition of Weston Area Health NHS Trust - given that Weston is generally considered to have an unsustainable model of urgent care. This risk will need to be managed alongside determining the sustainable catchment area of the new Southmead Hospital, operated by North Bristol NHS Trust (NBT);

- The ongoing delivery of minor injuries services across the area; ownership of these services by UH Bristol has the potential to significantly improve the sustainability of A&E performance standards through a changed case mix reflecting a greater stream of minors as many Trusts experience;

- The Trust's cancer case mix now means the Trust has to perform in the upper quartile of trusts for all cancer pathways which given the clinically complex nature of its services, as a tertiary provider, is a challenge. Any future changes to service case mix will need to be carefully considered for their impact on cancer standards;

- Right sizing critical care capacity to reflect the volume, speciality and case mix of services operated across the Trust is key to sustainable operational and quality performance;

- Successful implementation of the revised Trust Operating Model, as set out in the Trust's Operational Plan 2014-2016 and notably a reduction in the number of patients whose discharge is delayed, to support lower levels of bed occupancy which we know to be directly related to good flow and delivery of access standards.

Workforce Sustainability

The Trust currently has a broadly sustainable position in respect of workforce however there are a number of on-going issues and risks that will need to be addressed to ensure sustainability in the medium term. These include;

- Recruitment to hard to fill specialist roles including the resolution of hard to fill consultant posts notably in the areas of paediatric radiology, cellular pathology, oncology and acute physicians;

- Minimising the adverse impact of national changes to junior doctor numbers from 2016;

- Minimising the local impact of predicted national shortages in qualified nurses over the next three years.

Clinical Sustainability

The size of the Trust means that in broad terms, clinical sustainability is achievable. However there are a number of local issues and risks that will need to be actively managed to ensure this position is maintained and these include;

- Addressing non-compliance with national service specifications where commissioner derogations have not been secured;
- Restoring trust and confidence in paediatric cardiac services and delivering those services in line with the proposed standards for care;
- Ensuring the long term viability of pathology services through resolution of the strategic options work looking at the alternative models for delivery;
- Development of sustainable models for the retrieval of children and neonates from across the region, including agreement and implementation of a sustainable model for level 3 neonatal intensive care services;
- Address the service model and associated workforce implications for dental services including the way in which teaching and care delivery are aligned, working closely with university partners.

Financial Sustainability

Positively, the Trust retains financial headroom to support transition towards the challenges of 2015 and beyond, taking forward an underlying surplus of £14m into 2014/15 and from this platform, the Trust is forecasting a balanced plan for the five year period in its *base scenario* where the national efficiency requirement does not exceed 2.5% in 2015/16 and 2% from 2016/17.

In addressing the requirement for on-going cost reductions of this scale, the following are pre-requisites to a balanced financial plan over the next five years:

- The small number of significantly loss making savings are re-designed (or divested) and losses largely eliminated;
- A sustainable service and financial model is developed for South Bristol Community Hospital;
- Tariff uplifts that reflect acute sector inflation.

Five Year Sustainability

Assuming that tariff deflation is 2.5% net impact in 2015/16 and 2% net frpm 2016/17 and there are no significant additional challenges to sustainability identified at this point, beyond those set out in the three year forward look. However, not surprisingly, statements of assurance for a period five years hence are notably difficult to make, not least given the

potential for a change in Government during this time.

The most significant risks to on-going sustainability of services beyond the three year point are considered to be:

- The extent to which tariff funding reflects the developments in practice and quality standards expected – notably the extent to which they reflect the rising expectations with regard to staffing levels;
- The impact of predicted demographic change, and community service development, on the acuity and complexity of the acute sector case mix;
- The success of the Better Care Fund (or successor approaches) to managing demand for acute sector services to levels affordable by the commissioning sector;
- Tariff uplift which reflects acute sector inflation.

SECTION 2 – OUR PURPOSE, MISSION AND VISION

The Trust has spent the last nine months working closely with the Board and its staff to re-fresh its strategy to address the challenges ahead and ensure the viability and sustainability of its services. This strategy has been developed in the context of commissioners' strategic plans and their expressed commissioning intentions. The following section sets out the refreshed mission and vision for the organisation.

University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of hospitals in the heart of Bristol, a vibrant and culturally diverse city.

We have over 8,000 staff who deliver over 100 different clinical services across nine individual sites. With services from the neonatal intensive care unit to older peoples care, we offer care to the people of Bristol and the South West from the very beginning of life to its later stages. We are one of the country's largest acute NHS Trusts with an annual income of £575m.

Our **Mission** as a Trust is *to improve the health of the people we serve by delivering exceptional care, teaching and research, every day*.

Our **Vision** is *for Bristol, and our hospitals, to be among the best and safest places in the country to receive care.*

We want to be characterised by:

- *High quality individual care, delivered with compassion;*
- *A safe, friendly and modern environment;*
- *Employing the best and helping all our staff fulfil their potential;*
- *Pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;*
- *Our commitment to partnership and the provision of leadership to the networks we are part of, for the benefit of the region and people we serve.*

The Trust's strategic objectives for this five year period have been developed to ensure the Trust's principal activities are focussed upon the five key elements on the vision. Appendix 1 sets out the Trust's strategic objectives and the milestones for the forthcoming year.

SECTION 3 - THE CONTEXT IN WHICH WE AND OTHERS MUST OPERATE AND THE CHALLENGES WE FACE

3.0. The Context

As described, the work to produce this plan has been part of, and connected to, a broader review of our Trust strategy. The summary below sets out our thinking in terms of the challenges and choices we face not just as an organisation, but as a health system.

This section includes:

- The general challenges that we and others face in our Local Health Economy;
- A summary of our market analysis (full detail available on request);
- A summary of how we have analysed the sustainability of our services.

3.1. The General Challenges we and others face

As an organisation. We have described our forward challenge as *responding to the challenge of maintaining and developing the quality of our services, whilst managing with fewer available resources.* The simplicity and clarity of message within this statement is critical to our approach to engagement of staff around a common and shared purpose.

We have recognised the need to make strategic choices that directly address this challenge.

These choices include:

- To what extent should what we do contribute to the wellness of the populations we serve as well as helping those who suffer illness? What is our contribution to making the city healthier?
- Do we still want to focus - and deepen in some key areas - our specialist services? If so, how do we decide which ones?
- What should our approach to working with other providers be to ensure resilience and diversity within our services. Leadership – both within our own organisation and across the local health economy. What is our role in the Local and Regional Health Economy? What is our role in the Local and Regional Economy?
- Do we have the right model of partnership with our patients and the wider public?

Our response to these challenges and choices has been to develop a strategic framework that sets out our position as a Trust with regard to the key choices we face. This framework is included in Section 4.2 of this plan and is already being used to assess strategic choices we are considering now.

3.1.2 As part of a wider health system. We have also considered challenges faced by our Local Health Economy (LHE). We believe these to be:

- Changing the way in which the whole health and care system works, not just the individual organisations that comprise it. We are clear that we will need to think in new ways about the way in which resources are allocated across the health and care system, to align incentives that drive the right services and outcomes for patients and use this discussion as a way to drive changes to the structure of the system both in terms of how we collectively plan and how we organise the provision of care delivered by multiple providers;

- More specifically, we need to work together even more effectively to reduce the requirement for hospital services, by eliminating unnecessary admissions to hospital and also working better together to ensure that people do not stay longer in hospital than is necessary – and in particular that they can leave hospital when they no longer require hospital based care;

- We accept and embrace the need for change, but need to find ways to be bolder in the changes we seek and notably in our effectiveness to execute our whole system strategies and plans. Our current approach is incremental and based on marginal improvements to the current operating model at system level. This is likely to require us and our partners to be less risk averse in the way we work together and the changes we seek;

- Finally, we must avoid becoming fixed by physical location. What we refer to now as a hospital is one component of a broader network – physical and virtual –that makes up the health and care system. We need to find ways to build capability across all the different aspects of this system, including physical locations but also the networks of information and influence which also help us promote health or treat illness. Technology will have a huge part to play in supporting new ways of working, connecting providers involved in single pathways and supporting the vision of a single electronic patient record, accessible by all health and social care providers.

3.1.3 Some specific challenges in the next two years (a summary of analysis in our Operational Plan)

As well as the (medium term) issues above, we must also deal with a number of specific and pressing challenges in the short term (over the next two years). The way in which we deal with these is the subject of our Operational Plan 2014-2016, published in March of this year. Short term challenges include:

- Retaining our focus on quality as the underpinning requirement for the delivery of all our services and the key component of our reputation – and ensuring that we are compliant with the newly developed range of specifications for the provision of specialised services;

- Rising to the considerable operational challenges in the next two years across the acute sector of Bristol, we are opening two major new facilities, which together have the potential to improve significantly the services available to our local and regional populations - but we face a collective challenge in terms of ensuring that the transition to new operational models across the city is achieved smoothly;

- Accordingly, it is crucial that we find ways to take greater control of the urgent care pathway (Emergency Care) – including developing appropriate and sufficient capacity in social and community provision across our Local Health Economy;

- With regard to the Better Care Fund, there is the challenge of releasing approximately £30m of savings from within the acute sector across Bristol, North Somerset and South Gloucestershire, which are currently assumed. And second, there is the related challenge of avoiding double costing in the short term – a potential situation where costs continue to be incurred within the acute sector at the same time as the new costs of a service designed to either replace acute provision or reduce the requirement for acute services is also being borne.

In summary, the challenges of the next five financial years demand that we work more effectively across the Local Health Economy to address operational and financial challenges. We are already well focused on working with commissioners at both local and regional level as their understanding of their own objectives is developing – but we are also working to broaden the scope of our collaboration in the next two years in particular, including with local authorities and others via the Better Care Fund initiative.

3.2 Market Analysis

As well as the general analysis shown above, we have also conducted market analysis as part of the work to produce this strategic plan. The key points are summarised below.

3.2.1 Population - key messages:

- University Hospitals Bristol provides regional and tertiary services to a population of circa 5.3 million across the geographically and economically diverse South West region of England;
- Whilst the region has some of the best life expectancy in England, there is also a mixed picture of health in Bristol and the wider region, where the health of the population in deprived areas is poor;
- Bristol has one of the fastest growing populations of the English Core Cities, including a higher than average rate of growth in the child population;
- Neighbouring areas are seeing a high growth in elderly population. Bristol will see a 9% growth in the elderly population to 2020, but this is lower than the national projection of 23% whilst North Somerset is predicting growth in excess of 20% relating to expected housing expansion;
- Life expectancy is increasing, and it is projected that there will be a relatively large increase in people aged over 90 years in Bristol; health and social care requirements, especially in relation to people living with dementia and long term conditions, will therefore increase;
- Death rates in Bristol show that cancer, stroke and heart disease remain the highest causes of early deaths; early death rates from cancer remain significantly higher in Bristol than the national average. Smoking, alcohol and drug abuse account for a larg***e***r proportion of deaths/long hospital stays in Bristol than the national average.

Summary of Implications – The demand pressure for local services provided by the Trust will continue to grow, if external factors do not change. Despite a lower than average growth in older population, demand for services across Bristol will still grow. Further pressure will be felt by the faster than average growth in the younger population, which will put pressure on the growing portfolio of children's services. It is also concluded that demand for the Trust's specialised services such as Cancer and Cardiology services will grow relating to the ageing population.

3.2.2 Commissioning – key messages

- Affordability for acute sector activity and required developments continues to challenge commissioners. Regionally, NHS England is significantly over-committed on its expenditure for specialist services and locally, two of our three commissioning groups are in deficit and one significantly funded below its target resource level;
- In 2013/14 the highest proportion (47%) of income was derived from activity commissioned by BNSSG Clinical Commissioning Groups, with 40% being commissioned by NHS England Specialised Services commissioning;
- Commissioners continue to introduce efficiency measures, including net reduction in PbR and non-PbR tariff, whilst maintaining a focus on improved quality arising from reviews such as Francis and Winterbourne View;
- There will be fewer, bigger CQUINs at a local level. At a national level, in 2014/15 the pot of money available from CQUINs attributable to NHS England has reduced as PbR Excluded Drugs and Devices are not included in the contract value to which CQUIN applies;
- There will be a focus from commissioners on 7-day working and improving the city wide urgent care system, including Ambulatory Care, GP support unit and full utilisation of South Bristol Community Hospital;
- NHS England will focus on compliance with national service specifications, and whilst some investment has followed, non-compliance in many areas rests with the Trust to address;
- Contractual standards, with penalties for non-achievement will be an increasing feature of the commissioning landscape.

In summary, commissioners are facing increasing financial challenges, and their expectation is that trusts will need to share the burden of efficiency whilst aiming to drive up quality. This presents a significant challenge to the Trust in terms of viability of services and sustainability in terms of workforce and clinical quality. There will be both financial and non-financial impact from any ongoing non-compliance with national service specifications, which needs to be accounted for when considering the sustainability of certain specialties.

3.2.3 Activity trends – key messages

- The highest increase in admissions, in the last five years, has been from North Somerset, arising from an increase in population, most notably Portishead area.

- Admissions for patients aged over 75 have increased significantly in the last year from North Somerset and South Gloucestershire, showing the growth in elderly population playing out in the demand for our services. This is matched by the increase in Emergency Department attendances from those areas;
- Outpatient attendances see a similar trend, with a reduction in the proportion of attendances from Bristol CCGs and an increase from North Somerset and South Gloucestershire CCGs.

Summary - Evaluating the risks to sustainability of services needs to take account of the shift in activity trends but also the local priorities for North Somerset and South Gloucestershire. A shift in focus from those areas towards other services and/or service providers will impact on market share and potentially sustainability.

3.2.4 Market share – key messages

- There have been significant changes in market share but overall the Trust maintains a strong position locally and regionally. The greatest changes are attributable to recent service transfers including Head and Neck, Breast and Urology services;
- Gains in BNSSG commissioned work include Gastroenterology, Cardiology and Obstetrics;
- Losses in BNSSG commissioned work include Midwifery episodes, General Medicine, Upper GI surgery, A&E, Clinical Haematology and Ophthalmology. Gains across the South West include A&E, Obstetrics, Paediatrics (excluding transfer), and Thoracic surgery.
- Losses across the South West include Midwifery episodes, Clinical Haematology and Cardiology (although on the last two points the Trust remains in a strong market position);
- Across the South West, UH Bristol remains the main provider of Cardiac surgery (58.7%), Paediatric Surgery (98.4%) and Thoracic Surgery. Plymouth Hospitals NHS Trust is also a major provider in Cardiac and Thoracic Surgery and remain the main competitor for specialist service provision in the Peninsula.

Summary - UH Bristol remains strong on a number of fronts and should build on this strength in the face of competition from other providers. Ophthalmology presents a key risk, in light of local competition from both Royal United Hospitals Bath and the independent sector but the Bristol Eye Hospital brand remains strong.

3.3 Assessing the Sustainability of our services

3.3.1 Our Understanding of Sustainability

To support this assessment of the current resilience and future sustainability of the Trust and our services, we have developed a framework to analyse the current and future position. This framework is included at Appendix 3 for reference. The framework is based on three

components of sustainability, listed and described in brief below.

Component 1 - Market and Demand Sustainability

This component of sustainability of services relates to the rationale for continued provision of the service – the current demand, how the need for care is going to change and develop, the existence and intentions of competitors, and the views and plans of commissioners.

Component 2 – Clinical and Quality Sustainability

This component of sustainability of services relates to the key clinical and quality elements of a service. The key elements of analysis in this section will include compliance with standards and service specifications, our ability and preparedness to response to recommendations arising from national reports such as Francis, alongside current performance against key measures of quality.

Component 3 – Operational Sustainability

This component of sustainability relates to those things required for the day to day delivery of services to performance standards and clinical requirements and includes finance, workforce and estate issues.

Component 3a –Financial Sustainability

This is a sub-set of component three and utilises insights from both service line reporting (an assessment of profitability) alongside reference cost indices (an assessment of cost efficiency) to assess the current viability and on-going sustainability of individual services.

3.3.2 Identifying our Key Service Lines

Having developed an approach to sustainability, we have categorised our Key Service Lines at Trust Level. These key service areas are:

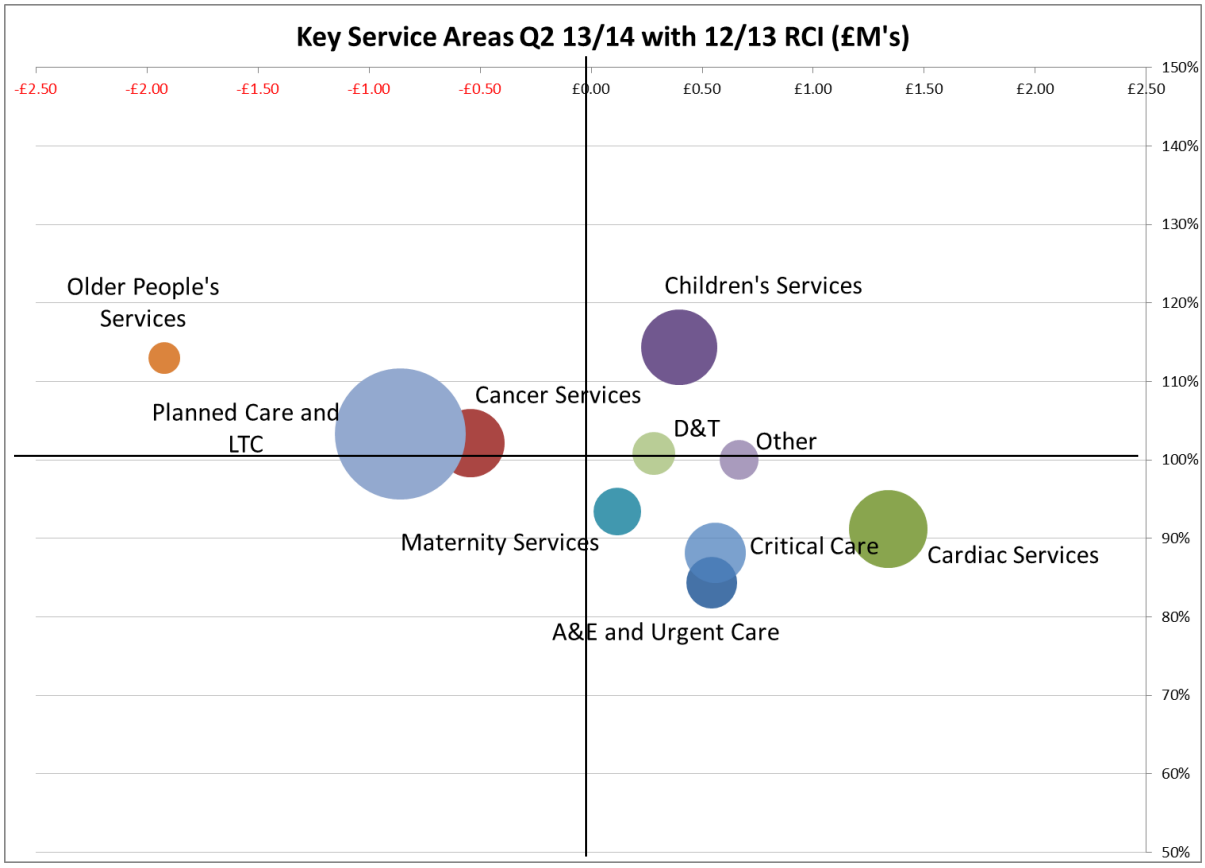
- Children's Services;
- Accident and Emergency (and Urgent Care);
- Older Peoples Care;
- Cancer Services;
- Cardiac Services;
- Maternity Services;
- Planned Care and Long Term Conditions;
- Diagnostics and Therapies (Radiology and Cellular Pathology in particular);
- Critical Care.

The starting point for our analysis has been to construct a top level summary of the risks to the sustainability of these key service areas using the sustainability framework developed and included here at Appendix 3. A summary of this analysis is at Appendix 4.

3.3.3 Working through our Sustainability Framework - Financial risk as a starting point

Using the framework we have developed, the work commenced with a more detailed analysis of risk with financial risk because this is one of the most obvious ways in which the potential unviability of a service can be understood. The overall financial position with regard to each of the key service areas described above is shown below.

The x axis shows deficit or surplus in £millions. The y axis shows Reference Cost Index (RCI). The size of the bubble is determined by income, used as a proxy for the financial importance of a service. Please note this chart is based on Quarter 2 2013/14 income and SLR information and 2012/13 RCI.



In order to generate this chart we have mapped the SLR reporting onto these service areas using a structure shown at Appendix 5. This presentation shows how each of our specific service lines maps onto the nine key service areas that we have identified.

The approach uses RCI alone as the best indicator of medium term financial sustainability of a service due to the impact of tariff changes over time, on SLR. Appendix 5 shows the RCI of each service line with services listed in descending order of RCI. Please note that this table is based on 2012/13 RCI data.

Further categorisation and our analysis of service lines on the basis of RCI has occurred and is described below:

- Less than 95 – These are services that we provide more efficiently than our peers

and might consider expanding as part of our Strategic Plan;

- 95 to 105 – These are services we provide at similar levels of efficiency to others;
- 105 and above – These are services which may be unsustainable from a financial perspective in their current configuration - and we must develop a strategic response to this challenge, and describe it in our strategic plan.

The group of services with RCIs of 105 and above (as at the end of FY 2012/13) have been highlighted in red at Appendix 5.

3.3.4 Initial Analysis of Clinical Risk –Service Specifications and Derogation.

We also conducted some general analysis of clinical risk with regard to specialised services compliance. This is summarised below.

Background

As at April 2014, NHS England listed 85 specialised or highly specialised services being commissioned by University Hospitals Bristol NHS Foundation Trust[1]. At this time, UH Bristol had declared that it was not fully compliant with the key requirements in 17 specifications (this equates to 20% of the specialised services which UH Bristol provides, which is in line with the national picture of compliance, confirmed by NHS England in February 2014).

Reasons for non-compliance include not meeting specific workforce requirements, not having appropriate facilities (particularly for children), process and systems not in line with specifications etc. In some cases, internal and external investment proposals were required to move towards full compliance with the key requirements. Service transfers and redevelopment of the Trust's estate, notably the Children's Hospital and Oncology Centre, will resolve some of the areas of non-compliance, particularly for Teenage and Young Adults (TYA) cancer services and paediatric neurosurgical services. Confirmation has also subsequently been given by NHS England that paediatric haematology rotas meet, subsequently revised, key workforce requirements.

There is ongoing derogation in respect of adult respiratory specifications which are currently under review nationally. An assessment of compliance with the revised specifications will be undertaken when published.

Of the 13 remaining service specifications where compliance has been derogated (accounting for 19 key requirements), three have been accepted by commissioners fully as derogations for which they are responsible (this includes vascular services which is pending its transfer to North Bristol NHS Trust). A further two services, paediatric and neonatal retrieval have received additional investment from commissioners which will address compliance in part, though there is recognition that further investment is needed to ensure full compliance, and commissioners have accepted responsibility for the derogations for these services also. There are therefore five commissioner derogations in total and the Trust is actively working on remedial plans to address all other areas of non-compliance.

[1] Position prior to transfer of specialist paediatric services from North Bristol NHS Trust

Risk

If the Trust does not achieve compliance there is a risk of remedial action through contract mechanisms and potentially financial penalties in the short term. In the longer term, depending on the scale of non-compliance and where the Trust is clearly an outlier, there is a risk that commissioners may choose to decommission services.

Mitigation

The services which remain non-compliant need to achieve compliance through additional internal or external funding (service development or activity funded – some of which has already been agreed for 2014/15), service reconfiguration or completion of existing action plans.

Chemotherapy e-prescribing for children remains an outstanding issue. Whilst this is being taken up nationally through the relevant specialised commissioning routes, this remains provider derogation and work is in hand to develop an action plan to take us towards compliance.

3.3.5 Identification of Specific Service Lines carrying major sustainability risk.

Having considered the sustainability risk to broad service areas, we then identified specific service lines which in our judgement are carrying sustainability risks across a number of different components of our sustainability framework. These specific services are set out at Appendix 4.

SECTION 4 – RESPONDING TO THE CHALLENGES WE HAVE IDENTIFIED

Having considered the context within which we operate, the challenges that we and others face, we conducted market analysis and considered the future sustainability of our services, and have chosen to respond in two broad ways.

The first has been to consider the choices we face and to set out our position in a way that creates clarity for people both within our own organisation and also people and organisations with whom we work across the Local Health Economy.

These statements, which together comprise our **strategic framework**, are set out in the first part of this section – along with a declaration of our **strategic intent**.

The second set of responses describe **what we plan to do** – and is the subject of the second part of this section (4.3 onwards). Here, we describe our plans in terms of:

- Our general approach to the key components of our mission and vision;
- A summary of our priorities in the short term and key elements of our operational plan for the next two years, and;
- The strategic initiatives that will address the challenges we, and others, face over the next five years (to 2020).

4.1 Our Strategic Intent

Our Strategic Intent

Our strategic intent is to provide excellent local, regional and tertiary services, and maximising the mutual benefit to our patients that comes from providing this range of services.

Our focus for development remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare.

As a University teaching hospital, delivering the benefits that flow from combining teaching, research and care delivery will remain our key advantage. In order to retain this advantage, it is essential that we recruit, develop and retain exceptionally talented and engaged people.

We will do whatever it takes, within the resources available to us, to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or out sourcing services that others are better placed to provide and delivering new services where patients will be better served.

The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way; however, where our patients' needs are not being met, the Trust will provide or directly commission such services.

Our patients – past, present and future - their families, their carers and other

representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide "high quality individual care, delivered with compassion" will be judged by them.

4.2 Our Strategic Framework – Our Position on the key choices we face

The purpose of this framework is to provide clarity on our position to those with whom we work, and to provide our own staff with guidance to shape the individual choices that they face in developing their own plans. It reflects the broad strategic intent of the Trust Board, and is set out in summary in the statements below.

To what extent should what we do contribute to the wellness of the populations we serve as well as helping those who suffer illness? What is our contribution to making the city and region healthier?

Our Position: In the course of delivering our "core" business, there are many opportunities to influence the health of the patients we treat, and importantly their families; any future service strategy should embrace these opportunities in more systematic ways. In particular, we want to work with others on those areas where we have a direct impact on people's requirements for the services we provide.

Do we still want to focus - and deepen in some key areas - our tertiary (specialist) services? If so, how do we decide which ones?

Our Position: Delivery of specialist services is a key part of the Trust's strategic intent. We are uniquely placed to be the provider of choice in the South West region for many specialist services. Our decision to expand our existing services or develop new should be based upon our ability to deliver services to the right standard and within the resources commissioners are willing to pay. UH Bristol should not proceed to diversify into specialist service areas already provided in the City other than in the case of an agreed service reconfiguration.

Out of hospital care – should we influence, commission or provide?

Our Position: We have no plans for the wholesale diversification into general community services provision. However, where existing community providers cannot meet the Trust's needs (and the needs of our patients for timely discharge) for community services that support our in-hospital services, there is a strong case for the Trust delivering or directly sub-contracting these services and we will do so if necessary.

Are there geographical limitations to our "DGH" offer – how would we describe the catchment area for this element of our service?

Our Position: The strategic rationale for expansion of our DGH catchment beyond BNSSG[2] is weak and as such we plan that this will remain our defined catchment. Any proposal to expand DGH services within this catchment will only be considered because of a well evidenced, positive contribution to the Trust and/or Divisions strategy or operational plan and

[2] Bristol, North Somerset and South Gloucestershire.

where safety, quality, operational and financial impact, are all acceptable.

Should we drive the development of our services under the UH Bristol@ model outside of our current catchment?

Our Position: Given the operational complexity associated with remote delivery of services, the UH Bristol@ model will be considered where the following key "qualifying conditions" have been met – the development is strategically aligned, it delivers a significant financial contribution to the service and safety, quality and operational impacts are all manageable.

What should our approach be to 'outsourcing' what we have always regarded as core business? In principle, is the Trust supportive of outsourcing (core) clinical services?

Our Position: In principle where there is a financial and operational benefit to outsourcing a clinical service it should be considered – however the "burden of proof" that this will not impact detrimentally on the service being outsourced or those retained in-house, which rely upon an outsourced service, will be necessarily rigorous.

Does the Trust support divesting in services it currently provides?

Our Position: Central to our decisions about service configuration should be the interests of patients. Services should not be divested simply because they operate at a loss. If the service in question is strategically aligned to the Trust's portfolio or is interdependent to other services then the priority should be to re-design the service to eliminate or reduce losses. However, where patients would be better served by a service being run by another organisation, divestment will be actively considered.

What is the Trust's approach to partnership working? Compete or collaborate?

Our Position: Despite the national policy context, there is limited local evidence that competition in the local health system has driven up quality or lowered cost. Where our aims and objectives can be achieved through working collaboratively with other organisations – NHS, independent, third sector - then this should be our default way of working.

The Trust recognises the value of working in partnership but also recognises the complexity and loss of agility and pace often associated with partnership working. Not all the work we do will be in partnership, but we will always seek this approach where there is evidence that patients will be better served – and the Trust's objectives will be better met (or only met) - by working in partnership.

Do we have the right model of partnership with our patients and the wider public?

Our Position: The "modus operandi" for working with our patients, with members and with the wider public is ill-defined and does not currently constitute a major Trust activity. However, recent events have served to highlight the importance of putting patients, their representatives and families at the heart of our approach to planning, delivering and evaluating services.

4.3 Our general approach - how we will deliver our mission and achieve our vision?

4.3.1 Our approach to delivering exceptional care

Our quality objectives for the next two years will focus upon:

- Working with people, to ensure that through their insights, we are well placed to provide a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm;
- Achieving clinical outcomes for our patients that are consistently in the upper quartile of comparable Trust performance.

We are committed to addressing the aspects of care that matter most to our patients which they describe as:

- Keeping them safe;
- Minimising how long they wait for hospital appointments;
- Being treated as individuals by all who care for them;
- Being fully involved in decisions about their care;
- Being cared for in a clean and calm environment;
- Receiving appetising and nutritional food;
- Achieving the very best clinical outcomes possible for them.

Like all NHS organisations the events and subsequent learning from Mid-Staffordshire, the Berwick Report and Keogh Reviews have shaped our approach to quality and more specifically how we listen and engage with our staff and our patients. We have published our response to the Francis and other reports, and in the process of working on this we identified a number of further issues that we also plan to address, including: perceived variation in attitudes to openness and sharing across the Trust, listening and learning more effectively throughout the Trust following incidents and near misses and making the process of change easier, and more rapid, across the Trust.

4.3.2 Our approach to delivering exceptional research

Our vision for research is to improve patient health through our excellence in world-class translational and applied health services research and embedding a culture of innovation.

Our approach has been shaped by recent national changes in funding that have encouraged and facilitated academics and NHS researchers to work closely together in larger and integrated multi-disciplinary teams. This integration and the focus on translational and

applied health services research has attracted additional infrastructural and programme grant funding and has also highlighted the need to promote the clinical research skill base in professions other than medicine.

The response by the Bristol healthcare research community over the last four years to the above changes in the national applied health services and biomedical research agenda has been transformational. We have worked with partner universities and NHS trusts in the region to form Bristol Health Partners (BHP), which was formally launched in May 2012. The aims of BHP are to generate significant health gain and improvements in service delivery by integrating, promoting and developing Bristol's strengths in health services, research, innovation and education. The way BHP is delivering these aims is to form Health Integration Teams (HITs). HITs include commissioners, public health and NHS specialists working with world-class applied health scientists and members of the public to develop NHS-relevant research programmes and drive service developments to improve health, well-being and healthcare delivery.

The strengths of BHP and its HITs have directly led onto to the recent award of an NIHR Collaboration for Leadership in Applied Health Research and Care for the West of England (CLAHRCwest) that is focused on research that is targeted at chronic diseases and public health interventions.

The research and implementation themes of BHP and CLAHRCwest dovetail with the stated aims and objectives of the West of England AHSN (WEAHSN) of the need for robust research to inform and accelerate the adoption and diffusion of evidence of best care. All three organisations are committed to active dialogue and reciprocal communication, seeing research and implementation as symbiotic. The above research and implementations workstreams will be facilitated and further strengthened by the new NIHR west of England clinical research network (CRN) hosted by UH Bristol.

Our Research and Innovation strategic objectives are to:

- 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;
- 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;
- Develop a culture in which research and innovation are embedded in routine clinical services leading to improvements in patient care;
- Work with our regional partners to strategically and operationally align our research and clinical strengths and support the delivery aims of our Health Integration Teams.

4.3.3 Our approach to delivering exceptional teaching

Our vision is to develop a culture of lifelong learning across all staff groups; ensuring

teaching is aligned with the values, synonymous with quality, cost, performance and the delivery of high quality individual care delivered with compassion. We wish to position ourselves as the premier provider of multi-professional student and staff education, teaching and learning to deliver the best clinical care. We work closely with our academic partners, University of Bristol, University of the West of England and other Higher Education institutions to achieve this.

With the changing nature of healthcare, competition in the market place and financial pressures, we have seen significant changes in placement capacity across the region in recent years. To address some of these fluctuations, UH Bristol has implemented changes within the undergraduate medical education provision with the development of clinical teaching fellows to improve the student experience.

UH Bristol is responding to the Health Education England funding review by working closely with our academic partners and local stakeholders to identify the best and most effective model for education provision for the future NHS workforce.

Our primary aim is to focus on creating and supporting the capabilities needed to provide high quality individual care, delivered with compassion.

The Trust acknowledges that with the increased technology, equipment and therapies, together with the development of new clinical specialities there is an increased knowledge and expertise required by health professionals within the Trust. Our main priority is to build the capability of all our staff, ensuring we design and commission appropriate teaching and education to enable staff to fulfil their potential.

We are modernising and investing in the education and teaching structure to ensure the entire workforce is equipped with the requisite skills and knowledge required to:

- Work as a team across professional and organisational boundaries, enhance the delivery of high quality, cost effective care to patients and their families under the care of UH Bristol;
- Maximise the contribution of all health staff to care for patients and their families, breaking down the historical barriers associated with role definition, ensuring that the individual practitioner best suited to deliver care is able to do at the time it is required;
- Support new ways of working and expanding the training and development of all practitioners.

Our Teaching and Learning strategic objectives are:

- To expand and develop our multi-professional education and training strategy to ensure we integrate teaching fully with research and clinical care;
- Develop a culture in which education and training are embedded in clinical practice to ensure optimal quality patient care;
- Through teaching, generating a workforce that is able to deliver services to the

broader health community outside of the Trust;

- Work with our local and regional hospitals, higher education and other educational institutions to provide and deliver robust, evidence-based training and education for all health care professionals;
- To develop innovative and creative strategies to generating new income to re-invest into UH Bristol NHS Foundation Trust Teaching and Learning services.

4.4 Our Priorities in the short term

The Trust Board maintains oversight of the Trust's core business activities and strategic objectives through the Board Assurance Framework (BAF) which also sets out detailed responsibilities for delivery and accountability at Executive level. The BAF is included at Appendix 1. Our Board level objectives in the medium term form the first part of our five year strategy and are listed below. They are structured according to the elements of our Trust Vision, and are as follows:

We will consistently deliver high quality individual care, delivered with compassion.

- To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model;
- To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners;
- Deliver a programme designed to enhance compassion in clinical staff;
- To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice;
- To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well;
- To achieve upper quartile performance in process and outcome measures for the Friends and Family Test (FFT);
- To ensure the Trust's reputation reflects the quality of the services it provides;
- To achieve upper quartile performance standards for all nationally benchmarked patient safety measures.

We will ensure a safe, friendly and modern environment for our patients and our staff

- To successfully deliver phase 3 and 4 of the BRI Redevelopment;

- Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audits have been implemented;
- Set out the future direction for the Trust's Estate;
- Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards.

We will strive to employ the best and help all our staff fulfil their individual potential.

- We will ensure that the workforce feel highly engaged and empowered by implementing a range of agreed actions to develop staff in their place of work and demonstrate a year on year improvement in the annual staff survey engagement score;
- We will take appropriate action to reduce the incidences of work related stress by introducing a number of measures that support all staff to undertake their role safely;
- We will equip our leaders with the requisite skills, behaviours and tools to develop high performing teams, so staff have objectives with a clear line of sight to the Trust's vision;
- We will revise the Teaching and Learning strategy to ensure the strategic priorities support an attractive and viable learning environment whilst continuing to provide exceptional care to our patients.

We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.

- Implement modern clinical information systems in the Trust;
- We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR and maintain our performance in initiating research) and remaining the top recruiting Trust within the West of England Clinical Research Network and within the top 10% of trusts nationally (published annually by NIHR);
- We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR);
- We will demonstrate the value of research to decision makers within and outside the Trust.

We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.

- Ensure organisation support for developments under the Better Care Fund;

- We will effectively host the Operational Delivery Networks that we are responsible for;
- We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care;
- We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network.

We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal

- Deliver minimum normalised surplus;
- Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas;
- Deliver minimum cash balance;
- Deliver the annual savings programme in line with the Long Term Financial Plan (LTFP) requirements;
- Refresh the Trust's Strategy including its direction for research & innovation and teaching & learning;
- Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decisions as they arise;
- Continue to develop the private patient offer for the Trust.

We will ensure we are soundly governed and are compliant with the requirements of our regulators

- Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above;
- Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in policy and practice;
- Robustly prepare for the planned Care Quality Commission inspection;
- Prepare for and achieve a successful outcome from the proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Quarter 2 2014/15;
- Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways;
- Improve cancer performance to ensure delivery of all key cancer targets.

4.5 Key Elements of our Operational Plan

As well as the Trust objectives listed in Section 4.4, we also maintain a specific focus on the key delivery elements of our Operating Plan and associated Operating Model that are necessary to address the short term challenges we face, through oversight in both the transformation work stream and the Senior Leadership Team.

Our Operational Plan has already been submitted (and published) and for ease of reference the key elements are included at Appendix 6. Again, these activities form a significant part of the first 18-24 months of our Strategic Plan.

SECTION 5 – OUR STRATEGIC PLANS

Our strategic plan focuses on the medium term and is organised around five key strategic initiatives, which are outlined below. These initiatives will provide the shape of planning activity for the Trust in the next few years as we firm up plans beyond the next two financial years. They represent the key areas of work for the Trust in strategic terms and describe where it is that we want to drive change and how.

5.1 Strategic Initiative 1 - Driving Engagement and Collaboration across the Local Health Economy

The Aim of this initiative is to:

Deal with the challenges that we and others have identified at system – and not organisational - level.

Our Strategic Plans in this area are:

- **Collaborating more ambitiously in operational terms in order to plan and operate the acute (hospital based) system – and Urgent Care in particular – in a collaborative way.** Specifically, we need to work together to ensure that new facilities in the region (Southmead and the redeveloped BRI) are utilised in a way that is focused on creating system, and not organisational, benefit and that the development of services in community and primary care is focused upon reducing the current reliance on hospital based care;

- We will set up a cross system **forum for the promotion of cross system strategic planning** and the deliberation and sharing of organisational plans. This forum will meet for the first time on the 13th of July;

- We plan to use this forum to explore a series **of 'Bristol scenarios'** that we will develop jointly with commissioners and local authorities and which will be the basis for joint strategic planning and the 'stress-testing' of organisational plans;

- **To focus on the greatest opportunities for improving the quality of local care** in the context of declining resources by the pursuit of more integrated services between acute, community and social care sectors;

- **To consider specific findings of the Acute Services Review** (summarised at Appendix 7). We remain committed to working with our acute hospital partner, North Bristol NHS Trust, and local commissioners, towards the consideration of which of the findings in the review merit implementation and how we should prioritise those we decide to take forward;

- **Continue to work together more effectively to reduce the requirement for hospital services**, by eliminating unnecessary admissions to hospital and also working better together to ensure that people do not stay longer in hospital than is necessary – and in particular that they can leave hospital when they no longer require hospital based care. Our focus for this work is the Better Care Fund. A

summary of the current plans in the Bristol Better Care Fund is given below.

We assess that the impact of these plans will be:

- **Greater coherence and consistency in the strategic planning** being done by major partners across the health economy (in particular other Trusts and CCGs) and a filling of the perceived vacuum in system wide planning which has materialised since revisions to the commissioning landscape two years ago;
- **A system wide response to the current challenges being felt across the local urgent care system** and a new integration of the provision of services, to older people and children in particular;
- We have **yet to confirm the potential benefits of the Better Care Fund** in terms of reducing hospital admissions but whatever benefit is accrued will also be balanced by a reduction in income. Our general mitigation of that impact however will be to increase income from our specialist provision – consistent with our stated strategic intent and recent trends. As a specific issue, there is also no current provision for potential 'double running' of costs as the out of hospital capability that will drive down hospital admissions is developed. This risk is considered to primarily be a risk for funders of care.

In Bristol, the Better Care Fund provides £3.8bn in 2015/16 for local health and social care within a newly created pooled budget to drive integration at scale and pace, providing a significant catalyst for change. The Better Care Fund Programme assumes a disinvestment of £15m from the acute sector across Bristol local authority area for future investment in community services and support. The fund has been developed to;

- Drive integration, partnership working and service transformation;
- Improve quality of care and outcomes for patients, service users and carers, by ensuring the right care, in the right place, at the right time;
- Give people greater control, place them at the centre of their own care and support, and provide them with a better service and quality of life;
- Help us manage pressures and improve long term sustainability;
- Enable a significant shift of care closer to home.

An increasing demand for quality services requires UH Bristol and other local partner organisations to work differently with a focus on providing (in particular):

- Single point of contact to access services from all agencies;
- Increased use of key workers who can operate across all agencies;
- Seamless transition from one service to another for users.

As a system, the vision is that by 2018, there will be better outcomes for users, which may include; personal health budgets, online appointments for patients, greater use of assistive technology and tele-health, and integrated care packages with lead accountable person.

This will be achieved through shared working to integrate information, staff, funding and

risk. Areas that have been identified include joint forecasting and modelling, shared data (CCG, Acute Trusts, and Council), 7 day working, joint rehabilitation and reablement teams, generic job roles, and joint discharge co-ordination centres in UH Bristol and NBT.

This work should help us as a Local Health Economy to:

- Shift Settings of Care closer to home;
- Reduce length of stay in hospital;
- Help users manage their care more effectively and;
- Provide more effective use of staffing and resources at a neighbourhood level.

The first draft of the action plan was submitted on 14th February 2014 and was supported by all partner organisations. The first phase of this work will focus on the integration of services for people with long term conditions and older people but the aspiration is that this will broaden over time to include other areas in adult, children and family services.

There is recognition that as services are transformed and move from one model to another, there is likely to be an increase in existing costs initially to support double running of services as it will not be possible to stop one model and implement a new one instantaneously. We are assuming that any implications for acute trusts resulting from the Better Care Fund Programme will be incorporated into future contract discussions**.**

5.2 Strategic Initiative 2 - Identifying and dealing with issues of sustainability

The Aim of this initiative is to:

Address the risks we have identified to the sustainability of our key service areas and to specific service lines. We also aim to use this opportunity to consider changes to our workforce model in the medium term.

Our Strategic Plans in this area are to:

- **Continue to focus on 'right-sizing' capacity of service lines** to match demand more closely and address Reference Cost Index (RCI) where it is high (see Section 3.3.3);

- **Re-examine the service mix which we deliver at South Bristol Community Hospital**, specifically recognising the longer term unsustainability of the current financial model for that group of our services. This work will be conducted over the autumn of 2014;

- **Address identified risk to the sustainability of key service areas or specific service lines**. Specifically we plan to redesign those services where sustainability risks are identified and notably to develop plans to address those services that out lie in respect of their financial sustainability highlighted by either their high cost base, as highlighted by their Reference Cost Index or their profitability, as indicated by their financial contribution demonstrated by Service Line Reporting analysis. A narrative

description of our strategic plans by key service area – and where appropriate by specific service line - is below;

We assess that the impact of these plans will be:

- **Addressing high RCI**. We are committed to reducing the RCI to 100 or less for all those services shown in red at Appendix 5. If delivered, this will result in approximately £29m of savings between 2016/17 and 2018/19;

- **Addressing broader sustainability.** We are confident that we have identified the issues that present a risk to the sustainability of our services. We have a number of current plans in place to address these issues but we also recognise that there are a number of further plans that need to be developed across all of our service areas in order to address sustainability in the medium term. We undertake to produce these plans by the summer of 2015, primarily as part of the next round of our business planning. That said, the speed at which we can work to develop these plans will depend on the speed at which we can work with others across the health economy – and in some cases this will take more than the next 12 months.

THE SUSTAINABILITY OF KEY SERVICE AREAS

Children's Services

Key issues in terms of the future sustainability of these services are linked to the growth in child population and the impact that will have on all services in the city. Alongside this is a growing sense that those presenting to our hospitals are more sick and their conditions more complex. Workforce issues, such as recruitment and retention of middle grade doctors, nursing and consultants in critical care, interventional radiology and paediatric pathology alongside continued efficiency requirements in the NHS will therefore make it harder for the Trust to achieve its objectives for sustainable, safe and excellent Children's Services.

Currently, our plans in place to address these issues include:

- Efficiency and savings programmes to address high cost services;
- Workforce and role redesign to fill skills gaps in "hard to recruit" services and roles;
- Considering our role in community paediatric services as a means of creating greater economies of scale and driving more integrated care provision to improve flow through specialist services;
- Focussed investment in key service requirements.

We will develop further plans (by summer 2015) to improve the sustainability outlook in years 3-5. We will particularly focus on:

- Improving links both in secondary care and across the health and social care system to stem the flow of patients into acute care;
- Improve our approach to the use of technology and innovative solutions;
- Recruitment and retention strategy, taking account of alternative workforce models;

- Building upon the opportunities, that the recently transferred services provide for further growth in both NHS and private work.

By 2020 we aim to have a reduction in reference costs where this is appropriate, a stable and effective workforce and system wide relationships that ensure the appropriate use of the Bristol Royal Hospital for Children.

Finally, the Trust recognises the loss of trust and confidence in its paediatric cardiac services and the impact this has had on the wider reputation of the Bristol Royal Hospital for Children– addressing this is a key strategic theme for the future.

Accident & Emergency (A&E) and Urgent Care

Key issues in terms of the future sustainability of these services are around our ability to meet access standards in the context of an ageing population with more complex health and social care needs. Our ability to perform will depend on how we are able to organise the capacity within the redeveloped BRI through new models of care to meet both demographic changes and city wide changes (such as the new A&E at Southmead and its role as the adult major trauma centre). There are also workforce issues including turnover of nursing staff, potential shortage of junior doctors and difficulty in recruiting acute physicians that must be addressed.

Currently, our plans in place to address these issues are closely linked to the re-development of the BRI and implementing the right model of care to ensure patient flow is optimised alongside work to conclude the implementation of changes to the Trust Operating Model. This is intended to significantly improve flow, through initiatives to reduce length of stay and thus drive down occupancy and plans to protect elements of the Trust's bed base to support the efficient and consistent delivery of elective care.

In addition to operational sustainability, the greatest threat to the Trust's long term sustainability is the excess costs evident in the medical specialities (notably older people's care) and urgent care pathways.

We will develop further plans (by summer 2015) to address issues directly within A&E but also across the health and social care system in Bristol to improve the sustainability outlook in years 3-5. We will particularly focus on:

- Taking a lead role in working with partners to build system wide resilience;
- Understanding barriers to patient flow and ensuring the models in the BRI match capacity with demand through a flexible workforce;
- Working with other acute trust and community partners to review workforce requirements across the city, enhancing the role of Enhanced Nurse Practitioners (ENP), designing innovative working models and providing incentives through training for medical staff;
- Ensuring services outside of hospital are of the right capacity and specification to support reduced reliance on hospital based care;

- Plans to address the significant excess costs, evident in our general medical service portfolio.

By 2020 we aim to have normalised the cost base of acute medical services, delivered a stable but flexible workforce that can meet the demands of demographic change and developed more effective integration with our community partners.

Older People's Care

Like A&E, the key issues in terms of the future sustainability of these services are in our ability to meet the needs of an ageing population with more complex health and social care needs, whose expectations of services are high. Continued need for system wide efficiency will impact on the resources to help move patients through the system in the safest and most effective way. There are currently high nursing costs which, if transferred to the re-developed BRI, will impact on our ability to implement new models of care. Lack of trainees and shortage of consultant geriatricians will also impact on the specialist input into the needs of older people, potentially impacting on our ability to improve patient outcomes quickly.

Currently, our plans in place to address these issues are closely linked to the re-development of the BRI and implementing the right model of care to ensure patient flow is optimised. This includes admission avoidance schemes and ensuring the patient pathways are enhanced, with consultant led, multi-disciplinary approach to care and appropriate skill mix across the department. There is significant interdependency with the transformation aspects of this plan.

However, the challenge of Older People's Care is one that, like A&E, requires a system response. We are committed to working with others on this work, with a particular focus on:

- Operational integration of the delivery of Older Peoples Care across the Acute and community settings in particular;
- Review and understand the causes of staff shortages to plan for longer term workforce requirements;
- Ensure the model of care, working environment, training and incentives enhance the staff experience of UH Bristol creating a happy and stable workforce.

By 2020 we aim to have achieved operational integration of the delivery of Older People's Care across the Local Health Economy and the redesign of the financial model that underpins the service at system level.

Cancer Services

Key issues in terms of the future sustainability of these services are in our ability to meet national access standards for cancer, which will be further exacerbated if we are unable to address workforce risks such as inability to recruit consultant oncologists and adequately staff Bone Marrow Transplant (BMT) services, potentially limiting growth. There is increased competition from NHS and non-NHS providers and if we fail to invest in research and

innovation, or recognise the key benefits of teaching and learning, then we risk the competitive edge to maintain sustainable services.

Currently, our plans in place to address these issues are:

- Continued presence and potential expansion of community chemotherapy services;
- Securing funding for research, especially paediatric cancer research;
- Focusing our specialist offering e.g. Children, Teenagers and Young Adults (TYA), Gamma Knife and BMT;
- Promoting the Bristol Haematology and Oncology Centre as a centre of excellence – a “re-branding” of our offer in this regard is underway following a major redevelopment and expansion of the centre.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Reviewing staffing needs and alternative, flexible working models to address workforce risk;
- Investment in technology and IM&T where required;
- Expansion into new service areas and catchments, alongside the repatriation of regional work from providers outside of the South West and most notably London.

By 2020 we aim to have in place not only a sustainable service built on the foundations of a strong flexible workforce, but a service which provides cutting edge care and research in Bristol and for the South West.

Cardiac Services

Key issues in terms of the future sustainability of these services are linked to the impact of other trust acute services on the ability of the Bristol Heart Institute (BHI) to deliver specialist services and increased competition as services become more routine and delivered at district hospital level and in the private sector. This increased competition has the potential to pull activity and consultants away from the service, impacting on the ability of the service to run an efficient and effective 24/7 service. Investment in imaging equipment, will also be a key initiative to ensure we maintain our competitiveness.

Currently, our plans in place to address these issues are:

- Working with other providers to secure tertiary referrals;
- Expand our interventional cardiology offering;
- Increase ring fenced cardiac critical care and surgical facilities;
- Improve productivity and reduce length of stay;
- Support acute services elsewhere in the Trust, but prioritise the Bristol Heart Institute for cardiac and specialist cardiology services.

We will develop – by summer 2015 - further plans to address sustainability in the medium

term, with particular focus on:

- Developing newer cardiac surgery techniques e.g. minimally invasive surgery;
- Development of clinical pathways to reduce emergency admissions, linking with ambulatory care;
- Reviewing the suitability and capability of imaging equipment to feed into forward looking capital investment plans;
- Continuing to support - and develop - academic leadership in clinical roles.

By 2020 we aim to have continued productive and competitive cardiac services, with appropriate technology to support the BHI in delivering cutting edge surgical and cardiology techniques.

Maternity Services

Key issues in terms of the future sustainability of these services are linked to the plateauing of birth rates across the city, but with increasing complexity resulting from an increase in maternal age at birth. In addition, midwifery recruitment difficulties are compounded by a lack of availability of midwives and services are already running with a high number of vacancies.

Services delivered to mothers living in North Somerset make up an important portion (c25%) of the UH Bristol activity and the long term sustainability of the service is inextricably linked to the future of Weston Area Health NHS Trust and its maternity service and the continued flow of patients from North Somerset.

Neither of the providers of level 3 neonatal care in the City is fully compliant with national service standards, notably in relation to workforce availability with both consultant and specialist nursing skills being scarce. The long term sustainability of this service is a key risk for the Trust and plans to address this are a key focus for action working closely with partners at North Bristol NHS Trust.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Workforce planning to address shortages and fill vacancies where necessary;
- The future model for specialist neonatal services across the City;
- Our ongoing role in the provision of services and support to maternity services in North Somerset.

By 2020 we aim to have a sustainable model for level 3 neonatal services and a maternity service, appropriately configured for the population we serve.

Planned Care and Long Term Conditions

Key issues in terms of the future sustainability of these services are related to our ability to protect sufficient capacity to consistently deliver planned care, to the desired standards and to "right size" our services (workforce and infrastructure) to reflect the changes in demand for this portfolio which includes growth from demographic impacts and reductions from the redesign of pathways shifting the focus of care towards community settings. Notably, successful implementation of the proposed Operating Model is critical to ensuring we can deliver operationally and financially sustainable services.

Alongside this are high cost bases in some surgical specialties, difficulty recruiting to specialist areas such as dentistry and anaesthesia and difficulty accessing nurse specialists across all surgical specialties which we must address.

Currently, our plans in place to address these issues are:

- Maximising the use of existing facilities and increased productivity measures in theatres and outpatients;
- Better use of peripheral sites, such as South Bristol Community Hospital;
- Clearly differentiating elective and emergency flow;
- Integrated working with primary and community care to assist early discharge;
- Implementing plans to reduce costs;
- Right sizing capacity in areas where we have excesses or deficits;
- Redesigning pathways, notably for the management of long term conditions, in partnership with primary and community providers.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Growth in market share and development of specialist and tertiary services;
- Working collaboratively across divisions, with other trusts and with primary care and community partners.

By 2020 we aim to be able to support the acute emergency services of the Trust, but be able to deliver productive, efficient outpatient and surgical services to elective patients and people with long term conditions.

Diagnostics and Therapies

The key issues in terms of the future sustainability of these services are increased desirability of community, as opposed to hospital delivered diagnostic and therapy services, against the backdrop of competition from any qualified/willing providers. If the Trust does not embrace technology and innovation in these areas, it could fall behind innovative competitors. This sits alongside specific issues of viability of services in the short term, such as cellular pathology and paediatric radiology and the longer term challenges of determining the future model for pathology services and how to respond to the challenge of seven day working within available resources, both workforce and financial.

Currently, our plans in place to address these issues are:

- Implementation of local pathology action plans;
- Integration of cellular pathology;
- Developing a clear sense of how the Acute Services Review findings could be implemented in D&T;
- Developing policies and processes, underpinned by the Trust Strategy, to determine which new business opportunities to bid for, or where to disinvest;
- Establish a rolling programme of capital investment in equipment and technology innovation.

We will develop – by summer 2015 - further plans to address sustainability in the medium term, with particular focus on:

- Engagement and investment in future technology and innovation;
- Working with partners to determine which services could move to the community;
- Agreeing the future model for pathology services i.e. to retain in house or outsource.

By 2020 we aim to be continuing to deliver general diagnostic services in such a way as to support the Trust as a whole, but with much greater focus on the delivery of therapies and diagnostics in the most appropriate place for patients. We also aim to have concluded any reorganisation of pathology services across the city.

Critical Care

Key issues in terms of the future sustainability of these services are mainly linked to the competing demands across the Trust for critical care facilities.

Currently, our plans in place to address these issues are:

- Developing ring fenced cardiac critical care within the Bristol Heart Institute;
- Right sizing of critical care capacity across the Trust and improved flow out of critical care to ward based settings;
- Protected pathway redesign to improve operational resilience and reduce cancellations of planned care.

By 2020 we aim to have the right level of capacity in critical care which can support the acute activity within the Trust, and ensure that the specialist, tertiary services can also be delivered effectively.

THE SUSTAINABILITY OF SPECIFIC SERVICE LINES

Appendix 4 describes the risks to specific lines and the key actions to address.

5.3 Strategic Initiative 3 - Broader programmes of change

This initiative sets out a series of 'hooks' for the development of broad change programmes to address the thematic challenges we have identified during our review. The details of this initiative set out our commitment to develop plans in these areas and will provide us with a strategic framework for our major change programmes. As they are developed, these plans will be incorporated into our Transforming Care programme (Strategic Initiative 5) and/or strategic objectives, flowing from the yet to be developed Strategic Implementation Plan which will be developed over the remainder of 2014/15.

The Aim of this initiative is to:

Take a thematic approach to dealing with broad areas of challenge that we have identified as a result of our strategic review.

Our Strategic Plans in this area are:

- **To review and refresh our approach to public engagement and patient and public involvement** in the development and delivery of our services;
- **Where necessary, review workforce models to ensure capacity is aligned with workforce.** In the medium term, this may include developing new models for our workforce to ensure that the most appropriate staff deliver services to ensure that they are cost effective and sustainable with a particular focus on the utilisation of our non-medical workforce;
- **To drive system level changes to the shape of our health and care systems on the basis of a new 'patient centred' understanding of value in health and care systems**;
- **Developing a much more active approach to data and the way we use and share it.** We must accept the underpinning role of information technology in getting better at this, but at the same time realise that better IT will not in itself be the answer. We must make data social (open and not proprietary) in a way that we have not done before;
- **To re-examine the way we use technology and how we understand its benefits** – specifically to consider how technology facilitates access to our services and advice as well as how it allows us to deliver those services more effectively and efficiently;
- Working **on technology and innovation from a system or regional perspective** – through organisations such as the Academic Health Science Network. Our organisations typically lack the expertise or economies of scale to develop and utilise new technology on an individual basis, but there is much to be gained if we can work with and for each other to utilise the potential of advances, such as 3-D printing.

We assess that the impact of these plans will be:

To transform our organisation by delivering major changes in the areas outlined above. In particular, we aim to:

- Be innovative in the way we think about how our application of resources actually creates value for patients and to redesign services on that basis;
- Use technology to facilitate access as well as improve service efficiency and quality;
- Focus in particular on the greater utilisation of our non-medical workforce as we implement our new organisational strategy.

5.4 Strategic Initiative 4 – Our Estate Strategy

The Trust Estates Strategy builds on our current 2005-2015 strategy which is set to be concluded in March 2016 following completion of Phase lV of the BRI development programme.

To date, strategy implementation has focussed on the development and optimisation of core clinical facilities to significantly improve adjacencies and co-locations of key services and retire estate that is no longer fit for purpose. This approach has resulted in the expansion of core clinical accommodation, elimination of poor quality accommodation including nightingale ward environments, and improvements in the built environment of more than 50 services.

Notably, the current strategy has realised £200m of estate investment to improve facilities for our patients, visitors and staff, supporting the Trust in delivering its mission.

The Aim of this initiative is to:

- Complete the current 15 to 20 year strategic asset management cycle which commenced in 2005.

The 2015-2020 estate strategy now concentrates primarily on ancillary and non-clinical estate provision - which is the final element of the asset management cycle - whilst ensuring the estate is 'future proof' for known or predicted clinical requirements.

Our Strategic Plans in this area include two major initiatives :

- To evaluate the options for the future use of the Old Building Site as set out in the strategy;
- Develop an outline business case for the redevelopment of land at Marlborough Hill (including the provision of approximately 1200 new parking spaces).

We assess that the impact of these plans will be:

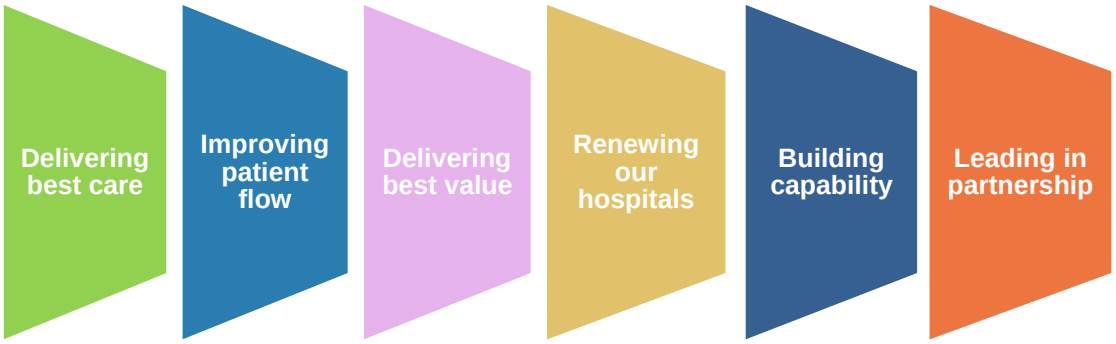
- Improved patient access through on-site, multi-storey parking provision, alongside

associated rationalisation of existing provision and enhanced drop off and site circulation;

- Replacement of Trust Headquarters (THQ) and Estates and Facilities accommodation arising from rationalisation of land on Marlborough Hill to accommodate multi-storey parking.
- Re-provision of:
    - Soon to be obsolete parent accommodation and further expansion to accommodate the impact of recent service and future service growth, notably the specialist paediatric transfer from Frenchay;
    - Accommodation for services displaced by any future service changes e.g. requirement for neonatal intensive care expansion.
- Retained space for:
    - An additional 24 bed ward or other clinical accommodation such as a care home;
    - Further expansion of Trust research and teaching offer, including enhanced medical school provision;
    - Displaced services in a scenario where disposal of Central Health Clinic and/or Tyndalls Park is deemed desirable.

5.5 Strategic Initiative 5 – Transforming Care

Transforming Care is the Trust's unifying strategy for improvement. It is the overarching programme of transformational change designed to drive us towards our vision for the Trust. Transforming Care is both a set of projects and a structured approach to support the organisation in making change happen and to enable all our staff to improve the services which our patients receive.



The programme is structured under the 6 "pillars" above, which provide focus on the areas we need to address in order to achieve our vision.

Transforming Care is already well established in the Trust and is the key mechanism by which we plan to execute our Operational Plan. It will remain a key component of our longer term strategic plan, and an outline of the way in which the key elements of the programme will develop is set out below.

The Aim of this initiative is to:

Build on the current work of Transforming Care by developing programmes to support the strategic objectives below and the priorities set for the coming year and beyond.

Our Strategic Plans in this area are:

Delivering Best Care

- We need to maintain our good position in care quality and outcomes and react when necessary to ensure consistency of high standards;
- We must promote innovation more strongly – for example by a greater focus on collaborative work and connection to the work of larger partnerships such as Bristol Health Partners.

Improving Patient Flow

- There is more to do – we need to be increasingly robust in both planned and unscheduled care;
- There is a twofold challenge - to become better at making and sustaining improvements and to convert those improvements into measurable performance improvement and efficiency savings;
- We need to align our efforts with health economy wide initiatives (e.g. Better Care Fund).

Delivering Best Value

- We must be more forensic about understanding and dealing with our cost base, using available intelligence such as reference costs and benchmarks to deliver increasing value for money.

Renewing Our Hospitals

- We must continue to implement our Estates Strategy;
- We must implement our clinical systems strategy moving to Paper Light and then onto Paper Free;
- We must continue to support clinical teams in adopting technologies that enable better access to and use of data to improve patient care;
- We must fully realise the transformational potential of our investment in information systems.

Developing Capability

- We must deliver a step change in staff engagement and staff experience through a cultural change programme, knowing this will bring further benefits in patient experience;
- We must deliver our workforce strategy across staff groups to develop our workforce aligned to the future needs of our patients.

Leading in Partnership

- We will address the unscheduled care pathway and complex discharge with our partners at system level;
- We need to develop greater agility in the way we work with others – so we can move to action more quickly without any loss of governance and assurance.

5.6 Strategic Implementation

The Trust is acutely aware that the success of any strategy lies in its successful execution. A detailed Strategic Implementation Plan, which will be overseen by the Trust's Senior Leadership Team is being developed and will conclude for the 2015/16 planning round.

Our mechanisms to drive strategic implementation are as follows:

Our Business Planning and Operating Plans

The first two years of this strategic plan are already in place and have been set out in detail in our Operational Plan. We will begin business planning again in October 2014 and will then look at the first of years 3-5 in our strategic plan in more detail. Successive years of the strategic plan set out in outline here will then be picked up and clarified as part of our annual Business Planning process.

Our model for planning and implementation will continue to reflect the balance of corporate and divisional initiatives within our overall business model of devolved autonomy to our five clinical divisions.

Medium Term Capital Plan

This plan is set out in our Financial Plan (Section 7) and contains the provisions for the major investments that we anticipate in our Estates Strategy in particular. The provision for spending on medical equipment, minor estates works and other infrastructure spending also includes the outline provisions for the estimated costs of addressing the sustainability challenges described in this Plan.

Transforming Care

Although it is itself one of our key strategic initiatives, Transforming Care is itself the overarching programme of change through which we drive delivery across the Trust. In simple terms, as specific strategic plans in each of our strategic initiatives are confirmed, they will be fed into and become part of the Transforming Care programme where they are intended to deliver a step change in performance or outcomes, and will be governed and managed via the auspices of that broader programme.

SECTION 6 – OUR STRATEGIC WORKFORCE PLAN

6.1 Introduction

This section sets out our current position, including our strengths, weaknesses, opportunities and threats in relation to our workforce agenda and describes the plans and programmes which will enable us to achieve our objectives over the next five years.

Our plans and programmes include delivering our services in different ways, optimising productivity and efficiency, and redesigning our workforce, ensuring that it aligns with the resources available and the needs of our services and patients.

6.2 Our Workforce in 2014

Our strengths, which we need to maintain and build on, are: our highly skilled, dedicated workforce; traditionally good partnerships with our trade union representatives, redevelopments which provide a better working environment for staff and a number of positive ratings in our staff attitude survey, including proportions of staff recommending the Trust as a place to work or receive treatment.

However, our analysis also shows that we have a number of weaknesses, for example turnover and sickness absence rates, which are higher than those of similar trusts, and financial challenges associated with the need to align staffing levels with activity and capacity, and to reduce bank and agency usage. We also have some key threats in the future: recruitment to key staff groups in a tight labour market, and the financial challenge of maintaining and developing the quality of our services with fewer available resources. These threats will bring opportunities, making it more important to work in partnership with local organisations and our own staff side, and providing staff with the chance to work in new ways and train for new roles.

SWOT Analysis May 2014

Strengths	Weaknesses

• Staff who are committed to delivering excellent patient care
• A developing culture of lifelong learning and personal development
• Highly regarded teaching trust – attractive to potential recruits
• Specialist tertiary service with highly skilled and expert workforce
• Traditionally good partnerships with our trade union representatives
• High appraisal rates, relative to sector
• Clear KPIs and action plans
• Areas of potential strength indicated by the staff attitude survey:
  ○ Numbers receiving job-relevant training, learning or development
  ○ Staff recommendation of the trust as a place to work or be treated
  ○ Not feeling pressured to attend work when unwell
• A modern and pleasant environment
	• Turnover above benchmarking peer Trusts
	• Sickness absence levels above benchmarking peer Trusts
	• Bank and agency levels above KPIs
	• Workforce costs higher than budget
	• Issues indicated in the staff attitude survey:
	  ○ Work related stress
	  ○ Health and safety training
	  ○ Well-structured appraisals
	  ○ Harassment and bullying from other staff
	  ○ Communication between senior management
	  ○ Equality and diversity training
	  ○ Discrimination at work
	  ○ Satisfaction with work quality

Opportunities	Threats
• Further opportunities to develop our workforce – new roles, different ways of working – providing staff with new opportunities and new skills • We can do more to optimise the productivity and operational efficiency of our systems, processes and staff • The need to change and adapt will drive change and provide scope to transform the way in which we deliver care through service and workforce redesign • We will need to engage even more closely with our staff and Trade Union representatives to support future changes • Academic partnerships can be developed which would produce benefits in shared expertise and skills, and workforce development. • We can do more to market potential employees the benefits of working at UH Bristol, including our status as a major teaching trust and being centre of expertise for specialist services • Partnerships with other providers could be further developed to learn from best practice, benchmark and work collaboratively in developing our workforce and delivering services	• National shortage of qualified nurses due to retirements likely to impact during 2015-17 • Difficulties in recruiting to certain areas, such as consultant radiologists, pathologists, oncologists and acute physicians • Changes to junior doctor numbers mean potential shortages 2016 onwards • Financial challenges due to reduced funding • Scale of change may be demanding for staff to accommodate • Funding and infrastructure to develop and train for new roles and new ways of working may be difficult to identify and secure • Potential national agreements regarding pay which may impact on our ability to deliver 7 day working • The age profile of some consultants and some specific areas of the service could result in cohorts of retirements, resulting in the loss of key skills

6.3 Our Workforce Vision

Our workforce vision is:

We will be an employer of choice, attracting, nurturing and developing a workforce that is skilled, committed, compassionate and empowered, so that we can deliver excellent care to our patients.

Our vision is underpinned by a number of strategic themes which are as follows:

- Supporting our leaders to deliver transformational change, creating a culture of high performance, continuous improvement and organisational transformation;
- Engaging our workforce, so staff feel valued, empowered and are committed to delivering excellent care;
- Recruiting and retaining the best staff to ensure that we can meet future demand to provide the exceptional quality of healthcare to our patients;
- Ensuring that staff are rewarded and recognised for high performance and that teams and individuals have clear accountability for their actions.;
- Developing a culture of lifelong learning across all staff groups within the Trust where Teaching and Learning supports the Trust values and strategies;

- Ensuring that we have a sustainable workforce which aligns capacity and staffing within the financial envelope, with safe and appropriate numbers of staff and skill mix, and minimal agency usage.

The work streams to deliver these priorities will be supported by partnership working, both across the Trust, with our trade union representatives, and with external partners, impacting on all staff groups. Progress against the work programmes which underpin these themes will be reported to the relevant workforce governance group on a quarterly basis.

6.4 Workforce Risks to Sustainability

Our key workforce risks – along with our mitigation plans – are considered below.

6.4.1 Workforce affordability

Risk: We recognise the future risk of delivering services within a reduced resource, particularly given the increasingly complex health needs of patients, and the requirement to provide services within extended hours.

Mitigation: There are a range of solutions which are being implemented to address the key issue of workforce costs, which include the following:

- We have reviewed our nursing levels, using the national Safer Care Nursing Tool, combined with an external review, benchmarks and review of risks. This has resulted in agreed general ratios which are already being met, even taking account of acuity and dependency requirements, providing the assurance that there are not significant increases in nursing levels required to achieve national benchmarks;

- Our consultant job planning database enables an assessment of capacity against service requirements. In addition, we have a rigorous approach to ensuring that new consultant posts are not established without a clear justification and business case. We have a specific workstream which will focus on securing further efficiencies from our medical workforce. We are also collaborating with NHS Employers to support their modelling of the implications of changes to the consultant contract, with the objective of reducing the financial impact of 7 day services;

- We are leading on a programme to develop workforce models as part of the Better Care Fund in the Bristol Health community. This work is in recognition of the increasing proportion of elderly who are admitted to our hospitals and the specific workforce and service redesign across health and social care which is required to ensure that patients are cared for in the most appropriate place by staff with the best possible skills;

- UH Bristol will also continue to develop the expectation that staff work across sites in the Bristol community, whether this is in a community setting, or for a different acute provider, in order that services continue to be sustainable and cost effective.

6.4.2 Changes to junior doctor training

Risk: By 2015, 80% of Foundation posts will be required to contain a 4 month Community

post, rising to 100% by 2017. These changes will result in significant reductions in junior doctor numbers working in the Trust. This will exacerbate the existing shortages in some areas of juniors and middle grade doctors.

Mitigation:

- Develop and implement an action plan, based on a cost benefit analysis, in partnership with Divisions, which will be focussed on the following solutions:
    - Instigate Academic F2 posts where available, which are funded by Health Education South West (HESW) with out of hours and on costs funded by UH Bristol;
    - Review and extend the Clinical Site Management Team;
    - Develop a "Teams at Night" programme, to ensure the cover at night is provided using cross-team approaches;
    - Review of roles to ensure that doctors are only undertaking tasks which specifically require medical input and ensure that processes are efficient in supporting junior doctors to increase efficiency;
    - Implement the Advanced Nurse Practitioner and Extended Practice Physiotherapist/Health Care Scientist roles which we already have in place in several areas such as the Emergency Department, Rehabilitation, Paediatrics and Cardiac, to cover other specialties as necessary;
    - Continue to work with Health Education South West to ensure there is appropriate training available to support the development of the new roles, and in particular, ensure that there is increased provision for non-medical prescribing training;
    - Ensuring we continue to collaborate with Health Education South West Severn Post Graduate Medical Education Deanery to understand as early as possible the potential impact in years beyond 2017.

6.4.3 Temporary Staffing Usage

Risk: Some use of temporary staffing is positive and providing the flexibility to supply additional staff during peaks and troughs of demand and to cover for maternity, sickness absence, and vacancies. However, temporary staffing usage currently exceeds budgeted establishment, and this would be a risk if not reduced in the future.

Mitigation:

- We have a range of actions which are being implemented to support and maintain reduced bank and agency usage through the reduction of the drivers, including vacancies and sickness absence and to further improve control mechanisms;
- We are also improving the way we use our rostering system, to ensure shifts are booked six weeks ahead, that rosters are signed off at an appropriate level, and that

staffing levels comply with agreed Chief Nurse staffing guidelines;

- There is enhanced reporting at Quality and Outcomes Committee and at Divisional Reviews to ensure that the agreed trajectory for reducing bank and agency usage is achieved.

6.4.5 Recruitment and Retention

Risk: Where there is a limited supply of a specific professional group and recruitment is challenging, this can result in difficulties in recruitment. National projections for the forecast future supply of registered nurses shows a likely reduction of between 6 and 11 per cent between 2013 and 2016, and baseline projections for supply and demand show a shortfall of nurses by 2016 (The Centre for Workforce Intelligence CfWI 2013). In addition, there are specialist areas which are difficult to recruit to, and given our age profile, service sustainability could be impacted when key staff with specialist expertise retire.

Mitigation:

- We have a range of recruitment activities which are focussed on attracting both newly qualified and experienced nurses, including participating in recruitment fairs, holding open days, and utilising the Trust Microsite;

- We have aligned workforce plans with recruitment to anticipate demand resulting from turnover and service developments;

- We are developing appropriate attraction packages, both to market the benefits of working in a specialist, tertiary teaching Trust, and in offering specific terms where appropriate, focussing on difficult to recruit areas, which include histopathology, pathology, radiology and oncology;

- We have taken the opportunity to transform our recruitment processes, implementing an assessment centre approach which will be extended to all staff groups, to ensure that we recruit for compassion as well as skills.

6.4.6 Sickness Absence

Risk: Our long term ambition is to achieve a sickness absence level of no more than 3%, with an interim target for 2014/15 of 3.5%. High levels of sickness absence are linked with reduced productivity and increased usage of temporary staffing, but these are challenging targets and there is a risk that they will not be achieved.

Mitigation:

- Our early priorities as part of our Staff Experience and Engagement programme include providing support for staff, in terms of wellbeing and tackling work-related stress in addition to the existing services for employees through our physio-direct service, allowing direct access to physiotherapy at the earliest sign of musculoskeletal injury, a staff counselling service and a programme to address stress related absence;

- We will also be scoping and piloting an Employee Assistance Programme, and will extend this subject to positive outcomes.

SECTION 7 - FINANCE STRATEGY

7.1 Introduction

The Financial Strategy commentary describes the Trust's assessment of the Strategic Plan for the period until 2018/19 and builds upon the Operating Plan submitted to Monitor in early April 2014. The commentary details the key assumptions, transactions and projections in support of the financial template for the "Base" scenario and "Downside" scenario.

7.2 Financial Sustainability

The Trust undertakes regular reviews of its Long Term Financial Plan and formally updates the Long Term Financial Plan on an annual basis in line with Monitor's annual planning cycle. The Trust has always adopted a prudent approach to financial planning and refers to the following criteria in assessing the affordability and sustainability of its plans:

- A recurrent or normalised surplus achieved in every year of the plan;
- An in year surplus of 1% of turnover excluding technical items to meet the Trust's loan principal repayments;
- A minimum cash balance of £20 million;
- A Continuity of Services Risk Rating of at least 3; and
- A maximum Reference Cost Index of 100.

7.3 The Base Scenario

7.3.1 Savings Plans

The Trust has delivered savings of £84.2 million since it became a Foundation Trust in June 2008. Going forward, the Trust believes the continued delivery savings at a rate of 4% is unsustainable having assessed the opportunity to transform its own services at c2%. For the purposes of the Strategic Plan submission, the Trust has set a strategic assumption of net tariff efficiency of 2.5% in 2015/16 and 2% from 2016/17 onwards as the Trust's "Base" scenario. This does assume that 'tariff leakage' is real and will effectively net off against the gross tariff efficiency. There remains some doubt about this but the strategic assumption is retained. In line with the Monitor guidance, should 'tariff leakage' reduce the gross efficiency deflator will also reduce in line. The Trust savings plan going forward is summarised below:

Base Scenario	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Savings requirement	10.0	8.4	8.5	8.7

It should be noted that, at this stage of the Strategic Plan, detailed plans are not in place to deliver the savings; these will need to be worked up in due course as the strategic direction is translated into savings plans.

7.3.2 Income

The income assumptions over the period of the Strategic Plan are as follows:

- Net nil activity growth pending a review of activity volumes and the impact of the Better Care Fund;
- An assessment of National Tariff gross uplift at 2.67% in 2015/16, 3.67% in 2016/17, 3.77% in 2017/18 and 3.87% in 2018/19 offset by a National Tariff gross efficiency requirement of 2% in each year. The net inflator of 0.67% in 2015/16 is necessary to cover increases in employer costs arising from NHS pension contributions. The net inflator of 0.17% in 2016/17 is due to an increase in National Insurance employer contributions. Smaller changes in later years is due to further increases in NHS pension contributions due to automatic enrolment of staff into the NHS pension scheme from 1st October 2017.
- MPET rebasing impact of £1.0 million in 2015/16 and £0.5million in 2016/17; and
- The receipt of charitable donations in 2015/16 of £3 million in support of the Trust's Medium Term Capital Programme.

7.3.3 Costs

The 2015/16 – 2018/19 cost outlook for the Trust should be considered in the context of an increasingly challenging environment. Pressures on spending, savings plans and transformation initiatives are intensifying and firm control will be required to avoid the Trust's medium terms plans being undermined. The main assumptions and considerations included in the Trust's cost projections are:

- Pay inflation 1.25% in 2015/16, rising to 2.73%, 2.88% and 3.04% by 2018/19 which includes a 1% pay ward and the impact of NHS pension and National Insurance contribution changes, drugs at 5%, clinical supplies 2% and capital charges at 2%;
- Recurrent savings delivery at 2.5% in 2015/16, followed by 2% each year;
- Payment of loan interest at £3.1 million in 2015/16 falling to £2.5 million in 2018/19;
- Loan principal repayment of £5.8 million each year; and
- A recurring risk reserve of £0.5 million in each year from 2015/16.

The following non-recurring costs are provided for:

- £1.0 million change / invest to save costs each year in recognition of the transformation requirement;
- £0.5 million transitional costs in support of the Trust's strategic capital schemes;
- £0.8 million technology implementation costs in 2015/16 and £1.0m each year from 2016/17;
- £0.5 million risk reserve in each year;
- £0.5 million contingency in 2016/17 rising to £1.25m in 2018/19; and
- £9.4 million gross impairment in 2015/16 arising from the writing down of capital cost to depreciated replacement cost of the BRI Redevelopment Phase 4.

7.3.4 Strategic Developments

Bristol Royal Infirmary Redevelopment

Commissioning of Phase 3 begins in June 2014 and will be completed in January 2015 providing up to date and modern estate. Phase 3 will enable the delivery of new models of care through the Acute Medical Assessment Unit which will improve service efficiency, patient flow and quality of care. The full year effect net recurring revenue cost of Phase 3 in 2014/15 is £6.9 million, the part year effect is £4.6 million. A key risk is the delivery of the planned length of stay reductions before the opening of Phase 3, and the delivery of length of stay savings post 2014/15. The bed closures are necessary to deliver the decant of patient services from the Trust's King Edward Building and the subsequent closure of the BRI Old Building in March 2016. The closure of the BRI Old Building delivers recurrent savings of £2.0 million from 2016/17 meaning the net recurring revenue cost of the scheme from 2016/17 is £4.9 million.

7.3.5 Other Service Developments

There are no further developments planned for the period 2015/16 to 2018/19.

7.3.6 Transactions

Breast Screening Transfer

The transfer of the Avon Breast Screening Service from UH Bristol to North Bristol NHS Trust is planned to take place from 1st August 2014. The transfer will reduce the Trust's income by £1.5 million and reduce the Trust's expenditure by £1.36 million resulting in a net loss to the Trust of £0.14 million.

Centralisation of Specialist Paediatrics

The project meets the long-term vision and strategy to centralise paediatric services delivering integrated paediatric services within the existing Bristol Royal Hospital for Children. The recurring revenue impact is financially neutral with increases in both income and expenditure of £16.1 million in 2014/15. The new service commenced in May 2014.

Vascular Transfer

The transfer of Vascular services from UH Bristol to form a Major Arterial Centre at North Bristol NHS Trust is now scheduled for October 2014. The recent full year effect assessment shows the transfer will reduce UH Bristol's income by £3.3 million and costs by £2.5 million resulting in a net loss to the Trust of £0.8 million.

Other Transactions

There are no further transactions currently planned for the period 2015/16 to 2018/19.

7.3.7 Capital expenditure

The Trust has a significant Medium Term Capital Programme investing £94.6 million from April 2015. This is summarised in the table below:

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m	Total Plan £m
Strategic schemes	12.0	6.1	8.9	7.3	34.3
Backlog works	2.4	2.7	2.7	2.7	10.5
IM&T	1.3	1.5	0.8	1.4	5.0
Operational capital	6.3	4.5	4.5	4.5	19.8
Medical equipment	2.5	7.9	5.3	5.3	21.0
Slippage	3.7	0.6	0.0	(0.3)	4.0
Totals	**28.2**	**23.3**	**22.2**	**20.9**	**94.6**

The Trust's major strategic schemes in this period are:

BRI Redevelopment Phase 4 £13.0 million

Phase 4 involves the refurbishment and conversion of the Trust's King Edward Building and the BRI Queen's Building upon opening of Phase 3 in January 2015. Phase 4 will complete by March 2016 and will ultimately allow for the decommissioning and disposal of the BRI Old Building in 2016/17 and 2017/18 respectively.

Strategic Capital £21.3 million

The Trust's Medium Term Capital Programme has set aside uncommitted strategic capital moneys of £21.3 million over the period 2016/17 to 2018/19.

7.3.8 Liquidity

The Trust's liquidity is fundamental to ensuring the Trust can meet its financial obligations arising from its revenue expenditure and capital investment as they fall due. The 2015/16 projected year end cash balance is £46.5 million, rising to £53.8 million in 2018/19. The Statement of Financial Position forecasts net current assets of £12.8 million at the 31st March 2016 rising to £18.7 million as at the 31st March 2019. This increase reflects the Trust's decreasing Medium Term Capital Programme over the period and includes assumed disposal proceeds of £2 million in 2017/18 relating to the BRI Old Building.

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Current Assets – Cash	46.5	46.7	50.2	53.8
Current Assets – Other	30.2	30.1	30.5	30.8
Current Liabilities	(63.9)	(64.8)	(65.3)	(65.9)

Net Current Assets	**12.8**	**12.0**	**15.4**	**18.7**

7.3.9 Continuity of Services Risk Rating

The Trust's forecast Continuity of Services Risk Rating performance is 3.5, rounded up to 4 over the period to 2018/19. The Trust's forecast liquidity days exceeds zero days for each of the financial years giving a liquidity metric rating of 4. The Debt Service Cover metric performance exceeds 1.75 times over the planning period giving a metric rating of 3. The components are summarised below:

	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
Liquidity - days	2.4 days	1.8	3.9	6.0
Liquidity metric	**4**	**4**	**4**	**4**
Debt service cover –	2.2 times	2.2	2.3	2.3
Debt service metric	**3**	**3**	**3**	**3**
Overall Rating (rounded up)	**4**	**4**	**4**	**4**

Rating 4	Rating 3	Rating 2
0 days	-7 days	-14
2.5 times	1.75 times	1.25 times

7.3.10 Summary Financial Results – Base scenario

The financial outlook for the Trust over the planning period remains one of strength relative to the Foundation Trust sector with a forecast Continuity of Services Risk Rating of 4 in each year of the Strategic Plan.

The Base scenario outlook continues the past decade of delivering net surpluses and forecasts:

- A normalised surplus in every year of the plan;
- A net surplus margin of 1%;
- A minimum Continuity of Services Risk Rating of 3; and
- A minimum cash balance of £20 million.

The financial results are summarised in the table below:

7.3.11 Summary Financial Projections – Base scenario

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Income	570.2	574.4	582.5	591.3
Operating expenditure	(527.0)	(533.3)	(540.6)	(548.7))
EBITDA*	43.2	41.1	41.9	42.6
Non-operating expenditure	(45.2)	(38.5)	(39.1)	(40.2)
Net surplus / (deficit)	**(2.0)**	**2.6**	**2.8**	**2.4**
Net surplus / (deficit) (excluding exceptional items)	**5.4**	**5.8**	**5.8**	**5.8**
Year-end cash	46.5	46.7	50.2	53.8
Continuity of Services Risk Rating	4	4	4	4

*Earnings Before Interest, Taxation, Depreciation and Amortisation

7.4 The Downside Scenario

The Trust has undertaken a simple “Downside” scenario as an illustration taking into account a national savings requirement set at 4% from 2015/16 onwards. All other assumptions and transactions are unchanged from the “Base” scenario. The savings requirement at 4% is summarised in the table below:

Downside Scenario	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Savings requirement @ 4%	15.9	16.4	16.4	16.4

The impact of the savings requirement at 4% and delivery at 2.5% in 2015/16 and 2.0% from 2016/17 are summarised in the table below:

7.4.1 Summary Financial Projections – Downside scenario

	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Income	564.3	560.1	559.8	560.0
Operating expenditure	(527.0)	(533.4)	(541.1)	(549.8)
EBITDA*	37.3	26.7	18.7	10.2
Non-operating expenditure	(45.3)	(38.4)	(39.1)	(40.2)
Net surplus / (deficit)	**(7.9)**	**(11.8)**	**(20.4)**	**(30.0)**
Net surplus / (deficit) (excluding exceptional items)	**(0.5)**	**(8.6)**	**(17.4)**	**(26.6)**
Year-end cash	40.6	26.4	7.1	(21.3)
Continuity of Services Risk Rating	3	2	1	1

*Earnings Before Interest, Taxation, Depreciation and Amortisation

The impact of the recurring saving requirement at c£16 million per year compared with recurring sustainable delivery at £8 million per year has a major compound effect of c£75 million over the planning period. The result is a Continuity of Services Risk Rating of 3 in 2015/16, 2 in 2016/17 and 1 in later years.

Clearly, the scale of mitigation required would need to be significant in order to first restore the Trust's cash balance and weak liquidity position. The only material mitigation available to the Trust would be an equivalent reduction of the Trust's Medium Term Capital Programme. This scenario would have a significant adverse impact upon the Trust's ability to provide high quality care and is, in relation to the Trust's criteria of financial sustainability, an unsustainable scenario.

The Trust does not believe that savings above that assumed in the base scenario are deliverable without adverse service and clinical impacts.

7.5 Changes to the 2015/16 Financial Plan

7.5.1 Introduction

Monitor received the Trust's 2014/15 – 2015/16 Operating Plan submission on 2nd April 2014. Having reviewed the Operating Plans of the Foundation Trust sector, Monitor has written to all Foundation Trusts asking them to consider their 2015/16 plans in light of the financial challenge.

7.5.2 Rationale for the changes

The 2015/16 plan was based on information and intelligence available to the Trust in March 2014. In the context of the Trust's savings delivery of £84.2 million since 2008 and a further savings requirement of £20.9million in 2014/15, it has become increasingly apparent that savings delivery in 2015/16 at 4% is not sustainable having assessed the opportunity to transform its own services at 2.5%. (In line with the provider efficiency metric from Monitor guidance).

7.5.3 Changes made

The following key changes have been made to the 2015/16 plan compared with the April submission:

1. The National Tariff uplift is assessed at 2.67% compared with 2.5% taking to consideration an initial assessment of the increasing cost of employer pension contributions;
2. The National Tariff deflation or saving requirement re-stated at -2.5% from -4% having assessed the opportunity to transform the Trust's services. In absolute terms, a 2.5% saving requirement equates to £10.0 million;
3. A re-assessment of pay inflation at 1.25% , up from 1% including the initial assessment of additional employer pension costs; and
4. An increase in capital expenditure of £3.5 million from £24.7 million to £28.2 million due to timing changes arising from an update of the BRI Redevelopment Phase 4 programme.

SECTION 8 - APPENDICES: COMMERCIAL OR OTHER CONFIDENTIAL MATTERS

Appendix 1 – Board Assurance Framework

Appendix 2 – Market Analysis

Appendix 3 – Methodology for Analysis of Sustainability Risk

Appendix 4 – Summary of Sustainability Risks and Mitigation Options

Appendix 5 – Mapping of Service Lines to Key Service Areas and RCI Analysis by service line

Appendix 6 – Key Elements of Our Operational Plan

Appendix 7 - Summary of the Acute Services Review

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
1	We will consistently deliver high quality individual care, delivered with compassion.	To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model	Develop integrated discharge processes, team and hub			Risk of lack of momentum through diverse leadership causing a delay in implementation.	Risk mitigated through bringing the individual projects together in coordinated themes.	Regular progress and exception reports to Transformation Board			COO	Senior Leadership Team
			Undertake a review of the need for, and nature of, further additional out of hospital capacity									
			Establish early supported discharge for priority pathways									
			Develop plans for weekend discharge based on findings from diagnostic and Breaking the Cycle									
			Implement a protected beds model covering key planned care pathways									
			Review adult critical care provision across the organisation with the aim of eliminating cancelled operations due to access to critical care									
			Ensure a robust operating model for BCH before next winter to prevent repeat of last year's dip in performance									
			Plan and co-ordination of the Breaking the Cycle week and mobilise follow up plan									
		To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners	Reach final agreement with specialised commissioners on standards that they will derogate			Commissioners decline to derogate standards in areas where compliance cannot be readily secured resulting in financial penalties and the need for Trust investment to achieve compliance	Working proactively with commissioners to understand rationale for derogation and providing appropriate evidence in support of request.	Compliance position reported to Clinical Strategy Group and SLT. Non-compliance recorded on Divisional Risk Registers.			D of SD	Clinical Strategy Group
			Develop action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners.									
		Deliver a programme designed to enhance compassion in clinical staff	Review values training to incl. evaluation of impact on behaviours			Stress in staff in the workplace (personal and work related) & vacancy rates, staff feeling unsupported impacts on people's ability to deliver compassionate care Weak leadership at team/dept level so team feel unsupported and uninformed	Development and implementation of a health and well being strategy, specific action plans to address any hotspots identified via staff FFT and "pulse checks", develop and implement a trust wide work related stress programme Leadership development of these in key leadership positions to be effective leaders	Delivery of transformational project plan, deliver against UH Bristol staff experience and engagement action plan			CN	Transformation Board
			Implement values based recruitment for RN's Midwives, NA's , domestic assistants, medical staff									
			Develop Compassionate care programme for UH Bristol nurses and midwives - following focus work to identify understanding/barriers to deliver of compassionate care									
		To establish an effective and sustainable complaints function to ensure patients receive timely and comprehensive responses to the concerns they raise and that learning from complaints inform service planning and day to day practice	To strengthen the Patient Support and Complaints Team resources to address the current lack of resilience.			Non appointment to key posts, high levels of sickness in team	External advertisement of positions/positive marketing, Occupational Health involvement	Delivery of complaints KPIs as per monthly complaints reporting		ref 2647	CN	Executive Directors
			Deliver the complaints annual work plan, which includes learning from Francis/Clywd Hart									
		To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Deliver the stretch and quality improvements as per 14/15 CQUIN schedule			Delayed sign off with commissioners and/or, lack of clear senior leadership ownership of delivery..	Nominated SLT leads to oversee delivery of individual CQUIN's, robust governance of delivery of CQUIN monitored via SLT, robust monitoring of annual quality objectives, delivery of flow projects.	delivery against annual quality objectives reviewed monthly via Flow Group, CQC and Trust Board.			CN	Clinical Quality Group
			Deliver all annual quality objectives described in the Trust's quality report									
		To achieve upper quartile performance in process and outcome measures for the Friends and Family Test (FFT)	Implement FFT in outpatient and day case settings			Data collection is currently only via a small no. of sources Internal patient facing coms around FFT is limited and not very visible FFT performance is difficult to predict and is affected by service pressures.	Implementation of alternative methods of collecting data/delivery of planned publicity drive/constant reinforcement and vigilance of requirement	Patient Experience Group monitors family and friends test monthly.			CN	Clinical Quality Group
			Explore options for increasing monthly response rate to meet increased national targets									
		To ensure the Trust's reputation reflects the quality of the services it provides	To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services			Workforce or other resource constraints prevent compliance.	Audit of compliance to assess gaps and risks to compliance. Close working with service and commissioners to ensure appropriate developments are supported to address non-compliance.	W&C quality and governance committee			MD	Clinical Strategy Group
			Fully engage with Sir Ian Kennedy Review of children's heart services with the aim of restoring trust and confidence in the service and addressing any shortcomings in care quality identified through the Review			Risk that the media does not accurately reflect the quality of the Trust's service offer and/or risk that areas of service quality fall below that expected	Proactive engagement with local media through Trust Communications Team. Programme approach to Kennedy review established to ensure effective engagement. Robust systems of clinical governance and assurance to ensure services are compliant with all necessary standards and specifications.	weekly media summaries and monthly communications report to Senior Leadership Team			D of SD	Senior Leadership Team
			Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities									
		To achieve upper quartile performance standards for all nationally benchmarked patient	Monitor performance and take corrective action when appropriate.			Risk that action plans and recovery actions are not progressed	Frequent and regular monitoring of safety performance parameters with regular Patient Safety updates through the Trust's				MD	Senior Leadership Team

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
		safety measures	Review Patient Safety Group function within Trust governance apparatus.				Patient Safety Group					
2	We will ensure a safe, friendly and modern environment for our patients and our staff	To successfully deliver phase 3 and 4 of the BRI Redevelopment	Helideck operational May 2014 ITU relocated (Aug), new surgical wards restructured (Aug), new assessment units (Oct), closure of Old Building to inpatient wards (Oct) and completion of inpatient provision in the new ward block (Jan) Complete and handover level 5 of new ward block to Children's Hospital (June) Completion of refurbished wards and ward move plan implemented by Q4 Queen's Lecture Theatre conversion completed and levels 9 & 10 remodelled by end of Q3 Surgical Assessment Unit completed and operational in Q3 Integrated Discharge Hub established. Q3. Staff Restaurant opened Q4. Successfully deliver Queen's Building Façade Project			Risk that acute medical model of care will not be in place in time for October 2014.	1. Division of Medicine asked to re-submit operating plan by end of June 2014 to deliver affordability of model. 2. ECIST to review acute medical model in June 2014 to understand model and to offer suggestions/support/alternatives.	Office of Governance and Commerce (Green rating received in May 2014).		2476 & 759	COO	Senior Leadership Team
		Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented	Interim Major Incident plan and Business Continuity plans in place to reflect changes to operational physical estate during BRI redevelopment and service moves by end Q2 Six month review following EPRR audit completed Major Incident Plan revised to reflect new BRI build by end of Q4			One individual responsible for Emergency Planning therefore, limited resource to enable full commitment to the process and a single point of failure for Resilience within the Trust.	Risk mitigated through changing the staff mix in the COO office.	Internal and External Audits			COO	Senior Leadership Team
		Set out the future direction for the Trust's Estate	Estates and Asset Management Strategy agreed by Board June 2014 Business Case for future use of Old Building Site and developed and agreed by Board by end of September Scope future priorities for refurbishment of remaining estate post BRI Phase IV and incorporate into forward strategic capital programme			Workforce capacity prevents timelines for strategy and Business Cases (BC) being met	Risk mitigated through externally sourced capacity	Strategy and BCs delivered to Board			D of SD	Senior Leadership Team
		Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards	Deliver expectations 1,3,7,8 (June 2014) Deliver remaining expectations			Delay in the procurement of an IT solution for measuring patient acuity and dependency/delay in Boards for displaying staff info (due to supplier)	Clear project plan/close working with IT/procurement and supplier (for IT element once identified)				CN	Senior Leadership Team
3	We will strive to employ the best and help all our staff fulfil their individual potential.	We will ensure that the workforce feel highly engaged and empowered by implementing a range of agreed actions to develop staff in their place of work and demonstrate a year on year improvement in the annual staff survey engagement score.	Structured programme of listening events to follow up Breaking the Cycle Together - consideration of Listening into Action methodology to equip managers To create a cohesive performance management framework for all staff groups, enabling staff to delivery high quality patient care Development and implementation of a Staff Recognition and Suggestion Scheme Build the capability of our leaders to embed a culture of behaviour and style of management which supports staff in fulfilling their duty of candour Ensure managers build their skills to enable high quality appraisals and objective setting			Slippage of projects due to absence of key project leads / resources. Slippage of one project impacting adversely on another objective/action due to interdependencies.	Continuous monitoring of resources and project plans to identify and rectify resourcing gaps as early as possible. Closely manage interdependent projects to timescale, with frequent updates.	Review by Transformation Board			DWOD	Senior Leadership Team
		We will take appropriate action to reduce the incidences of work related stress by introducing a number of measures that support all staff to undertake their role safely	Develop a Trust-Wide Work-Related Stress Action plan - using existing Divisional Stress plans to run in parallel with the development of a Trust Health and Well Being Strategy Health & Safety - evaluate policy and practice to focus high quality patient care to support the reporting learning from incidents including physical violence Discrimination - review and scope opportunities for revised e-learning package to support managers			Failure to implement Health and Wellbeing/Stress action plan due to lack of funding and resource.	Appropriate investment in HWB with identified resource and funding. Continuous monitoring of resources and project plans to address resourcing and funding gaps.	Review by Health and Safety Risk Manager Group			DWOD	Senior Leadership Team
		We will equip our leaders with the requisite skills, behaviours and tools to develop high performing teams, so staff have objectives with a clear line of sight to the Trust's vision.	Identify and agree who are our leaders and managers , clearly articulating and agreeing what it means to be a leader, with clear competencies and standards of behaviour. Introduce comprehensive programme of quarterly leadership forums, annual leadership conference and access to learning sets - to ensure leaders understand the opportunities and			Failure to comprehensively identify all staff with leadership roles due to limited definition of "leaders".	Agree definition of leaders e.g. those who are responsible for the development, performance and wellbeing of a number of staff and identify all those who fall within the definition, rather than relying on grade to indicate leadership.	Review by Transformation Board			DWOD	Senior Leadership Team

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
			Revise appraisals to include feedback on leadership competencies and behaviours - to include 360 or staff feedback.									
			Develop and agree a 1 - 3 year Organisational Development plan to provide continuous and systematic leadership development and the need to understand what leadership means as a cultural proposition.									
		We will revise the Teaching and Learning strategy to ensure the strategic priorities support an attractive and viable learning environment whilst continuing to provide exceptional care to our patients.	To review the existing strategic priorities with the Teaching & Learning Steering Group			Misalignment of priorities with Trust strategic risk. Failure to work in partnership with providers and HEE.	Comprehensive review of education, teaching and learning.	Review by Teaching and Learning Group.			DWOD	Senior Leadership Team
			Revise the priorities in line with the draft strategic vision for UH Bristol									
			To provide a revised Teaching & Learning Strategy in March 2015									
4		Implement modern clinical information systems in the Trust	Phase 2 Implementation			IT implementations are inherently high risk generally.	Proper programme monitoring and management processes will manage the generic risks.	IM&T Committee and CSIP Committee			DoF	Information Management and Technology Committee
			Phase 3 Design									
		We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR)	(a) Monitor our performance and analyse reasons for failure to meet the benchmark (performance initiating research), putting in place measures to address those reasons			(a) failure to engage with services which can influence our performance in meeting the benchmark. (b) multiple stakeholders have different agendas and priorities (c) resistance of workforce to taking on more flexible (cross specialty) roles; true flexibility and mobility of research funding is required. (d) focus on clinical pressures consumes clinical divisions making it difficult to focus on research. (e) 'one size fits all' approach may not be suitable	(a) identify areas where there are blocks and work with them to streamline processes and help them understand their part and impact in delivering research. (b) clear communication, defined work plan and accountabilities agreed between R&I and division of W&C (c) standardised core JDs for research delivery staff; engagement by research matron with B7 research staff to understand need for flexibility (d) increased engagement and regular meetings with divisional staff at all levels. (e) work with each division to reach suitable solution.	Progress reports to Trust Research Group			MD	Trust Research Group
			(b) Develop and implement, in collaboration with the division of W&C, a sustainable staffing model to deliver paediatric research by the end of 2014/15									
			(c) Work towards developing a more flexible and agile mechanism to deploy the research delivery workforce across the trust in line with the R&I 'Workforce' work plan.									
			(d) Provide clinical divisions with the information they need to oversee and manage research performance, increasing visibility within divisional boards.									
			(e) Achieve common agreed processes across clinical divisions for job planning and recommendation of research SPA allocation.									
	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR)	(a) Oversee and performance manage small grants which have been pump-primed by UH Bristol/Above and Beyond funding to deliver their objectives, increasing the conversion rate to NIHR grants over 2013/14 levels.			(a) and (b) capacity to manage process effectively may impact on performance (c) focus solely on UH Bristol opportunities may detract from allocating time to collaborative work	(a) and (b) new post (in development) to support research grants manager will release capacity (c) use cross-organisational networks currently in existence to maintain awareness of opportunities	Progress reports to Trust Research Group			MD	Trust Research Group
			(b(Identify opportunities for new submissions for NIHR grant funding within existing external and pump-priming grant holders									
			(c) identify collaborative opportunities for grant applications with our local and regional partners.									
		We will demonstrate the value of research to decision makers within and outside the trust	(a) Routinely identify recently completed grants and collate information about the outputs and potential impact			(a) clinical impact difficult to identify/quantify until some time after research has taken place (b) recognition of impact can be difficult to quantify (c) failure to identify appropriate stakeholders within the organisation	(a) maintain rolling programme of review; include impact on clinical care of the research practice during conduct. (b) engagement with clinical and research staff both directly and through the network of research staff (c) engagement with clinical division	Progress reports to Trust Research Group			MD	Trust Research Group
			(b) Identify clinical areas where the conduct of research has had a defined impact on the service delivery									
			(c) Disseminate information to relevant stakeholders (internal and external)									
		Transformation Priorities	Refresh our Transforming care programme, renewing the priority projects to achieve the aims of each pillar and mobilising focussed, benefits driven, rapid delivery project teams			Do not identify the right actions to address underlying issues We allow progress to drift	Scope sign off and monthly progress review by Transformation Board	Progress updates to Trust Board			COO	Transformation Board
			Establish structured progress monitoring by PMO reporting monthly to Transformation Board			Do not intervene to keep progress on track	Structured review by Transformation Board	Progress updates to Trust Board			COO	Transformation Board
			Mobilise delivery at pace; Communicate intentions to build organisation engagement and buy in			Do not act with pace	Transformation Board to hold to account for delivery	Progress updates to Trust Board			COO	Transformation Board
5		Ensure organisation support for developments under the Better Care Fund	UH Bristol to be represented at BFC meetings and provide steer on changes to the services we provide			Risk that the plans do not fully consider the existing savings plans required by the Trust (4%) and other partners.	Risk mitigated by highlighting this risk in the Bristol BCF submissions and ongoing attendance at meetings.	Better Care Fund external reviews.			COO	Senior Leadership Team
			Model any impact on UH Bristol services from proposed changes to models of care developed through the BCF Programme									

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	We will effectively host the Operational Delivery Networks that we are responsible for.	Establish governance arrangements for both Critical Care Networks.			Clinical Directors for ODNs do not lead on agenda.	Hold assurance meetings with ODN Clinical Leads.	Evidence of delivery against objectives			MD	Senior Leadership Team
		We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.	Fully engage with BHP agenda and governance. Fully engage with AHSC governance and assist with strategic planning.			Trust does not contribute to AHSc and BHP research agendas	Attendance at key AHSN and BHP Board and Executive meetings	Minutes evidencing attendance			MD	Senior Leadership Team
		We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network	Establish robust internal governance including Board reporting for the CRN and CLARHC			Risk that CRN leads fail to lead on research agenda.	Monthly governance meetings with CRN Clinical Lead and Chief Operating Officer.	Minutes from governance meeting and feedback to Executive Team via work programme			MD	Senior Leadership Team
6	We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal	Deliver minimum normalised surplus	Achieve full delivery of annual CRES programme (detail provide below) and positive contract settlement with CCG and NHSE commissioners			LA sign off and North Somerset CCG to re-admissions	On-going discussions	Oversight by operational planning core group			DoF	Finance Committee
		Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.	SLR development Use of result in informing Business Planning			Risks include non-adoption of efficiency opportunities by the Clinical Directors.	Risks not yet mitigated particularly re Medicine Division.	Updated Operating Plan at end of June will describe how the efficiency opportunities have been adopted in the Business Plans.			DoF	Finance Committee
		Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m			No risk at present.	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.			DoF	Finance Committee
		Deliver the annual Cash Releasing Efficiency Savings (CRES) programme in line with the LTFP requirements	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Review. Develop recurrent CRES plans to ensure all non-recurrent CRES is secured recurrently by Q3 2014 and delivery 14/15 CRES requirement on a normalised basis			It is considered that there is minimum risk to the plans currently identified. The real risk to delivering the target is a lack of new schemes coming through the pipeline process. There is a risk that there is a lack of knowledge and skill set amongst Trust staff in order to identify new savings schemes as well as a potential shortage of capacity in terms of time available for existing staff to focus on savings programme delivery.	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. Work streams have been refreshed and are identifying additional savings through productivity. The Trust has engaged and experienced CIP Director who is working with Divisions in order to identify new savings and ensure delivery of existing schemes.	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.		741	DoF	Finance Committee
		Refresh the Trust's Strategy including its direction for research & innovation and teaching & learning	Complete sustainability review of Trust key service areas and incorporate findings and response into Trust strategy and Monitor Five Year Strategic Plan concluded and approved by Board in June 2014			Workforce constraints prevent strategic plan from being completed.	Prioritisation of tasks within SD and Finance Teams	Programme Update to Clinical Strategy Group and Board on regular basis			D of SD	Senior Leadership Team
		Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.	Appraise the risks and benefits associated with forthcoming major, strategic choices e.g. SBCH, Community Child Health, Weston Area Health Trust and ensure the Board is adequately briefed and supported to make choices.			Workforce constraints prevent strategic plan from being completed and/or access to information to adequately evaluate strategic choices is not accessible	Prioritisation of tasks within SD and Finance Teams. Working closely with procurement leads in tendering organisations to ensure access to information.	Programme Update to Clinical Strategy Group and Board on regular basis			D of SD	Senior Leadership Team
		Continue to develop private patient offer for the Trust	Private patient 'front door' up and running and Private Medical Insurance contracts signed by end of Q1 Private Patient Strategy for 2015-2020 developed and presented to the Board by end of Q4 Monthly income and expenditure reports in place by end of Q2			Development of PP marketing approach is taking longer than anticipated which is impacting on agreement of the colour scheme for the 'front door' Private Patients Manager vacancy resulting in gap in resources for 3 month period.	Work underway between private services and communications to develop proposal for marketing approach. New Deputy Chief Operating Officer commences role in August 2014.	Private Patients Steering Group			COO	Senior Leadership Team
7		Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.	Achieve EBITDA, Return on Assets, Net Surplus Margin and Liquidity ratio in line with plan			Delivery of CRES plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting			DoF	Finance Committee

Reference	Strategic Objectives	Annual Objective 2014-15	Key Activities 2014-15	Progress Towards Achievement of 2014-15 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2014-15	How are the risks to achievement being mitigated? (controls)	Source of Assurance that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group
						activities income in line with SLA and Trust Plan		to Monitor via Finance Committee and Trust Board.				
		Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in practice and policy	Review, develop, consult and establish a new structure for the Trust Secretariat and recruit to all vacant post by end of December 2014.			Failure to secure staff support for proposed structure and/or recruitment to vacant posts is not achieved in a timely fashion.	Engage staff and their representatives in development of future structure and formally consult staff. Ensure roles, responsibilities and salaries are such that roles are attractive in market place.	Regular updates to Executive team through work programme oversight			Deputy CEO	Risk Management Group
			To review effectiveness of Board sub-committees including approach to workforce governance			Delayed appointment to Trust Secretary vacancy.	Establish satisfactory interim arrangements and commence recruitment as soon as practical with aim of new TS starting in October 2014.	Regular updates to Executive team through work programme oversight			Deputy CEO	Risk Management Group
			To scope and develop Terms of Reference for work programme to address current shortcomings in approach to Procedural Document Management.			Workforce constraints prevent project from being scoped and progressed.	Interim Trust Risk Manager appointed and PDM an early priority.	Regular updates to Executive team through work programme oversight			Deputy CEO	Risk Management Group
			Develop and deliver actions arsing from on-going external governance reviews e.g. Lawson Review, W&C Governance Review			Workforce constraints during interim period of TS vacancy delay implementation.	Establish satisfactory interim arrangements and commence recruitment as soon as practical with aim of new TS starting in October 2014. Establish action priorities and ensure focus on implementation of those.	Regular reports to Risk Management Group			Deputy CEO	Risk Management Group
		Robustly prepare for the planned Care Quality Commission inspection.	Develop and coordinate delivery of an action plan to coordinate preparation for CQC visit.			Vacancy for CQC project manager.	Out to advert. Contingency temporary staff if do not recruit.	Regular reports to CQC steering group and SLT/Execs			CN	Senior Leadership Team
			To develop a clear communicational support plan for staff.								CN	Senior Leadership Team
	We will ensure we are soundly governed and are compliant with the requirements of our regulators	Prepare for and achieve successful outcome from proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Q2	To provide all necessary information, in a comprehensive and robust fashion, in advance of visit			Workforce capacity constraints	Prioritisation of this work, above lower priorities	Regular updates to Executive team through work programme oversight			Director of SD	Executive Directors
			Ensure team are adequately prepared for Monitor visit and key messages are appropriately develop and clearly communicated throughout the process.			Lack of preparation and availability of key personnel.	Adequate preparation	Regular updates to Executive team through work programme oversight			Chief Executive	Executive Directors
		Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	To review findings of IST following their visit and agree actions to address recommendations and any resulting impact on RTT performance			Activity is on track against plan but the backlog numbers of patients waiting over Stage of Treatment (SOT) first outpatient waits is not reducing as per trajectory. Increases in demand over and above planned trajectory. Ability to recruit to vacancies / new consultant posts to support increased demand in system.	Weekly tracking of delivery against the first outpatient wait recovery plan. Improvements in the first outpatient wait PTL process, supported by validation to ensure PAS holds accurate data. Discussions with Emerson's Green to assess options for outsourcing where capacity issues exist.	RTT Steering Group RTT Operational Group Divisional PTL Meetings Elective Care (ECIST) external review Service Delivery Group		1967	COO	Senior Leadership Team
			Recovery plan for non-admitted monitored weekly and RTT non-admitted delivered by end of Q2									
			To be consistently achieving agreed waiting time standards - No patient waiting over 13 weeks for outpatients, no elective patient cancelled due to lack of beds and no patient waiting >40 weeks on a RTT pathway									
		Improve cancer performance to ensure delivery of all key cancer targets	Establishment of monthly Cancer Performance Steering Group			Ability to increase capacity for Thoracic pathways ahead of the vascular transfer. Vascular transfer not occurring in October 2014. ITU / HDU capacity and acuity. Where delays occur due to late referral, risk they will not accept responsibility for the breach.	Assessing options for putting on non-recurrent additional capacity to tackle the short term capacity pressures. Recruiting to Cancer Network posts who will take forward improvements in timeliness of inter-provider referrals. Vascular service transfer being overseen by the BRI Redevelopment Board. Operating Model 2014/15 - Planned Care / Protected Pathways project.	Cancer Steering Group Cancer Operational Group Cancer PTL Meeting Service Delivery Group		1412	COO	Senior Leadership Team
			Achievement of 62 day cancer standard from Q3 onwards									
			Transfer of breast screening patients on the cancer register to have been completed accurately by end of Q2									

APPENDIX 2 – MARKET ANALYSIS

1. The region

University Hospitals Bristol NHS Foundation Trust is a provider of regional and tertiary services to the South West. The South West has the largest land area of the regions in England (18%) and a population of circa 5.3 million. The South West is a diverse region from a geographical, economic and health standpoint. Of the nine regions in England, the South West has the highest life expectancy for women (83.5 years; England: 82.6 years) and third highest for men (79.5 years; England: 78.6 years), both above the England average. However, according to the latest Office of National Statistics (ONS) Integrated Household Survey (April 2011 to March 2012), 19.4% of the region's adult population still reported that their general health was "not good". This reflects the considerable variation across the region in reported health, with a greater percentage of people reporting poor health in the more deprived areas. In the latest Index of Multiple Deprivation, 121 of the region's Super Output Areas (3.9%) are ranked within the most deprived 10% in England. Forty percent of these areas lie within Bristol and Plymouth, but the remainder are spread across 14 smaller local authorities. So within a region with some of the best life expectancy of anywhere in the country, there is a mixed picture for the health of the population, with clear challenges within the Bristol area, which is the major catchment area for the Trust.

2. Bristol, North Somerset, South Gloucestershire (BNSSG)

In addition to being a provider of tertiary services the Trust is a major provider of local hospital services to Bristol, particularly in the central and southern parts of the city, and derives the majority of its patient care income from the commissioners representing the greater Bristol area. The Bristol urban area includes parts of neighbouring local authority areas of North Somerset and South Gloucestershire, and covers a population of circa 914,000. The University Hospitals Bristol estimated catchment is 686,000 of the BNSSG area. Around 30% of urban Bristol population lies outside of the Bristol local authority area. In the last ten years Bristol's population is estimated to have grown by 9.7%, which is significantly higher than the England and Wales average (7.1%). It is the third fastest growing city of the Core Cities, with much of the growth being focused on the central Bristol area, in particular Cabot and Lawrence Hill, which are a core part of the catchment area of the Trust. However, most recent projections expect growth to slow to a rate more similar to the England average (8.1% between 2010 and 2020).

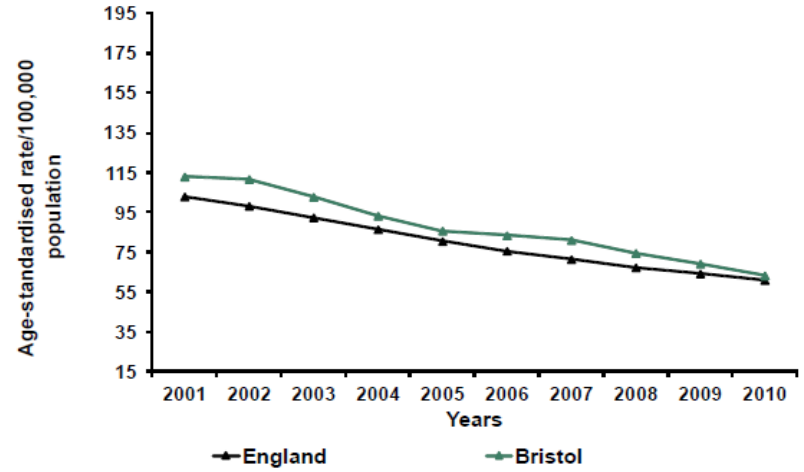
3. Changing demographics and health needs

In contrast to North Somerset and South Gloucestershire, which have a rapidly growing elderly population, Bristol has a young population profile. The average (median) age of the population in Bristol is 33 years, compared with 39 for England and Wales. The majority of the population increase has been in young working adults (20 to 34 year olds), which is attributed in the Joint Strategic Needs Assessment to international immigration. The under 5s have, however, shown the largest single rise of any age group in the area. Although in recent years there has been a reduction in the number of older people in Bristol future projections estimate there will be a greater than 9% growth in older people by 2020. This is significantly lower than national projections (23%). However, people are living longer, and it is projected that there will be a relatively large increase in people aged over 90 years in

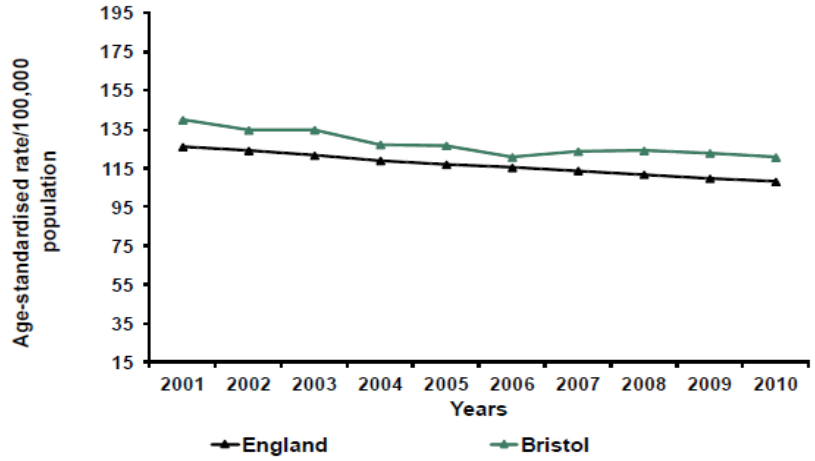
Bristol, which will have a disproportionate impact in terms of health and social care needs especially in the context of increasing numbers of people living with dementia and long-term health conditions.

The life expectancy of the population of Bristol is 78.0 years for men and 82.6 years for women. This is lower than the averages for the South West and England (South West averages of 79.5 for men and 83.4 for women, respectively). According to the most recent Joint Strategic Needs Assessment for Bristol, the main health issues for the city mirror the national picture, with cancer continuing to represent the biggest killer of people under the age 75 (38%) followed by cardiovascular disease (23%). However, whilst the gap between the England average and Bristol early death rates from heart disease and stroke have closed in the last five years (see Graph 1), early death rates from cancer remain significantly higher in Bristol than for England as a whole (Graph 2).

Graph 1 – Bristol and England average early death rates from heart disease and stroke



Graph 2 – Bristol and England average early death rates from cancer



Bristol is also an outlier for smoking related deaths, alcohol related stays in hospital and drug misuse (see Figure 1 which shows the Health Profile 2013 – Bristol). The health issues identified in the most recent Joint Strategic Needs Assessments for the wider BNSSG area are summarised as part of the recent Bristol Acute Services review, as shown in Table 1.

This analysis shows the Trust's portfolio of work remains well aligned with the key health challenges of the local area, in particular cancer and heart disease

Figure 1 – Bristol Health Profile 2013 (published by the Public Health Observatories – Sept 2013)

Health summary for Bristol

E06000023

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — 25th Percentile — England Average — 75th Percentile — England Best

Domain		Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1	Deprivation	110488	25.8	20.3	83.7		0.0
	2	Proportion of children in poverty	19670	26.1	21.1	45.9		6.2
	3	Statutory homelessness	299	1.6	2.3	9.7		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1530	51.7	59.0	31.9		81.0
	5	Violent crime	10149	23.0	13.6	32.7		4.2
	6	Long term unemployment	3228	11.0	9.5	31.3		1.2
Children's and young people's health	7	Smoking in pregnancy ‡	722	10.6	13.3	30.0		2.9
	8	Starting breast feeding ‡	5368	81.1	74.8	41.8		96.0
	9	Obese Children (Year 6) ‡	640	19.1	19.2	28.5		10.3
	10	Alcohol-specific hospital stays (under 18)	46	57.4	61.8	154.9		12.5
	11	Teenage pregnancy (under 18) ‡	262	39.7	34.0	58.5		11.7
Adults' health and lifestyle	12	Adults smoking	n/a	21.0	20.0	29.4		8.2
	13	Increasing and higher risk drinking	n/a	23.3	22.3	25.1		15.7
	14	Healthy eating adults	n/a	27.8	28.7	19.3		47.8
	15	Physically active adults	n/a	55.4	56.0	43.8		68.5
	16	Obese adults ‡	n/a	22.7	24.2	30.7		13.9
Disease and poor health	17	Incidence of malignant melanoma	50	13.1	14.5	28.8		3.2
	18	Hospital stays for self-harm	1228	274.9	207.9	542.4		51.2
	19	Hospital stays for alcohol related harm ‡	10651	2435	1895	3276		910
	20	Drug misuse	4989	16.9	8.6	26.3		0.8
	21	People diagnosed with diabetes	17672	4.6	5.8	8.4		3.4
	22	New cases of tuberculosis	82	18.6	15.4	137.0		0.0
	23	Acute sexually transmitted infections	5088	1189	804	3210		162
	24	Hip fracture in 65s and over	394	469	457	621		327
Life expectancy and causes of death	25	Excess winter deaths ‡	176	16.5	19.1	35.3		-0.4
	26	Life expectancy – male	n/a	78.0	78.9	73.8		83.0
	27	Life expectancy – female	n/a	82.6	82.9	79.3		86.4
	28	Infant deaths	18	2.7	4.3	8.0		1.1
	29	Smoking related deaths	573	219	201	356		122
	30	Early deaths: heart disease and stroke	235	63.3	60.9	113.3		29.2
	31	Early deaths: cancer	445	120.7	108.1	153.2		77.7
	32	Road injuries and deaths	133	31.5	41.9	125.1		13.1

‡ For comparison with PHOF Indicators, please go to the following link: www.healthprofiles.info/PHOF

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 2012 16 % adults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 2011/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011

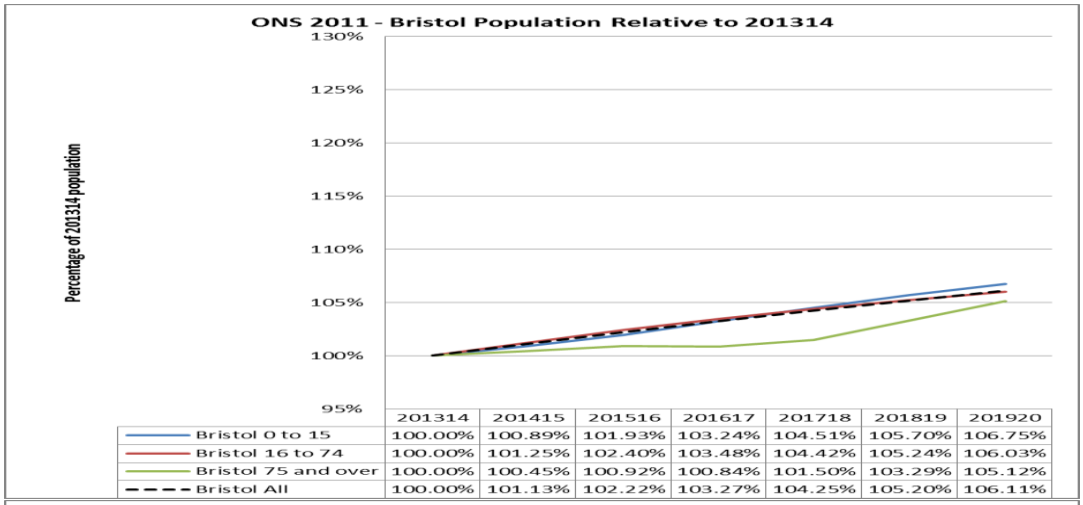
Table 1: Summary of public health challenges for Bristol, North Somerset & South Gloucestershire (BNSSG) as described in the Bristol Acute Services Review

	Bristol	**North Somerset**	**South Gloucestershire**
Demographics	• Population 441,330* • Rapidly growing population, mainly amongst people of working age • Diverse ethnic population	• Population 210,430* • Two thirds live in areas; the rest live in rural • Population is growing at faster rate than the national population • Rapidly growing elderly population	• Population 262,000* • Population is growing at a faster rate than the national population • Rapidly growing elderly population • 60% live in urban north Bristol, the rest in market towns / rural
Socio-economic conditions, and health	• Deprivation is higher than average • Strong economy, but some areas with persistent unemployment • Significant variation in health across population • 27% of children living in poverty • Life expectancy lower	• Better life expectancy than England average, though lower in deprived areas (10.5 years lower for men) • Deprivation lower than England average, although 5,955 children live in poverty	• Deprivation is lower than England average, although 6,100 children in poverty • Region has had relatively strong economic performance • Life expectancy higher than England average, though lower in deprived areas
Health priorities	• Reduction of health inequalities • Improving cancer outcomes • Cardiovascular • Mental Health • Substance misuse • Obesity risk factors • Long terms conditions	• Dealing with population growth • Caring for the elderly (particularly dementia) • Lifestyles issues e.g. smoking, sexual health, immunisation • Coronary disease • Joint working with local partners to address inequalities	• Tackling health in deprived areas • Increasing physical activity • Premature deaths from cancer • Ageing population demands • Depression • Dementia • Lifestyle issues of young people

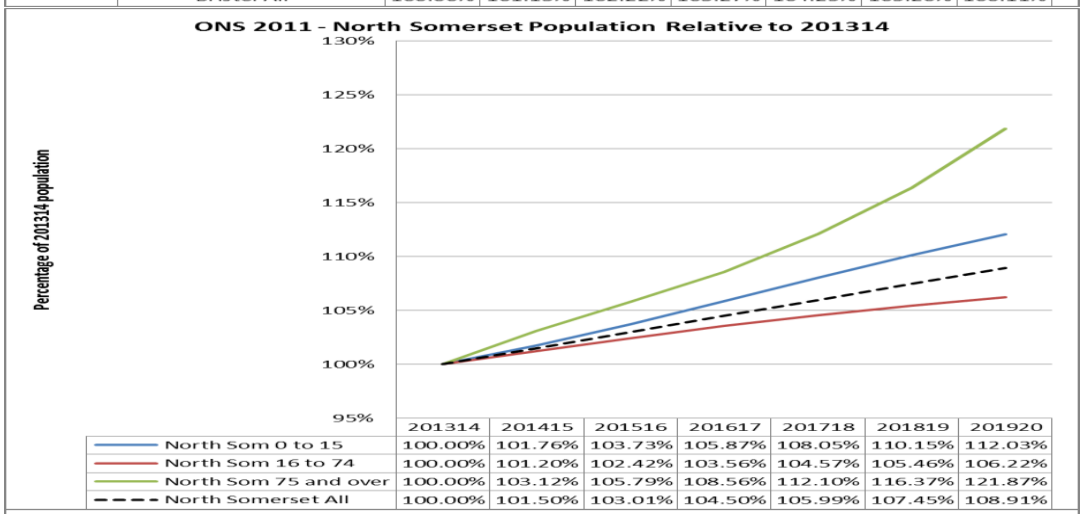
Source: Bristol Acute Services@ the Case for Change, (Jul 2012); joint Strategic Needs Assessment, South Gloucestershire (Dec 2008); JSNA South Gloucestershire Draft (Jan 2013); JSNA Executive Summary North Somerset (2011); *Sub-national population projections for England, ONS, (Sept 2012).

The following graphs (Graphs 3 to 5) show population projections, split by age-group, for each of the three CCGs, as derived from the Office of National Statistics (ONS) most recent population estimates (2011).

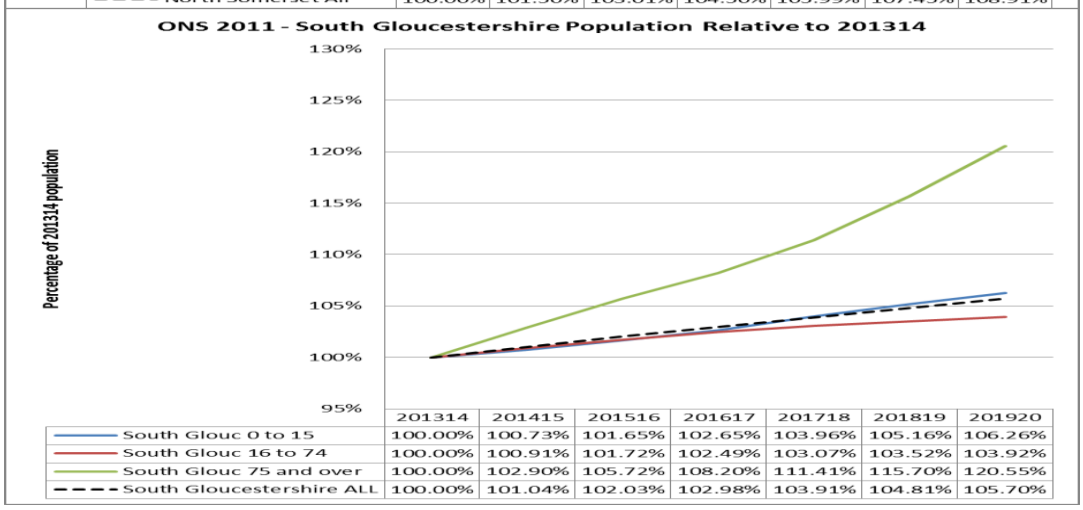
Graphs 3 to 5 – Population growth estimates from the ONS (2011), by age band, for Bristol, North Somerset and South Gloucestershire.



	201314	201415	201516	201617	201718	201819	201920
Bristol 0 to 15	100.00%	100.89%	101.93%	103.24%	104.51%	105.70%	106.75%
Bristol 16 to 74	100.00%	101.25%	102.40%	103.48%	104.42%	105.24%	106.03%
Bristol 75 and over	100.00%	100.45%	100.92%	100.84%	101.50%	103.29%	105.12%
Bristol All	100.00%	101.13%	102.22%	103.27%	104.25%	105.20%	106.11%



	201314	201415	201516	201617	201718	201819	201920
North Som 0 to 15	100.00%	101.76%	103.73%	105.87%	108.05%	110.15%	112.03%
North Som 16 to 74	100.00%	101.20%	102.42%	103.56%	104.57%	105.46%	106.22%
North Som 75 and over	100.00%	103.12%	105.79%	108.56%	112.10%	116.37%	121.87%
North Somerset All	100.00%	101.50%	103.01%	104.50%	105.99%	107.45%	108.91%



	201314	201415	201516	201617	201718	201819	201920
South Glouc 0 to 15	100.00%	100.73%	101.65%	102.65%	103.96%	105.16%	106.26%
South Glouc 16 to 74	100.00%	100.91%	101.72%	102.49%	103.07%	103.52%	103.92%
South Glouc 75 and over	100.00%	102.90%	105.72%	108.20%	111.41%	115.70%	120.55%
South Gloucestershire ALL	100.00%	101.04%	102.03%	102.98%	103.91%	104.81%	105.70%

4. Local activity trends

Analysis undertaken of University Hospitals Bristol spells over the last five years shows that a greater number and percentage of patients were admitted from the North Somerset area in 2013/14 relative to previous years (see Table 2 below). The majority of this increase has been in emergency admissions, with the percentage of emergency admissions from North Somerset rising from 13.4% in 2012/13 to 14.0% in 2013/14.

Table 2 – The percentage of spells (including day-cases and regular day/night attenders) from each CCG in each of the last 5 years.

CCG	2009/10	2010/11	2011/12	2012/13	2013/14*
Bristol	57.6%	57.9%	58.0%	57.9%	55.6%
North Somerset	15.7%	15.8%	15.6%	15.7%	16.4%
South Gloucestershire	12.3%	11.5%	11.4%	11.4%	12.2%
Other	14.5%	14.8%	14.9%	15.0%	15.9%

* Please note data for 2013/14 is up to and including December 2013.

Admissions for patients aged 75 years and over have increased significantly between 2012/13 and 2013/14, in both North Somerset and South Gloucestershire, with North Somerset now making-up over 20.4% of admissions for that age group (Table 3). The most recent Joint Strategic Needs Assessment for both these areas highlighted the rapidly growing elderly population, which this analysis bears-out.

Table 3 - The percentage of spells for patients aged 75 years and over from each CCG in each of the last 5 years (all work-types)

CCG	2009/10	2010/11	2011/12	2012/13	2013/14*
Bristol	59.7%	60.3%	60.4%	60.7%	58.3%
North Somerset	18.7%	19.0%	19.2%	19.2%	20.4%
South Gloucestershire	11.4%	10.1%	10.0%	9.1%	10.5%
Other	10.2%	10.6%	10.4%	11.0%	10.8%

* Please note data for 2013/14 is up to and including December 2013.

Consistent with the increasing levels of emergency admissions from North Somerset and South Gloucestershire, there has been a similar rise in Emergency Department attendances from these areas (see Table 4).

Table 4 - The percentage of A&E attendance from each CCG in each of the last 5 years.

CCG	2009/10	2010/11	2011/12	2012/13	2013/14*
Bristol	69.6%	69.4%	69.2%	68.6%	68.0%
North Somerset	11.2%	11.5%	11.4%	11.9%	12.1%
South Gloucestershire	8.3%	8.5%	8.7%	8.7%	8.8%
Other	10.9%	10.6%	10.8%	10.8%	11.1%

* Please note data for 2013/14 is up to and including December 2013.

The distribution of outpatient attendances across BNSSG and Other CCGs (Table 5) is showing a similar pattern to other work-types in 2013/14, with a decrease in the proportion of attendances for Bristol CCG patients, but an increase in North Somerset and South Gloucestershire.

Table 5 - The percentage of outpatient attendances from each CCG in each of the last 5 years.

CCG	2009/10	2010/11	2011/12	2012/13	2013/14*
Bristol	56.5%	57.6%	57.2%	56.9%	52.6%
North Somerset	15.4%	15.3%	15.6%	16.1%	17.0%
South Gloucestershire	14.2%	13.5%	13.7%	13.8%	17.1%
Other	13.9%	13.7%	13.5%	13.2%	13.3%

* Please note data for 2013/14 is up to and including December 2013

5. Market Analysis

There have been some significant changes in the market share of University Hospitals Bristol, although overall the Trust maintained a strong position in the market both locally and regionally. Some of these changes in market share reflect the transfer of Head & Neck services to the Trust at the end of March 2013, and the associated transfer out of breast surgery and urology.

The Trust's market share of BNSSG commissioned work remains consistent, with only a small number of gains or losses, other than those relating to recent service transfer. University Hospitals Bristol has seen a 5% or greater proportional gain in market share of BNSSG commissioned work between 2012/13 and 2013/14, in the following specialties:

- Gastroenterology – (8.8% increase in inpatient and day-case work combined) – *this is likely to be due to the increased activity associated with backlog clearance in 2013/14;*
- Cardiology (11.0% increase inpatient work; 8.7% increase including day-cases);
- Obstetrics (5.5% increase).

The following specialties showed a 5% or greater proportional loss of BNSSG market share, again excluding those specialties that were the subject of service transfers:

- Midwifery episodes (11.0% decrease);
- General medicine (8.9% decrease in inpatient spells) - *this may be due to the introduction of the Ambulatory Care Unit, and a reduction in Trust spells, rather than an actual loss of market share;*
- Upper GI surgery (8.0% decrease in inpatient and day-case work combined; 0.1% decrease in inpatient only) – *suggests a loss or reduction of day-case work;*
- Accident & Emergency (admissions under the A&E specialty; 7.4% decrease) – *this may be due to the introduction of the Ambulatory Care Unit, and a consequent reduction in spells, rather than an actual loss of market share;*
- Clinical haematology (5.4% decrease in inpatient and day-case work combined);
- Ophthalmology (5% decrease in inpatient and day-case work combined; 28% decrease in inpatient work) – *may reflect a change in clinical practice/recording rather than a loss of inpatient market share.*

Excluding those areas that were the subject of the recent service transfer, University Hospitals Bristol has seen a 5% or greater proportional gain in market share across the South West between 2012/13 and 2013/14, in the following specialties:

- Accident & Emergency (admission under A&E specialty; up from 9.8% market share to 12.8%);
- Obstetrics (up from 10.6% to 11.4%);
- Paediatrics (up from 10.0% to 10.7%);
- Thoracic surgery (up from 57.8% to 61.6%).

Market share losses, of 5% or greater proportional loss, have been seen in the following specialties, again excluding those specialties that were the subject of service transfers:

- Midwifery episodes (down from 9.3% market share to 7.9%) – *with an increase in market share for North Bristol NHS Trust in particular (from 17.6% to 19.1%), as reflected in the BNSSG analysis;*
- Clinical haematology (down from 15.6% to 14.3%) – *the Trust continues to be ranked second highest for market share in the region behind the Royal Devon & Exeter NHS Foundation Trust, although there have been increases in market share across a range of providers in the South West;*
- Cardiology (down from 13.9% to 13.2%) - *the Trust continues to be ranked second highest for market share in the region behind the Royal Bournemouth and Christchurch Hospitals, although there have been increases in market share across a range of providers in the South West.*

Most high volume specialties with a greater than 33% share of the South West market performed well in 2013/14. Cardiac Surgery maintained 58.7% of market share in the South West in 2013/14, a small increase from 58.5% in 2012/13, with Plymouth Hospitals continuing to be the other main provider in the region. The market share for Paediatric Surgery increased from 95.2% in 2012/13 to 98.4% in 2013/14. Thoracic Surgery increased its market share from 57.8% in 2012/13 to 61.6% in 2013/14, with Plymouth Hospitals continuing to be the other provider in the region and showing a loss in market share. Ophthalmology was one of the few specialties to show a loss of market share for inpatient work, decreasing from 46.2% in 2012/13 to 44.3% in 2013/14. However, when day-cases were included in the analysis, Ophthalmology showed an increase in market share, from 13.8% in 2012/13 to 14.3%. The day-case analysis shows that a number of providers within the region have increased their market share, including Royal United Hospitals Bath. Along with the local move towards more work being undertaken in the independent sector, this change in market share poses a potential risk to the future service income.

Within the South West, University Hospitals Bristol makes-up 8.3% of the Emergency Department attendances, and is the joint second largest provider of A&E services (by volume), along with Royal Devon & Exeter NHS Foundation Trust, after Gloucestershire Hospitals NHS Foundation Trust.

APPENDIX 3 – METHODOLOGY FOR THE ANALYSIS OF SUSTAINABILITY RISK

This note is a summary of our approach to assessing sustainability of services in our Trust. It describes the three main criteria of sustainability as we have chosen to define it and provides guidance to Divisions and others in terms of what sort of questions they should ask – and what factors they should consider – when analysing the sustainability of the services they provide.

Context - Why we are assessing the sustainability of our services.

As a Foundation Trust we are directed to provide a Strategic Plan to Monitor which will cover the next 5 years. In the guidance issued regarding the development of this plan, Monitor has placed a premium on the analysis of the sustainability of services and the identification of risks to that sustainability. Our Strategic Plan must summarise the key risks to the sustainability of our services in the medium term and summarise the major strategic initiatives that we are developing to mitigate those risks.

Central to this therefore is a consistent approach to the assessment of sustainability. This approach is presented here and should be used by Divisions to analyse the full range of their service lines.

There is a wide range of existing work on which we can draw to inform the analysis of sustainability of service lines – specifically:

- Work in the autumn of 2013 led by Clinical Directors as part of the Strategy Review;
- Work to develop Operating Plans.

This exercise to assess the sustainability of service lines and risks to that sustainability should largely be a summary of the work included in the work listed above and not (in principle) require the generation of significant new work.

The UH Bristol Approach

As agreed at our discussion on the 29th of April, we shall consider the key components of sustainability of services to be as follows:

- Market and Demand Sustainability;
- Clinical and quality Sustainability;
- Operational Sustainability.

Guidance on each of these components is below, and should be used by Divisional teams when analysing their service lines. The structure below is not designed to be exhaustive or restrictive, and Divisions should include any other analysis or content that they consider relevant.

The Components of Sustainability of Services

Component 1 - Market and Demand Sustainability

This component of sustainability of services relates to the rationale for continued provision of the service – the current demand, how the need for care is going to change and develop, the existence and intentions of competitors, and the views and plans of commissioners.

1.1 Demand. This section is where to consider the current demand for the service in question and whether that demand has increased or decreased in recent years.

1.2 Any changes in the need for care. This is where the key drivers of the need for care over the next 5-10 years should be considered. Examples of these drivers are:

- The impact of known demographic changes;
- The impact of anticipated changes in the prevalence of conditions related to this service;
- The potential impact of (known) new services models that have the potential to fundamentally change the way the service is delivered.

1.3 Existence and Intentions of Competitors. Consideration must be given to the impact of competitors and the risks they present to the demand for the provision of a service by UH Bristol.

1.4 Commissioning Plans. These are a key determinant of the sustainability of our services and there must be consideration in service line analysis of the impact of known (or anticipated) commissioning plans. If there is a potential divergence between the plans of UH Bristol and the intentions of commissioners it must be identified as it is a key risk to the sustainability of a service.

Component 2 – Clinical and Quality Sustainability

This component of sustainability of services relates to the key clinical and quality elements of a service. The key elements of analysis in this section will include:

2.1 Key Clinical Elements of a Service. This section should refer to any guidance regarding the basic clinical components required to deliver a service. It should draw on:

- Relevant guidelines from Royal Colleges regarding (for example) the de minimus level of activity required;
- Relevant service specifications;
- Consideration of access to appropriate diagnostic capability.

The analysis here should identify any risks to these clinical components of the service:

2.2 Key Quality Elements of a Service. This section should consider the sustainability of the service in accordance with the three elements of the Trust approach to quality:

- Patient Safety;
- Clinical Effectiveness (if necessary as it will have been dealt with in 2.1);
- Patient Experience.

Component 3 – Operational Sustainability

This component of sustainability of services relates to those things required for the delivery of the service on a routine basis.

3.1 Workforce. This section should analyse any risks to the sustainability of the workforce of a service. Divisions should consider the following types of questions:

- Does workforce align with capacity (e.g. appropriate numbers of PAs)?

- Is the skill mix safe and affordable?
- Are key staff due to retire in the next 5-10 years – can these be easily replaced?
- Do you envisage any difficulty in recruiting to the service - any future supply issues?
- Will changes in junior doctor numbers impact on this service in the future?
- Do staff have the right skills for service requirements over the next 5-10 years?
- Are there any plans for workforce redesign?
- Are there consistently high levels of turnover, sickness or vacancies?

3.2 Other Resource Requirements. This section should cover any other enabling resources required for the delivery of a service. This will include the Estate requirements specifically but should also include any other relevant resources that are not Workforce or Finance.

3.3 Finance. Consideration should be given to the financial sustainability of a service. This section will connect to analysis of future demand and known commissioner plans, but should also be used to look specifically at key financial information and the implications these numbers have for a service. This information must include:

- SLA numbers and surplus or deficit (margin) as a % of income;
- Reference Cost Index including any trend.

APPENDIX 4 – SUSTAINABILITY RISK AND MITIGATION

RISK AND MITIGATION OPTIONS BY KEY SERVICE AREA

Children's Services

Risk	Mitigation
• Capacity to meet the demand of a growing local child population (bucks the national trend)	• Greater links with secondary care in the region trying to avoid acute admissions • System wide work with partners such as social service to limit impact of changing demographics
• Complexity of patients with increased societal expectation resulting in highly dependent children requiring high dependency nursing • Recruitment and retention of consultants and other staff in key areas such as PICU, interventional radiology, paediatric pathology etc. • Difficulty in recruiting middle grade doctors and nursing • Expected reduction in training posts	• Improve approach to the use of technology and innovation • Recruitment and retention strategy for nursing staff • Workforce planning, taking account of alternative workforce models at all grades
• If Community Paediatrics and CAMHS continues to be provided by another provider – lack of income potential and lack of control over input at the Trust	• Decide on involvement – tender or help shape service
• Compliance with specialised services specifications requiring internal and external investment • Increase in cost of medical interventions	• Focus investment on key services where designation is the aim
• If tariff income continues to be deflated investment potential reduces and ability to meet fixed costs • Deflation in income for teaching and research	• SLR initiatives • Continue to present cases for external investment in key regional services

Accident & Emergency (and Urgent Care)

Risk	Mitigation
• Impact of city wide changes in demand and capacity to meet demand at BRI • Success in urgent care and A&E avoidance initiatives could leave the Trust over capacity in this area • Potential tender for walk in sexual	• Continue to monitor system wide capacity with partners • Lead in work to build system wide resilience

Risk	Mitigation
health services • Non-delivery of key targets impacting across the Trust • If proposed new models of care do not work there will be continued pressure on A&E resulting in overcrowding, poor performance and poor clinical quality and safety • Potential shortage of junior and middle grade doctors impacting on capacity to meet demand • High turnover of nursing staff • Difficulty recruiting acute physicians	• Build resilient service, centralising where necessary and using technology such a POC testing to compete effectively • Matching capacity to demand by developing a flexible workforce within new model of care • Understand barriers to patient flow • Working with partners to improve integration of assessment and funding pathways for continuing care • Bristol wide review of workforce requirements, monitoring local availability of junior and middle grade doctors • Enhance roles of ENPs, building flexibility across the system through innovative working models • Provide incentives through training (e.g. clinical fellows) to build a stable, retained workforce

Older People's Care

Risk	Mitigation
• Ageing population increasing the demand for services, and complexity of frail elderly patients increasing • Expectation of the ageing population due to advances in medicine • System wide reduction in budgets risks insufficient resources to match demand and complexity • If the Trust and wider system are not able to deliver new models of care • High nursing costs within existing model transferring to new models would translate to unsustainable reference costs • Potential workforce shortages as a result of lack of trainees and consultant	• Enhancing the patient pathway • Admission avoidance schemes • Providing care of the elderly expertise within other specialties/divisions • Building aspects particular to older people care into all areas of training, including increased training in dementia • Strengthen and develop elderly care department to lead and innovate in pathways from admission avoidance to early discharge • Make best use of new building to allow an appropriate consultant led MDT approach with appropriate skill mix across the department • Understand the underlying causes of shortages and address through succession and training plans

Risk	Mitigation
geriatricians • High nursing turnover and reliance on bank staff	• Ensure model of care, working environment and incentives enhance the experience of staff, creating a more stable and happy workforce

Cancer Services

Risk	Mitigation
• Inability to deliver community services, closer to people's homes – impact on acute capacity in the Trust but also shift to other providers	• Continue to deliver and consider expansion of community chemotherapy services • Continue to provide strong advice and support to primary care to aid transition for patients from acute service • Patient and carer training programmes • Share care models with local hospitals for TYA and children
• Not investing in research and innovation and not recognising the key benefits of teaching and learning	• Prioritise research in this area in the Trust research strategy, especially as one of a small number of Paediatric cancer research centres
• Increased competition from both NHS and non-NHS providers	• Focus our specialist offering, e.g. TYA, Gamma Knife and BMT
• Cost per patient of specialist trials increases as sub-division of cancer types increases	• Use of commercial trials to fund posts to support the portfolio of research and expand our position as a regional leader in clinical trials to increase revenue per trial to match increasing cost
• Not having systems and processes in place to capture national datasets • Not implementing peer review measures putting patient safety at risk	• Implementing the recommendations of the peer review, investing where necessary in IM&T systems and processes to ensure compliance at national level
	• Promote BHOC as a national and international centre of excellence
• Continued poor performance against cancer treatment targets – financial, reputational and regulatory consequences	• Ensure capacity and flexibility to cope with fluctuations in demand – working with other divisions to ensure appropriate and available access to ITU/HDU beds
• Inability to recruit to Consultant Oncologist posts against the age profile	• Explore alternative workforce models e.g. consultant radiographer role • Review staffing requirement for BMTs

Risk	Mitigation
of the current consultant workforce • Ensuring sufficient staffing for BMTs so as not to limit potential in this growth area	

Cardiac Services

Risk	Mitigation
• Specialist services becoming more common place and provided competitively at DGH level • Increased competition pulling activity and consultants from 24/7 BHI rota • Ensuring sufficient numbers to meet requirements of specialised services commissioners and service specifications	• Work with other providers to secure tertiary referrals and define role in the region • Expand interventional cardiology capacity • Develop partnership with Hammersmith Hospital in delivering Pulmonary Hypertension service • Develop clinical pathways to reduce emergency admissions of low risk patients, linking with ambulatory care • Maintain and develop academic leadership in clinical roles
• Not investing in cardiac imaging to remain competitive with emerging new competitors	• Review suitability and capability of imaging equipment and consider investment in advanced imaging capacity
• Impact of any increased demand through A&E on cancelling elective work carried out at the BHI and limits ability to expand specialist cardiac services	• Review management and delivery of imaging with D&T division
• Patient expectation and demand will rise	• Increased ring fenced cardiac critical care capacity • Support Trustwide acute services, but Trust to prioritise cardiac services at BHI
• High reference costs in Cardiology	• Develop newer cardiac surgical techniques – e.g. minimally invasive surgery with higher procedural costs but reduced length of stay and improved competitiveness from better patient experience

Risk	Mitigation
	• Improve productivity, e.g. enhanced and extended day case activity such as Radial Lounge development

Maternity Services

Risk	Mitigation
• Levelling off of birth rates across the city • Complexity of ageing maternal population	• Development of outpatient/ambulatory care/emergency facilities for women across BNSSG competing with other providers • Clarify permanence of provision of fetal medicine at Royal United Hospitals Bath
• Risk to relationships and configuration of services to North Somerset if another provider acquires Weston Area Health Trust	• Consider integration of services with Weston in context of wider Weston provision
• Viability of two level 3 NICU centres in the city	• Explore options for centralisation of level 3 services and increase NICU capacity and consultant provision • Development of Neuro intensive care • Remodelling of maternity services to maximise effectiveness of NICU whilst balancing maternity services across the city
• Reduction in trainee and consultant numbers • High level of midwife vacancies	• Address through workforce planning

Planned Care and Long Term Conditions

Risk	Mitigation
• Impact of city wide changes affecting elective activity • Changes in commissioning and increase in INNF putting peripheral services and non-BRI delivered services at risk	• Build excellence in outcomes and further develop and potentially increase market share of the specialist, tertiary care based specialties delivered on the BRI and BEH sites (e.g., OG, HPB, and Thoracic).
• Not meeting occupancy requirement and reduced lengths of stay following BRI redevelopment	• Maximise use of existing available facilities, through increased productivity through theatres and outpatients.
• Not matching capacity to demand to ensure efficient use of resources • Access to nurse specialists (e.g. cancer) across surgical specialties	• Increase productivity, access and profitability through increased use of peripheral sites (SBCH, STMH).
• Difficulty recruiting to specialist areas	• Develop a clear differentiation of elective and emergency flow within the

Risk	Mitigation
such as specialist dentistry and anaesthesia • Reference costs high in some surgical specialties	Division • Work collaboratively across divisions and with local Trusts (NBT/Weston) to understand and respond to opportunities and threats • Integrated working with primary care for earlier discharge of patients

Diagnostics and Therapies (D&T)

Risk	Mitigation
• Trustwide impact if unsustainable core diagnostic and therapy services • Hospital delivered services becoming less desirable than community models (both diagnostics and therapies) • Increased competition and potential increase in commissioner procurement such as AQP • Falling behind competitors if new technology and innovation is not embraced • Reputational and viability risk of not implementing the histopathology action plan and knock on effect of being able to recruit and retain critical workforce • Not investing in new and replacement capital equipment will impact on the ability of diagnostic services • High levels of vacancies, especially in pathology and radiology	• Develop a clear sense of how the Acute Services review could best be implemented in D&T • Decide which services should move to community (including transfer to other providers) • Engagement and investment in future technology and innovation • Horizon scanning and developing a policy and process underpinned by Trust strategy to determine which options for business expansion to bid for and/or where to disinvest • Implementation of local pathology action plans • Integration of cellular pathology • Establish rolling programme of capital investment, looking forward to ensure best chance for investment • Address through workforce planning

Critical care

Risk	Mitigation
• Competing demands across the Trust for critical care facilities	• Develop ring fenced BHI, integrated and increased critical care capacity working in synergy and within Trust Strategy

RISK AND MITIGATION OPTIONS BY SPECIFIC SERVICE LINE

Service Line	Risk	Mitigation

Paediatric Cardiac	• Age profile presents a medium term risk in a service that is difficult to recruit to	• Address workforce issues through workforce planning and the service must implement recommendations of the forthcoming independent review
General Paediatrics	• Becoming more and more tertiary in nature – so this service is being squeezed.	• Succession planning • Consider UH Bristol's role in community paediatrics
Paediatric Renal Transplant	• A high quality but low volume service – so its viability may be in question in the medium term	• Consider options for investment and expansion on a regional footing or whether to disinvest
Emergency Department	• This is described in detail in the Key Service Areas section	• This is described in detail in the Key Service Areas section
Older people's care	• This is described in detail in the Key Service Areas section	• This is described in detail in the Key Service Areas section
Chemotherapy	• High RCI but one of the main cost drivers (Healthcare at Home) has been removed (so need to confirm if this is still an issue of medium term viability and whether expansion of the community model will further reduce RCI. Competition in this market is growing	• Consider opportunities to expand community offering in North Somerset • Continue to develop community services at SBCH and Concorde Centre
Cardiology	• RCI is high but recent initiatives may have addressed this	• Develop long term sustainable medical staffing model • Further improve efficiency through enhanced and extended day case activity e.g. Radial Lounge
Cardiac Services	• A different type of challenge – we aren't doing enough and specialised services are becoming more common place at DGH level	• Sustained application of day of surgery admission • Development of new techniques, which have additional cost but may enhance patient flow, safety and experience

Neonatology	• Issue is viability of two L3 NICU centres in the city	• Consider centralisation of Bristol level 3 NICU
Dentistry	• Insufficient consultant availability and reliance on junior medical workforce will impact on ability to reduce RTT waits and sustain good RTT performance	• Short term locum recruitment • Workforce planning to address in medium term • Address seasonal shift in capacity to meet demand, working with partners such as the University
Theatres	• A general challenge, associated with high level of turnover and recruitment/retention. • Effective use of theatres and recovery impacting on the ability of the Trust to deliver elective activity efficiently • Non pay costs need to be managed to ensure RCI remains appropriate	• Review difficulties in recruitment and retention of theatre nursing • Improve list utilisation through implementation of a reliable and accurate theatre scheduling system, based on hotel booking systems, which integrates with Medway • Consider employing project manager to support theatre manager in transformation change projects, commencing with implementation of Theatre Scheduling • Rationalise the number of budgets across the division • Make best use of procurement to bring down supplies costs
Gynae and Gynae Oncology	• Decreasing levels of activity and increase in AQP provision presents challenge to supporting emergency and specialised work across the city. Also potential workforce and skills shortages	• Decide on implementation of the recommendations in the Acute Services Review
Clinical Genetics	• High RCI and organisational decision required about how to develop the service, with possible risk from future designation of this service	• Develop our position and consolidate plans with North Bristol NHS Trust • Consider growth and expansion of the service
Specialised	• Aspects of the service are	• Implement action plan to

Endocrine	delivered across the two trusts in the city, presenting a challenge to compliance with the specialised services specification based on city wide pathway development	address compliance with peer review and specialised service specification, focusing on city wide pathway development and role of Endocrine CNS
Stroke	• If the service continues to be split across the city, the Trust may not be able to attract best practice tariffs to make service more sustainable into the future • If services were transferred to NBT to fit with neurology services there, income reduction may impact on delivery of stroke rehabilitation at UH Bristol	• Investment/disinvestment decision to be made, to benefit patients across the city • Investment will require additional recruitment to offer 24 hour thrombolysis • Workforce plan would need to be flexible to support other acute care of the elderly activity • Maintain strong and viable stroke rehabilitation services – working with commissioners on rehab pathways
Tuberculosis	• Low volume service with aspects delivered by two trusts in the city • Continued service would require workforce to match	• Consider whether transfer to NBT alongside infectious disease service is best for patient's city wide • Maintain clinics at UH Bristol through flexible respiratory service
Cellular Pathology	• Medium term question about integration across Bristol. • Also an area of 'culture risk' associated with perceptions of recognition and valuing by the Trust	• Decisions required on city wide integration and implementation of local action plans
Radiology	• Key area of sustainability risk in the Division. Solution may require fundamental review not simply activity/demand management	• Review the capacity required to support a radiology service which doesn't just cope but is able to comfortably meet increased demand • Increase recruitment and

		plan how to retain radiology staff • Investment in education and training to “grow our own” • Alternative models of working to allow flexibility to manage fluctuations in demand

APPENDIX 5 – MAPPING SLR ONTO KEY SERVICE AREAS – SERVICE AREA FINANCIAL SUMMARY Using 2013/14 Q2 SLR information

	A&E and Urgent Care	Cancer Services	Cardiac Services	Children's Services	Maternity Services	Older People's Services	Planned Care and LTC	Critical Care	D&T	Other	Overall
RCI (2012/13)	**84**	**102**	**91**	**114**	**93**	**113**	**103**	**88**	**101**	**-**	**100**
Service Lines	A&E at BCH (103)	Chemotherapy (127)	Paediatric Cardiac Surgery (124)	Clinical Genetics (394)	Maternity (93)	Care of the Elderly (113)	Homeopathy (206)	Intensive Therapy Unit (95)	Chemical Pathology (163)	Family Planning (142)	
RCI in brackets	A&E Inpatients (90)	Clinical Haematology (104)	Cardiology (120)	Paediatric Nephrology (145)			BMT at Bristol Haematology (129)	Neonatal Intensive Care Unit (87)	Direct Access Radiology (121)	Genito-Urinary Medicine (58)	
	A&E at BRI (85)	Radiotherapy (94)	Paediatric Cardiology (102)	General Paediatrics (121)			Cystic Fibrosis (127)	Paediatric Intensive Care Unit (83)	Diagnostic Imaging (108)	Accounting Adjustments	
	A&E Ophthalmology (48)	Medical and Clinical Oncology (79)	Cardiac Surgery (81)	BMT at Bristol Children's (115)			Rehabilitation (123)	Paediatric HDU	Adult Therapies (106)	Child Death Review	
	A&E Inpatients D&T		Cardiac High Dependency Unit (49)	Paediatric Rheumatology (115)			General Medicine (121)	Medical HDU	Audiology (85)	Clinical Physiology	
	Medical Assessment Unit			Paediatric Gastroenterology (114)			Urology (121)		Direct Access Pathology (84)	Home Enteral Feeding	
	Short Stay Assessment Unit			Paediatric Cystic Fibrosis (113)			General Surgery (119)		Direct Access Breast Screening	Homecare - Medicine	
				Paediatric Dietetics (112)			Trauma & Orthopaedics (114)			Homecare - Specialised	
				Paediatric Trauma & Orthopaedics (103)			Colorectal Surgery (112)			Paediatric Pathology	
				Paediatric ENT (99)			Dermatology (109)			Patient Transport	
				Paediatric Oncology (99)			Upper Gastrointestinal Surgery (109)			Screening Service	
				Paediatric Metabolic Disorders (95)			Thoracic Medicine (108)			Service Transferred Out	
				Paediatric Surgery (90)			Rheumatology (106)			South West Med IT	
				Paediatric Dermatology (83)			Endocrinology (102)			Specialist Nursing	
				Paediatric Neurology (69)			Hepatology (99)				
				Audiology - Paediatric			Maxillo Facial (98)				
				Other Paediatric Service			Gynaecology (96)				
				Paediatric Physiotherapy & OT			Breast Surgery (93)				
							Ear, Nose and Throat (93)				
							Vascular Surgery (92)				
							Ophthalmology (92)				
							Thoracic Surgery (86)				
							Neurology (85)				
							Gastroenterology (Medicine) (83)				
							Gastroenterology (Surgery) (83)				
							Pain Management (75)				
							Dental Services (68)				
							Haemophilia (68)				
							Oral & Dental - Paediatric (41)				
							Oral Services (25)				
							Bowel Cancer Screening				
							Clinical Trials				

APPENDIX 6 – KEY ELEMENTS OF OUR OPERATIONAL PLAN

Our Operational Plan sets out how we will address the specific challenges that we face as an organisation over the next two financial years (2014/15 and 2015/16). In summary, we will:

- Focus on the successful implementation of a revised operating model across the Trust that will deliver the following benefits:
    - Improvement of the consistency with which we deliver elective care and a significant reduction in the cancellation of planned care – we will cancel fewer operations;
    - Implementations of the findings of a trust wide review of the provision of critical care. This will allow us to further improve the consistency with which we deliver planned care and reduce cancellations of planned surgery because of the unavailability of critical care beds;
    - Eliminating a large number of cancer pathway delays and deliver planned activity;
    - Addressing shortcomings in the quality of our care associated with the high numbers of patients whose discharge from acute care is delayed;
    - Restoring our A&E performance through delivery of reduced bed occupancy in the emergency care beds;
    - Reduction in the number of patients remaining in hospitals after the point at which they no longer require hospital care. This is fundamental to Trust performance in the next two years and we plan to achieve this improvement via the following specific initiatives:
        - The establishment of an integrated discharge hub, co-locating professionals from acute services, social care and community providers, and re-designing discharge processes and practices to support rapid assessment and care planning for patients who no longer require acute care;
        - Rapid commissioning of additional out of hospital transitional care beds to assist with the discharge of patients who no longer require hospital care but for whom discharge is delayed for whatever reason;
        - Establishment of an Early Supported Discharge (ESD) function to enable those patients who are “homeward bound” to be discharged earlier – this will replicate the model we already operate for stroke patients;
        - Revision of our approach to weekend discharge with the aim of significantly increasing the proportion of patients with a predicted weekend discharge who go on to be discharged.
- Successfully transfer specialist paediatric and cleft services from North Bristol NHS Trust (NBT) to UH Bristol and transfer out vascular services and breast screening to NBT;
- Successfully commissioning and opening of the Bristol Royal Infirmary Redevelopment, including decommissioning of the then redundant estate;
- Restore any lost trust and confidence in paediatric cardiac services through engagement in the proposed Independent Review and effective reputation management alongside the need to ensure

sustainability of the service model through effective support for staff and families currently working and cared for within the service;

- Build on the revision to the Trust's leadership structures that have brought new leadership into each of the Trust's five clinical Divisions with emerging evidence that these changes are delivering benefit;

- Go further to deliver our vision of truly effective staff engagement; pleasingly our National Staff Survey results for staff engagement show small improvements on last year and we exceed the sector average but we recognise this as an area where our success rests upon us excelling in this domain; as such our new Director of Workforce and Organisational Development has signalled this as one of her early priorities;

- Implement a new approach to working with patients, our Members and the wider public;Continue to deliver a financial surplus for the next two years and unlock the £15m disinvestment assumed in the current plans for the Better Care Fund.

APPENDIX 7 – KEY FINDINGS OF THE BRISTOL ACUTE SERVICES REVIEW

INTRODUCTION

The purpose of this paper to is to provide the Bristol Health Wellbeing and Adult Social Care Scrutiny Commission with information about the outcome of the Bristol Acute Services Review and next steps.

The Review identified a financial challenge facing the two acute Trusts in Bristol in excess of £230 million over the next five years. The challenge expressed at a whole health economy level (not just the acute sector) is in the order of £290 million. This is on top of significant reductions in local authority funding which in turn has the potential to adversely affect the care of vulnerable people.

A significant proportion of these savings are for local health organisations to deliver by focusing on internal cash releasing schemes. The evidence from the Review, however, suggests that the overall scale of change required can only be delivered through ambitious, health economy-wide solutions, especially those aimed at the integration of health and social care.

CONTEXT

Since April 2013, University Hospitals Bristol NHS Foundation Trust (UH Bristol) and North Bristol NHS Trust (NBT) have led a joint project to review the issues facing acute services in Bristol.

The Trust Boards agreed the following scope for the Bristol Acute Services Review:

1. Hospital specialty review: a review of eleven specialties (grouped as seven service areas), conducted through benchmarking analysis, best practice review and consideration of alternative service models submitted to stakeholder workshops. The specialities examined were:

    - Trauma & Orthopaedics and Rheumatology;
    - General Surgery;
    - Maternity & Neonates;
    - Cardiology;
    - Plastic Surgery & Dermatology;
    - Gynaecology;
    - Clinical Haematology and Medical Oncology.

2. Whole system urgent care pathway review: a review at patient pathway level of the urgent and emergency care system in Bristol, North Somerset and South Gloucestershire, building on the existing programmes of work being undertaken by the Clinical Commissioning Groups and the Healthy Futures Programme and including consideration of the hospital-based specialties of general medicine, geriatric medicine, emergency medicine and stroke care.

3. Addressing the financial challenges ahead: development of a range of options aimed at addressing the financial challenges facing the two Trusts whilst ensuring the sustainable long-term delivery of safe, high quality care.

CONDUCT OF THE REVIEW

The Bristol Acute Services Review was overseen by a programme board chaired by Professor Steve West, Vice-Chancellor of the University of the West of England and including representatives of NHS England, the Trust Development Authority and Clinical Commissioning Groups, as well as Non-Executive Directors and officers of the two Trusts.

The scope of the specialty review work-stream was determined jointly by the Medical Directors and Chief Nurses of both Trusts, while the decision to review the urgent and emergency care system in Bristol, North Somerset and South Gloucestershire was taken jointly with health and social care partners at the Healthy Futures Programme Board. Options for addressing the financial challenges facing the two Trusts were developed and prioritised jointly by the executive teams of both Trusts.

External advice was commissioned from PWC, using funds made available by the former NHS South of England Strategic Health Authority.

The service review was clinically led and achieved strong clinical engagement across the two organisations at all stages. A range of clinical workshops were held at speciality and pathway level with close working by a number of clinical leads across the two Trusts. Feedback from the process and workshops demonstrated an appetite to continue these valuable conversations. Personal and clinical relationships have developed, laying the foundation for improved clinical services.

The system-wide review involved many stakeholders, including commissioners and partners in primary, community and social care and public health.

Patient and public involvement was secured where possible through existing Trust mechanisms, with additional support from Health Watch and the Bristol Equalities Health Partnership. A formal workshop took place on the 16th of July with very positive feedback.

The Review concluded at the end of July 2013 with submission of final reports to the Chief Executives of both Trusts. The findings have been considered separately by the Trust Boards and presented to both the Clinical Commissioning Group Partnership Board for Bristol, North Somerset and South Gloucestershire and the Healthy Futures Programme Board.

FINDINGS

FINANCIAL CONTEXT

The review identified a financial challenge facing the two acute Trusts in Bristol in excess of £230 million over the next five years. The challenge expressed at a whole health economy level (not just the acute sector) is in the order of £290 million.

The review estimated that the potential for savings across the health economy ranged from £124m to £184m –although this latter figure assumes a saving of £60m as a result of integrated care, which is probably very optimistic.

A significant proportion of these savings are assumed to be deliverable by focusing on internal cash releasing schemes – although the figure is broadly consistent with the acknowledged 2% ‘normal’ rate for savings across the FT sector.

Overall however, the evidence from the Review, suggests that the overall scale of change required can only be delivered through ambitious, health economy-wide solutions, especially those aimed at the integration of health and social care.

SERVICE REVIEW

The eleven specialties for detailed analysis were short-listed through formal prioritisation by the Medical Directors and Chief Nurses of both Trusts, taking account of appropriate benchmarking information and other intelligence.

The Review identified a number of opportunities within the eleven specialties that may merit further exploration.

It should be noted that the estimated total savings derived from these opportunities does not exceed £2 million. Nevertheless, these options may deliver patient benefit, outcome gain, reduction in the need for increased investment to secure compliance with national standards or general improvements which increase the professional standing and national profile of the Bristol health system.

It is important to note, however, that the review has not produced a definitive set of recommendations for the Trusts and health community to take forward. Rather, it has identified multiple opportunities for further examination by relevant players in the health and social care system.

URGENT AND EMERGENCY CARE SYSTEM

It is clear that significant efforts are being made by all organisations involved in the commissioning and provision of urgent and emergency care and these efforts should be recognised in the approach to further work.

The health system has a wide range of schemes, in various stages of development and implementation aimed at improving the quality and efficiency of urgent care. The Review suggests that successful delivery of these schemes is hampered by a lack of coordinated approach across the system and multiple forums for planning and delivery and unclear accountabilities.

Current urgent and emergency care pathways are too complicated, involve multiple entry points, are difficult for patients to navigate and reliant on multiple agencies with unclear responsibilities for management.

Key areas for focus, largely derived from the views of system players inside Bristol, North Somerset and South Gloucestershire, include:

- Discharge planning and implementation;
- Increasing management of patients in or closer to their homes;
- Co-location of community urgent care services;
- The emergency care ambulatory care pathway;
- Geriatrician input early in the pathway and outside of the hospital setting;
- Seven day working across the health and social care system;
- Early identification of complex patients with input from social care partners;
- System wide bed management;

- Undertaking the continuing healthcare process outside the acute hospital setting.

FURTHER OPTIONS FOR ADDRESSING THE FINANCIAL GAP

The Review identified a number of options for internal consideration by the two Trust Boards, including the rationalisation or outsourcing of corporate functions.

On a wider scale, it demonstrated the potential contribution of integrated care, notably in relation to the frail elderly pathway, in reducing system costs and realising patient benefit.

International evidence (such as from the Valencia region in Spain) of a fully integrated and embedded model with outcome based commissioning indicated that an overall health economy saving of 30% was possible. Applying this percentage to the Bristol health economy spend on the frail and elderly of £200m suggests a potential saving of £60m. Integrating across other care pathways could achieve further financial benefits.

The Review acknowledged the medium term nature of likely developments to integrate existing care provision and highlighted potential interim benefits in securing out of hospital care for those patients for whom the skills and resources of an acute hospital are no longer needed - not only in delivering more cost effective care but in ensuring patients are cared for in environments more suited to their needs as early on in their recovery as possible.

In preparation for the coming winter, both acute trusts are currently in discussion with health and social care commissioners about the development of additional out of hospital capacity through the deployment of reablement funds, such as those accrued through readmission penalties and emergency marginal tariffs.

NEXT STEPS

Among all participants, there is a growing appetite for positive changes which will support more integrated care.

Discussions since July about next steps have produced a broad categorisation of the different options presented in the reports into the following:

1. **Options that require joint working by health and social partners across the health economy**

   The Clinical Commissioning Groups in Bristol, North Somerset and South Gloucestershire have confirmed the intention to take forward planning for improvements to the urgent and emergency care system on a locality basis under the auspices of the newly-created Urgent Care Fora.

   The Healthy Futures Programme Board has agreed to take a system-wide overview of the programme, recognising the importance of ensuring effective communication and coordination between these fora.

2. **Options that can be taken forward by each Trust independently**

   These are for each Trust to appraise, using established internal planning and prioritisation processes.

3. **Options that involve cooperation between the two Trusts**

   There is a limited number of options in this category, involving potential adjustments to existing service models or care pathways.

   Priorities for further work will be set jointly by the Trusts' Partnership Programme Board, according to key criteria likely to include avoidance of investment necessary to address a lack of service resilience and impact on the quality of care, meeting commissioner compliance standards, especially for specialised services designation, and addressing structural inefficiencies in existing pathways, where these exist.

   Already in progress between the Trusts are a number of collaborative ventures, including the centralisation of specialist paediatric services at the Bristol Royal Hospital for Children, and a review of vascular services. These follow the recent centralisation of breast, urology and head and neck, ear, nose and throat and oral maxillofacial services between the two organisations. The Trusts have instigated a review of lessons learned and a benefits evaluation from these recent service transfers to inform future service developments.

   While the two Trusts remain committed to working in partnership to make improvements to patient care, changes in executive leadership at North Bristol NHS Trust, the requirement to progress existing collaborative schemes and the significant short and mid-term operational pressures facing both organisations mean that the Trusts have yet to agree priorities for further joint working and the programme approach to be adopted, including mechanisms for further patient and public involvement.

CONCLUSION

The Bristol Acute Services Review concluded in July having identified a very challenging financial outlook for the acute sector in Bristol and the wider health and social care system.

The Review fell short of identifying a means of closing this financial gap across the two acute Trusts.

However, it clearly demonstrated that the greatest gains, in potential to improve patient care and reduce overall system costs, will come through integration of services between the health and social care sectors, alongside the simplification of the existing urgent and emergency care pathways in Bristol, North Somerset and South Gloucestershire.

Pursuit of this agenda will require consensus across the Bristol health and social care economy, especially clinical ownership and leadership across the whole health system, commitment to major service change by individual organisations and appropriate co-ordination and programme governance by a strategic partnership of health and social care commissioners, public health and providers.

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University Hospitals Bristol NHS Foundation Trust

Quality Report 2013/14

Government and Public Sector

27/05/14

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Contents

Audit Code and scope of this work

We have performed this work in accordance with Monitor's *Detailed guidance for external assurance on quality reports 2013/14* and Monitor's *Detailed requirements for quality reports 2013/14* which were issued in February 2014, and the NHS Foundation Trust Annual Reporting Manual 2013/14. This is available from the Chief Executive of the NHS Foundation Trust.

Reports and letters prepared by external auditors and addressed to governors, directors or officers are prepared for the sole use of the NHS Foundation Trust, and no responsibility is taken by auditors to any governor, director or officer in their individual capacity, or to any third party. The matters raised in this report are only those which have come to our attention arising from or relevant to our work that we believe need to be brought to your attention. They are not a comprehensive record of all the matters arising, and in particular we cannot be held responsible for reporting all risks in your business or all internal control weaknesses. This report has been prepared solely for your use in accordance with the terms of our engagement letter dated March 2014 and for no other purpose and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

Background and scope

Background

NHS foundation trusts are required to prepare and publish a Quality Report each year. The Quality Report has to be prepared in accordance with the NHS foundation trust Annual Reporting Manual ('the FT ARM').

As your auditors, we are required to undertake work on your Quality Report under Monitor's Audit Code and Monitor's 'Detailed Guidance for External Assurance on the Quality Reports 2013/14' ('the detailed guidance') which was published in February 2014.

The purpose of this report is to provide the Board and Board of Governors of University Hospitals Bristol NHS Foundation Trust ("the Trust") with our findings and recommendations for improvements, in accordance with Monitor's requirements. It is referred to by Monitor as the "Governors" report.

Scope of our work

We are required by Monitor to review the content of the 2013/14 Quality Report and three performance indicators and produce two reports:

- Limited assurance report: This report is a formal, public document that requires us to conclude whether anything has come to our attention that would lead us to believe that:
  - The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM and *Monitor's 'Detailed requirements for quality reports 2013/14'*;
  - The Quality Report is consistent in all material aspects with source documents specified by Monitor; and
  - The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 *Detailed guidance for external assurance on quality reports"*.

  A limited assurance engagement is less in scope than a reasonable assurance engagement (such as the external audit of accounts). The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited compared to a reasonable assurance engagement.

- Governors report: A private report on the outcome of our work that is made available to the trust's Governors and to Monitor.

Our limited assurance report is restricted, as required by Monitor, to the content and two performance indicators only. The Governors report covers all of our work and, therefore, a third local indicator.

Content of the Quality Report

We are required to issue a limited assurance report in relation to the content of your Quality Report. This involves:

- Reviewing the content of the Quality Report against the requirements of Monitor's published guidance, as specified in Annex 2 to Chapter 7 of the FT ARM and Monitor's *Detailed requirements for quality reports 2013/14*; and
- Reviewing the content of the Quality Report for consistency with the source documents specified by Monitor in the detailed guidance.

Performance indicators

We are required to issue a limited assurance report in respect of two out of the three indicators specified by Monitor.

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	Specified indicators criteria
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	See appendix C of the Quality Report
Clostridium difficile	See appendix C of the Quality Report

Our procedures included:

- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgments made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosure; and
- reading documents.

Local indicator

We are also required to undertake substantive sample testing of one further local indicator. This indicator is not included in our limited assurance report. Instead, we are required to provide a detailed report on our findings and recommendations for improvements in this, our Governors report. The Trust's Governors select the indicator to be subject to our substantive sample testing. The indicator selected is the reduction in medication errors which caused 'moderate', 'major' or 'catastrophic' harm to patients. This is defined on page 14 of the Quality Report.

Summary of findings

No issues have come to our attention that lead us to believe that the Quality Report has not been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2013/14* and the *Detailed requirements for quality reports 2013/14*

No issues have come to our attention that lead us to believe that the 2013/14 Quality Report is not consistent with the other information sources defined by Monitor

Limited Assurance Report

As a result of our work, we are able to provide an unqualified limited assurance report in respect of the content of the Quality Report

Performance indicators

Our findings relating to the performance indicators are summarised as follows:

Performance indicators included in our limited assurance report	Findings
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	We noted one instance where a six day pause was applied to a patients waiting time. The cancer register was unable did not provide sufficient information in relation to the reasons for this pause. The pause was deemed to be appropriate following discussion and subsequent investigations with the Cancer Manager. The indicator value reported in the Quality Report is 80.7%; from our testing we have recalculated the indicator value to be 80.3%. This difference is due to adjustments made to previous month's data and due to recognising cases during March 2014. This difference has not been adjusted by the Foundation Trust. This has no impact on our limited assurance opinion as this difference is not judged to be material.
Clostridium difficile	No issues identified; no impact on our limited assurance

opinion

For further information refer to page 5.

Limited Assurance Report

As a result of our work, we are able to provide an unqualified limited assurance report in respect of the mandated performance indicators.

Performance indicator not included within our limited assurance report	Findings
Reduction in medication errors which caused 'moderate', 'major' or 'catastrophic' harm to patients	No errors identified in sample tested. One instance was noted where there was no evidence of manager sign off of the incident on the Safeguard Incident Management System. One further instance was noted where the description of the incident as per the Safeguard Incident Management System required additional clarification was required the Safe Medication Manager Co-ordinator to agree the rating classification of the incident.

For further information refer to page 8.

Annual Governance Statement

We identified no issues relevant to the Quality Report.

For further details, see page 9.

Detailed findings

Review against the content requirements

We reviewed the content of the 2013/14 Quality Report against the content requirements which are specified in Annex 2 to Chapter 7 of the *FT ARM 2013/14* and Monitor's *Detailed requirements for quality reports 2013/14*.

A small number of amendments were made to the draft Quality report. No further issues came to our attention that led us to believe that the Quality Report has not been prepared in line with the *NHS FT ARM 2013/14* or Monitor's *Detailed requirements for quality reports 2013/14*.

Review consistency against specified source documents

We reviewed the content of the 2013/14 Quality Report for consistency against the following source documents specified by Monitor:

- Board minutes for the period April 2013 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;
- Feedback from the Bristol Clinical Commissioning Group dated 14/5/2014;
- Feedback from Governors dated 16/05/2014;
- Feedback from Healthwatch Bristol and Healthwatch South Gloucestershire dated 15/5/2014;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2013 national patient survey dated 08/04/2014;
- The 2013 national staff survey dated 25/02/2014;
- Care Quality Commission quality and risk profiles dated 31/07/2013; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 27/05/2014

A small number of amendments were made to the draft Quality Report. No further issues came to our attention that led us to believe that the Quality Report is not consistent with the information sources detailed above.

Performance indicators on which we are required to issue a limited assurance conclusion

As required by Monitor we have undertaken sample testing of two performance indicators on which we issued our limited assurance report:

- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers; and
- Clostridium difficile

We are required to evaluate the key processes and controls for managing and reporting the indicators and sample test the data used to calculate the indicator back to supporting documentation. Our work is performed in accordance with the Monitor's *Detailed guidance for external assurance on quality reports 2013/14* which was issued by Monitor in February 2014 and included:

- Identification of the criteria used by the Trust for measuring the indicator;
- Confirmation that the Trust had presented the criteria identified above in the Quality report in sufficient detail

that the criteria are readily understandable to users of the Quality Report;

- Obtaining an understanding of the key processes and controls for managing and reporting the indicator through making enquiries of Trust staff and through performing a walkthrough;
- Reconciling the reported performance in the Quality Report to the data used to calculate the indicator from the Trust's underlying systems;
- Testing a sample of relevant data used to calculate the indicator back to supporting documentation; and
- Considering the completeness of the data reported and performing sample testing on this where relevant.

We only tested a sample of data, as stated above, to supporting documentation. Therefore, the errors reported below are limited to this sample.

We have also not tested the underlying systems, for example the patient administration system and the data extraction and recording systems.

Our findings are set out below. Recommendations arising from these findings are presented in Appendix A.

Clostridium Difficile	
Reported performance:	
2013/14 Threshold: **35**	2013/14 Actual: 38
Criteria identified:	
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • Infections relate to patients aged two year old or more; • A positive laboratory test result for Clostridium Difficile recognised as a case according to the Trust's diagnostic; • Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken; and • The Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).	
Overall Conclusion:	
Our substantive testing of the indicator identified no issues. No impact on our limited assurance report resulting in an unmodified report in respect of this indicator.	

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers		
Reported performance:		
2013/14 Target: 85%	2013/14 Actual (per Quality Report): 80.7%	
Criteria identified:		
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant; • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date that the referral is *received* by the Trust; and • The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.		
Issues identified through work performed:		
No.	**Issue**	**Impact on limited assurance report**
1.	We noted one instance where a six day pause was applied to a patients waiting time. The cancer register did not provide sufficient information in relation to the reasons for this pause. The pause was deemed to be appropriate following discussion and subsequent investigations with the Cancer Manager. The indicator value reported in the Quality Report is 80.7%; from our testing we have recalculated the indicator value to be 80.3%. This difference is due to adjustments made to previous month's data and due to recognising cases during March 2014. This difference has not been adjusted by the Foundation Trust. This has no impact on our limited assurance opinion as this difference is not judged to be material	*No impact on our limited assurance report.*
Conclusion:		
Our substantive testing of the indicator identified **one** issue. There is no impact on our limited assurance report resulting in an unmodified report in respect of this indicator.		

Performance indicators not included within our limited assurance report

Monitor also requires us to undertake substantive sample testing of a local indicator selected by the Governors, the results of which are not included within our limited assurance report.

We are required to evaluate the key processes and controls for managing and reporting the indicator and sample test the data used to calculate the indicator back to supporting documentation. We only tested a sample, as stated above. Our reported errors below are limited to this sample.

Our findings are detailed as follows:

The reduction in medication errors which caused 'moderate', 'major' or 'catastrophic' harm to patients		
Reported performance: 0.68%		
2013/14 Actual: 0.68%		
Criteria identified:		
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: Medication incidents reported where degree of harm is recorded as 'moderate', 'major' or 'catastrophic' harm, as a percentage of all medication incidents reported.		
Issues identified through work performed:		
No.	**Issue**	**Impact**
1.	One instance was noted where there was no evidence of manager sign off of the incident on the Safeguard Incident Management System. One further instance was noted where the description of the incident as per the Safeguard Incident Management System required additional clarification was required the Safe Medication Manager Co-ordinator to agree the rating classification of the incident.	This had no impact upon the reported indicator
Conclusion:		
Our substantive testing of the indicator identified no issues with an impact on the reported indicator.		

The recommendations associated with these findings are presented in Appendix A.

Annual Governance Statement

In their *Detailed Guidance for External Assurance on Quality Reports 2013/14* Monitor requires Foundation Trusts to include a brief description of the key controls in place to prepare and publish a Quality Report as part of the Annual Governance Statement in the 2013/14 published accounts.

The Annual Governance Statement, within the Foundation Trust's 2013/14 Annual Report, includes the following statement specific to the Quality Report:

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

Whilst these reporting requirements contribute to ensuring that the content of the Quality Report presents a balanced view of the quality of services provided by the Trust, we also take steps to ensure that appropriate controls are in place to ensure the accuracy of the data upon which we base our statements on quality. These controls are undertaken in accordance with the Quality Strategy (2011-2014) and the Data Quality Strategy which describes the standards of data quality assurance required for data supporting information used by the Board and for public reporting. Examples of data accuracy controls for the Quality Report include checks by the author to ensure that published data is consistent with that reported to the Board during the year, a Data Quality Framework covering metrics mandated for Quality Reports from 1 April 2013, and the External Auditor examines the accuracy of three of the indicators.

The Clinical Quality Group monitors the progress of quality objectives at quarterly intervals during the year; this monitoring is reported to the Board. This process ensures there is continuity throughout the production of Quality Reports, and any inconsistencies are challenged by the Clinical Quality Group.

Our governors are instrumental in agreeing the content of sections of the Quality Report in which we have freedom to report other key quality themes from the past year. The governors undertake this work formally under the auspices of the Quality Project Focus Group.

We follow good practice guidance such as those issued by the Kings Fund by ensuring a wide degree of continuity for clinical themes reported from one year to the next. This ensures that we remain demonstrably committed to ensuring transparency as well as keeping the Quality Report current and fresh.

We invite third parties to comment on an early draft of the Quality Report and listen to requests to amend content or introduce any new quality themes which those third parties feel might be necessary to achieve a fair and balanced view of quality during the year.

As part of our report on the financial statements we were required to:

- Review whether the Annual Governance Statement reflects compliance with Monitor's guidance; and
- Report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements.

The work we undertook on the Annual Governance Statement as part of our work on the financial statements identified no issues relevant to the Quality Report.

Appendix A: Matters arising from our limited assurance review of the Foundation Trust's 2013/14 Quality Report: Performance indicators

	Observation	Recommendation
	Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	
1.	We noted one instance where a six day pause was applied to a patients waiting time. The cancer register did not provide sufficient information in relation to the reasons for this pause. The pause was deemed to be appropriate following discussion and subsequent investigations with the Cancer Manager.	All pause periods should be recorded on the cancer register.
	The reduction in medication errors which caused 'moderate', 'major' or 'catastrophic' harm to patients	
2.	One instance was noted where there was no evidence of manager sign off of the incident on the Safeguard Incident Management System. One further instance was noted where the description of the incident as per the Safeguard Incident Management System required additional clarification was required the Safe Medication Manager Co-ordinator to agree the rating classification of the incident.	All entries to the Safeguard Incident Management System should be reviewed by a manager and should be sufficiently clear regarding incident classification.

In the event that, pursuant to a request which University Hospitals Bristol NHS Foundation Trust has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify PwC promptly and consult with PwC prior to disclosing such report. University Hospitals Bristol NHS Foundation Trust agrees to pay due regard to any representations which PwC may make in connection with such disclosure and xxx NHS Foundation Trust shall apply any relevant exemptions which may exist under the Act to such report. If, following consultation with PwC, University Hospitals Bristol NHS Foundation Trust discloses this report or any part thereof, it shall ensure that any disclaimer which PwC has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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University Hospitals Bristol NHS
NHS Foundation Trust

Quality Report
2013/14

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Embracing change
Recognising success
Working together
Our hospitals.

Contents

Note:
The requirements to report in line with the *2013/14 Detailed Guidance for External Assurance on Quality Reports* published by Monitor have been satisfied as follows:

Part 1 - Statement on quality from the Chief Executive	page 2

Part 2 – Priorities for improvement and statements of assurance from the Board	
Priorities for improvement – plans for 2014/15	page 2
Statements of assurance from the Board	page 51

Part 3 – Other information	
Review of quality performance	This information can be found in the reports for the three domains of quality. See pages 7 - 43
Overview of the quality of care based on performance in 2013/14 against indicators mandated for inclusion in Quality Accounts / Reports	page 4
Performance against key national priorities	page 45

Statement on quality from the Chief Executive

Welcome to this, our sixth annual report describing our quality achievements. Our mission is to provide exceptional healthcare, research and teaching every day.

The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates that its services are safe, clinically effective and that we are providing treatment in a caring and compassionate environment. The report is an open and honest assessment of the last year, its successes and challenges.

Last year we set a large number of quality objectives, the majority of which we achieved. I am particularly pleased to be able to report significant improvements in hospital-acquired healthcare infection (reductions in reported cases of *Clostridium difficile*, MRSA and MSSA) and pressure ulcer prevention. I am also reassured by the Trust's overall mortality rate which continues to be lower than the national average: this means that more patients survive in our care than would normally be expected for the severity of their condition. But there is no room for complacency: there are other aspects of care described in this report where we would have liked to make more progress. For example, despite our concerted efforts, too many patients still say that they were not told about potential side effects of medicines when they were discharged from hospital – an area where we will continue to seek improvements in 2014/15.

Overall, 97% of patients consistently report that the care they receive from us is good, very good or excellent and our monthly scores in the new NHS Friends and Family Test are better than the national average. I am likewise encouraged that 71% of staff, compared to a national average of 62%, say that they would recommend us as a place to work or receive treatment, although our aspiration must be to improve this score further in the future.

Looking ahead to 2014/15, we have taken a different approach to the process of selecting our quality objectives. We began 2014 by hosting an open event where members of the public were able to tell us about the things about hospital care that mattered most to them. At the same time, the Trust has been experiencing unprecedented operational pressures on its services: the number of very sick patients requiring emergency admission to hospital has increased and a higher proportion of them are over 85 years old. This has had a significant impact on the number of beds needed for emergency medical patients and that, in turn, has increased the number of operations cancelled on the day of surgery. Taking all of this into account, we have chosen a set of objectives for 2014/15 which are focused on patient 'flow' through our hospitals and designed to be truly transformational: reducing cancelled appointments, making sure that patients are treated on a ward appropriate to their clinical condition, and eradicating the practice of moving patients out-of-hours for non-clinical reasons. We have also added a fourth objective which is about refreshing our approach to public engagement and involvement, providing continued assurance

that when we consult people about changes to services, the process is open and candid and that as an organisation we listen to and act upon people's views and concerns.

In 2013/14, we received three inspections from the Care Quality Commission, each of which highlighted aspects of care that we could improve. You can read more about this in the appendix to this report. Inspections are opportunities for us to learn and also to receive external validation of the high quality of our services, many of which are described in this Quality Report. At the time of writing, we have just received notice that the CQC will be visiting us in September to carry out a comprehensive review of our services and, no doubt, to check that we have made the improvements that we said we would. Going into this inspection, I am pleased to report that University Hospitals Bristol is rated by the CQC as being in a select group of hospitals considered to be at lowest risk of non-compliance with care quality standards.

I would like to thank everyone who has contributed to this year's report, including our governors, commissioners, local councils, and the outgoing Local Involvement Networks. To the best of my knowledge, the information contained in this Quality Report is accurate.

Robert Woolley
Chief Executive

Overview of 2013/14

The University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of general and specialist hospitals, employing around 7,000 whole time equivalent staff and with a turnover of approximately £500 million. We are also the major medical research centre in the South West of England. During 2013/14, the Trust provided treatment and care to around 72,000 inpatients[1], 57,000 day cases and 115,000 attenders at our emergency departments[2]. We also provided approximately 447,000 outpatient appointments[3].

Our goal has been that each and every one of these patients should be safe in our care, have an excellent experience of being in our care, and the right clinical outcome: the hallmarks of a quality service. Last year, we set ourselves 16 quality objectives: we are delighted to have fully achieved 11 of these, partly achieved four more and to have made significant improvements in other important aspects of quality which are documented in this report.

In the pages which follow, you will be able to read a detailed account of our performance in 2013/14. Each objective has been assigned a 'traffic light' or 'RAG' rating:

RED	**Not met**
AMBER	**Partially met**
GREEN	**Fully met**

Table 1 on the next page provides an overview.

[1] Elective, emergency, maternity and births
[2] Bristol Royal Infirmary, Bristol Royal Hospital for Children, and Bristol Eye Hospital
[3] 145,000 new outpatient attendances; 302,000 follow-up attendances

Table 1

We wanted to...		How did we get on?
1	Increase harm free care as measured via the NHS Safety Thermometer	GREEN
2	Reduce hospital acquired healthcare infections	GREEN
3	Reduce medication errors	GREEN
4	Extend medicines reconciliation ('getting the medicines right')	GREEN
5	Improve the early identification and escalation of care of deteriorating patients	GREEN
6	Improve levels of nutritional screening and specifically 72 hour nutritional review of patients	AMBER
7	Implement the NHS Friends and Family Test	GREEN
8	Ensure that patients continue to be treated with kindness and understanding on our wards	GREEN
9	Explain medication side effects to inpatients when they are discharged	RED
10	Focus on improving the experience of maternity patients	AMBER
11	Ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward	AMBER
12	Achieve the best practice tariff for hip fractures (this involves achieving eight indicators including surgery within 36 hours of admission to hospital)	GREEN
13	Ensure patients with diabetes have improved access to specialist diabetic support	GREEN
14	Ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan	GREEN
15	Continue to implement our dementia action plan	AMBER
16	Commence a baseline review of available clinical outcome data	GREEN

In February 2012, the Department of Health and Monitor announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2013/14 is summarised in the table below. Where relevant, reference is also made to pages of our Quality Report where related information can be found. The Trust is confident that this data is accurately described in this Quality Report. A Data Quality Framework has been developed by the Trust which encompasses the data sets which underpin each of these indicators and addresses the following dimension of data quality: accuracy, validity, reliability, timeliness, relevance and completeness. The Framework describes the process by which the data is gathered, reported and scrutinised by the Trust. Further details are available upon request. (Comparisons shown are against a benchmark group of all acute trusts with the exception of patient safety incidents where the benchmark group is acute teaching hospitals only).

Item 05d

Mandatory indicator	UH Bristol 2013/14	National average 2013/14	National best 2013/14	National worst 2013/14	UH Bristol 2012/13	Page ref.
Venous thromboembolism risk assessment[4]	97.7%	95.6%	100%	80.3%	96.3%	9
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)[5]	17.1	15.0	0.0	30.7	18.4	11
Rate of patient safety incidents per 100 admissions[6]	10.04	7.9	12.8	4.9	8.78	18
Percentage of patient safety incidents resulting in severe harm or death	0.2%	0.4%	0.0%	0.9%	0.8%	18
Responsiveness to inpatients' personal needs	Comparative data for 2012/13: UH Bristol score 72.4; England median 67.4; low 57.4; high 84.4. (Comparative data for 2013/14 will not be available from the Health & Social Care Information Centre until August 2014)					N/A
Percentage of staff who would recommend the provider	71%	64%	89%	40%	71%	32
Summary Hospital-level Mortality Indicator (SHMI) value[7] and banding	95.7	100	68.5	121.1	96.4 Band 2	38
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'[8]	19.4%	20.9%	44.9%	0%	17.6%	N/A
Patient Reported Outcome Measures	Comparative groin hernia data for 2012/13: 70.6% of UH Bristol patients reported an improved EQ-5D score (national average 50.2%); 41.2% of UH Bristol patients reported an improved EQ-VAS score (national average %). Comparative data is not currently available for the full year 2013/14 from the Health & Social Care Information Centre. UH Bristol PROM data for varicose veins does not meet the publication threshold.					44
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for 2012/13 or 2013/14 from the Health & Social Care Information Centre.					45
Emergency readmissions ithin 28 days of discharge: age 16 or over	Comparative data for 2011/12: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for 2012/13 or 2013/14 from the Health & Social Care Information Centre.					45

Table 2

[4] Latest nationally published data covers April 2013 – January 2014; UH Bristol score is for full financial year
[5] Latest nationally published data covers April-December 2013
[6] Published (validated) data is for the first six months of the financial year only – NRLS acute trusts group
[7] In-hospital deaths plus deaths within 30 days of discharge: October 2012 – September 2013
[8] Specialty 315, diagnosis Z515: October 2012 – September 2013

Patient Safety

Our ongoing commitment

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improve the safety of our services and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by conducting thorough investigation and analysis when things go wrong, identifying and sharing learning and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident and will strive to eliminate avoidable deaths as a consequence of care we have provided. We will also work to better understand and improve our safety culture and to successfully implement proactive patient safety improvement programmes.

OBJECTIVE 1

We wanted to increase harm free care as measured by the NHS Safety Thermometer

The NHS Safety Thermometer is a national tool used to measure and benchmark the level of harm experienced by patients due to pressure ulcers, falls, venous thromboembolism and catheter associated urinary tract infections. The Safety Thermometer involves conducting monthly point prevalence audits of all eligible inpatients (approximately 750 patients per month) and assessing whether they have experienced any of these four types of harm. The tool measures "new" harm likely to have occurred since the patient was admitted to one of our hospitals and "old" harm likely to have occurred prior to admission. The audits are conducted by front-line nursing staff, providing real-time feedback to the team about areas of good practice and areas for improvement.

Harm free care

Our chosen measure for this is the percentage of patients with no new harm. For 2013/14, we set an improvement target that by Quarter 4 of 2013/14 at least 97.7% of patients would experience none of the four harms described above. This target was based on the best performing trusts in our acute teaching trust peer group in the final quarter of 2012/13[9] using national NHS Safety Thermometer data[10]. We achieved 98.0%. Our progress in increasing the proportion of patients with no new harm throughout 2013/14 is shown in Figure 1. The improvement in this measure has been largely achieved by the reduction in hospital acquired pressure ulcers from 39 in Quarter 4 2012/13 to 14 in Quarter 4 2013/14. Our Safety Thermometer audits also

[9] This is the same acute teaching trust peer group used by NHS England for benchmarking patient safety incident data submitted to the National Reporting and Learning System. 97.7% was the threshold for the upper quartile.

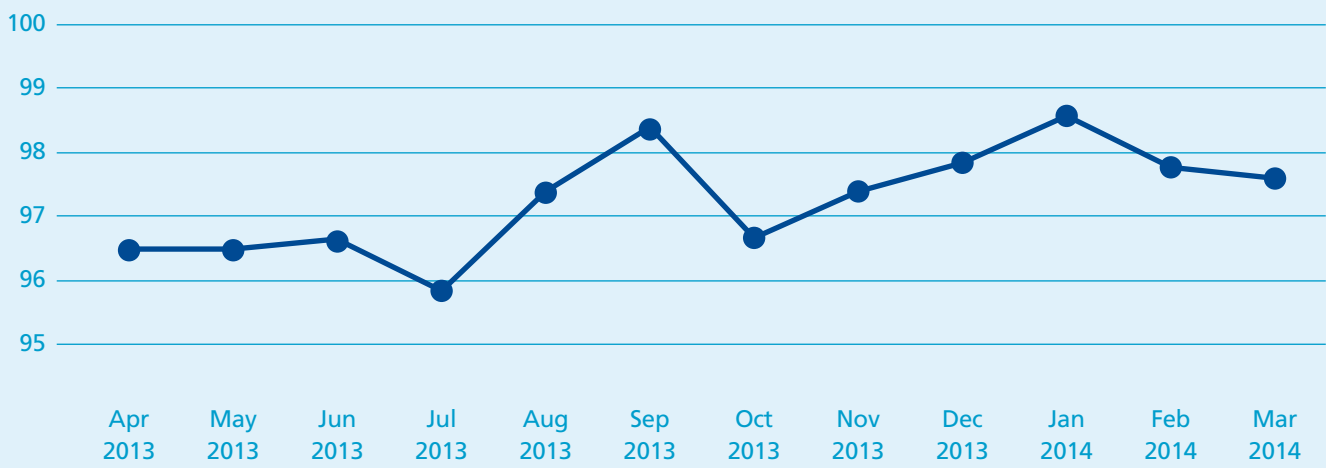
[10] Source: Health and Social Care Information Centre

show that we have reduced the number of falls resulting in patient harm from 42 in Quarter 4 2012/13 to eight in Quarter 4 2013/14.

In 2014/15 we intend to increase our annual target by rebasing it with reference to our improved performance in 2013/14.

Figure 1

Source: NHS Safety Thermometer



Patient falls

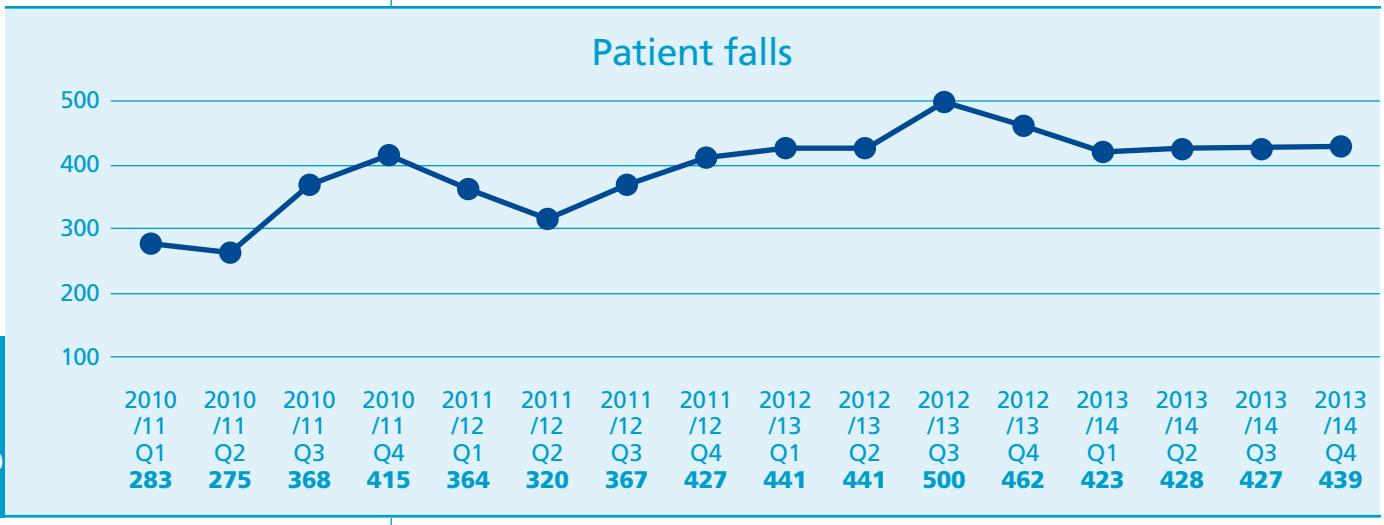
Patient falls are the most commonly reported safety incident in the NHS inpatient setting and occur in all adult clinical areas. Falls in hospital lead to injury in approximately 30% of cases, with up to 5% leading to serious injury. As many as half of all falls involve a degree of cognitive impairment, with 75%[11] of falls occurring in patients aged 65 or over. The number of elderly patients admitted to the Trust is rising steeply. The majority of falls are not witnessed and a significant number occur in the early hours of the morning; not all falls can be prevented. During 2013/14, we developed a method for estimating the impact the age of our patients has on the incidence of inpatient falls and used this to compare the number of expected falls with the number of actual falls.

Our target for 2013/14 was to achieve a total number of reported patient falls of less than the national average of 5.6 per 1,000 bed days (National Patient Safety Agency data). We achieved this target in four out of 12 months and an overall rate of 5.7 falls per 1,000 bed days. This compares to two months and a rate of 6.0 in 2012/13. Cases where inpatient falls had a 'major' impact reduced from 17 in 2012/13 to 14 in 2013/14: this was despite a significant rise in the number of 'at risk' patients in the 75 year plus age group being admitted to our hospitals. Further work is required to achieve this target consistently and ensure the level of harm to patients as a result of falls continues to decline.

In 2012, the Royal College of Physicians published 'Fallsafe', an approach to the management and prevention of avoidable falls in hospital. The Trust piloted Fallsafe at the end of 2012 and then implemented the approach across 28 wards during 2013/14. Fallsafe involves educating, inspiring and supporting clinical staff to deliver assessments and interventions through a care bundle approach, supported by a falls assistant project post. Divisions report regularly on their progress to the Trust's Falls Steering Group.

[11] National Patient Safety Agency, 2007 data

Figure 2

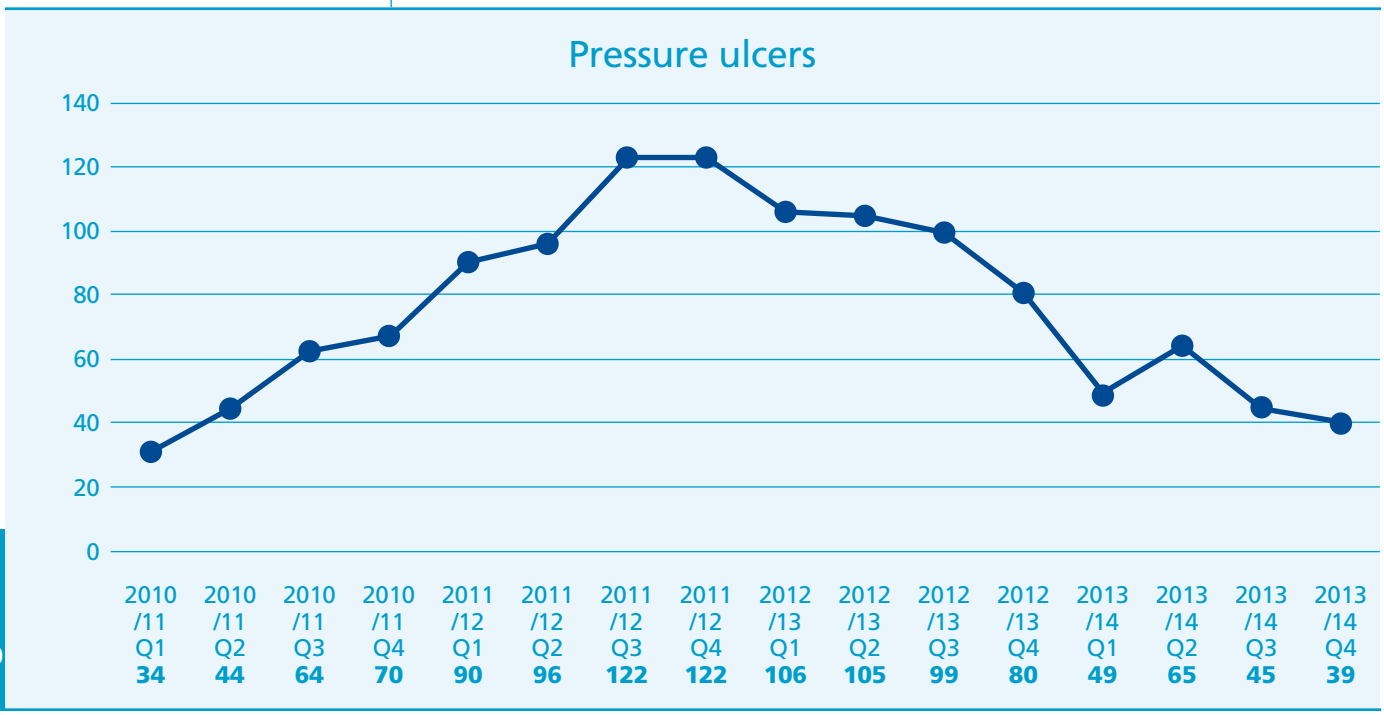


Source: Ulysses Safeguard system

Pressure ulcers

Pressure ulcers range from being small areas of sore or broken skin to more serious skin damage that can lead to life-threatening complications. In 2013/14, a national Commissioning for Quality and Innovation (CQUIN)[12] indicator was mandated for reduction of one of the four types of harm measured by the NHS Safety Thermometer. We agreed a CQUIN target with our commissioners to reduce the number of hospital acquired grade 2-4 pressure ulcers by 15%[13] which equated to no more than 25 grade 2-4 hospital acquired pressure ulcers per month on average during 2013/14. For the purposes of the CQUIN, pressure ulcers were measured as a monthly average in six monthly blocks: we achieved an average of 19 cases per month for the first half of 2013/14 and an average of 14 per month for the second half of the year, i.e. we achieved the CQUIN.

Figure 3



Source: Ulysses Safeguard system

In 2013/14, we also set an internal Trust target to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1,000 bed days (based on a percentage reduction of a previous NPSA benchmark): we achieved a rate of 0.656 per 1,000 bed days. This compares with a rate of 1.264 in 2012/13. Examples of actions taken in 2013/14 to achieve this improvement include:

- Monthly review of pressure ulcers and feedback to each division through steering group.
- New wound assessment documentation (to meet requirement of NICE clinical guideline 29).

[12] The Commissioning for Quality and Innovation (CQUIN) payment framework is a developmental process which enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals

[13] measured through robust incident reporting rather than the point prevalence methodology of the NHS Safety Thermometer.

- New dressing formulary to standardise treatment Trust-wide.
- Launch of monthly formal training for all registered nurses on pressure care and wound assessment; training also provided for nurse assistants.
- New Trust-wide contract for dynamic mattresses, achieving a better specification of dynamic mattress and cost savings at the same time.
- Revised root cause analysis tool for pressure ulcers to enable clearer identification of causes of pressure ulcers, as per external review recommendation.

Additional actions planned for 2014/15 include a review of our contract for topical negative pressure equipment, new static foam mattresses for trolleys in theatres and emergency departments and the development of a pan-Avon dressing formulary to standardise treatment in acute and community setting, achieving cost savings and improved access to dressing treatments.

Venous thromboembolism
(Mandatory indicator)

Venous thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. It is estimated that there are 25,000 deaths from VTE each year in hospitals in England: reducing incidence of VTE is a national quality priority within the NHS Outcomes Framework.

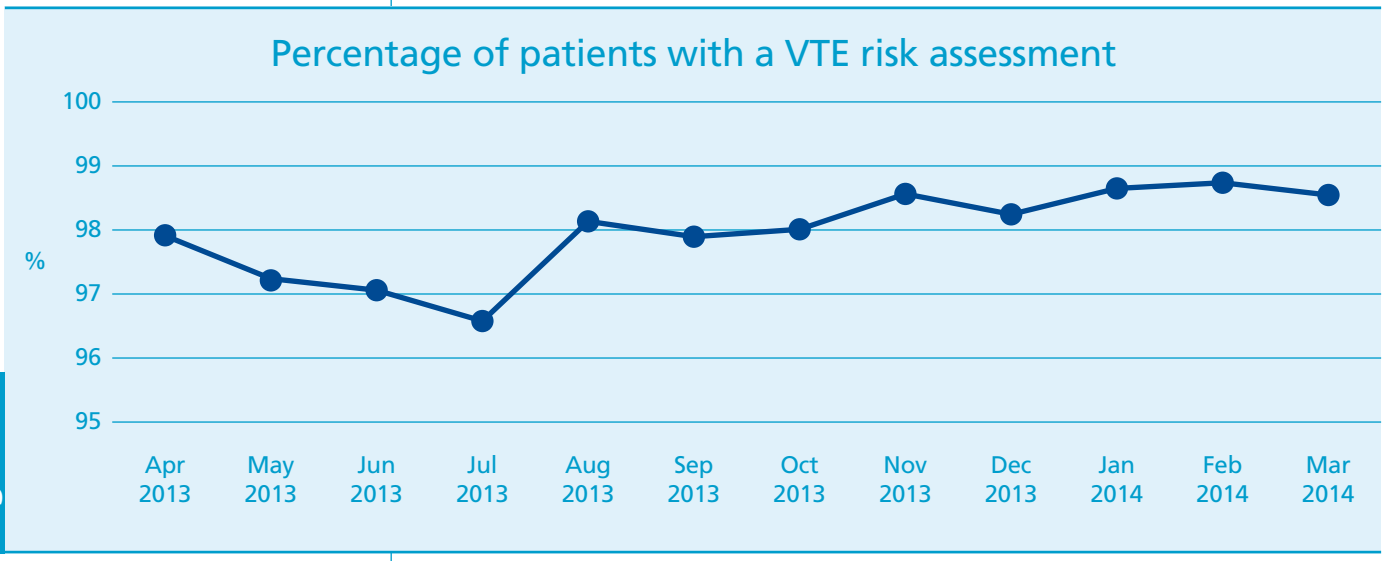
In 2013/14, we wanted to sustain improvements in VTE prevention by continuing to screen patients for risk of VTE and ensuring patients at risk receive appropriate thromboprophylaxis.

We achieved a national CQUIN target of 95%+ compliance with VTE risk assessments. The CQUIN was measured quarterly, but in fact the Trust achieved a 95%+ target for VTE risk assessment in every month during 2013/14, as shown in Figure 4. For the year as a whole, 98.0% of inpatients received a risk assessment. This compares with 96.4% in 2012/13.

We also achieved a 90%+ target[15] for appropriate thromboprophylaxis for ten of the 12 months during 2013/14 as shown in Figure 5. For the year as a whole, 93.4% of inpatients identified as being at risk received appropriate thromboprophylaxis. This compares with 94.6% in 2012/13.

The Trust considers its VTE risk assessment data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. Full details of our data quality framework for this indicator are available upon request.

[15] Based on the previous year's CQUIN target

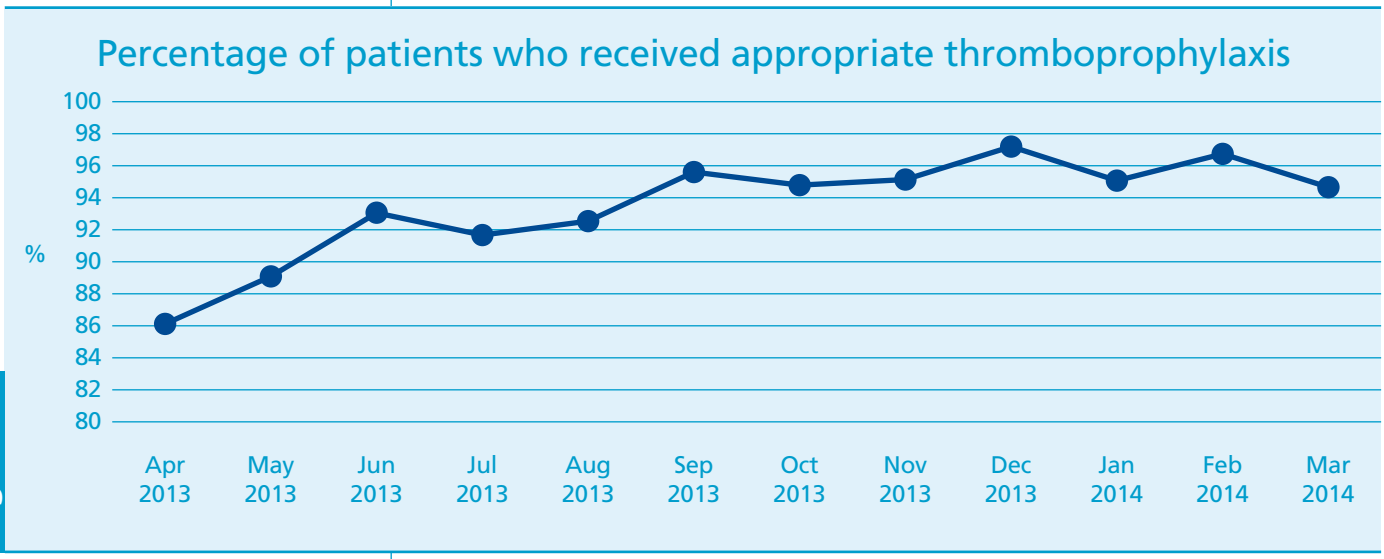


Source: Ulysses Safeguard system

Figure 4

Figure 5

Source: Ulysses Safeguard system



The Trust has taken the following actions in 2013/14 to sustain 95%+ compliance with VTE risk assessments, and so the quality of its services:

- Extending the provision of VTE project nurses to sustain and embed focus on VTE prevention and provide supplementary training by targeting any teams and staff groups where there is evidence of reduced levels of compliance or where, through reported patient safety incidents, patients have been identified as having acquired a VTE in hospital.
- Continuing to focus on VTE prevention training, including induction, update sessions and e-learning.

Also during 2013/14, we agreed with our commissioners details of a nationally mandated CQUIN to investigate hospital associated thrombosis. We agreed to conduct a modified root cause analysis investigation for at least 90% of all identified hospital associated thrombosis in 2013/14. Root cause analysis enables us to learn from these incidents and take action to help prevent future similar incidents where modifiable factors are identified which have contributed to the incident. There were no modifiable factors identified in the majority patients (39 out of 52) who developed hospital associated thrombosis in quarters 1-3 of 2013/14 i.e. the thromboses were deemed unavoidable. Investigations for those identified in quarter 4 will be completed by the end of May 2014.

Learning from root cause analyses has highlighted the need for additional guidance for continued pharmacological thromboprophylaxis (usually by administration of blood thinning injections) for an extended period following discharge from hospital for additional groups of patients with specific kinds of lower limb fractures. We have also identified the need for more education on the use of anti-embolic stockings and that the use of sequential compression devices[15] may help reduce hospital associated thrombosis in some stroke patients for whom pharmacological thromboprophylaxis is too risky in the early days following a stroke. As a result of this, sequential compression devices are now available on the stroke unit and staff are being trained in their use. They will also be implemented in Ward 200 at South Bristol Community Hospital.

For 2014/15, our goal is to sustain over 95% of patients being risk assessed for VTE, to continue to focus on increasing the proportion of our patients who receive appropriate thromboprophylaxis and to continue our analyses of hospital acquired thrombosis to identify any further opportunities for learning.

[15] sequential compression devices involve sending pressure pulses of air into these sleeves (baggy stockings) to stimulate circulation: the devices are for high risk stroke patients only and are used from assessment through to discharge including during rehabilitation.

OBJECTIVE 2

We wanted to reduce hospital acquired healthcare infections

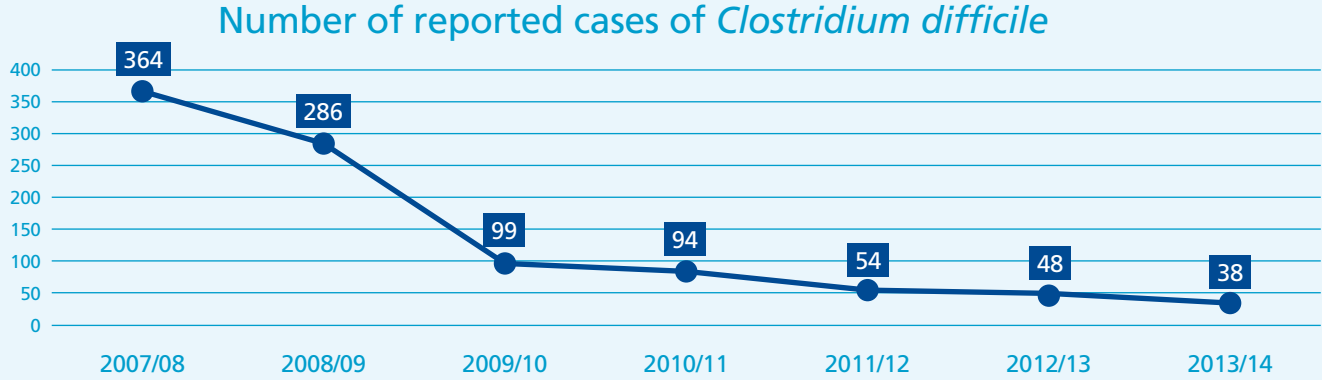
Clostridium difficile
(Mandatory indicator)

The Trust's focus on preventing healthcare acquired infections (HCAIs) is constant and ongoing. In 2013/14, we were disappointed that we exceeded our nationally determined target for *Clostridium difficile* (the Trust reported 38 cases against a target of 35) but nonetheless very pleased to have achieved a 21% reduction in reported cases compared to 2012/13.

The Trust considers its *Clostridium difficile* data is accurate because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the collection and validation of the data and its submission to a national database (full details are available upon request).

Figure 6

Source: Public Health England Data Capture System



The Trust has taken the following actions in 2013/14 to achieve reductions in *Clostridium difficile* infection and so improve the quality of its services:

- Patients continue to be nursed in a separate cohort area and are not admitted back into the general patient population for their duration of stay in hospital.
- Patients are monitored on a daily basis by the infection control team. When patients are discharged, patients' rooms are deep-cleaned. A hydrogen peroxide vapour is used for added assurance of cleaning.
- Antibiotic prescribing is monitored.
- Hand hygiene audits are undertaken each month. If the required standard is not reached, audits are repeated weekly until three consecutive weeks at the required standard are achieved.
- Patients with *Clostridium difficile* are managed by gastro intestinal consultants and an infection control doctor.
- Study sessions have been delivered to general practitioners and nursing home managers to improve community management of *Clostridium difficile*.
- The introduction of Procalcitonin testing of acute admissions, to reduce the antibiotic use and duration of antibiotic treatment.

Meticillin resistant *Staphylococcus aureus* (MRSA)

The Trust had two cases of MRSA in 2013/14, which represents a significant improvement compared to 2012/13 (10 cases). Root cause analysis of cases reported in 2012/13 showed there were issues with intravenous (IV) line management and practice. An IV access coordinator post was therefore agreed by the Trust and as a result, we have:

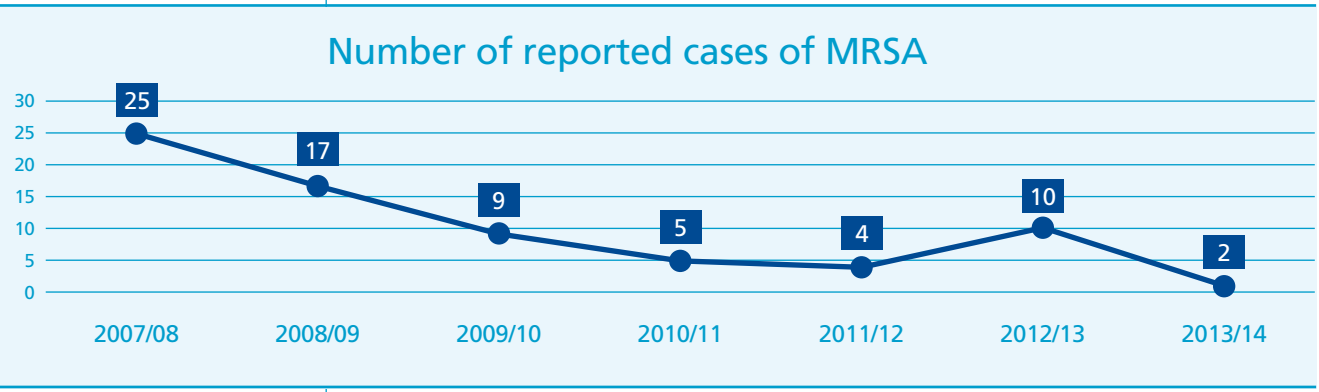
- Established the current level of line management and practice by undertaking clinical shifts and auditing aseptic non touch technique (ANTT) practice across adult areas.

- Made ANTT a part of essential training for all new clinical staff.
- Coordinated the setting of Trust-wide care standards regarding vascular access.
- Developed a Trust-wide central line complications protocol.
- Reviewed Trust-wide IV line databases to ensure a consistent approach to data capture.
- Developed and rolled out a Trust-wide IV device selection matrix.
- Reduced blood culture contamination rates.

Neither of the two MRSA cases in 2013/14 was IV line related.

Figure 7

Source: Public Health England Data Capture System



Meticillin susceptible *Staphylococcus aureus* (MSSA)	**In 2013/14, the Trust recorded 27 cases of MSSA bacteraemia. This was better than our target (29) and an improvement on previous years (36 in 2012/13; 39 in 2011/12). The same actions are in place to reduce MSSA bacteraemia as for MRSA.**
Norovirus	**In 2013/14, the Trust had a total 47 ward or bay closures (16 and 31 respectively) as a result of norovirus. This compares to 88 closures in 2012/13. The average (mean) length of time for a ward closure was nine days: two days more than 2012/13 but the same level as in 2011/12. We continue to follow national norovirus guidelines and report outbreaks through the Public Health England hospital norovirus outbreak reporting system.**
Hand hygiene and antibiotic compliance	**We continue to train all staff in infection prevention and control measures. In March 2014, our monthly hand hygiene audit showed 98% compliance. Antibiotic compliance (checking the appropriateness of the antibiotic; whether start and stop dates are recorded; the prescriber's name is legible) is monitored on a monthly basis. In March 2014, the Trust achieved its target of 90% compliance (90.7% of 946 cases audited). The Trust introduced a new antibiotic guideline smartphone app into adult services in February 2014 and we anticipate that the equivalent app for paediatric services will be made available later in 2014.**

OBJECTIVE 3

We wanted to reduce medication errors

In 2013/14, for the third consecutive year, we set ourselves the objective of continuing to drive down levels of medication errors which cause 'moderate', 'major' or 'catastrophic' harm to patients. The reduction of medication errors causing serious harm is a national quality priority within the NHS Outcomes Framework.

Once again, more than 99% of reported medication incidents at our Trust in 2013/14 did not result in major harm to patients (18.4% of incidents were low harm,

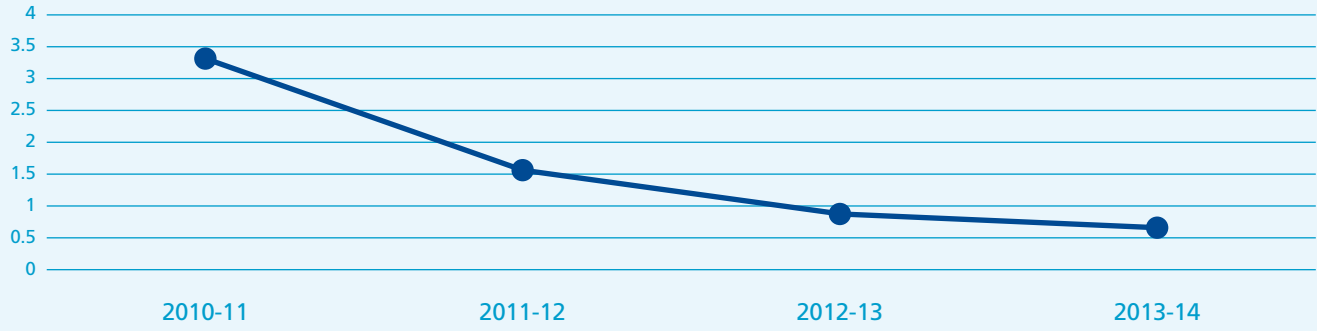
61.2% negligible harm (defined as no obvious harm or damage to the patient) and 19.7% were identified as a 'near miss'. Our target was to improve on our 2012/13 performance when 0.88% (14/1,594) of reported medication incidents involved moderate, major or catastrophic harm to patients.

In 2013/14, 0.68% (13/1,910) of medication related incidents resulted in moderate (10/13), major (2/13) or catastrophic (1/13) harm. This represents an improvement on our performance in 2012/13 (0.88%). Changes in 2013/2014 which have contributed to this include a face to face session with all clinical staff at induction on safer medicines management and the successful implementation of a multidisciplinary action plan to reduce omitted doses, along with ongoing work from the learning and feedback from reported incidents.

Figure 8

Source: Ulysses Safeguard system

Medication errors resulting in moderate or greater actual harm



In 2014/15, our aim is to comply with the Patient Safety Alert NHS/PSA/D/2014/005 (Improving medication error incident reporting and learning), whilst ensuring the level of moderate or greater harm resulting from medication errors is kept to a minimum.

As in 2012/13, we also set ourselves the goal of reducing omitted doses of critical medicines. This is important to patient safety and quality of care to ensure that the patient receives the maximum benefit from their medicines. From a baseline of 2.59% of patients having a non-purposeful omitted dose (measured by sampling methodology in over 500 patients each month, monitoring the previous three days of treatment), our target was to achieve less than 2.25%. We were successful in reducing the percentage of omitted doses of critical medicines to 1.91% (sampling around 1,000 patients per month) – a 26% reduction, following successful implementation of a multidisciplinary action plan. In 2014/15, our aim is to maintain this low level of omitted doses of critical medicines.

OBJECTIVE 4

We committed to extend the practice of medicines reconciliation ('getting the medicines right')

Medicines reconciliation (locally termed 'getting the medicines right') is a process recommended by NICE[16] which is designed to prevent medication error at hospital admission. Medicines reconciliation involves reviewing and documenting a patient's medicines against the best available sources of information, such as GP records or medicines brought in from home. UK-based evidence indicates that medicines reconciliation is effective in reducing medication errors and resulting patient harm.

In 2013/14, we agreed a CQUIN target with our commissioners to carry out medicines reconciliation within one working day for at least 95% of patients admitted to our hospitals, averaged across identified assessment and cardiac wards. We also

[16] The National Institute for Health and Clinical Excellence - Patient Safety Guidance Number 1 (December 2007)

committed to extend medicines reconciliation to our oncology, haematology and gynaecology wards, with a target of at least 85% averaged across those areas. Table 3 shows performance by ward and that our targets were achieved.

Table 3

Ward	2012/13			2013/14		
	Number of patients reviewed	Medicines reconciliation carried out within one working day	Aggregate percentage	Number of patients reviewed	Medicines reconciliation carried out within one working day	Aggregate percentage
2	318	95.3%	94.6%	265	99.6%	98.0%
17	140	99.3%		255	98.0%	
CCU	125	97.6%		260	98.5%	
51	120	90.0%		255	96.1%	
51	127	90.6%		265	97.0%	
53	167	93.4%		255	98.8%	
61	0	N/A	N/A	220	94.5%	92.0%
62	0	N/A		189	97.9%	
78	0	N/A		200	83.5%	

Source: ward based audits

In 2014/15, our aim is to maintain coverage in all admissions wards with similar percentages to those achieved in 2013/14. We aim to utilise the national medication safety thermometer risk assessment tool in identified hospital wards to highlight and trend potential medication risks which need to be communicated to primary care clinicians with a view to reducing the incidence and severity of risk. We also aim to evaluate patient re-attendance rates and identify any interventions to mitigate future risk and any common themes.

OBJECTIVE 5

We said we would improve the early identification and escalation of care of deteriorating patients

As well as using nursing skills and experience to assess the condition of our patients, we also use objective measurements of vital signs, called "observations". This includes, as a minimum, measuring the temperature, pulse, respiration rate and blood pressure of the patient.

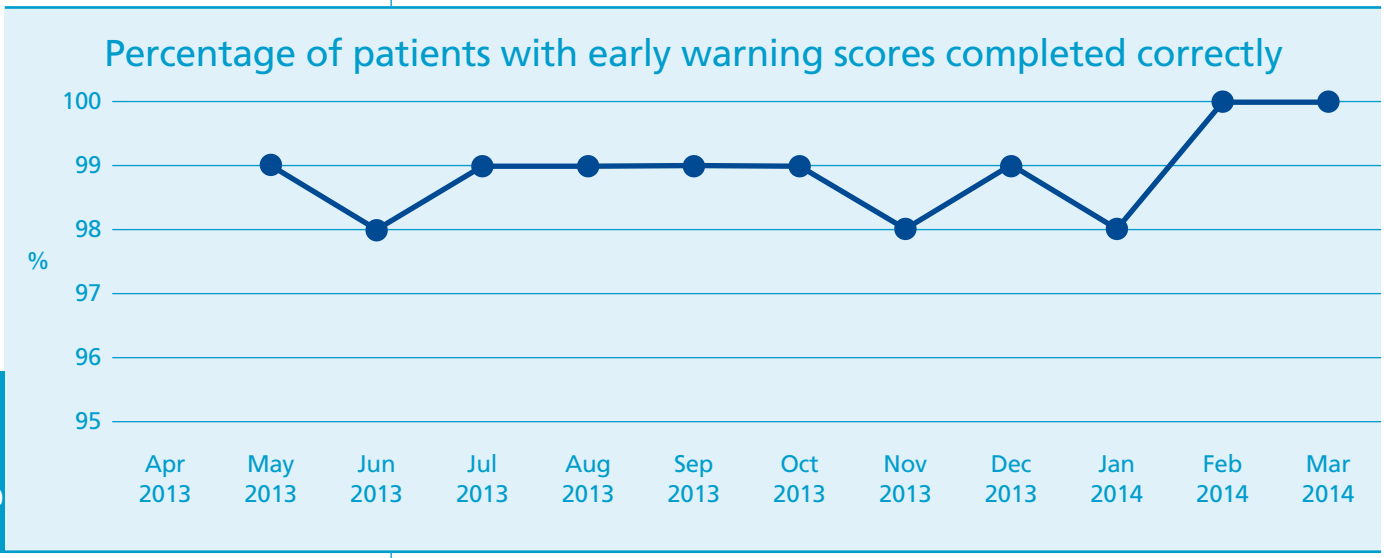
These are plotted on our "Bristol Observation Chart" and when individual measurements are outside of the normal parameters, a score is assigned depending on how abnormal they are. The individual scores are then added up to produce an early warning score or "EWS". Generally, the higher the EWS, the more sick the patient is and a pattern of increasing EWS indicates a deteriorating patient. Agreed EWS scores trigger actions by nurses in response to this early warning. A EWS of four is the default point at which a patient is identified as requiring review by a senior nurse or doctor within 15 minutes, known as escalation, although patients with a lower EWS can be escalated if there is additional cause for concern. When this escalation takes place, nurses are required to use a structured communication tool known as "SBAR" (Situation, Background, Assessment and Recommendation) to

give the senior nurse or doctor information about the patient in a clear succinct and accurate way so that they can respond promptly as needed.

We agreed a local CQUIN target with our commissioners to ensure that 95% of observations of vital signs were measured correctly and the EWS was correctly calculated, and that the SBAR tool would be used to escalate at least 70% of deteriorating patients with a EWS of four or more in the third quarter of the year, increasing to 80% in the final quarter. Each month, we audited 500-600 patients; in 11 out of 12 months, at least 98% of patients had their early warning scores completed correctly every month (the score for January was 97.8).

Figure 9

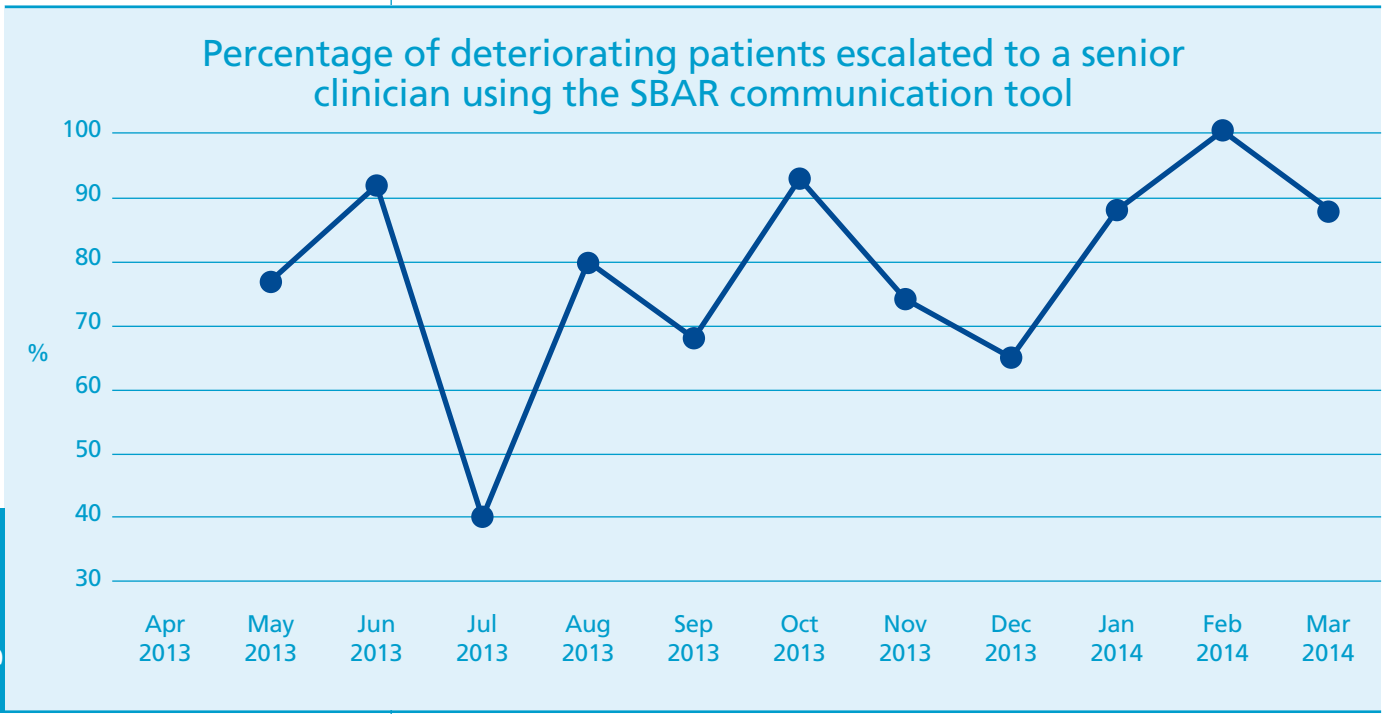
Source: monthly audit



Use of the SBAR communication tool to escalate deteriorating patients for review by a senior clinician has taken time to become established practice. The monthly fluctuations shown in Figure 10 are also due in part to the small numbers deteriorating patients, i.e. small changes in patient numbers can lead to significant changes in percentage compliance. Figure 10 does however show an overall improvement throughout 2013/14 and we achieved 90.5% for quarter 4 against our 80% target.

Figure 10

Source: monthly audit



In 2014/15 we aim to sustain the improvements in identifying deterioration and acting on this for the sickest patients, and in addition we will focus on improving responses to less sick patients who may be in earlier stages of deterioration.

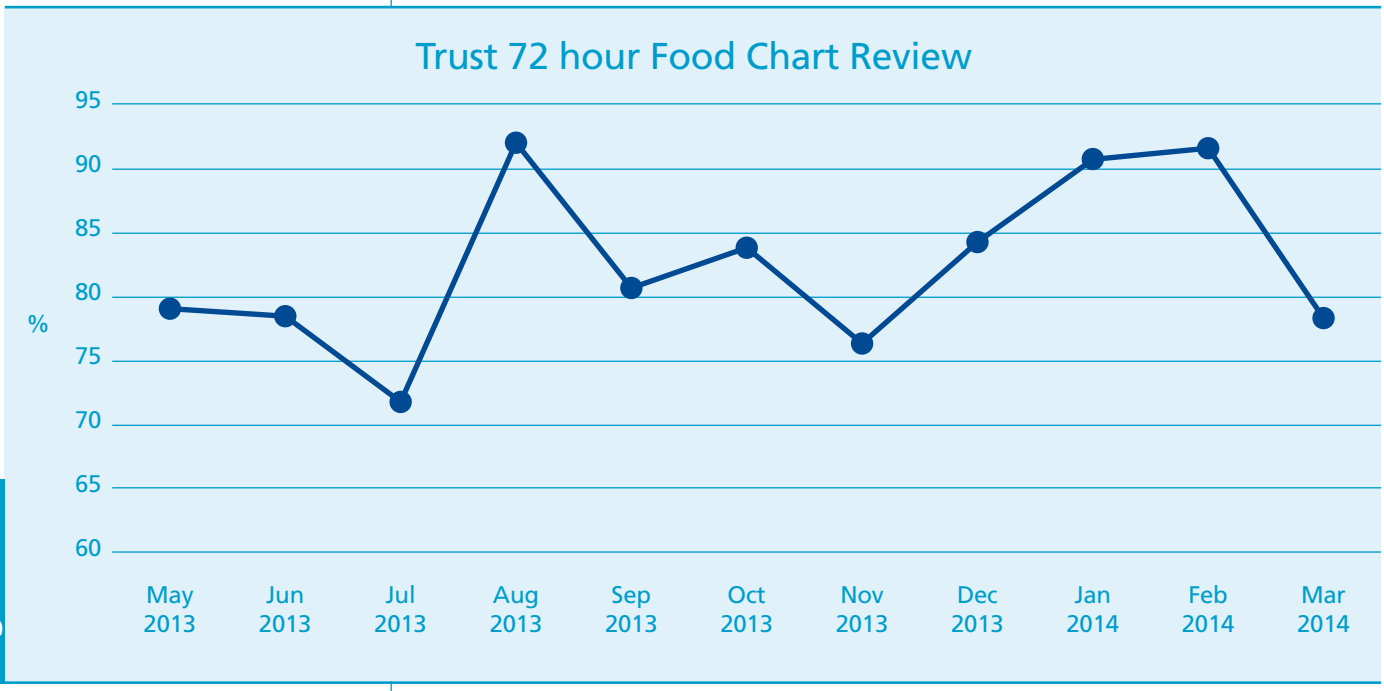
OBJECTIVE 5

We wanted to improve levels of nutritional screening and specifically 72 hour nutritional review of patients

In previous Quality Reports, we have explained how we have used feedback from the Care Quality Commission to improve the quality of nutritional care that patients receive, and how we are using volunteer staff to support patients who need help at mealtimes. All patients are screened for risk of malnutrition when they are admitted to hospital. If a patient is identified to be at risk, a number of agreed actions follow, including the requirement to complete a food chart and to formally review this 72 hours after admission. For 2013/14, we agreed a CQUIN target with our commissioners that in the final quarter of the financial year, at least 90% of adult patients who had initially been assessed as being at risk of malnutrition would receive a nutritional review after 72 hours. Performance against this indicator is monitored via the NHS Safety Thermometer; results form part of the supervisory sisters' key performance indicators and are reported to the monthly Nutrition Steering Group. Actions and improvements for wards that are not achieving the required levels of nutritional review are a standing agenda item for the group.

Despite a considerable amount of work at ward level, the CQUIN was not achieved. We met the required target in January and February 2014, but a dip in performance in March pulled our quarterly score down to 87.2%. Nonetheless, Figure 11 points to a positive trend in recent months and we are focussing on restoring this pattern of improvement at the start of 2014/15. Overall compliance for the period May 2013[17] – March 2014 was 82.5%.

[17] This is when data collection began



Source: NHS Safety Thermometer

Figure 11

Item 05d

REVIEW OF PATIENT SAFETY 2013/14

This section explains how the Trust performed during 2013/14 in a number of other key areas relating to patient safety, which are in addition to our stated annual objectives.

Rate of patient safety incidents reported and proportion resulting in severe harm or death

(Mandatory indicator)

The percentage of reported incidents resulting in severe harm is 0.2% (12 incidents) for the period April-September 2013. This represents a reduction compared both to the previous six months (0.5%, 31 incidents) and the corresponding period in 2012/13 (0.7%, 35 incidents) as reported in our 2012/13 Quality Report. The percentage of reported incidents resulting in death remains at 0%[18] (1 death) for the period April-September 2013. This represents a reduction compared both to the previous six months (0.1%, three deaths) and the corresponding period in 2012/13 (0.1%, four deaths) as reported in our 2012/13 Quality Report, and is below the average rate of our peer group (0.1%). The provisional percentage of reported incidents resulting in severe harm or death was 0.34% (39 severe harm incidents; and 2 potentially avoidable deaths) for 2013/14 as a whole[19]. The Trust considers its incident reporting data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the identification and review of incident data prior to submission to the National Reporting and Learning System (full details are available upon request).

In 2014/15, the Trust intends to take the following actions to continue to reduce harm from avoidable patient safety incidents:

- Complete our five year proactive patient safety improvement programme (renamed Safer Care Southwest) in October 2014 and participate in the safety improvement work of the new regional patient safety collaborative/s.
- Continue to investigate incidents proportionally to their level of harm or risk, and improve how we share learning and take action across the organisation to reduce the likelihood or impact of the same kind of incident happening again.
- Build on our improvements in 2013/14 for key patient safety issues for the Trust such as reducing the medication errors, reducing inpatient falls and improving the identification of the deteriorating patient and ensuring prompt review by a senior clinician.
- Pilot and, if successful, implement a system for systematic review of adult mortality.[20]

Also see the Trust's quality objectives for 2014/15 on page 47 of this report.

[18] technically 0.000166% (1/6012)

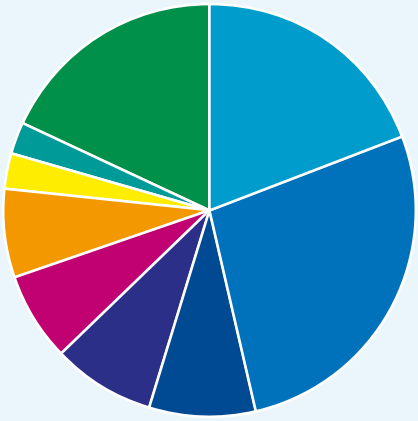
[19] Consisting of data for first six months of 2013/14 which has been validated by NRLS, and data for the second six months of the year which is sourced from the Trust's Ulysses Safeguard system

[20] There already exists a well-established Child Death Review Process

Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2013/14, the Trust Board was informed of serious incidents via its monthly quality dashboard. The total number of serious incidents reported for the year was 73 compared to 91 in 2012/13. Of the 73 initially reported, five were either downgraded or a downgrade request has been made at the time of writing (April 2014). A breakdown of the themes from these incidents is provided in Figure 12 on the next page.

Serious incidents 2013/14



Pressure ulcers	14
Falls	20
Black escalation	6
Safeguarding	6
Information governance	5
Drug incident	5
Never event	2
Power loss	2
Other	13

Source: UH Bristol Serious Incident Log

Figure 12

N.B.: The category "other" includes all categories where only one serious incident of its type was reported.

All serious incident investigations have robust action plans which are implemented to reduce the risk of recurrence. Actions taken by the Trust to reduce falls and hospital acquired pressure ulcers are documented elsewhere in this report. Serious incidents are governed by national definitions through NHS England.

Never events

'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They are incidents where there is clear potential for causing severe harm or death. "Never" is an aspiration: these errors should not happen and all efforts must be made to prevent these mistakes from being repeated. This means that the overriding concern for the NHS in implementing the national never event policy framework is to discuss these events when they occur and to learn from the mistakes that were made (Department of Health 2010).

Two never events occurred in University Hospitals Bristol in 2013/14:

1. A case of wrong site surgery: an emergency procedure was commenced on the wrong side. The mistake was identified shortly after the start of the procedure, remedial action was taken and then the procedure took place on the correct side. The patient came to minor harm; they were informed of the mistake afterwards and a sincere apology was offered. This incident was not prevented by the WHO[21] surgical safety checklist which was completed prior to the procedure starting. The root cause analysis investigation identified, among other things, that making the site of surgery visible within the surgical field after the patient was draped (covered with sterile sheets to reduce the risk of infection during the operation) would probably have prevented this incident. This change in practice will be implemented and a further serious incident panel investigation has been commissioned by the medical director to identify further broader systemic and organisation-wide recommendations.

2. A retained foreign object following emergency surgery: a removable part of a disposable instrument became inadvertently detached during use and was left inside a patient. The patient required a further minor procedure to remove the object. The patient and family were informed of the retained object when its presence was identified and an apology was offered. An immediate action was instigated to ensure all disposable items are included in surgical counts. A serious incident panel investigation was commissioned by the medical director to identify any systemic and organisation-wide learning.

For 2014/15, a proactive Trust-wide review of systems in operating theatres is already underway to identify further risk-reduction actions which can be taken to prevent surgical never events. In February 2014, NHS England published a report of its Never

[21] World Health Organisation

Events Taskforce which was commissioned in response to the recognition that surgical never events are the most commonly reported types of never events. The report identified NHS-wide actions to be taken to with the aim of eradicating surgical never events. Recommendations from the report will form part of the Trust's proactive review, as described above.

NHS England's provisional data for 2013/14 shows that a total of 312 never events occurred in NHS trusts, of which 132 involved a retained foreign object and 89 involved wrong site surgery. At least one never event was reported by 159 NHS trusts, with the maximum number reported by any single trust being eight. Never events are governed by national definitions.

NHS England Patient Safety Alerts

At the end of 2013/14, there were no outstanding alerts relating to University Hospitals Bristol NHS Foundation Trust.

Patient Experience

Our ongoing commitment

We want all our patients to have a positive experience of healthcare. All our patients and the people who care for them, are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support. Our staff should be afforded the same dignity and respect by patients and by their colleagues. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's Values. Through our core patient surveys, we have a strong understanding of the things that matter most to our patients: these priorities continue to guide our choice of quality objectives. Our clinical divisions continue to be focused on providing a first class patient experience.

Report on our patient experience objectives for 2013/14

OBJECTIVE 7

We were required to implement the Friends and Family Test in adult inpatient, emergency department and maternity services

The Friends and Family Test (FFT) is a national survey designed to give patients an opportunity to comment on the care they have received and to help people to make decisions about where they have their NHS treatment in the future. The FFT was launched nationally in adult inpatient and emergency department (ED) services on 1st April 2013, and was subsequently extended to maternity services on 1st October 2013. Patients are asked whether they would recommend the care they received to their friends and family. At University Hospitals Bristol, inpatients and ED patients are given an FFT card as part of their discharge from hospital. In maternity services, women are asked to complete the FFT on up to four occasions in relation to their antenatal community midwifery care, their experience in hospital giving birth and/or on the postnatal ward, and in respect of the postnatal care provided by their community midwife.

In last year's Quality Report, we published "net promoter scores" (the technical term for the scores generated by the FFT question) from our own monthly survey. This year, we are replacing this with the official national FFT data. To date, the Trust's FFT scores in the inpatient and ED elements of the survey have been consistently better than the national average (see Figure 13).

There were two national Commissioning for Quality and Innovation (CQUIN) payments associated with the FFT survey in 2013/14[22]. The Trust met the first element of this CQUIN, having implemented the FFT in adult inpatient wards, emergency departments

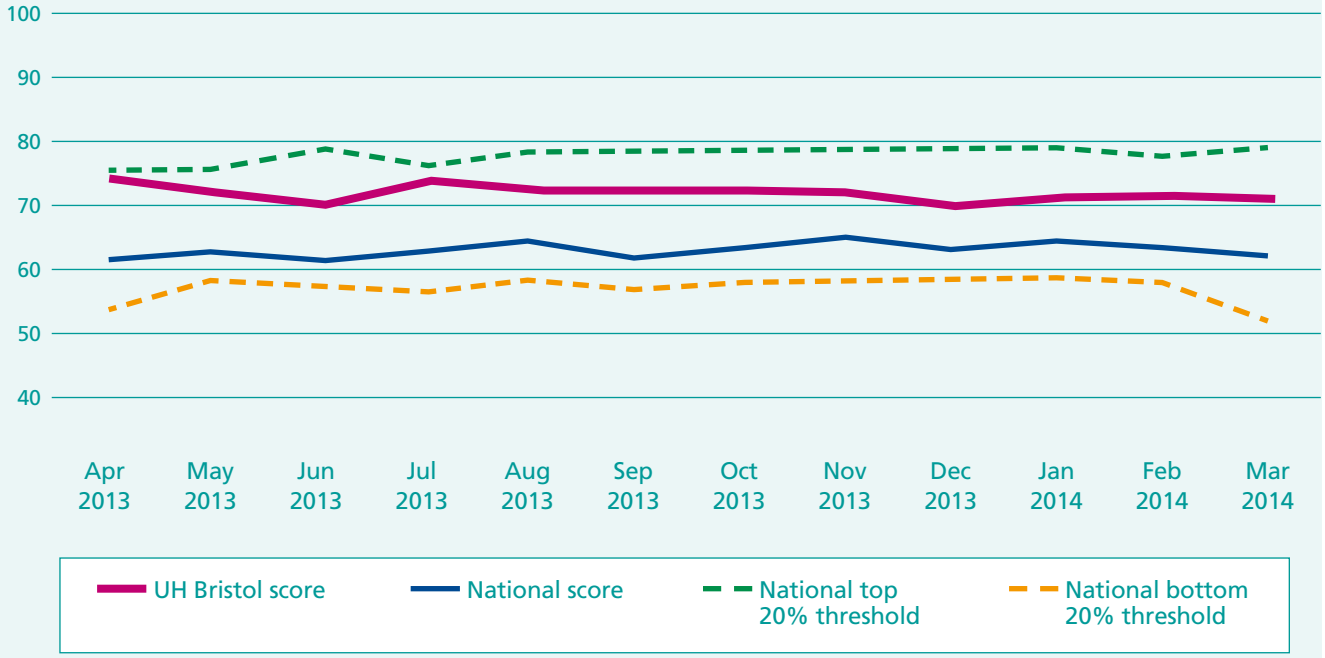
[22] Note: there is another element of this CQUIN which is associated with a score in the NHS National Staff Survey

and maternity services as per the Department of Health's guidance. We also secured half of the value of the second element: although we achieved a 24.6% response rate in the final quarter of the year (against a target of 20%), we had previously underachieved in the first quarter of the year (8.4% against a target of 15%).

Figure 13

Source: UH Bristol Friends and Family Test survey / NHS England

Family and Friends test score (inpatient and emergency department) with national benchmarks



National benchmarks for the maternity FFT have recently been released: we are achieving above national average scores in the community midwifery and care during birth elements of the survey (see Table 4). The Trust's FFT score relating to care on postnatal maternity wards has fluctuated around the national average, influenced by the relatively low number of responses being collected on the maternity wards at present. The Trust has agreed a set of actions to improve the response rates in these areas.

Table 4

Source: ward based audits

Maternity FFT scores	October	November	December	January	February	March
UH Bristol antenatal community midwifery score	73	72	66	75	77	65
Overall national score	64	65	63	67	67	Not available
UH Bristol care during birth score	92	91	68	92	92	86
Overall national score	76	77	75	78	75	Not available
UH Bristol postnatal wards score	50	69	30	76	59	62
Overall national score	65	66	66	65	64	Not available
UH Bristol postnatal community midwifery score	90	80	78	84	82	79
Overall national score	71	72	78	75	75	Not available

In 2014/15, all NHS hospital trusts will be required to be extend the FFT into outpatient and day case care and there will be a new national FFT for staff. The required response

rates for the inpatient and emergency department FFT CQUINs will increase in 2014/15. We are developing plans to ensure that all of these targets are achieved.

OBJECTIVE 8

We wanted to ensure that patients continue to be treated with kindness and understanding on our wards.

As well as asking patients whether they would recommend us, another important measure of patient experience is whether people feel that they have been treated with kindness and understanding – a hallmark of compassionate care. Last year, we achieved excellent scores on this patient-reported measure and set an objective to sustain this in 2013/14. We are delighted to report that we succeeded: our survey scores have been consistently above 90 points throughout 2013/14 to date (see Figure 14). The Board will continue to monitor our monthly kindness and understanding score in 2014/15.

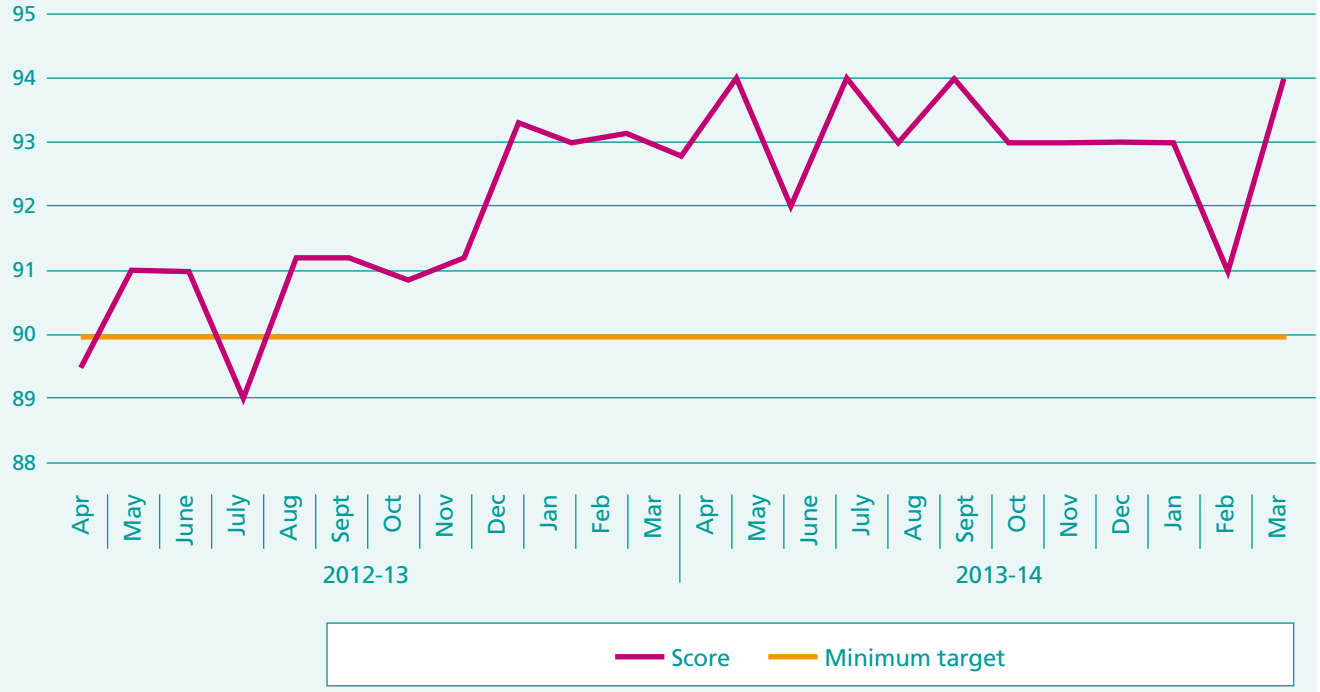
What our patients said in our monthly inpatient survey:

"Every time I've been in the Bristol Royal Infirmary, I have found everyone, from consultants, doctors, nurses, catering staff and even cleaners kind, helpful and polite. I could not fault anyone."

"I had a bad heart attack and had some memory loss, but after the fifth day I started to get back to my old self, all I can think of was how great all the staff in the BRI treated me and made me very at ease. In one of the most scariest and hardest times of my life if it was not for the great care I received and not just medical, I don't think I would be here now, they helped in so many ways I would like to thank everyone of them for their great care and understanding."

Figure 14

Patient ratings of kindness and understanding on UH Bristol's ward



Source: UH Bristol monthly inpatient (patients aged 12 and over), parent and maternity surveys

Item 05d

OBJECTIVE 9

Explain potential medication side effects to inpatients when they are discharged

Telling patients about the potential side effects of the medications that they are taking away with them from hospital is an important aspect of patient experience and patient safety. Although the Trust's performance is similar to most other NHS trusts, as measured in the national inpatient survey, it is an aspect of care where almost all NHS trusts have considerable scope for improvement.

What our patients said in our monthly inpatient survey:

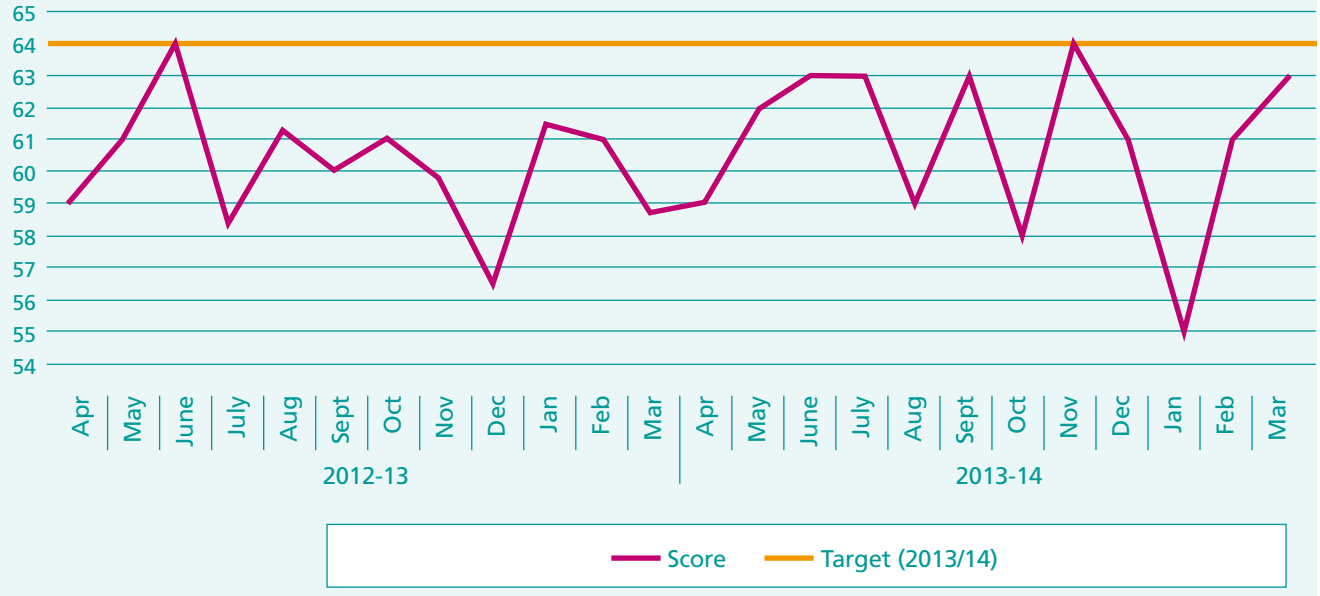
"When I left hospital there was no advice on any side effects or pain issues to be expected."

"Give more explanation of side effects and what you may expect during recovery both whilst in the hospital and when you get home. I had some issues and problems which were normal but would have been less stressful if warned in advance."

Despite our best efforts, our performance in 2013/14 has remained disappointing – albeit still in line with the national average. A new e-tool has also been developed by our pharmacy department to enable ward staff to provide each patient with a tailored list of potential medication side effects for the medication they are leaving hospital with. The system has been successfully piloted on a small number of wards and in the new discharge lounge, and will now be rolled out across the Trust. Informing patients about medication side effects will also form part of the Trust's new inpatient discharge checklist, due to be rolled out in early 2014/15.

Although there was evidence of an improvement in patient experience between May and July 2013, the subsequent data pattern suggests that this improvement was most probably due to natural statistical variation (see Figure 15).

Figure 15 Explaining potential medication side effects to patients when they are disharged



Source: UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys

OBJECTIVE 10

We wanted to improve the experience of maternity patients

Patient experience ratings on postnatal wards are generally lower than other inpatient wards. This is a national trend which is reflected at University Hospitals Bristol NHS Trust. Since 2012/13, the Trust has made a concerted effort to improve the experience of people who use our maternity service and postnatal care in particular. Developments in 2013/14 have included three projects supported by the Trust's patient experience and involvement team:

- improving the patient experience of women who have an induced labour;
- holding patient experience workshops for newly recruited midwives focussing on how their role impacts on patient experience; and
- identifying and supporting a consultant-level patient experience champion who will lead patient experience and involvement initiatives in postnatal care.

Elsewhere, a new midwifery-led unit has been opened at St Michael's Hospital and antenatal ward staffing is being reconfigured to improve patient experience, especially for induction of labour. Funding has been secured for three band 7 posts to focus on breast feeding and bereavement services. Previously in 2012/13, we ran a series of "Patients at Heart" workshops for maternity staff at St Michael's Hospital, which has contributed to a reduction in complaints.

What our patients said in our monthly maternity survey:

"The care I received from staff at St Michael's both during my pregnancy, the birth and post natal 6 day stay was excellent."

"Midwifery Led Unit at St Michael's – excellent care and a wonderful overall experience. Would highly recommend to anyone having a baby."

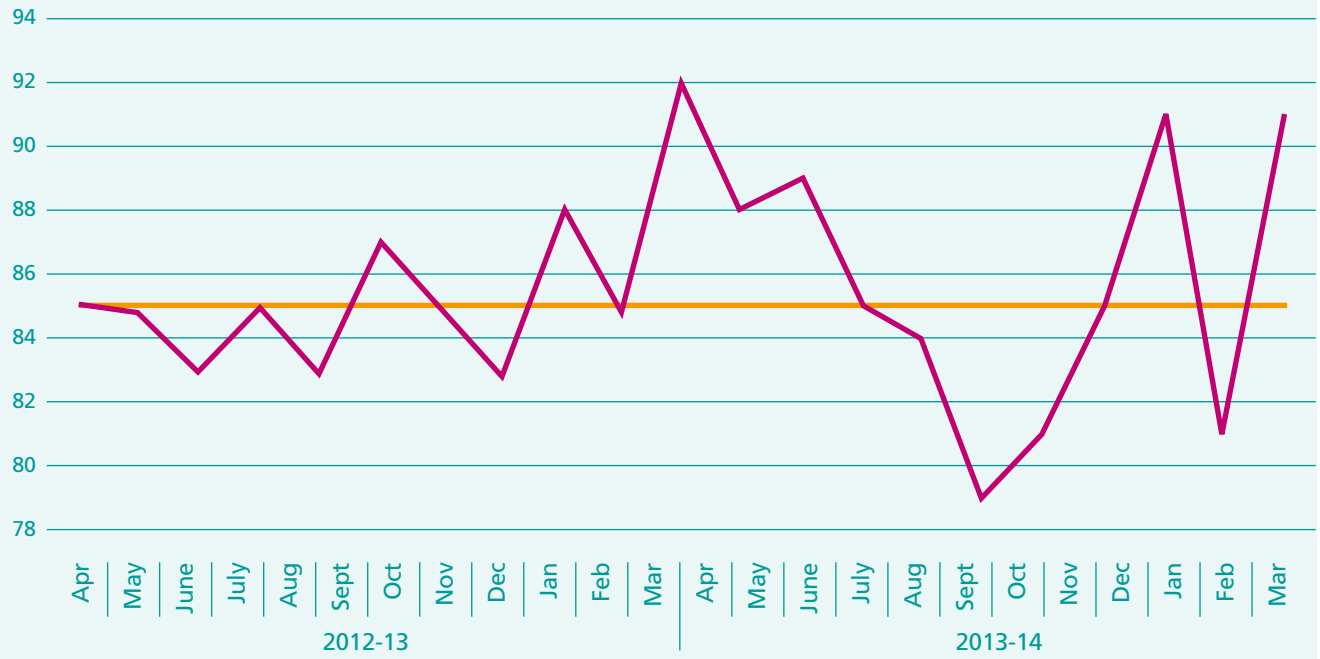
"Faultless care on delivery suite...very caring and personable. Disappointed with ward care."

Our scores in the 2013 national maternity survey were excellent[23]: the Trust was rated as being [statistically significantly] better than the national average, having previously been on the threshold of being in the worst 20% of trusts nationally in 2010. However our own monthly survey of maternity patients has shown fluctuating scores relating to kindness and understanding on postnatal maternity wards (see Figure16). In the third quarter of 2013/14, our score deteriorated during a time of adjustment for the service: postnatal wards were being reconfigured and a number of new midwives were appointed. These changes will have a positive effect on postnatal ward experience and our scores from November 2013 have started to reflect this.

In 2014/15, the maternity service will continue to focus on improving patient experience on the wards by evaluating and acting upon patient feedback. As part of this, our supervisors of midwives will be going onto the wards and into other patient areas to talk to women about their experiences of midwifery and obstetric care. In response to previous patient feedback, we are also planning to introduce the practice of allowing some partners to stay on the wards.

[23] The national maternity survey results reflected the experience of women who gave birth at the Trust in March 2013. The results were released in December 2013.

Figure 16



Source: UH Bristol monthly maternity survey

REVIEW OF PATIENT EXPERIENCE 2013/14

This section explains how the Trust performed during 2013/14 in a number of other key areas relating to patient experience, which are in addition to the specific objectives that we identified.

What our patients said in our monthly survey:

"I was taken care of in a manner that was very caring and professional. I did not have a single complaint. They saved my life and took excellent care of me."

Local patient experience 'tracker' score

Our local patient experience tracker is based on the following aspects of care that our patients have told us (through previous surveys) matter most to them:

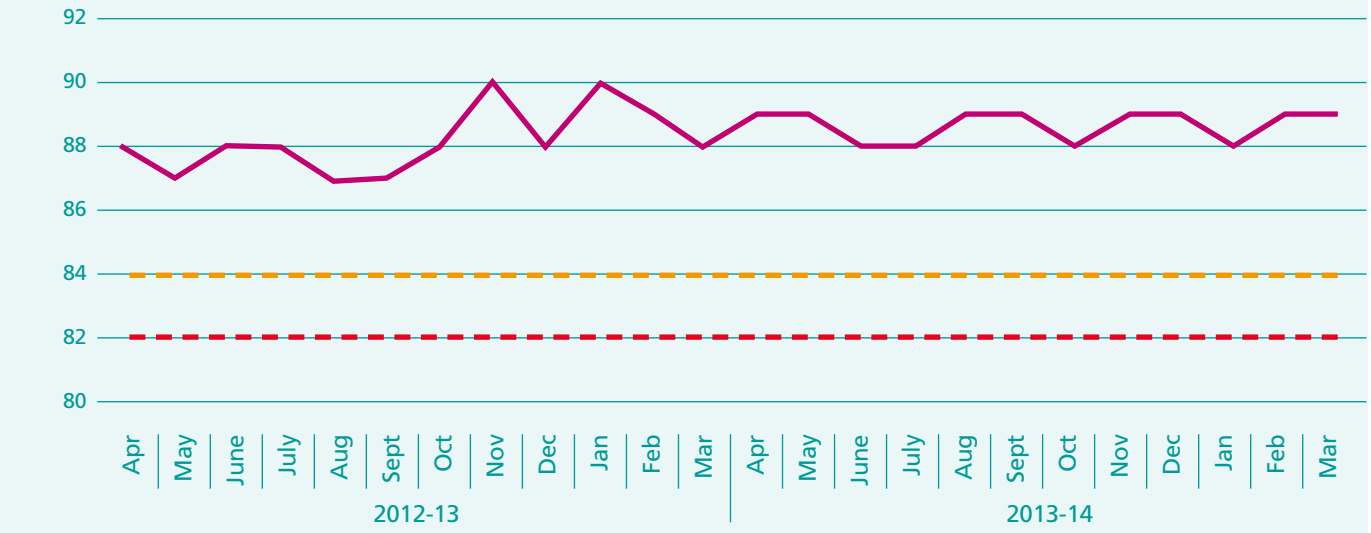
- Involvement in decisions about care and treatment
- Being treated with respect and dignity
- Doctors and nurses giving understandable answers to the patient's questions (i.e. communication)
- Ward cleanliness

This is a key quality assurance indicator that is reported to our Trust Board each month. If standards were to begin to slip, this would be identified in the survey and actions would be taken to remedy this. Throughout 2013/14, our tracker score has been consistently above our minimum target. The Board will continue to monitor the monthly tracker score in 2014/15.

Source: UH Bristol Monthly inpatient survey (patients aged 12 and over)

Figure 17

UH Bristol inpatient experience quality tracker



Note: the alert limit would represent a statistically significant deterioration in the Trust's score, prompting us to take action in response

Score — Alert threshold — Alert threshold

Overall care ratings

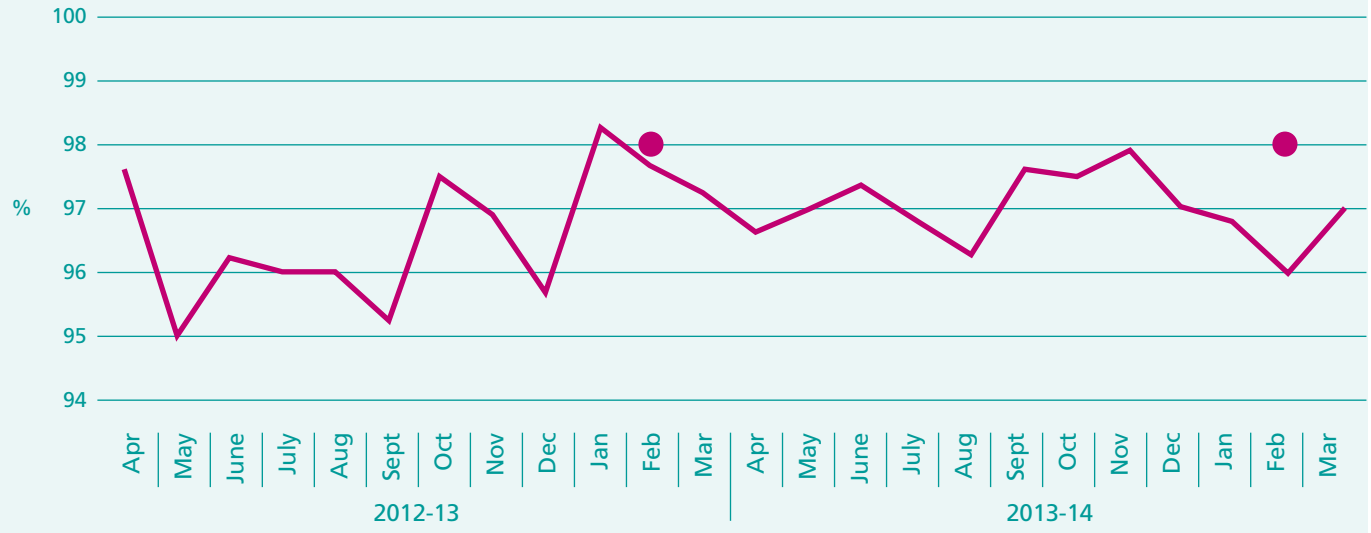
Another way of measuring overall experience of care is to pose that question directly to patients. In 2013/14 (to January 2014), 97% of all survey respondents aged 12 and over rated the care they received at the Trust as excellent, very good, or good (see Figure 18). A similar score (98%[24]) was achieved for outpatient services in the Trust's annual outpatient survey.

[24] provisional data

Source: UH Bristol monthly inpatient (patients aged 12 and over)

Figure 18

Percentage of patients rating the care at UH Bristol as excellent, very good or good

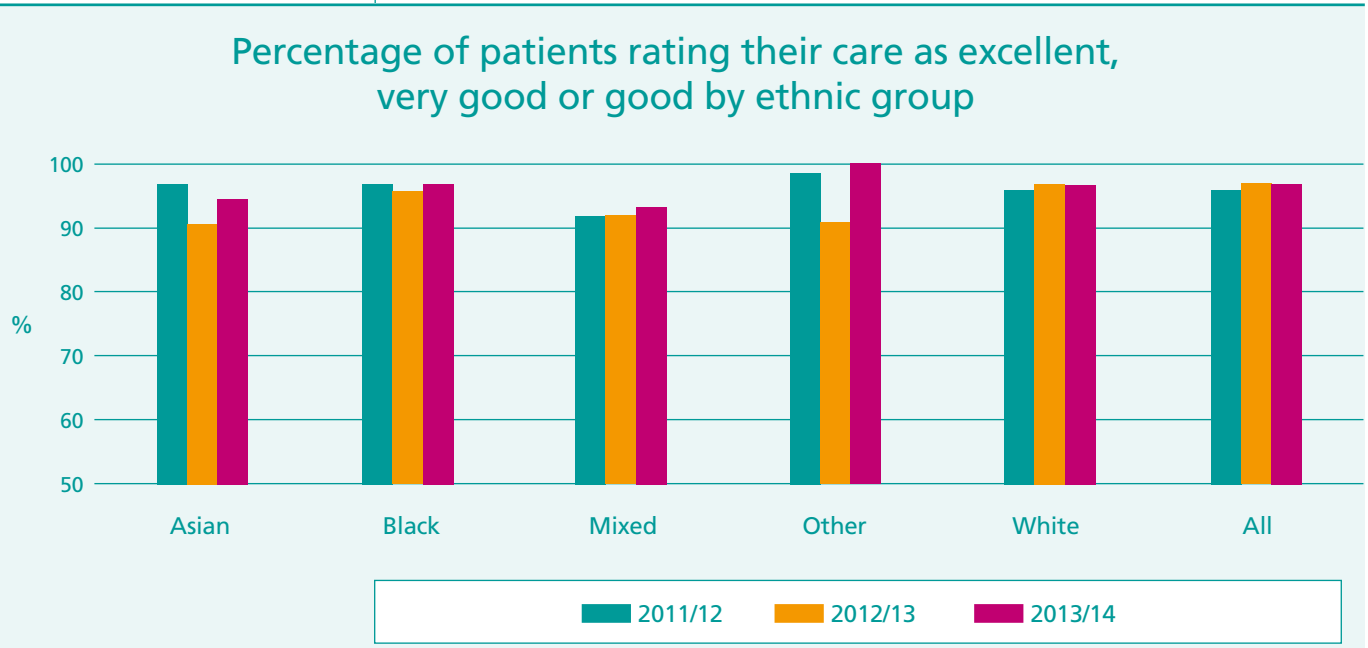


Inpatients — Outpatients

We continue to monitor patient-reported experience data to ensure that there is no evidence of statistically significant variation in reported experience according to the ethnicity of our patients. The differences shown in Figure 19 are not statistically significant, i.e. they are most likely caused by chance fluctuations in the data.

Figure 19

Source: UH Bristol Monthly inpatient survey (patients aged 12 and over)



Complaints

In 2013/14, 1,442 complaints were reported to the Trust Board, compared with 1,651 in 2012/13, 1,465 in 2011/12 and 1,532 in 2010/11). This equates to 0.21% of all patient episodes, against a target of <0.21%.

Figure 20 demonstrates shows the number of complaints received each month as a proportion of patient activity. The volume of complaints received throughout the year has remained steady. The sharp increase in complaints in March 2014 was largely attributable to the cancellation of routine surgery and outpatient clinics during a period when the Trust was experiencing significant pressures on services, including an increase in emergency admissions. 40% of complaints received in March were attributable to appointments and admissions.

Staff in our Trust work hard to ensure that complaints are investigated thoroughly and that our response letters are open, honest and comprehensive. Our target for 2013/14 was that no more than 47 complainants would tell us that they were dissatisfied with the quality of our response. In the event, 62 complainants told us that they remained unhappy: a significant and disappointing increase compared to the 20 cases we reported in 2012/13. All response letters are carefully checked by our Patient Support and Complaints Team before being sent to the Chief Executive's office for further checking and then signing. We continue to educate and train staff in response-writing skills: a recent example being collaborative training events with the Patients' Association. In 2014/15 we plan to introduce a new system of routinely asking complainants to confirm the key objectives of making their complaint, in order to ensure that the Trust provides responses which reflect the complainant's core concerns.

Last year, we reported that we had identified an administrative error affecting the validity of data about whether the Trust was responding to complaints within agreed timescales. This error affected our historic data, so it is not possible to provide accurate comparative data for years prior to 2013/14, suffice to say that the true picture will have been notably worse than the one previously reported. The error was identified in May 2013, after which concerted effort was put into improving response times, including improvements in our internal monitoring of the progress of complaints investigations. As a result, Figure 21 below shows significant improvement during 2013/14. We are confident that we will see this pattern of improvement sustained in 2014/15. In 2013/14 as a whole, 76.4% of complaints were responded to within the timescale agreed with the complainant, against a target of 98%.

Figure 20

Source: UH Bristol Ulysses Safeguard system

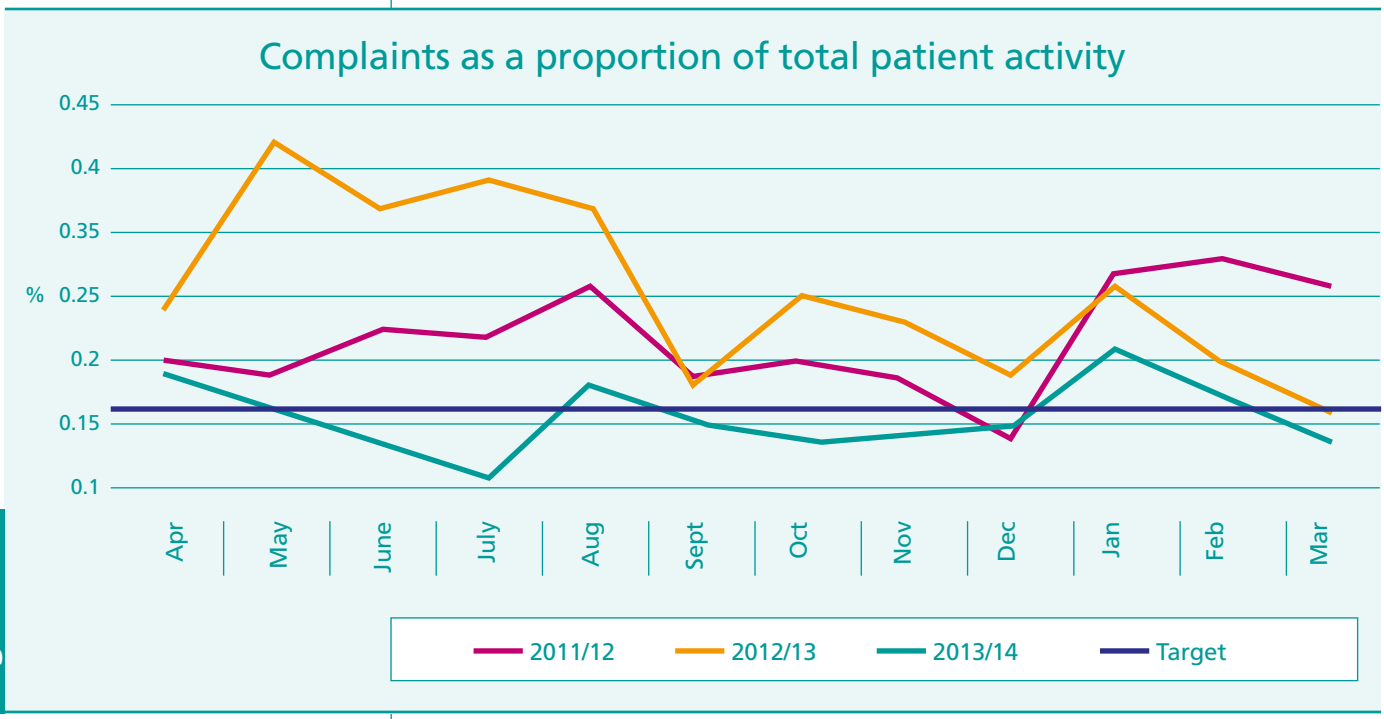
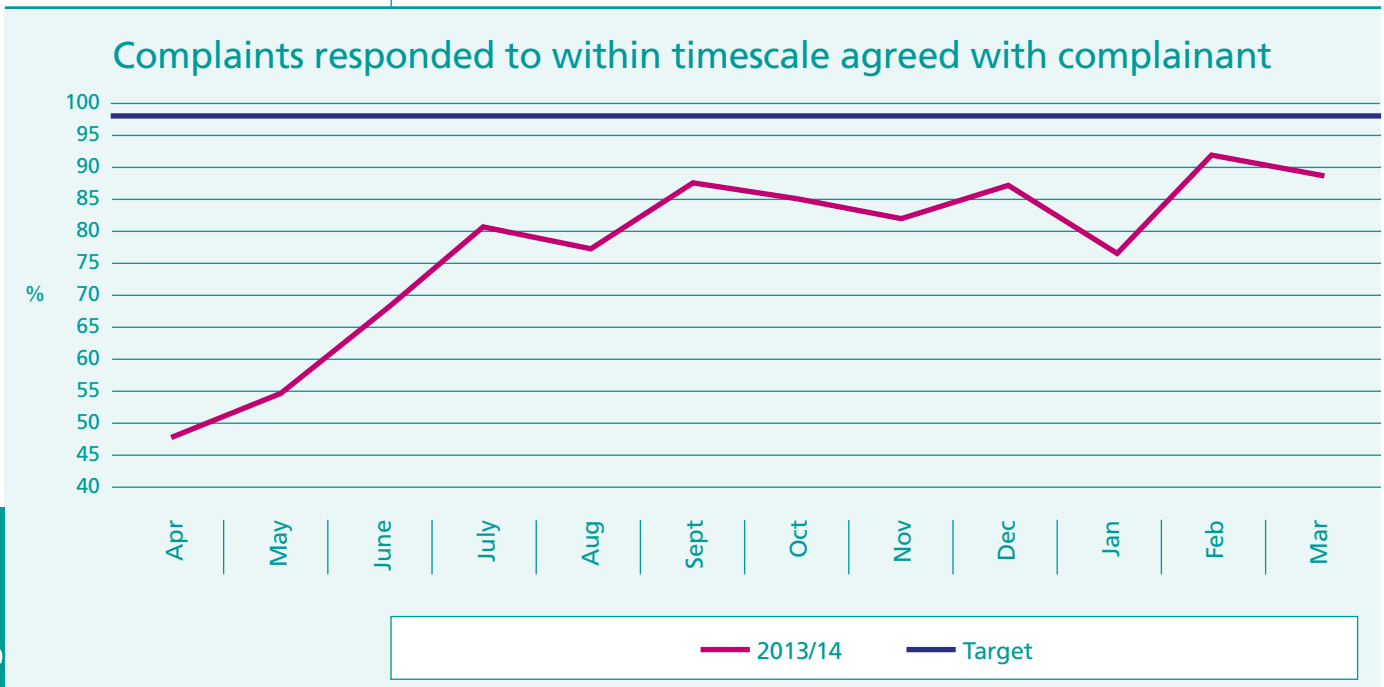


Figure 21

Source: UH Bristol Ulysses Safeguard system



2013/14 has been a year of change for our Patient Support and Complaints team. In December 2013, the team relocated from its temporary home in the Bristol Dental Hospital to a prominent location in the new Bristol Royal Infirmary Welcome Centre. Complaints management has had a high profile across the whole of the NHS in 2013/14, partly as a result of the Francis Report into failings at Mid Staffordshire NHS Foundation Trust, partly in response to the subsequent Clwyd-Hart Report, and also following important recommendations published by the Parliamentary and Health Service Ombudsman. Our action plan in response to these various publications was presented to our Trust Board in January 2014 and will be implemented throughout 2014/15. One of the early actions in this plan is the above-mentioned collaborative project with the Patients Association (ongoing at the time of writing), the overall objective of which is to gain a better understanding of, and learn from the experience of people who complain about our services.

More detailed information about complaints themes and learning will be published in the Trust's annual complaints report later in 2014.

Improving patient experience in outpatients services

The Trust has been working hard in 2013/14 to improve its outpatient services. An outpatients improvement programme, led by the Director of Finance, has involved the majority of outpatient departments across the Trust, focussing on productivity, efficiency and improving patient experience.

First and foremost, we have been listening to our patients. One of the things that patients have complained about is not being able to speak to outpatient staff to enquire about their appointment or to book and rebook their appointment, leading to frustration, anxiety and appointment slots being wasted. In order to address this, the Trust has invested in a central appointment centre, located in the new Bristol Royal Infirmary Welcome Centre and manned by experienced call handlers who work to a target of 95% of calls being answered within 60 seconds. This has significantly improved patient access and has seen a marked reduction in complaints. We aim to continue to extend the appointment centre service in 2014/15 to cover the majority of outpatient services in the Trust.

We have also been working to reduce waiting times in clinic, another significant source of patient complaints. In particular, we have been working with staff at the Bristol Eye Hospital to smooth out the flow of appointments and reduce queues and waits in clinic.

We understand that it is not always easy for patients to get into the city for their appointment, so – where clinically appropriate – we have been offering telephone appointments where a clinician can consult with a patient over the phone.

Finally, we have been working hard to reduce the number of patients who do not turn up for their appointment. In 2013/14, approximately 62,000 patients "did not attend". This represents 7% of appointments: a significant improvement compared to almost 10% in 2012/13. The Trust has invested in an appointment reminder system that sends a text message to the patient seven days and 24 hours before their appointment (or an automated call reminder to their landline). We will continue to improve the productivity and efficiency of our outpatient services in 2014/15 to ensure we offer the public value for money and patients a better experience of our outpatient services.

National Staff Survey 2013

As in previous years, in line with the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual NHS Staff Survey which have a bearing on quality of care. Relevant results from the 2013 survey are presented below. Questionnaires were sent to a random sample of staff across the Trust (this includes only staff employed directly by the Trust): 439 Trust staff took part in this survey, representing a response rate of 52% (around the average for acute hospital trusts in England). This compares with a 55% response rate in 2012.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated respectfully and with dignity and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated and treat each other in line with the Trust's values, and with the same level of dignity and respect which we expect for our patients. These values (respecting everyone, embracing change, recognising success and working together) are a guide to our staff about how they are expected to behave towards patients, relatives, carers, visitors and each other. The values are embedded in values-based recruitment, in staff induction, through training, and are clearly and regularly communicated.

Item 05d

Table 5

'Key finding'	UH Bristol Score 2013	UH Bristol score 2012	UH Bristol score 2011	UH Bristol score 2010	National average score 2013	National best score 2013
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	74% Lowest (worst) 20%[25]	78% (average)	74%	76%	79%	86%
Percentage of staff agreeing that their role makes a difference to patients	91% (average)	92% highest (best) 20%[26]	92%	92%	91%	95%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (to other staff or to patients)	39% highest (best) 20%	39% highest (best) 20%	39%	39%	33%	18%
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	90% Average	91%	96%	91%	90%	97%
Staff recommendation of the Trust as a place to work or receive treatment (Mandatory indicator [27])	3.76 Above (better than) average	3.66	3.65	3.68	3.68	4.25

Source: NHS Staff Survey

[25] i.e. this score was in the lower quintile (worst 20%) of NHS acute trusts

[26] i.e. this score was in the upper quintile (best 20%) of NHS acute trusts

The score for staff recommending the Trust as a place to work or receive treatment is a statistical aggregation of responses to four related questions in the annual survey, as detailed below:

Table 6

Question / statement	UH Bristol score 2013	National average (median) score for acute trusts 2013	UH Bristol score 2012
"Care of patients / service users is my organisation's top priority"	69	68	63
"My organisation acts on concerns raised by patients / service users"	72	71	72
"I would recommend my organisation as a place to work"	60	59	60
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	74	64	71
Staff recommendation of the trust as a place to work or receive treatment	3.76	3.68	3.66

Source: NHS Staff Survey

Item 05d

The Trust considers that this data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. The reported data is taken from a national survey[28], which the Trust participates in through an approved contractor, adhering to guidance issued by the Department of Health.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated with dignity, respect and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated and treat each other with the same level of dignity and respect we expect for our patients.

Whilst the 2013 staff survey results are positive in terms of overall staff engagement and the recommendation of the Trust as a place to work or receive treatment, the overall results are mixed. Key actions for 2014/15 will therefore include:

- Working with leaders to share the Trust's vision and mission
- Reviewing our staff appraisal system and the quality of appraisals
- Setting clear expectations for leaders in the organisation and supporting their development
- Developing a Trust-wide work related stress action plan
- Reviewing e-learning package to support managers in addressing work-based discrimination
- Implementation of the NHS Family and Friends Test for staff and other 'pulse checks' to gauge staff perceptions on a regular basis
- 360 degree feedback on lived values for all senior leaders.

[27] In the NHS Staff Attitude Survey, trusts receive a score out of a maximum of five points for each question: this score equals the average response given by their staff on a scale of 1-5 where 5 means that they 'strongly agreed' with the statement "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". The mandatory indicator on p5 of this report, made available by the National NHS Staff Survey Co-ordination Centre, analyses the same data in a slightly different way: in this instance, the indicator measures the percentage of staff who said that they either 'agreed' or 'strongly agreed' with the statement, "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

[27] Important note: the UH Bristol figures quoted for 2010 and 2011 and 2012 are those which will be found in the 2010, 2011 and 2012 NHS Staff Attitude Survey reports. The 2010 figures may differ slightly from the 2010 figures quoted in the 2011 NHS Staff Attitude Survey report; the 2011 figures may differ slightly from the 2011 figures quoted in the 2012 report and the 2012 figures may differ slightly from the 2012 figures quoted in the 2013 report. This is because the Picker Institute, which runs the surveys, re-calculates the data each year. The Picker Institute has advised that either version of the data is appropriate for publication: we have chosen to use the original data for purposes of consistency and transparency.

Clinical effectiveness

Our ongoing commitment

We will ensure that the each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best achievable outcome.

Report on our clinical effectiveness objectives for 2013/14

OBJECTIVE 11

We wanted to ensure that at least 90% of stroke patients were treated for at least 90% of the time on a dedicated stroke ward

Improving the care of stroke patients is a national priority within the NHS Outcomes Framework. There is extensive evidence to show that care on a dedicated stroke unit reduces patient mortality, disability and the likelihood of requiring institutional care following stroke. There is a national standard which states that at least 80% of stroke patients should be treated for at least 90% of the time on a dedicated stroke unit. Our local stretch objective is that 90% of patients should spend 90% of their time on ward 15, our dedicated stroke unit. The Trust operates with a protected bed standard operating procedure for stroke care, designed to ensure that a direct admission bed is always available on ward 12 to support direct admissions. In 2012/13, we were disappointed that only 79.3% of stroke patients spent at least 90% of their time on ward 12: we therefore retained this as a quality objective for 2013/14.

In 2013/14, we reviewed and reissued our stroke pathway, emphasising the importance of direct admissions. As a result of this review, 'sit rep'[29] meetings are now used to discuss whether a protected bed for stroke admissions is available and if not, what plans in place to address this. In 2013/14 to date (data to February 2014) we are pleased to have improved our performance to 84.0% - better than the national target, but still short of our own. We achieved our 90% target in one month during the year. Our performance reflects the operational challenges of protecting a dedicated stroke bed at all times as there are occasions when all the stroke beds are occupied and therefore an empty bed is not available. In 2014, the stroke unit will increase its bed base to 25 beds from 19 currently to reflect activity and support delivery of this ambition.

[29] Twice daily clinical operations meetings where all bed-holding divisions and the clinical site managers meet to review predicted and actual patient activity, designed to ensure the smooth flow of patients into and out of hospital

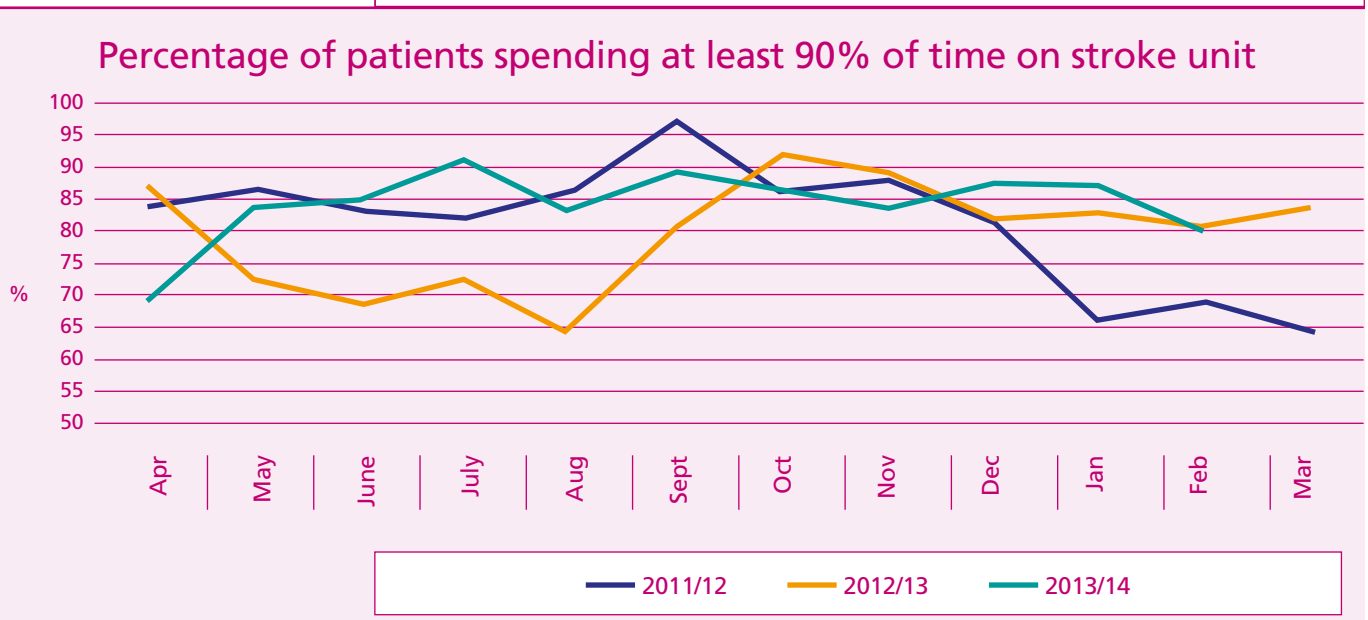
Item 05d

What our patients said in our monthly survey:

"My father had previously had a stroke two years ago and at times he finds it difficult to understand what people are saying but all the staff he encountered during his stay went out of their way to make sure that he understood what was being done and why. He cannot praise your staff at the BRI highly enough and would recommend to anyone the BRI hospital."

Figure 22

Source: weekly discharge data validated by consultant



OBJECTIVE 12

We wanted to achieve the best practice tariff for hip fractures

Best Practice Tariffs (BPTs) help the NHS to improve quality by reducing unexplained variation between providers and universalising best practice. Best practice is defined as care that is both clinical and cost effective: to achieve the BPT for hip fractures, trusts have to meet eight indicators of quality as recorded in the national hip fracture database. The indicators are:

- Surgery within 36 hours from admission to hospital
- Ortho-geriatric review within 72 hours of admission to hospital
- Joint care of patients under a trauma and orthopaedics consultant and ortho-geriatrician consultant
- Completion of a joint assessment proforma
- Multidisciplinary team (MDT) rehabilitation led by an ortho-geriatrician
- Falls assessment
- Bone health assessment
- Abbreviated mental test done on admission and pre-discharge.

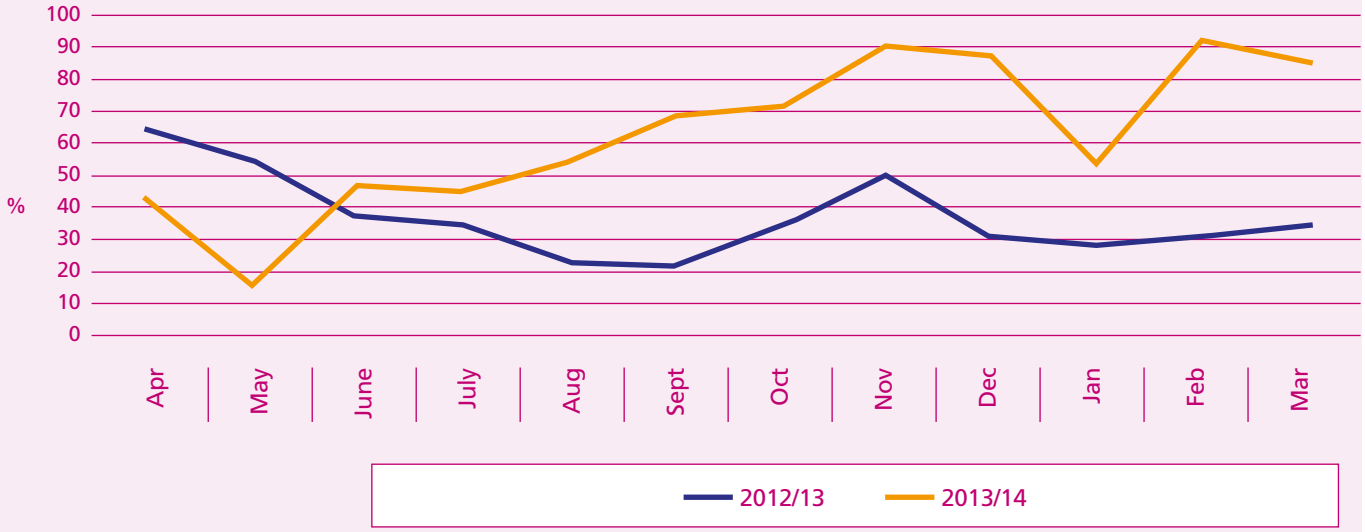
We are pleased to report that University Hospitals Bristol NHS Trust's performance against the national best practice tariff for hip fracture management has significantly improved in 2013/14, compared to 2012/13 as shown in Figure 23. In November 2013 and February 2014, we achieved our target: more than 90% of cases achieved the BPT. Overall performance for 2013/14 was 59.7% (to February 2014): significantly better than in 2012/13 (36.5%), but we know that there is much work still to do. The Trust has historically struggled to achieve the BPT due to poor performance against time to theatre and ortho-geriatric review, despite consistently achieving over 90% for the other six indicators. The improvement in 2013/14 performance has been as a result

of increased access to trauma theatre, with a daily consultant-led trauma list running since April 2013; and the appointment of two consultant ortho-geriatricians since November 2013.

Despite the increased investment in resources, delivering best practice consistently remains a challenge, especially during times of peak demand, as demonstrated in Figure 23. Time to theatre performance is affected by overall trauma admissions, and by occasions when more than three hip fracture patients are admitted in a 24 hour period.

Figure 23

Hip fracture best practice tariff



Source: National Hip Fracture Database

In 2014/15, our Hip Fracture Steering Group will be focussing on delivering best practice in a sustainable way by improving the utilisation of trauma theatre sessions to reduce delays in patients undergoing surgery.

OBJECTIVE 13

We wanted to ensure patients with diabetes have improved access to specialist diabetic support

Previous studies have identified that at least 15% of the Trust's inpatient population at any one time is likely to have diabetes. We know that specialist input and advice for this group of patients, over and above the treatment and care they receive for the cause of their admission, can improve clinical outcomes and longer term health.

In 2013/14, funding was agreed to expand the Trust's diabetes inpatient specialist nurse (DISN) team. We appointed 3.5 whole time equivalent diabetes inpatient specialist nurses and agreed a CQUIN target with commissioners that at least 39% of patients with diabetes in our Division of Surgery, Head and Neck services would be reviewed by a DISN during their stay in hospital and at least 22% in our Division of Medicine and Division of Specialised Services, measured across the final two quarters of the year. We were delighted to achieve this CQUIN: 42% for Surgery, Head and Neck; and 22.1% for the combined Divisions of Medicine and Specialised Services.

Looking ahead to 2014/15, funding has been secured to make the DISN post in Surgery, Head and Neck services into a permanent position, and discussions are currently ongoing in other divisions in the hope of achieving similar longer term appointments. Funding has also been secured to develop, organise and deliver a Trust-wide diabetes educational programme in 2014/15.

What our patients said in our monthly survey:

"I am now in regular telephone contact with the [Diabetes Inpatient Specialist Nurse] team... I am hugely grateful for these services and convinced they have kept me out of hospital. As a diabetic I feel that much closer liaison with DISN team is essential to get well whilst in hospital and after discharge."

OBJECTIVE 14

We wanted to ensure that ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan

The Trust's learning disabilities steering group is committed to ensuring that we constantly seek to improve the experience of care amongst patients with learning disabilities / autism and their carers, and that in doing so we meet our legislative obligations, for example with regards to the Equality Act (2010) and Mental Capacity Act (2005). This includes 'reasonable adjustments' to the ways in which services are delivered, including the removal of physical barriers and/or providing extra support for people during their time in hospital.

Recent developments include:

- An admission pack including staff photographs, information about accommodation, facilities and car parking.
- Differentiated inpatient comments cards using an 'easy read' format.
- Accessible patient information leaflets for Avon Breast Screening and the Congenital Heart Team at the Bristol Heart Institute.
- The ongoing development of patient and carers' appointment and admission letters in easy read formats.
- The launch of a 'Hospital Passport' across the Trust – this is a document which patients complete prior to admission and which moves with them as their care is transferred. The passport is accessible for download from the Trust external web page and can be emailed via a secure link direct to the learning disabilities nurse in preparation for admission.
- The recruitment of over 100 link nurse in adult services throughout the Trust supporting the role of the hospital liaison nurse and raising awareness about patients with learning disabilities.
- Development of an online referral system which will be launched in 2014.

Our quality objective for 2013/14 was to ensure that patients with an identified learning disability and additional health needs or conditions such as autism were risk assessed within 48 hours following admission, and that they received full reasonable adjustments.

For the year to February 2014, 86.3%[30] of adult patients with a learning disability were risk assessed within 48 hours, therefore meeting our target of 85%. We consistently achieved – and bettered – this target throughout the second half of 2013/14.

83.1% of adult patients with a learning disability received full reasonable adjustments during their stay in hospital (significantly exceeding our board-reported target of 58%[31]). When performance dipped notably in July 2013 (50%), recovery actions were immediately and successfully put in place including additional staff training and support, and identifying link nurses in underperforming areas.

[30] Data source – audit of learning disability and autism risk assessment and reasonable adjustment documentation

[31] Target agreed with commissioners using baseline audit data

What our patients said in our monthly survey:

"My daughter has a severe learning disability so we completed the hospital passport prior to admission. This proved to be invaluable and provided her with a specialist bed and enabled both my husband and I to stay with her at all times."

OBJECTIVE 15

We committed to continuing to implement our dementia action plan

The term "dementia" covers a range of progressive, terminal brain conditions which currently affects more than 73,000 people in the South West of England. Enhancing the quality of life of people with dementia is a priority of the NHS Outcomes Framework.

In 2013/14, we made significant progress both in relation to meeting the requirements of the NICE quality standard for dementia (statements 1, 5 and 8) and the South West Dementia Standards. In November 2013 our lead nurse for dementia received a national award in the category of "Best Dementia Nurse Specialist / Dementia Lead" in recognition of the Trust's progress in improving care for people with dementia. By the end of the financial year, 93% of relevant staff had attended "An Hour to Remember" training. All new staff receive dementia awareness training as part of their induction to the Trust.

Progress in relation to the South West Dementia Standards in 2013/14 has been evidenced by our annual dementia care audit, which has demonstrated an increase in compliance in the use of:

- The visual identification system ("Forget-me-not") used to identify patients with cognitive impairment / dementia
- The "This is me" booklet, which is designed to give staff a better understanding of who the patient is, in order to facilitate person-centred care
- Cognitive screening undertaken upon admission to identify baseline cognitive function and the identification of delirium or possible dementia.

The lead nurse for dementia co-ordinates this work through approximately 130 dementia "champions" across the Trust. A local conference for dementia champions is held twice a year, one of which is organised jointly with North Bristol NHS Trust.

We have established a befriending scheme pilot project using volunteers to offer activities and companionship to frail older adult inpatients and frail older adults with a dementia. The scheme was launched in October 2012 and has received positive feedback from staff and patients. We are currently developing a ward-based volunteer model to sustain this service in the longer term. Elsewhere, the environmental work undertaken on ward 4, funded by the Prime Minister's Challenge fund has provided a dementia-friendly environment which has influenced the new build and refurbishment work plan in the Bristol Royal Infirmary. This includes the use of way-finding cues, i.e. appropriate signage, use of colour, artwork and hand rails.

The expansion of the older person's assessment unit (OPAU) in January 2014 has assisted in minimising unnecessary moves and transfers of our most complex frail patients whilst facilitating timely comprehensive assessment by our older adult care physician team. In October 2013, we achieved a score of 100% in our "transfer" audit, i.e. no patient with cognitive impairment was moved unnecessarily between the hours of 8pm and 8am. This audit will be repeated at the end of April 2014.

The national CQUIN for dementia continues to challenge us: we partially achieved the CQUIN for 2013/14. Plans are underway to develop an electronic data capture

solution by the autumn of 2014 to help us to identify, assess and refer patients with dementia[32].

Finally, on 22 January 2014, the Care Quality Commission undertook an unannounced dementia themed inspection. Inspectors observed care on the older person's assessment unit, as well as visiting the medical assessment unit and the emergency department. The inspection team identified a range of practice: some excellent, some inconsistent. Trust has developed an action plan to address the issues identified.

What our patients said in our monthly survey:

"As a nurse/health visitor myself I was delighted to observe the care and compassion shown by the nursing, medical auxiliary staff to two elderly women: one lady with dementia, another in significant pain. The staff, although busy, were calm, positive, smiled and listened.

"The care I received was excellent. The only comment I have to make was that another patient on my ward was suffering with dementia and the staff did not seem to know how to deal with her behaviour. I own a nursing home specialising in dementia care and feel staff training in this area would be beneficial."

OBJECTIVE 16

We committed to commence a baseline review of available clinical outcome data

As part of the Trust's Clinical Effectiveness and Outcomes Strategy for 2013-2016, The Trust committed to undertaking a baseline review of available clinical outcomes data in all major clinical specialities. An initial meeting, chaired by the medical director, took place in September 2013. In October 2013, the Clinical Effectiveness Group agreed that a pilot scoping exercise should be undertaken to better understand the current clinical, process and patient-reported outcomes currently available within the Trust. A selection of clinical areas were chosen for this to be explored in more detail and discussed with clinical staff. Current national clinical audits were also reviewed to establish the type of outcomes reported.

National clinical audits focus largely on process measures. Around half of the national audits in which the Trust is currently participating also report clinical outcomes, focused largely around mortality/survival rates. Only three collect Patient Reported Outcome Measures (PROMs) or patient-reported experience measures (PREMs), although newly commissioned projects are increasingly planning to incorporate these measures.

Locally, more in-depth discussions have been held with physiotherapy, dermatology, rheumatology and respiratory medicine. The Trust's physiotherapy department has already developed a clinical outcomes group to take this work forward and has a system in place for the collection and reporting of outcome measures according to each clinical pathway. This work is in its early stages but pathway leads have been identified and possible PROMs identified (a combination of EQ5D and other condition-specific measures). An electronic system has been developed to capture heath status before intervention/treatment and the team is now working on capturing data post-intervention. In dermatology, rheumatology and respiratory medicine, disease severity scoring systems are used pre and post intervention, however this data is not captured electronically for aggregation and analysis. Elsewhere, surgical specialties participate in relevant national PROMs (see page 42).

By coincidence, the Trust has therefore seemingly been through a very similar thought process to the Care Quality Commission who have developed 'intelligent monitoring'[33] during the last year, based to a large extent on mortality measures. From the work

[32] Our aim has been to use case-finding questions with at least 90% of patients aged 75 years within 72 hours of emergency admission to hospital, in order to identify dementia; to assess and investigate 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; and to refer at least 90% of clinically appropriate cases to a general practitioner to alert that an assessment has raised the possibility of the presence of dementia.

[33] At the time of writing, the CQC's intelligence monitoring places the Trust in Band 6, which indicates the lowest level of risk of non-compliance

we have undertaken so far, it is clear that there is enthusiasm from clinical staff to understand outcomes in more depth. The Trust will continue to explore this area, looking at how electronic systems might contribute to this agenda. We will also continue to publish outcome data as part of NHS England's 'Consultant Level Outcome' requirements.

REVIEW OF CLINICAL EFFECTIVENESS 2013/14

This section explains how the Trust performed during 2013/14 in a number of other key areas relating to clinical effectiveness, which are in addition to the specific objectives that we identified.

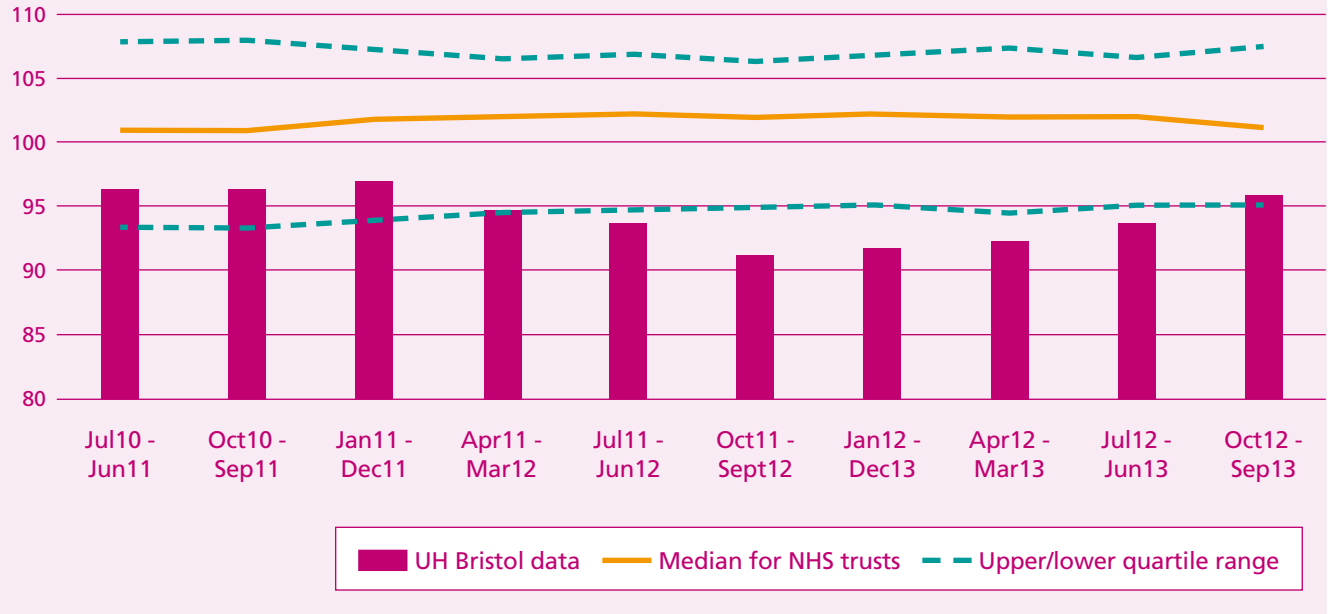
Summary Hospital-Level Mortality Indicator (SHMI)
(Mandatory indicator)

The Summary Hospital-Level Mortality Indicator (SHMI) is a measure of all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. It should be noted that SMHI does not provide definitive answers: rather it poses questions which trusts have a duty to investigate.

In simple terms, the HSMR 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. In Figure 24, the blue vertical bars are University Hospitals Bristol NHS Trust data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles. The graph shows that patient mortality at UH Bristol, as measured using SHMI, is consistently lower than the national norm. The most recent comparative data available to us at the time of writing is for the period October 2012 to September 2013 and shows the Trust as having a SHMI of 95.7.

Figure 24

Summary Hospital Mortality Indicator (SHMI)



Source: CHKS benchmarking

The Trust considers its SHMI data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework (full details are available upon request). This includes data quality and completeness checks carried out by the Trust's IM&T Systems Team. SHMI dated is governed by national definitions.

Adult Cardiac Surgery Outcomes

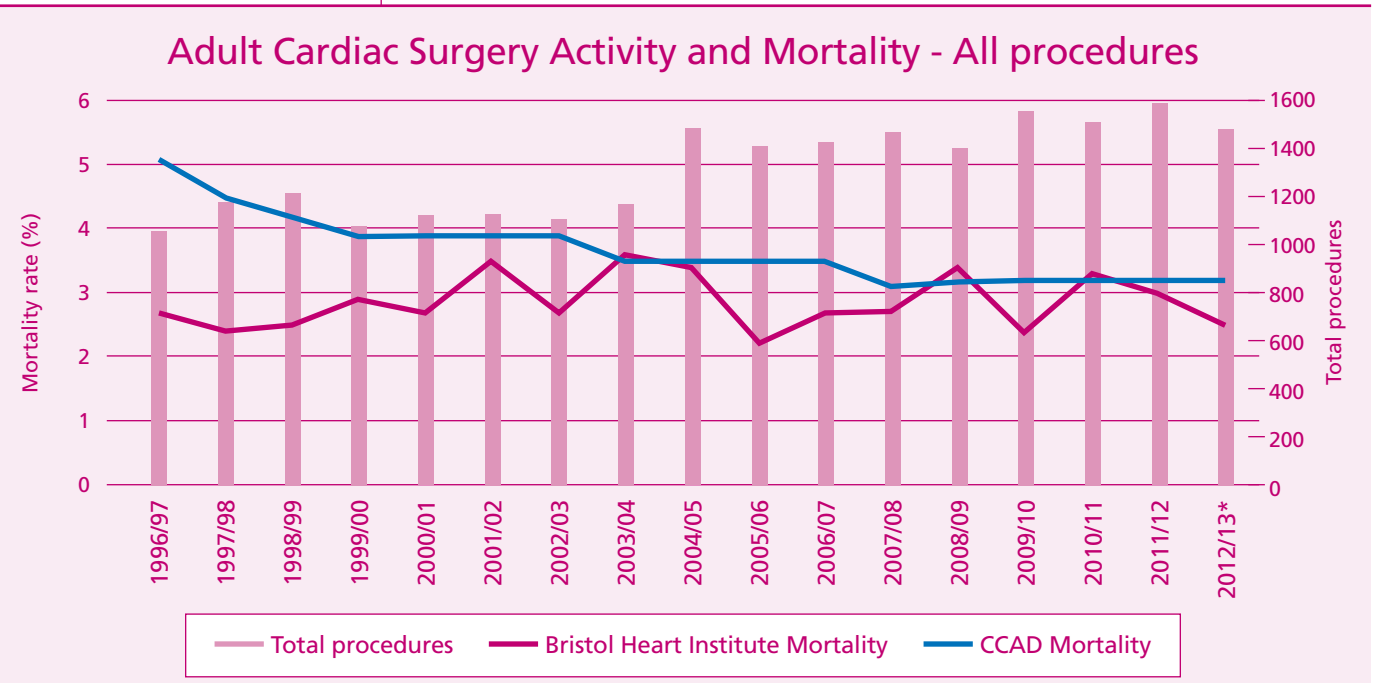
The Bristol Heart Institute is one of the largest centres for cardiac surgery in the United Kingdom. The centre currently performs approximately 1,500 procedures per annum. The Trust has supported a cardiac surgical database

for more than 20 years which now contains information relating to clinical outcomes for more than 25,000 patients. This is an extremely valuable resource for research and audit, service planning and quality assurance. An annual analysis of cardiac outcomes is published and can be viewed in detail on the trust website (http://www.uhbristol.nhs.ukabout-us/key-publications).

In general, our adult cardiac outcomes measured in terms of mortality have been better than the UK average for all procedures. Figure 25 shows a pattern of increasing activity and a crude mortality rate which is below the national average. It should be noted that the 2013/2014 data is preliminary at the time of writing (April 2014) as the discharge status of some patients is still awaited.

Figure 25

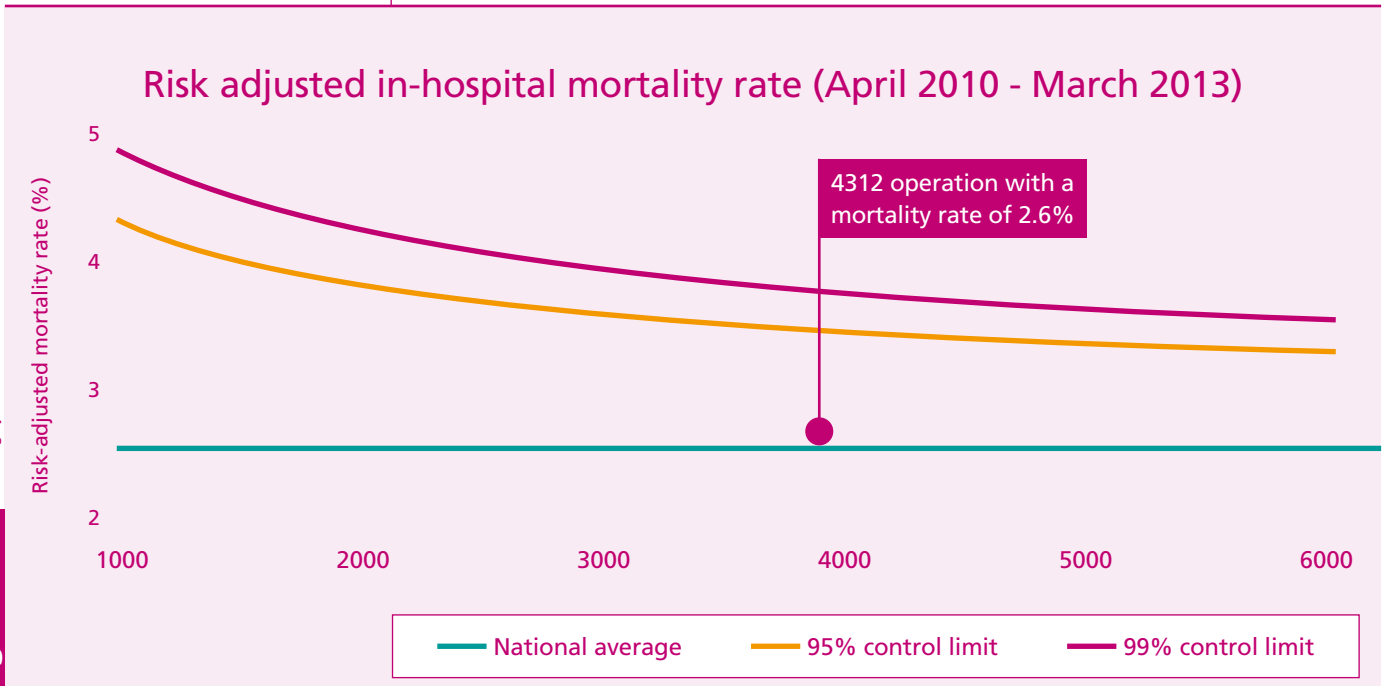
Source: Central Cardiac Audit Database / Patient Analysis Tracking System



Cardiac surgical outcomes data is collected and analysed under the auspices of the National Institute for Cardiovascular Outcomes Research (NICOR) at University College London. NICOR publishes reports on national cardiac surgery outcomes periodically and these can be viewed at http://www.ucl.ac.uk/nicor/audits/adultcardiac/reports. On an annual basis, NICOR provide data for individual surgeons and for the organisation as a whole using national contemporary comparators.

Figure 26 is a funnel plot of crude mortality for all cardiac surgical operations. This data is analysed in three year epochs to ensure the cohort is of adequate size. Alert lines are included at various levels to draw attention to levels of mortality which might be of concern. The outcomes predicted are adjusted to compensate for differences in the risk profile of different centres. Figure 26 shows that for the period 2010-2013, for all cardiac surgical operations and with appropriate risk adjustment, outcomes for patients at UH Bristol was very close to UK average performance.

Adult paediatric surgery outcome data is governed by nationally agreed definitions through NICOR.



Source: Central Cardiac Audit Database / Patient Analysis Tracking System

Figure 26

Paediatric Cardiac Surgery Outcomes

The Bristol Royal Hospital for Children (BRHC) provides a congenital cardiac service to the whole of the South West of England and South Wales serving a population of 5.5 million people functioning as a network with the cardiac centre at University Hospital of Wales in Cardiff with the Welsh consultants also providing sessions in BRHC. The pathway starts in the antenatal period with close collaboration with fetal cardiology and fetal medicine and transitions into the adult congenital cardiac services provided at the adjacent Bristol Heart Institute.

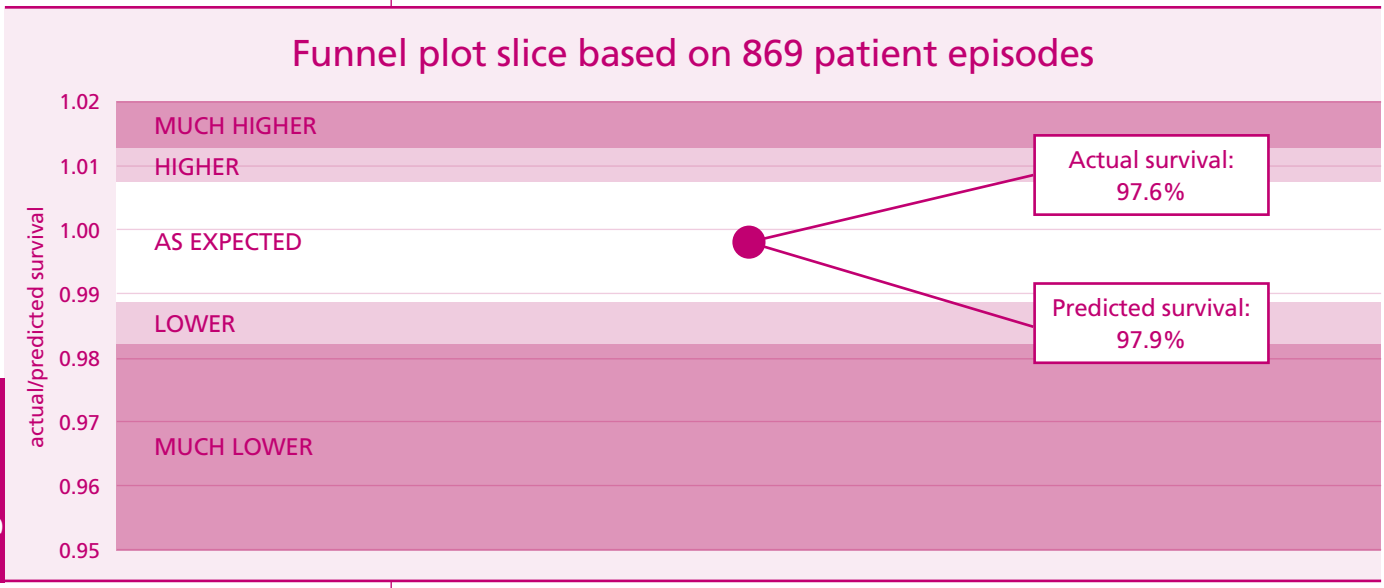
Patient safety is our priority. We actively seek to learn from incidents and have a positive reporting culture. Mortality from cardiac surgery remains very low and is well within expected limits. Each child death is subject to a child death review to enable any aspects of care to be scrutinised and recommendations made to ensure that we can continually improve our care. We report each death to the Child Death Overview Panel for further scrutiny and where appropriate to the Coroner.

We have seen approximately 325 surgical cases in each of the last four years. Crude survival has remained constant at approximately 98% which is the same average survival reported over all centres in the country. This has been achieved despite the continuing increase in complexity of cases. Crude survival is however a very coarse demonstration of the quality of outcomes because children born with congenital heart disease frequently have associated co-morbidities that influence their clinical outcome as much as the cardiac defect. Consequently, as risk profiles vary between centres, direct comparison between units is inappropriate. Recently, more sophisticated statistical analysis has been introduced by the National Institute for Cardiovascular Outcomes Research (NICOR) that includes risk-stratification using a scoring system called the PRAiS score. In this analysis, the overall risk of a child dying following cardiac surgery is considered in the context of the risks of a number of independent co-morbidities and this risk is then compared against the centre's own risk profile rather than a pooled national average. The most recent analysis is shown in Figure 27; essentially the expected survival rate following cardiac surgery in Bristol in the period 2010-2013 is exactly what would be expected from the risk profiles of the cases treated.

Paediatric surgery outcome data is governed by nationally agreed definitions through NICOR.

Item 05d

Figure 27



The last year has seen cardiac services in Bristol Royal Hospital for Children come under scrutiny. In 2013, we opened a high dependency area on ward 32 as part of a continual development in service provision and in response to concerns raised previously by the Care Quality Commission. Prior to this, high dependency care was provided on PICU and supported by the PICU outreach team on the ward. An independent review into paediatric cardiac services in Bristol was announced in February 2014 by Professor Sir Bruce Keogh, medical director of NHS England, after he met with a group of families who have expressed concerns about their experience of care in Bristol. Although the precise nature of the review is still to be confirmed, the Trust has welcomed it and hopes that it will restore trust and confidence in the service. Our aim is to work in partnership with the review team and the families themselves, to demonstrate the safety and quality of the service today, and to address any residual concerns that the review may highlight.

Our ongoing monthly survey of parents of children cared for on ward 32 shows that 98% of parents consistently rate their experience of care as good, very good or excellent[34].

[34] Data for 12 months prior to and including December 2013

Patient Reported Outcome Measures (PROMs)
(Mandatory indicator)

Since 2009, Patient Reported Outcome Measures (PROMs) have been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery.

Two of these procedures – groin hernia surgery and varicose vein surgery – are carried out at the Bristol Royal Infirmary, part of the University Hospitals Bristol NHS Foundation Trust. PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a 'visual analogue scale' (VAS); and finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

The most recent full-year data available from the NHS Health and Social Care Information Centre is for 2012/13 (provisional). The number of UH Bristol patients who underwent varicose vein surgery and returned PROM questionnaires was too small for the data to be publishable due to inherent statistical unreliability and to protect patient confidentiality. In 2012/13, 17 patients returned groin hernia PROM questionnaires in this time period, 70.6% of whom (12/17) scored more highly on the EQ-5D index after surgery than before; this compares with 50.2% in England (10,113/20,161).41.2% of UH Bristol patients (7/17) scored more highly on the EQ-VAS scale after surgery than before; this compares with 37.7% in England (7775/20642).

The Trust considers its groin hernia PROM data to be as described. The Trust follows nationally determined PROM methodology and outsources administration to an approved contractor. The Trust recognises that gaps in staff and process from October 2012 until November 2013 have meant that PROM participation rates are lower than expected. These issues have been addressed and we are hopeful of improving our response rate for the groin hernia PROM. However, based on the number of varicose vein operations currently being performed at the Trust, it is doubtful whether publishable data will become available for this PROM in the future.

28 day readmissions
(Mandatory indicator)

The Trust monitors the level of emergency readmissions within 30 days of discharge from hospital. Readmission within 30 days is used as the measure, rather than 28 days, to be consistent with Payment by Result rules and contractual requirements. The level of emergency readmissions within 30 days of a previous discharge from hospital was lower in 2013/14 than in the previous year (2.70% in 2013/14 v 3.03% in 2012/13). The most recent national risk adjusted data (2011/12) for the 28-day emergency 'indirectly standardised' readmission rates for patients aged 16 years and above, shows the Trust to be better than average for our peer group (acute teaching trusts). Of the 23 acute teaching trusts for which data is available, the Trust is ranked sixth best (i.e. the sixth lowest readmission rate), with an indirectly standardised emergency readmission rate of 11.15% compared to the median for the group of 11.87% (lower and upper confidence intervals of 10.80% and 11.51% respectively). For patients under the age of 16, the Trust has a standardised readmission rate of 7.8%, which is lower (i.e. better) than the national median readmission rate of 8.4%, despite the Trust's case-mix being biased towards the more complex cases. The readmission rates for both age groups are significantly lower than that of the previous reported year, with the readmission rate for patients aged 16 years and over dropping from 11.93% in 2010/11 to 11.15% in 2011/12, and from 8.2% in 2010/11 for patients under the age of 16 to 7.8% in 2011/12.

The Trust considers its readmission data is robust because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. These includes checks on the completeness and quality of the clinic coding, checks conducted of the classification of admission types and lengths of stay as recorded on the patient administration system, and the reviews undertaken of the data quality returns on the commissioning data sets received from the secondary uses service.

The Trust continues to review specialty-level benchmarking data through its Quality Intelligence Group, to monitor and improve readmission rates, and so the quality of its services. Where specialties are identified as having higher readmission rates than expected, relative to the national and/or clinical peer group, in-depth case notes reviews are conducted to identify any underlying causes of the increased levels of readmissions.

Objectives for 2014/15

We have applied a different approach this year in determining out annual quality objectives. In recent years, we have set ourselves a large number of goals, many of which we have achieved. In some cases, objectives have been continued from one year to the next as part of continuous improvement. This year we felt that these recurring objectives should be seen as "business as usual" and that we should instead focus on a much smaller number of objectives that have the potential to genuinely transform patient care. Following a public consultation event in January 2014, an on-line survey which attracted over 200 responses (including from staff) and in discussion with our governors, we have agreed five objectives:

Reducing numbers of cancelled operations

Cancelled operations are a waste of time and resources; and the process of cancelling operations is distressing and inconvenient for patients. Our aim is to significantly reduce the number of last minute cancellations (i.e. on the day of admission) for non-clinical reasons.

Minimising patient moves between wards, including out of hours

Risks of healthcare associated infection are greatly increased by the extensive movement of patients. We also know from patient feedback that moves between wards for non-clinical reasons impact adversely on their experience of care. Our aim is to reduce the average number of ward moves per patient (excluding assessment and observation wards), measured using a baseline which we will establish using data gathered in the first quarter of 2014/15. We also want to ensure that no patients are moved out-of-hours other than for clinical reasons.

Ensuring patients are treated on the right ward for their clinical condition

There is emerging evidence of a correlation between increased mortality and the practice of 'outlying' patients[35]. Our aim is to reduce the number of days patients spend as 'outliers' using a baseline which we will establish using data gathered in the first quarter of 2014/15.

Ensuring no patients are discharged from our hospitals out of hours

Our aim is to ensure that no patients are discharged out of hours, as defined in our hospital discharge policy[36].

We will achieve these four objectives through implementation of five key executive-led transformation projects:

[35] NHS Institute for Innovation and Improvement

[36] Currently 10pm – 7am

- Creation of integrated discharge services, co-locating organisations responsible for managing patients with complex care needs
- Commissioning of out of hospital transitional care beds
- Earlier supported discharge pathways; a Trust-wide review of critical care services
- Implementation of an operational model which enables elective and urgent tertiary activity to continue during periods of high demand for acute medical care through the emergency department.

Reviewing and refreshing the Trust's approach to patient and public partnership

The Trust has a strong record of patient and public involvement, but we recognise that this involvement is not always systematic and mainstreamed within the organisation. In 2014/15, we will undertake at least two significant pieces of work, one of which will focus on the experience of a 'seldom heard' patient group (to be determined during quarter 1 of the year), and use these as a basis for developing a new model of engagement for wider implementation.

How we will monitor our quality objectives

The four objectives relating to patient flow will be owned by the Trust's transformation board. The objectives about patient and public partnership will be overseen by the Trust's patient experience group. Progress in achieving all five quality objectives will additionally be monitored via the Board Assurance Framework and detailed quarterly reports to the Trust's Clinical Quality Group and the Quality and Outcomes Committee of the Board.

Performance against key national priorities

Summary of performance against national priorities and access standards

In the 2013/14 Annual Plan, risks to compliance with the Accident and Emergency 4-hour standard, the *Clostridium difficile* quarterly trajectory and the Referral to Treatment Time (RTT) Non-admitted standard were declared. This gave the Trust an Annual risk rating of Amber-Red. The Trust held an Amber-Red Governance Risk Rating during the first two quarters of the year. Following the introduction of the new Risk Assessment Framework, which came into effect on the 1st October 2013, the Trust achieved a Green rating in quarter 3. Disappointingly, the Trust triggered the criteria for potential escalation in quarter 4, with a Service Performance Score of 4.0 and repeated failure against three standards (*Clostridium difficile*, A&E 4-hours and RTT Non-admitted standard). At the time of this report, the Trust is awaiting the outcome of this anticipated escalation.

Last year proved to be another challenging year for the Trust, although improvements in performance against the national standards continued to be made in some key areas, in particular healthcare associated infections. Whilst the target reduction in the annual number of *Clostridium difficile* infections was not achieved, there has been a 21% reduction in *Clostridium difficile* infections in 2013/14 compared with 2012/13. Although the Department of Health target of zero MRSA (Meticillin Resistant *Staphylococcus Aureus*) bacteraemias was not achieved in 2013/14, material reductions in the number of cases were also realised, from the 10 reported in 2012/13 to one confirmed case in 2013/14[37].

[37] Although two MRSA bacteraemias were formally reported in 2013/14, one was a contaminated sample, with the patient being confirmed as negative for MRSA on repeated testing.

The waiting times standards for the treatment patients within 18 weeks of referral (Referral to Treatment Times - RTT) were achieved in each month of the year for patients requiring an admission as part of their treatment (admitted pathways), and also for those patients not yet treated and waiting at month-end (ongoing pathways). However, the standard for patients not requiring an admission for their treatment within 18-weeks (non-admitted pathways) was only achieved in the first quarter of the year. This was due to a combination of long waiting times for patients that were transferred to the Trust as part of the Head & Neck service transfer from North Bristol NHS Trust, but also lengthening waits in a number of specialties for first outpatient appointments, due to rising demand. Overall, performance against the cancer waiting times standards remained strong, with seven of the eight national standards being achieved in every quarter. The 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer, was not achieved in quarters 2 and quarter 4. The standard was achieved in quarters 1 and 3 with agreed reallocation of breaches of standard to other providers, following late referral. Further details of the analysis of the causes of the failure of this standard are provided in extended narrative section of this report. A programme of rapid improvement work was

instigated at the end of quarter 2 to address the leading causes of breaches of cancer waiting times standards, as identified through reviews of individual breaches. This work will continue to be progressed in 2014/15. Following the work undertaken in 2012/13 to reduce delays to specialist screening practitioner appointments and colonoscopy diagnostic procedures, significant improvements in performance were seen against the 62-day standard for screening referred patients in 2013/14, with the standard being achieved in every quarter.

Disappointingly, the Trust failed to achieve maximum 4-hour wait in A&E for at least 95% of patients in three quarters of the year, but did achieve the national standard in six individual months. The failure to achieve the 95% standard for the year as a whole was despite a significant programme of improvement work undertaken on patient flow during the year. Improvements in key measures of patient flow and patient experience have, however, been demonstrated. These include a reduction in ambulance hand-over delays (46% reduction in delays in December, and a 60% reduction in delays in January, compared with the same month last year), 33 fewer last-minute cancellations due to ward bed availability in 2013/14 compared with 2012/13, and a 26% reduction (between October and March) in the number of days patients spent outlying from their correct specialty ward, compared with the same period in the previous year.

In quarter 4 the Trust launched a programme of seven projects to be taken forward as part of the Trust's 2014/15 operating model, led by the Trust's senior leadership team. These projects build upon the work already undertaken as part of the patient flow programme. The Trust did not achieve the national standard for operations cancelled at the last minute for non-clinical reasons, but unlike last year, reductions in cancellations were realised, primarily through improved ward bed availability. The planned programme of work on patient flow should significantly improve bed availability, which was the leading cause of last-minute cancellations of surgery in those months when the 0.8% national standard was not achieved.

Full details of the Trust's performance in 2013/14 compared with 2013/12 are set out in the table below, which shows the cumulative year-to date performance. Further commentary regarding the 18 week RTT, A&E 4 hour, cancer and other key targets is provided overleaf.

Extended narrative about national access targets

18 weeks Referral to Treatment (RTT)

The Trust achieved a maximum wait of 18 weeks from Referral to Treatment for over 90% of patients requiring an admission for treatment, in every month in 2013/14. In addition, the Trust achieved the target for patients whose RTT clock had not yet stopped, with over 92% of patients waiting less than 18 weeks at each month-end. The Trust only achieved the standard of at least 95% of patients that don't require an admission as part of their treatment waiting less than 18 weeks from referral, in quarter 1 in 2013/14. This dip in performance followed the transfer of the Head & Neck service from North Bristol NHS Trust in March 2013, with more patients transferring, and more patients having a longer waiting time than expected, at the point of transfer. In addition, there was a significant rise in the level of outpatient referrals during 2013/14, which has resulted in waiting times for first outpatient appointments lengthening. During quarter 4, work has been undertaken to re-assess the level of capacity required to meet this new level of demand. Target waiting times for new outpatient appointments have also been reviewed, from which weekly activity plans have been generated. These plans will be enacted during quarters 1 and 2, following which the non-admitted standard should be achieved again from the start of quarter 3.

A&E 4-hour maximum wait

The Trust failed to meet the 95% national standard, for the percentage of patients discharged, admitted or transferred within four hours of arrival in one of the Trust's emergency departments. As in 2012/13, performance was below the national standard in quarters 1, 3 and 4. Despite the failure to achieve the 4-hour standard in these three

Performance against national standards

Table 6

National standard	2011/12	2012/13	2013/14 target	2013/14[38]	Notes
A&E maximum wait of 4 hours	96.0%	93.8%	95%	93.7%	Target met in 1 quarter in 2013/14 (Q2)
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	26	57	15 mins	15	Target met in 3 quarters in 2013/14 (not Q1)
A&E Time to Treatment (minutes) median within 60 minutes	20	53	60 mins	52	Target met in every quarter in 2013/14
A&E Unplanned re-attendance within 7 days	1.7%	2.6%	< 5 %	1.6%	Target met in every quarter in 2013/14
A&E Left without being seen	1.0%	1.9%	< 5%	1.8%	Target met in every quarter in 2013/14
MRSA Bloodstream Cases against trajectory	4	10	Trajectory	2	One of the two cases was a contaminated sample only
C. diff Infections against trajectory*	54	48	Trajectory	38	Cumulative target failed in each quarter in 2013/14
Cancer - 2 Week wait (urgent GP referral)	95.9%	95.0%	93%	96.6%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (First treatment)	98.1%	97.0%	96%	96.9%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	96.7%	94.9%	94%	95.1%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.9%	99.8%	98%	99.8%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	99.3%	98.7%	94%	97.6%	Target met in every quarter in 2013/14
Cancer 62 Day Referral To Treatment (Urgent GP Referral)*	87.0%	84.1%	85%	80.7%	Target met in 2 quarters in 2013/14 (not Q2 or Q4)
Cancer 62 Day Referral To Treatment (Screenings)	94.4%	90.0%	90%	93.7%	Target met in every quarter in 2013/14
18-week Referral to treatment time (RTT) admitted patients	91.7%	92.6%	90%	92.7%	Target met in every month in 2013/14
18-week Referral to treatment time (RTT) non-admitted patients	97.9%	95.7%	95%	93.1%	Target met in every month in 1 Q1 2013/14
18-week Referral to treatment time (RTT) incomplete pathways	N/A	92.2%	92%	92.5%	Target met in every month in 2013/14
Number of Last Minute Cancelled Operations	0.87%	1.13%	0.80%	1.02%	Target failed in each quarter in 2013/14
28 Day Readmissions (following a last minute cancellation)[39]	93.3%	91.1%	95%	89.6%	Target failed in each quarter in 2013/14
6-week diagnostic wait	99.5%	89.7%	99%	98.6%	Target failed in 3 quarter in 2013/14 (achieved in Q3)
Primary PCI - 90 Minutes Door To Balloon Time	91.0%	91.7%	90%	92.9%	Target met in every quarter in 2013/14
Infant Health - Mothers Initiating Breastfeeding[40]	76.2%	80.6%	76.3%	81.6%	Target met in every quarter in 2013/14

Achieved for the year and each quarter | Achieved for the year, but not each quarter | Not achieved for the year | Target not affected

* defined in Appendix C

[38] Due to the timing of this report the figures shown in the above table are for the year to date ending March 2014, with the exception of cancer and primary PCI, which are up to and including February 2014.

[39] IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures readmissions to hospital within 28 days following a previous discharge

[40] The Infant Health standard shown is a target set by the Trust

quarters, there have been some demonstrable improvements in key aspects of patient flow, including a reduction in ambulance hand-over delays, the number of last-minute cancellations due to ward bed availability, and the number of bed-days patients spend outlying from their correct specialty ward. The Trust also achieved each of the A&E clinical quality indicators, in particular showing an improvement in performance against the 15-minute Time to Initial Assessment for patients arriving by ambulance.

During each month in 2013/14, the level of ambulance arrivals was significantly higher than the same month in the previous year, averaging a 9% increase year-on-year. However, the level of emergency admissions remained similar to that in previous years within the Bristol Royal Infirmary, which is thought to be a result of the ambulatory care unit being able to manage appropriate patients without an admission to hospital. Although the number of emergency admissions did not increase, the proportion of over 75 year olds being admitted rose during the winter of 2012/13 and remained at these levels into quarter 1 2013/14. A further 8% increased on the 2012/13 winter levels was experienced during the winter of 2013/14. Older patients often have more complex health conditions and need more intensive medical input before they can leave hospital. This steep rise in the age of patients being admitted to hospital was a main contributor to the dip in performance in each quarter in 2013/14.

In the Bristol Royal Hospital for Children, the increased level of ambulance arrivals was associated with an increase in emergency admissions via the emergency department, with levels increasing by an average of 39% across November and December 2013, relative to the same period in the previous year. This level of increase in emergency admissions is exceptional and resulted in record high levels of admissions. This was due to the high levels of respiratory illness in the community, which mirrored the national picture. This led to significant bed pressures, which heavily contributed to the failure to achieve the A&E 4-hour standard in quarter 3 at a Trust level.

The Trust's senior leadership team has initiated a review of the Trust's operating model for adult services, which includes seven projects aimed at improving the efficiency with which the Trust operates. This programme of work focuses on a range of initiatives aimed at improving patient flow, including the development of discharge services integrated with Bristol City Council and Bristol Community Health, to promote better ways of working between the three organisations responsible for managing patients with complex health needs, the commissioning of more out of hospital beds, establishing early supported discharge pathways, and a Trust-wide review of Critical Care. This work programme will not only help to reduce extended stays in hospital and demand for beds, especially from elderly patients that have the most complex of care needs, but it will also help to improve quality of care and patient experience. Reducing pressure on beds will also improve flow through the front door of the hospital, and in so doing support the Trust in recovering performance against the A&E 4-hour target.

Cancer

As reported in the summary section above, performance against seven of the eight key national cancer waiting times standards remained strong in 2013/14, with full achievement of these seven standards in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved in quarter 2 or quarter 4. This was due to a combination of high volumes of the more 'unavoidable' causes of breaches of standard, such as late referrals from other providers, clinical complexity, and patient choice to delay diagnostics and treatments, but also some more avoidable causes of breaches, such as elective cancellations due to critical care capacity, delays in outpatients for certain specialties and delays to admitted diagnostic procedures being booked due to capacity constraints. Unlike in 2013/14, the 62-day wait from referral to cancer treatment for patients referred from one of the three national screening programmes was, however, achieved in each quarter. This follows the sustained reduction in waiting times for the initial specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures, as a result of work undertaken to reduce delays in the latter half of 2012/13. Following the transfer-out of the high performing breast and urology cancer services,

and the transfer in of the head and neck cancer service at the end of 2012/13, the Trust now has a more complex portfolio of cancer services. In combination with increasing levels of breaches due to late referral by other providers, medical deferral and patient choice to delay pathways, consistent achievement of the 62-day standard will require performance significantly above the national average in most tumour sites. A rapid improvement group was established at the end of quarter 2 in order to effect improvements in those pathways for which breach analysis had identified avoidable causes of breaches. Improvements in performance were demonstrated in quarter 3, across a range of tumour sites. However, there was a deterioration in performance during quarter 4. This was primarily due to a further increase in the number and proportion of breaches attributed to unavoidable reasons, increasing from 49% in quarter 2 to 69% in quarter 4. Further improvement work will be undertaken in 2014/15, using the information gained from the monthly review of the causes of breaches, and learning from other organisations obtained from telephone interviews conducted with better performing equivalent providers.

Other standards

During 2013/14, the Trust cancelled 1.02% of operations on the day of the procedure for non-clinical reasons, such as bed availability and emergency patients need to take priority. This represents an improvement on 2012/13 when 1.13% of procedures were cancelled. This improvement was primarily due to a reduction in cancellations due to the lack of a ward bed being available, and reflects the significant programme of work on improving patient flow, implemented during the year. However, the lack of a ward bed resulted in higher levels of cancellations in January and February 2014 in particular. The lack of a critical care bed also resulted in a high level of cancellations relative to that seen in previous years. The programme of work developed to support the 2014/15 operating model should further improve both ward and critical care bed availability in 2014/15 and reduce the last-minute cancellation rate. This should also help the Trust readmit patients within 28 days of their operation being cancelled, as achievement of this standard is very dependent upon the level of cancellation of operations at any point in time.

During quarter 3, the Trust received a performance notice from Bristol Clinical Commissioning Group. This made reference to the failure to achieve the RTT, 4-hour and cancer standards, as outlined in the summary above, but also the failure to consistently meet the standard of 99% of diagnostic tests being carried-out within six weeks of referral. Significant improvements in performance have been realised in 2013/14, with performance against the 6-week diagnostics standard increasing from 89.7% in 2012/13 to 98.6% in 2013/14. This was a result of service capacity for gastrointestinal endoscopies being increased to meet the higher level of demand. Following further work to increase capacity in services such as cardiac stress echo and cardiac MRI scanning, which have also seen a significant recent growth in demand, the 99% standard was achieved for quarter 3 2013/14 as a whole. However, further work is being undertaken to ensure a more consistent performance against the standard in 2014/15.

In 2013/14, the Trust reported further improvements in the percentage of mothers initiating breast feeding, from 80.6% to 81.6%. Improvements were also reported in the door to balloon 90 minute reperfusion standard. The reperfusion standard relates to a procedure that is carried-out to improve blood flow to the heart. A catheter is inserted into a blood vessel in the groin or arm and then moved up to near the heart, through which a small balloon is inflated to squash the fatty plaques or deposits in the blood vessel to improve blood flow to the heart. The door to balloon time measures the time from the arrival of the patient in the Trust through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel). During the year, 92.9% of patients received reperfusion within the 90 minute standard, compared with 92.4% in 2012/13. The call to balloon times 150 minute standard measures the time from the call for professional help through to the commencement of reperfusion treatment. As in 2012/13, the Trust failed to meet the 90% local stretch target. However this continued to reflect the time it took for the patient to get to the hospital (call to door time), rather than the time from arrival to treatment.

APPENDIX A
Statements of assurance from the Board

1. Review of services

During 2013/14, University Hospitals Bristol NHS Foundation Trust provided clinical services in 70[41]specialties via five clinical Divisions (i.e. Medicine; Surgery, Head & Neck Services; Women's & Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2013/14, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, SHMI) as part of monthly performance reporting. The data reviewed covered the three dimensions of quality i.e. patient safety, patient experience and clinical effectiveness. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by University Hospitals Bristol NHS Foundation Trust services reviewed in 2013/14 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2013/14.

[41] Based upon information in the Trust's Statement of Purpose (which is in turn based upon the Mandatory Goods and Services Schedule of the Trust's Terms of Authorisation with Monitor)

2. Participation in clinical audits and national confidential enquiries

For the purposes of Quality Accounts and Reports, the Department of Health publishes an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of local clinical audit programmes. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of percentage participation and case ascertainment[42]. The information which follows relates to this list.

During 2013/14, 39 national clinical audits and three national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, the Trust participated in 95% (37/39) national clinical audits and 100% (3/3) national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

[42] i.e. the number of individual patents we submit data on compared to how many we should have submitted data on (usually outlined through Hospital Episode Statistics or similar)

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Acute		
Case Mix Programme (CMP)	Yes	Yes
Emergency use of oxygen (British Thoracic Society)	Yes	No
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death	Yes	Yes
National Audit of Seizures in Hospitals (NASH)	Yes	Yes
National emergency laparotomy audit (NELA)	Yes	Yes
National Joint Registry (NJR)	Yes	Yes
Paracetamol overdose (care provided in emergency departments)	Yes	Yes
Severe sepsis and septic shock	Yes	Yes
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes

Item 05d

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Cancer		
Bowel cancer (NBOCAP)	Yes	Yes
Head and neck oncology (DAHNO)	Yes	Yes
Lung cancer (NLCA)	Yes	Yes
Oesophago-gastric cancer (NAOGC)	Yes	Yes
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes
Cardiac Rhythm Management (CRM)	Yes	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	Yes
Coronary angioplasty	Yes	Yes
National Adult Cardiac Surgery Audit	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Heart Failure Audit	Yes	Yes
National Vascular Registry	Yes	Yes
Long term conditions		
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	Yes	Yes
Diabetes (Paediatric) (NPDA)	Yes	Yes
Inflammatory bowel disease (IBD)	Yes	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes
BTS Paediatric bronchiectasis (British Thoracic Society)	Yes	No
Renal replacement therapy (Renal Registry)	Yes	Yes
Rheumatoid and early inflammatory arthritis**	Yes	Yes
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Other		
Elective surgery (National PROMs Programme)	Yes	Yes
Women's and Children's Health		
Child health clinical outcome review programme (CHR-UK)	Yes	Yes
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes
Moderate or severe asthma in children (care provided in emergency departments)*	Yes	Yes
Neonatal intensive and special care (NNAP)	Yes	Yes
Paediatric asthma	Yes	Yes
Paediatric intensive care (PICANet)	Yes	Yes

* Organisational aspects only

The Trust did not participate in two national audits under the auspices of the British Thoracic Society and is undertaking relevant local audit activity instead.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Item 05d

Name of audit / Clinical Outcome Review Programme	% Cases Submitted
Acute	
Case Mix Programme (CMP)	1190*
National Audit of Seizures in Hospitals (NASH)	100% (30/30)
National Joint Registry (NJR)	98% (49/50)
Paracetamol overdose (care provided in emergency departments)	100% (50/50)
Severe sepsis & septic shock	100% (50/50)
Severe trauma (Trauma Audit & Research Network, TARN)	68% (200/294)
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	38*
Cancer	
Bowel cancer (NBOCAP)	94% (162/173)
Head and neck oncology (DAHNO)	90*
Lung cancer (NLCA)	80% (144/180)
Oesophago-gastric cancer (NAOGC)	99% (149/150)
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	985*
Cardiac Rhythm Management (CRM)	100% (792/792)
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (742/742)
Coronary angioplasty	100% (1423/1423)
National Adult Cardiac Surgery Audit	100% (1481/1481)
National Cardiac Arrest Audit (NCAA)	133*
National Heart Failure Audit	100% (403/403)
National Vascular Registry	98% (145/148)
Long term conditions	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	99% (100/101)
Diabetes (Paediatric) (NPDA)	1354*
Inflammatory bowel disease (IBD)	100% (40/40)
Older people	
Falls and Fragility Fractures Audit Programme (FFFAP)	345*
Sentinel Stroke National Audit Programme (SSNAP)	100% (121/121)
Other	
Elective surgery (National PROMs Programme)	27% (33/122)
Women's & Children's Health	
Moderate or severe asthma in children (care provided in emergency departments)	100% (50/50)
Neonatal intensive and special care (NNAP)	100% (2739/2739)
Paediatric intensive care (PICANet)	100% (671/671)

*No case requirement outlined/unable to establish baseline from HES data

The reports of ten national clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2013/14. The Trust is taking the following actions to improve the quality of healthcare provided:

College of Emergency Medicine (CEM) audits

- The Medway system has been altered to allow better electronic capture of data relating to consultant review or discussion.

- Monthly reporting against the CEM quality standard has been introduced to inform further actions required by pinpointing times / days when standards are less likely to be adhered to.

National Audit of Dementia

- A care pathway for frail older people which incorporates people with a dementia will be developed. Access to intermediate care services to allow people with dementia to be admitted to intermediate care directly will be part of this review.
- A review of the model of care for the older adult admissions wards is to be undertaken.
- A clinical guideline is being developed to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation using a recognised tool (confusion assessment method).
- An electronic discharge summary for all patients who are 75 years and over will be developed which contains mandatory fields to include abbreviated mental test score, cause of cognitive impairment, symptoms of delirium, and behavioural and psychological symptoms of dementia.

National Cancer Audits

- Significant progress has been made with the lung, bowel and head and neck audits in 2013. All three audits returned their best ever standard of submission in terms of data completeness and quality.
- Easy format written guidance on data entry has been produced, along with reports that allow multidisciplinary team coordinators to easily identify and rectify data gaps, and their managers to monitor this. This system has received positive feedback from coordinators and clinicians.
- All national audit submissions have undergone clinical quality assurance prior to submission. Monthly submission has been introduced along with a robust system for identifying 'rejected' records enabling these to be quickly fixed.
- The Trust's cancer manager continues to work closely with the Somerset Cancer Register to ensure the best use of the register and influence its development.

National Diabetes Audit (NADIA)

- Increased diabetes specialist nursing input was allocated via CQUIN funding to help improve the care that diabetic patients receive as inpatients.

National Cardiac Arrest Audit (NCCA)

- All cardiac arrests are now reported on the Trust incident reporting system (Ulysses Safeguard) to enable learning from these incidents.

Falls and Fragility Fractures Audit Programme - National Hip Fracture Database

- The appointment of a specialist hip fracture nurse (and audit nurse responsible for data) has resulted in a significant improvement in data quality, and patient care as a whole.
- A business case was approved and implemented to increase ortho-geriatrician input, increase trauma theatre allocation and implement direct access beds.

National Vascular Registry

- A written pathway of care for Transient Ischaemic Attacks (TIAs) and non-disabling stroke for Bristol Bath and Weston Vascular Network is being developed to ensure that the agreed protocol for referral is followed to help avoid any unnecessary delay.

National Neonatal Audit Project

- A preterm breast feeding project has been started aiming to improve rates of breastfeeding at discharge.

The outcome and action summaries of 205 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2013/14; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Trust's Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2013/14[43].

[43] Available via the Trust's internet site from July 2014

3. Participation in clinical research

Developing and delivering research of the highest quality to improve outcomes for patients is at the centre of what we do at University Hospitals Bristol NHS Trust. Research is embedded within the care we provide and our aim is to offer the chance to participate in research to as many of our patients as we can. As evidence of our continued commitment to providing research to our patients, the number of patients receiving relevant health services provided or sub-contracted by University Hospitals Bristol NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 9739 and 86% of these were recruited into NIHR research. We currently have 775 active research projects, 85 of which are our own sponsored trials which include clinical trials of investigational medicinal products and other interventional trials in areas such as surgery. We recognise that the speed with which research is set up impacts on how quickly we can gather the evidence to change patient care. We have been working hard to improve our set up times: as testament to this, there were three international studies in 2013/14 where the Trust was first to recruit patients.

We believe that strong collaborations underpin our ability to deliver effective healthcare through research across our region. We were therefore delighted that UH Bristol was selected as the host NHS Trust for the new Clinical Research Network: West of England, which launched in April 2014 and will be the local branch of the NIHR for the region. We also saw further exciting developments with UH Bristol awarded the hosting of the CLAHRC West (Collaboration for Leadership in Applied Health Research & Care), which will bring £9 million in new funding to the region. CLAHRC West will increase the scale and pace of translating research into practice and implementation of novel applied health research findings, and will support clinicians and researchers in changing the way services are provided across the region.

Alongside our two biomedical research units – Cardiovascular and Diet, Lifestyle and Nutrition - which support the translation of basic research into patients, UH Bristol-led research continued to grow in 2013/14 with seven project and programme grants awarded and two grants opened to recruitment. This included the work of Sarah Hewlett, Arthritis Research UK Professor of Rheumatology Nursing. Her work on fatigue associated with rheumatoid arthritis which patients had considered to be an overwhelming problem that was previously ignored by health care teams, has led to international consensus that fatigue must be measured in all clinical trials of rheumatoid arthritis treatments, putting it firmly on the international research agenda. As a continuation of this the research team is currently recruiting to a multi-site research trial led from UH Bristol to test a potential therapy for reducing arthritis fatigue.

4. CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The amount of potential income in 2013/14 for quality improvement and innovation goals was approximately £10.32 million, based on the sums agreed in the contracts.

The delivery of the CQUINs is overseen by the Trust's Clinical Quality Group. Further details of the agreed goals for 2012/13 and 2013/14 are available electronically at http://www.uhbristol.nhs.uk/about-us/how-we-are-doing/ .

In line with national guidance, in order to qualify for CQUIN payments in 2013/14, the Trust had to satisfy at least 50% of the pre-qualification criteria applicable to the Trust, namely demonstrating that plans/trajectories were in place for: intra-operative fluid management, international and commercial activity, Digital First, and carers for people with dementia. Commissioners confirmed that the Trust had met these criteria.

The CQUIN goals were chosen to reflect both national and local priorities. Twenty

seven CQUIN targets were agreed, covering more than 60 measures. There were four nationally specified goals: Friends and Family Test (expand coverage; improve response rate and improve performance on staff test), NHS Safety Thermometer (reduce incidence of pressure ulcers); venous thromboembolism (increase percentage of patients risk assessed and ensure a root cause analysis performed in all hospital acquired cases); dementia care (improve case finding and referral for emergency admission; provide clinical leadership and education; provide support to carers).

The Trust achieved 19 of the 27 CQUIN targets and eight in part, as follows:

- NHS Safety Thermometer
- Venous thromboembolism (VTE)
- Intra operative fluid management (High Impact Innovation)
- Digital First (High Impact Innovation)
- End of life care: preferred place of death
- Medication errors
- Cancer treatment summaries
- Deteriorating patient
- Inpatient diabetes specialist nurse
- Adult learning disability
- Children's learning disability
- Quality dashboards
- Neonatal breast feeding
- Paediatric Intensive Care Unit: minimise number of patients accidentally extubated
- Paediatric Intensive Care Unit: prevention of unplanned readmissions in 48 hours
- BMT donor acquisition measures
- Cardiology access to catheter laboratory within 24 hours
- Radiotherapy increased access to Image Guided Radiotherapy (IGRT)
- Haemophilia, ensuring patients have joint scores
- Friends and Family Test (in part)
- Dementia (in part)
- Patientflow measures (in part)
- System flow measures (in part)
- Nutrition and dietetics (in part)
- Enhanced recovery (in part)
- Transition (in part)
- Cardiac inpatient waits less than 7 days (in part)

5. Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The Trust received three CQC inspections during 2013/14.

On 26 April 2013, the CQC inspected maternity services (St Michael's Hospital) and Ward 32 (Bristol Royal Hospital for Children) in order to check that the Trust had implemented action plans and achieved compliance following a previous scheduled inspection (Outcome 13, staffing, in maternity services) and responsive review (Outcome 4, care and welfare of people who use services and 14, supporting staff, on Ward 32). The Trust was found to be compliant.

On 19 November 2013, the CQC undertook a responsive review of theatres and adjacent areas in the Bristol Royal Hospital for Children. The CQC concluded that the Trust was non-compliant with Outcome 8 (cleanliness and infection control) and Outcome 16 (assessing and monitoring quality of service provision). The subsequently agreed action plan has been completed and the Trust is currently awaiting re-inspection to test compliance.

On 22 January 2014, the CQC visited the Trust's main site as part of a national themed inspection of dementia care. The CQC inspection team's report noted a number of areas of good practice, but also that practice in some aspects of dementia care was inconsistent. The CQC concluded that the Trust was

non-compliant with Outcome 4 (care and welfare of people who use services). An action plan has been submitted to the CQC with the majority of actions scheduled for completion by the end of June 2014.

The CQC has not taken enforcement action against the Trust in 2013/14 or issued any formal outlier alerts. University Hospitals Bristol NHS Trust's most recent CQC Intelligent Monitoring report lists the Trust in Band 6, i.e. the CQC's lowest (best) inspection risk band.

6. Data quality

University Hospitals Bristol NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 99.4% for admitted patient care; 99.7% for outpatient care; and 96.0% for accident and emergency care (these values are the same as in 2012/13 for outpatients but higher for both admitted patients and A&E which improved from 93.7% in 2012/13).
- which included the patient's valid General Practice code was: 99.9% for admitted patient care; 99.9% for outpatient care; and 99.4% for accident and emergency care.

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2013 - January 2014 as at Month 10 inclusion date)

The Trust's 2013/14 score for Information Quality (Secondary Use Assurance) in the Information Governance Toolkit was 87%. The Information Governance Assessment Report overall score was 85% and was graded green.

University Hospitals Bristol NHS Foundation TRUST was subject to the Payment by Results clinical coding audit during 2013/14 by Capita Health (which has replaced the Audit Commission).

The audit covered 200 Finished Consultant Episodes. The audit was for 100 admissions in the single Healthcare Resource Group (HRG) of CZ (Mouth, Head, Neck and Ear) and 100 cases admitted via A&E with a length of stay of zero days. The following levels of accuracy were achieved:

- Primary procedure accuracy: 94.5%
- Primary diagnosis accuracy: 95.5%

(Due to the sample size and limited nature of the audit these results should not be extrapolated.)

The Trust has taken the following actions to improve data quality:

- The data quality programme involves a number of regular data quality checks and audits throughout the year including checking against patient notes. This takes place across the Trust and all issues with data quality are reported back to the Information Risk Management Group for appropriate action.
- Internal Audit has audited a sample of outpatient areas to check the accuracy of outpatient data on the Medway Patient Administration System this year. Results to be finalised.

APPENDIX B
Feedback about our Quality Report

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

The Council of Governors again welcomes the opportunity to make comment on the Trust's quality report on patient safety, patient experience and clinical effectiveness for all service users.

Governor involvement

The Trust's Council of Governors receives reports relating to quality issues from its governor groups and challenges the Trust Board to account for any failings in the quality of care.

Early in 2014 the governors Quality Project Focus Group contributed suggestions on the format and content of the report. The group is chaired by the Deputy Chief Executive with the Medical Director and the Chief Nurse also in attendance. It meets every two months and reviews the Trust's quality and access performance as a standing agenda item using the data in the most recent board reports together with any views from personal observation and reports from members and users of our services.

Comments about the Quality Report

Corporate objectives were affected by higher than expected levels of activity, acuity and the increased numbers of elderly patients needing treatment. The inability to discharge to suitable providers of care in the community put severe pressures on bed availability. This Quality Report examines the Trust performance against the targets it set itself last year. The final section outlines objectives for further service improvement during next year, 2014/15. We think that this is the right approach in that it facilitates comparisons year to year.

Overview

Opening paragraph could state the relationship UH Bristol has with the two Universities, in terms of teaching, learning, education and research / clinical based evidence practice. Quality objectives are set out on page 4 of the report and shows an overall improvement in quality, which is to be commended. A further breakdown of each of the 16 quality objectives has been provided on subsequent pages of the report. From the initial presentation of how UH Bristol performed against each of quality indicators, it is pleasing to see an overall improvement in care, particularly in:

- Reduce hospital-acquired healthcare infections (although the *Clostridium difficile* average for UH Bristol is still above the national average (table 2)).
- Reduce medication errors.
- Improve the early identification and escalation of care of deteriorating patients (particularly post-Francis / Keogh etc).
- Ensure that patients continue to be treated with kindness and understanding on our wards.
- Achieve best practice tariff for hip fractures management.
- Patients with diabetes have improved access to specialist support.
- Patient centred care is offered to those patients who may require it the most.
- Establish a baseline for clinical outcome data within the Trust.

It is also helpful to have some background in terms of the rationale behind the inclusion of table 2 (page 5) and it is acknowledged that this table is still incomplete at the point of publication of version 2.

Patient safety - The NHS Safety Thermometer: Objective 1:
The Trust reported achievement of its objectives in delivering improvements in harm free care in respect of the incidence of pressure ulcers, patient falls, venous thromboembolism and catheter related urinary tract infections. We note that target achievement is based on harm free care being delivered to not less than 97.7% of patients overall using benchmarking from similar best performing trusts.

It would be helpful to know what the annual target values for harm free care will be for the Trust in 14/15, it is unclear at present what the rebase value is. The graph (figure 1) is however helpful and it is encouraging to see the work being undertaken by staff to reduce the incidence of patient falls. There is an important statement around the incidence of falls amongst patients in the 75 plus age group, which does have significance, along with the introduction of the 'Fallsafe' initiative across the Trust, which reports to the falls steering group. It would be helpful to have some of the key findings / themes from the Fallsafe initiative included within the report, even if it just some headlines.

The achieved results for pressure ulcer management are good and the Trust has achieved its target set in line with commissioners. It is also helpful to see some qualitative examples of actions that have been undertaken to reduce the incidence of pressure ulcers within the Trust. Having projected actions for 2014/15 was also helpful, in particular the introduction of a pan-Avon dressing formulary, which could be brought to a future Governors meeting, in terms of providing an educational session.

Screening for VTE prevention continues to improve within the Trust along with the introduction of a root cause analysis for patient who had experienced incidence of VTE. Greater education and the introduction of sequential compression devices is to be commended and as such good practice is now being disseminated out to South Bristol Community Hospital.

Patient safety- Reduce hospital-acquired healthcare infections: Objective 2:
Clostridium difficile target was not met as part of the Trust's focus on preventing HCAIs, however it should be noted that achieving an overall reduction of 21% in reported cases is a significant improvement. Figure 6 (page 12) is very helpful in demonstrating how significant the results are over a seven year period and the ongoing actions to further reduce this figure.

MRSA incidences have also significantly improved and the Governors welcome the use of root cause analysis to identify the base of the two reported cases. Investment in an IV access co-ordinator post within the Trust demonstrates commitment to further resolving any potential future cases and also to promote effective / standardised practice across the Trust.

MSSA and norovirus results show an improvement compared with the previous year's report and it is pleasing to see the Trust achieve its target of 90% for hand hygiene and antibiotic compliance. The governors have requested that this is a standing item on report.

Patient safety- Reduce medication errors: Objective 3:
Improvement on the 2012/13 quality report with reference to the reduced moderate / major medication related incidents. The reason behind this reduction is provided and it is pleasing to see that learning and feedback from reported incidents forms part of the quality enhancement process. The trend presented in figure eight is helpful in terms of further highlighting the significant improvements made over the last four years in terms of reducing the incidence of medication errors within the Trust. It is also pleasing to see that the Trust will aim to comply with the PSA and the 2013/14 Trust quality report will benchmark against this external quality standard. The governors have however specifically asked for this indicator to be included as they had highlighted it as a performance issue during the current year.

Patient safety – Extend medicines reconciliation: Objective 4:
Medicines reconciliation figures for 2013/14 are improved and the Trust should be commended for exceeding their set CQUIN target. It would be helpful if wards 61, 62 and 78 (table 3) could be labelled (i.e. are these the oncology, haematology and gynaecology wards?). It would also be useful if an actual target could be set for 2014/15, rather than stating a 'similar percentage'. This will help to quantify the improvements made year on year, especially for the new wards that have come on-line this year as part of the quality review process.

Patient safety – Improve the early identification and escalation of care of deteriorating patients: Objective 5:
The background to the use of an EWS is helpful, especially in the context of how care is initially provided, mapped against the implementation of SBAR, where required. It is pleasing that the Trust's CQUIN target of 95% has been exceeded and the use of the SBAR communication tool has been effective overall. It would be useful to provide some further explanation as to why it has taken some time for the SBAR tool to become established practice. Is there, for example, the need for greater education and training?

Patient safety – Improve levels of nutritional screening and specifically 72 hour nutritional review of patients: Objective 6:
Why was the agreed CQUIN target of 90% (for patients who had initially been assessed as being at risk of malnutrition would receive a nutritional review after 72 hours) only introduced in the final quarter of the financial year? The overall compliance is disappointing and it would be useful to know what additional measures are being put into place for 2014/15. Were there any particular patient groups that were more at risk than others with reference to malnutrition when admitted to hospital?

It is reassuring that the rate of patient safety incidents reported and proportion resulting in severe harm or death has reduced and the actions for 2014/15 are encouraging. There is also appropriate linkage to the Trust's quality objectives for 2014/15, which is provided towards the end of the document.

The case studies presented under the sub heading of 'Never events' are useful and highlight the subsequent actions / investigation process. It may be helpful to have some examples of what the proactive review would look like (mentioned on page 20 of the Quality Report).

Patient experience:
The experience of maternity patients was an indicator in last year's quality report and was included as a focus for action as a result of some poor results in the previous national survey. Obviously, some progress was made because the national survey in 2013 recorded some excellent results, with some deterioration in the third quarter. Medication side effects are not consistently explained on discharge, disappointing in common with most trusts.

The Productive Outpatient Project is helping to improve the outpatient communication process and is worth a mention. Table 5 on page 31 is disturbing and suggests that conditions at work for staff have deteriorated such that we now find ourselves in the bottom 20% of trusts but then the same survey gives a better than average score for staff recommending the Trust as a place to work or receive treatment.

Patient experience - Implement the friends and family test: Objective 7:
It is pleasing to see that the results for the FFT initiative are higher than the national average for the Trust, although it would be helpful to state why there was underachievement in the first quarter of the year with the response rate (8.4% against a target of 15%). The actions being proposed in terms of capturing additional feedback from maternity wards is encouraging, along with the increased response rates for emergency departments and inpatients for 2014/15. What is the payment from meeting the CQUIN targets used for? Is it re-invested in training for example?

Patient experience - Ensure that patients continue to be treated with kindness and understanding on our wards: Objective 8:
It is really pleasing to see the survey scores consistently above 90% throughout the year. Inclusion of qualitative information is useful, but this could have been expanded upon. I would have personally put three or four qualitative statements in this section. This is a real achievement for the Trust and it should be celebrated.

Patient experience - Explain potential medication side effects to inpatients when they are discharged: Objective 9:
Are there any plans to have additional training and education for staff and / or patient forums, in order to further promote the available knowledge and understanding around potential medication side effects? This has been recorded as 'red' on the performance dashboard and there probably a need for a sentence around commitment to training / education etc.

Patient experience - Improve the experience of maternity patients: Objective 10:
This has been recorded as 'amber' on the performance dashboard; however it is good to see the creation of the three specific projects within the Trust. Improving the patient experience on the wards should ideally build upon the initial findings of the three specific projects.

Looking at figure 20 (complaints as a proportion of total patient activity) there appears to be a cyclic trend with the data (i.e. in terms of peaks when complaints are made). The governors are encouraged that the Trust will be continuing to work collaboratively with the Patients Association in 2014/15. It is acknowledged that 2013/14 has been a year of change for the Patient Support and Complaints team and there is reference to reports such as the Francis inquiry and making sure that dealing with patient complaints is more high profile than in previous years.

The provision of a central appointment centre is seen as being a positive move by the Governors, which will hopefully alleviate patients' and carers' anxieties around appointments and access to services. Furthermore the use a text messaging service to remind patients about their forthcoming appointment is also a positive move by the Trust, with the hope of further reducing the DNA rates within the Trust.

With reference to the results presented in table 5 (page 31 / 32) it is a concern that 39% of staff have witnessed potentially harmful errors, near misses or incidents in the last month. This figure is the same as the last three consecutive years and the Trust should consider how they should look to action this key finding.

The proposed actions for 2014/15 are welcomed, particularly the expectations for leaders within the organisation, a Trust wide stress action plan and the implementation of an e-learning package to support managers in addressing work based discrimination.

Clinical effectiveness - 90% of stroke patients were treated for at least 90% of their time of a dedicated ward: Objective 11:
We share the disappointment at the figures related to this particular outcome (79.3% vs a local stretch objective of 90%). The review of reissuing of the Trust's stroke pathway is welcomed and improvements appear to be under way and the data presented in figure 22 for 2013/14 indicates less fluctuation throughout the months of the year, compared to previous years. This should be seen as a positive outcome for the Trust. These results are the same as last year probably for the same reason – protected beds not always available due to black escalation bed pressures. Note: to be carried forward to next year's objectives.

Clinical effectiveness - Achieve best practice tariff for hip fractures: Objective 12:
The overall improvement in achieving BPT for this particular objective is welcomed, however (as stated in the report) there is still work to be done. It would be helpful to know more details of the objectives set for the Hip Fracture Steering Group,

particularly for the pressure points during the year in terms of being able to meet the BP. The Governors highlighted this as a performance issue for action during the year.

Clinical effectiveness - Ensure patients with diabetes have improved access to specialist diabetic support: Objective 13:
It is pleasing to see that this CQUIN target has been met and DISN post in SNH services will now be permanent. Positive feedback statement from a patient example is helpful.

Clinical effectiveness - Ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan: Objective 14:
The recent developments within the Trust in relation to this particular objective are welcomed. In addition the target set by the Trust for adult patients with a learning disability being risk assessed within 48 hours was exceeded, which is pleasing.

Commitment to continuing to implement our dementia action plan: Objective 15:
It is pleasing to see the inclusion of the award given to the Best Dementia Nurse Specialist / Dementia Lead within the Trust. The introduction of the 'hour to remember' scheme has also been a positive move for the Trust. The increased use of the visual identification scheme (linking with the SW Dementia Standards) is pleasing, as is the provision of a local conference, in conjunction with North Bristol NHS Trust. Would it be useful to involve the city's two universities in future conferences, with a view to including healthcare students and academic staff who are involved in education and training?

The qualitative comments included within this section of the report are helpful and reflects the hard work of staff within the Trust, however there is no presentation of results as to the current position of the Trust in terms of how the CQUIN target is being met. From board reports the governors know that the Trust fell a long way short of our target for assessment and follow up here. Governors have just raised it as a performance issue (last quality project focus group). It would be useful to know what specific actions will be taken in 2014/15 to address this particular objective.

Commitment to commence a baseline review of available clinical outcome data: Objective 16:
It is pleasing to see this being introduced across all major clinical specialities.

Review of clinical effectiveness 2013/14:
It is pleasing to see that the overall patient mortality rates within the Trust are significantly lower than the national norm. The same is true for the adult cardiac outcomes and the data within figure 26 (funnel plot) is really useful, as is the date within figure 27. It demonstrates transparency to include the independent review of paediatric cardiac services within the Trust and the governors see this as a positive step. The figure of 98% for parents of children feedback on the care received whilst at the BRH for Children is also a very positive reflection of the overall delivery of care by staff within the Trust.

Objectives for 2014/15:
It is really helpful to have a summary of the objectives for the 2014/14 quality cycle within the Trust. These are clear and transparent objectives that resonate with the areas of improvement required within the Trust. The review and refresh of the Trust's approach to patient and public partnership is also welcomed by the governors. Again, it would be good if the two Universities were also asked to be involved in this work stream.

Summary of performance against national priorities and access standards:
This is helpful, however there are challenges with meeting national standards (that have been highlighted in previous governor reports), particularly access targets (pages 48-53).

Summary:
We commend this report for its transparency and thoroughness and feel that it is an accurate representation of the Trust's position on quality issues. Progress on quality objectives has been achieved during the year but the rate of improvement has slowed and, as stated at the beginning of this commentary, there are factors at play which can only be mitigated by additional resources (or reduced activity) either internally generated (by further efficiency savings) or through initiatives by our external healthcare partners. The theme of clinical research is present within the report, which should also be commended.

The Trust will have a delicate balance to manage with the challenges to its quality agenda by increasing levels of activity, greater sickness in the community it serves, the increasingly elderly patient profile, and funding. Demand management in the fourth quarter is still a problem.

The Council of Governors will explore any questions raised in this statement via the governors' quality project focus group.

b) Statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and Healthwatch South Gloucestershire welcome the opportunity to comment on the University Hospitals Bristol Quality Account and applaud the Trust on its overall financial and clinical health. Healthwatch Bristol and Healthwatch South Gloucestershire fully support the Trust's identification of its "hallmarks of quality" and notes the full achievement of 11 of the 16 quality objectives. Healthwatch also finds the document well structured and likely to be informative and helpful to the general reader. By and large the document is balanced and readable although rather lengthy. Figures tend to be supported by annotations and descriptive and explicatory passages in the text, which again is helpful to lay readers. The footnotes are also a useful and helpful support for the public understanding of sometimes rather difficult data.

Healthwatch Bristol and Healthwatch South Gloucestershire applaud the overall green light on the NHS Safety Thermometer and commend the Trust's participation in the piloting of 'Fallsafe' and the efforts of the Trust's Falls Steering Group. In this respect, as falls are an ever present concern of the public, Healthwatch appreciates the imaginative formula for calculating and comparing expected and actual falls and applauds the strenuous efforts that the Trust has made and its achievement of its goals in this area in four out of 12 months. It strongly supports the participation of staff in clinical applied research and complements the Trust on the long overdue acquisition by Bristol and hosting of a CLAHRC at UH Bristol attracting substantial new funds and recommends appropriate public participation in such research projects.

Healthwatch Bristol and Healthwatch South Gloucestershire also commend the reduction achieved in HCAIs and share the Trust's disappointment that it did not achieve its stated target for *Clostridium difficile*. It notes the commendable achievements in hand hygiene and antibiotic compliance. Conversely, Healthwatch can only express its concern at the occurrence of two never events and although infinitesimal in statistical terms reminds the Trust that for each such patient the effect is 100%. It notes with satisfaction the rigour and robustness of the Trust's proactive review. Similarly with the SHMI indicator it strongly applauds the fact that the score is substantially better than the national median score but notes that it is far from the national best.

Healthwatch Bristol and Healthwatch South Gloucestershire compliment the Trust on its above average achievements in the community midwifery and care during birth elements of the survey. They also applaud the Trust's achievement in compassionate care, a reflection of basic values in a Trust. Perhaps Figure 13 and Table 4 could have been a little clearer in helping lay readers to separate out response rates and scores based on respondents.

Healthwatch Bristol and Healthwatch South Gloucestershire note with some concern that almost 30% of staff would apparently not recommend the provider but takes some

comfort from the fact that this achievement is substantially higher than the 2013/14 national average. It is disappointing also to note that more than one fifth of staff do not feel happy with the quality of work and patient care they are able to deliver and to note the statistically fairly steady score in this regard over the last couple of years. Healthwatch notes the slight improvement in the score staff recommending the Trust as a place to work but also notes the relative immobility of that score over the past few years. (The flow-over of Table 5 makes it rather difficult to read.)

Given the very positive results on the experience of care quality tracker, Healthwatch Bristol and Healthwatch South Gloucestershire share the Trust's disappointment that explanation of the side effects of medication to inpatients when they are discharged was not satisfactorily achieved, and it notes with resigned sadness that this was in line with the national average. It welcomes the remediation strategy proposed, including the new e-tool and it looks forward to improvement over the coming year, whilst noting the need for such a strategy to take account of vulnerable populations, such as but not exclusively older persons and those with learning difficulties. In this respect Healthwatch commends the Trust on its evolving strategies and action plans in its approach to those with special needs and dementia. In spite of the amber result on nutritional screening, Healthwatch commends the innovatory approach using volunteer staff and the achievement of universal screening of patients on entry. Prudent caution is needed when assessing the number of complaints, which can be a very fluid indicator, elusive in its interpretation and reflecting to some extent the ease and security, with which complaints can be made, as well as affording a genuine reflection of dissatisfaction on the part of patients. Although the number of complaints is tiny compared with the volume of patients, it is an important dimension of the perceived reputation of the Trust and the Trust is to be commended for its continuing efforts to improve its performance in the area and to give satisfaction to patients, as reflected for example in the agreed timescale response scores.

Finally Healthwatch thanks the Trust for the professional transparency and openness of the Quality Account combined with its accessibility and informative format Healthwatch strongly supports the Trust's approach to continuous improvement of quality and staff professional development. It also supports the chosen five objectives for 2014/15 and looks forward to their achievement.

c) Statement from South Gloucestershire Health Scrutiny Select Committee

The Trust was invited to a meeting of the South Gloucestershire Public Health & Health Scrutiny Committee on 23 April to give a short presentation on the highlights of its draft Quality Report 2013/14 and answer members' questions.

The Committee welcomed the news that of the 16 objectives set last year, the Trust had achieved 14[44], which included reducing hospital acquired infections, reducing medication errors and ensuring patients with an identified special need, including those with a learning disability, have a risk-assessment and a patient-centred care plan.

The Trust provided more detail on the two objectives that it had not made as much progress on as it would have liked: ensuring that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward; and explaining medication side effects to inpatients when they are discharged. In relation to the latter issue a member suggested that the patient or carer could be asked to sign a document to confirm they have been advised of side effects or the potential consequences of not taking a medicine. The Trust acknowledged this point and responded that it would consider the introduction of a tick sheet to record that contact had been made.

The Committee probed further about the objective for 2014/15 "Making sure patients are cared for on the right ward for their clinical condition" and whether this relates to the objective in the previous quality account about the cancellation of planned procedures due to emergency patients being admitted onto wards. In response it was confirmed that this has been a challenge for the Trust and a lot of work has already been done to reduce the impact on planned operations.

[44] Later revised to 11 in light of year-end data which had been unavailable at the time of this meeting

In addition the Trust was asked for more information on how patient panels and patient experience drive improvements, to which the Trust reported that its patient survey work helps develop its patient experience plans and allows it to formulate objectives.

In response to a question about whether the Trust had any concerns with local commissioners not supporting bids / business cases the Trust stated that it had no concerns and was working collaboratively with commissioners.

Finally, the Committee would like to make one comment on its scrutiny of pathology services. At a meeting earlier this year members were disappointed to learn that University Hospitals Bristol had withdrawn from Severn Pathology, a joint venture with the North Bristol NHS Trust. The Committee felt that good progress had been made and was, therefore, concerned about this decision. A further scrutiny meeting will take place in due course.

d) Statement from Bristol Health and Adult Social Care Scrutiny Commission

At its meeting of 15 April the Commission received a presentation setting out the Trust's progress against its 2013/14 priorities, and its proposed priorities for 2014/15. There was general consensus amongst members that the priorities chosen were appropriate. The Commission was particularly pleased to note the progress made against the Objectives for 2013/14, especially those listed under Achieved/targets met. Members were disappointed about the 2013/14 Objective for stroke patients only being partially achieved. They supported more resources being put into this service. Members had concerns about the 2013/14 Objective relating to medication side effects being underachieved. Members supported the Quality Objectives for 2014/15.

e) Statement from Bristol Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2013/14 is made by Bristol Clinical Commissioning Group following a review by the governing body.

Bristol CCG welcomes UH Bristol's quality account, which provides a comprehensive reflection on the quality performance during 2013/14. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

The CCG is pleased to note UH Bristol's improved achievement against its objectives for 2013/14 with 11 of the 16 objectives met. The CCG also supports the plan to see these objectives as 'business as usual' for the coming year, and welcomes the approach to focus on a smaller number of transformational objectives to support improved patient care and patient experience following wide public consultation.

The quality account identifies progress in relation to:

- Early identification of the deteriorating patient and appropriate escalation of their care
- Reduction of hospital-acquired healthcare infections. We note that the targets for both MRSA and *Clostridium difficile* were not met, however, the CCG acknowledges the significant reduction in the number of these infections and the work undertaken to support improvements to clinical environments following a Care Quality Commission unannounced inspection to children's cardiac theatres.
- Improving patient experience in outpatients. The CCG supports the learning implemented in this specific area which has led to improved patient experience and increased productivity and efficiency in the outpatient services.
- Successful implementation of the Friends and Family Test within adult inpatient, emergency department and maternity services and achievement in both the response rate and net promoter targets.
- Comprehensive monthly patient experience surveys demonstrating a high percentage of positive responses.

Item 05d

The CCG is pleased to see how UH Bristol has improved specialist diabetic support for patients and would welcome the continued focus on this area going forward into 2014/15 in line with one of the CCG priorities.

The quality account also demonstrates the improvements made in the management of patients suffering from a stroke and the CCG supports the ongoing work in this area to achieve further improvements.

The CCG will continue to work closely with the Trust in areas which need further improvement:

- Nutritional screening
- Dementia action plan implementation
- Experiences of maternity patients
- In delivering the eight indicators of quality for best practice tariff for hip fractures
- With improvement plans to support staff engagement and wellbeing including the implementation of the NHS Friends and Family Test for staff.

We would welcome seeing in the 2014/15 objectives greater identification on learning from complaints and experiences of both patients and staff and the presentation of the data by service level. We would also welcome strong reference to effective partnership working across the community and good communication and engagement with key stakeholders with the aim of improving and developing patient safety and quality centred clinical pathways within the 2014/15 objectives.

Having reviewed the quality account we welcome the improvements and progress made by the Trust and acknowledgement of where further improvement work is needed and we look forward to working with UH Bristol in 2014/15.

APPENDIX C
Performance indicators subject to external audit

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer;
- An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant;
- The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait);
- The clock start date is defined as the date that the referral is received by the Trust; and
- The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Clostridium difficile

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- Infections relate to patients aged two year old or more;
- A positive laboratory test result for *Clostridium difficile* recognised as a case according to the Trust's diagnostic;
- Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken; and
- The Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

APPENDIX D
Statement of Directors' Responsibilities

2013/14 Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to April 2014
  - Papers relating to Quality reported to the board over the period April 2013 to April 2014
  - Feedback from the commissioners dated 14/5/2014
  - Feedback from governors received 16/05/14
  - Feedback from Local Healthwatch organisations received 15/5/14
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[45]
  - The 2013 national patient survey (published 8/4/2014)
  - The 2013 national staff survey (published 25/2/2014)
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 28/05/2014
  - CQC quality and risk profiles dated 31/07/2013[46]
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

John Savage Chairman
28 May 2014

Robert Woolley Chief Executive
28 May 2014

[45] This report is due to be received by the Board in July 2014

[46] After which, QRPs for acute trusts were replaced by Intelligence Monitoring Reports (commencing October 2013)

APPENDIX E
External audit opinion

Independent Auditors' Limited Assurance Report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified indicators	Specified indicators criteria
Clostridium difficile	Appendix C of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Appendix C of the Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2013/14" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2013 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;

- Feedback from the Bristol Clinical Commissioning Group dated 14/5/2014;
- Feedback from Governors dated 16/05/2014;
- Feedback from Healthwatch Bristol and Healthwatch South Gloucestershire dated 15/5/2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2013 national patient survey dated 08/04/2014;
- The 2013 national staff survey dated 25/02/2014;
- Care Quality Commission quality and risk profiles dated 31/07/2013; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 27/05/2014.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales ("ICAEW") Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by University Hospitals Bristol NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

PricewaterhouseCoopers LLP
Chartered Accountants
Bristol

28 May 2014

The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for the Council of Governors Meeting to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 5e Achievement on Corporate Quality Objectives – Quarter 1 2014/15

Purpose

To provide an update to the Council of Governors on progress towards achieving the Trust's corporate quality objectives for 2014/15.

Abstract

In May 2014, the Board approved the Trust's Quality Report for 2013/14, which included a number of specific quality objectives for 2014/15. This year, following public consultation, the Trust has a much smaller number of objectives which are focused largely on improving the 'flow' of patients through our hospitals. The Quality Report states that the Trust will achieve these objectives through implementation of the various related Transformation projects. An additional objective is to review and refresh the Trust's approach to patient and public involvement and engagement.

Good progress has been made in Quarter 1 to confirm the scope of these objectives, gather baseline data, agree measurable targets and develop improvement plans.

Recommendations

Members of the Council of Governors are invited to receive this report for assurance.

Executive Report Sponsors

Medical Director

Chief Nurse

Authors

Head of Quality (Patient Experience and Clinical Effectiveness)

Appendices

Quarter 1 update on Corporate Quality Objectives

Previous Meetings

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

Executive Team	Senior Leadership Team	Quality & Outcomes Committee	Finance Committee	Audit Committee	Other
	16 July 2014	25 July 2014			

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Quarter 1 update on Corporate Quality Objectives**

Report to: **Council of Governors**

Author: **Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**

Date: **17th July 2014**

Introduction

In May 2014, the Board approved the Trust's Quality Report for 2013/14, which included a number of specific quality objectives for 2014/15. This year, following public consultation, the Trust has a much smaller number of objectives which are focused largely on improving the 'flow' of patients through our hospitals. The Quality Report states that the Trust will achieve these objectives through implementation of the following executive-led Transformation projects:

- Creation of integrated discharge services, co-locating organisations responsible for managing patients with complex care needs
- Commissioning of out of hospital transitional care beds
- Earlier supported discharge pathways; a Trust-wide review of critical care services
- Implementation of an operational model which enables elective and urgent tertiary activity to continue during periods of high demand for acute medical care through the emergency department.

An additional objective is to review and refresh the Trust's approach to patient and public involvement and engagement.

These same objectives also form part of the Trust's Annual Plan and Board Assurance Framework.

Quarter 1 performance

The Trust's quality objectives for 2014/15 are summarised below with two RAG ratings: one indicating progress to date; the other indicating a predicted RAG rating for the annual Quality Report (Account).

We said we would:	Progress to date	Predicted RAG rating in Quality Account
1. Reduce numbers of cancelled operations	Green	Green
2. Minimise patient moves between wards, including out of hours	Baseline to be established	Green
3. Ensure patients are treated on the right ward for their clinical condition	Green	Green

4. Ensure no patients are discharged from our hospitals out of hours	Baseline to be established	Green
5. Review and refresh the Trust's approach to patient and public partnership	Green	Green

This report which follows describes progress made towards achieving these objectives in more detail.

Quality objectives

1. Reducing numbers of cancelled operations

Cancelled operations have a major impact on the service provided for patients causing distress and inconvenience; they are also a cause of inefficiency as they waste time and resources. In order to address this issue, a protected bed/pathway model is being developed which aims to ensure we have identified theatre, ITU/HDU and ward resources in line with our planned care schedule. These plans will come on line in Quarter 2 to further support progress to date.

Our Quarter 1 target was for no more than 1.03% of operations to be cancelled at the last minute for non-clinical reasons: we achieved 1.02%.

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Percentage of operations cancelled at last minute for non-clinical reasons	1.02%	0.92%	10% reduction - applied to seasonal variation	Target 1.03%	Target 0.82%	Target 0.81%	Target 1.00%
			Performance to date	1.02%			

2. Minimising patient moves between wards, including out of hours

Risks of healthcare associated infection are greatly increased by the extensive movement of patients. We also know from patient feedback that moves between wards for non-clinical reasons impact adversely on their experience of care. Our aim in 2014/15 is to reduce unnecessary ward moves by 15%*. Baseline data has been established in Quarter 1. An improvement plan will now be developed and implemented by the Trust's clinical site team working across the clinical Divisions.

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Average number of ward moves per patient	2.26	Varying by quarter	Target reduction increasing to 15%* in Quarter 4, applied to seasonal variation	Baseline 2.32	Target 2.20	Target 2.09	Target 1.97

* 15% target to be validated following development of improvement plan

3. Ensuring patients are treated on the right ward for their clinical condition

There is emerging evidence of a correlation between increased mortality and the practice of 'outlying' patients[1]. Our aim is to reduce the number of days patients spend as ward outliers (except for reasons of infection control) in order to improve patient experience and outcomes of care. Baseline data has been established in Quarter 1. An improvement plan will now be developed and implemented by the Trust's clinical site team working across the clinical Divisions.

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Number of outlier bed-days	10622	9029	Overall 15%** reduction – applied to seasonal variation with increasing improvements across the quarters	Target 2444	Target 1688	Target 2114	Target 2783
			Performance to date	2419			

Our Quarter 1 target was a total number of outlier bed-days of no more 2444: we achieved 2419.

** 15% target to be validated following development of improvement plan

4. Ensuring no patients are discharged from our hospitals out of hours

Our aim is to ensure that no patients are discharged out of hours, as defined in our hospital discharge policy.

A briefing relating to this objective has been presented to the Service Delivery Group and an improvement plan will be developed in Quarter 2 once baseline data has been confirmed.

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Number of discharges out of hours	To be determined with appropriate ward exclusions (e.g. observation wards, assessment wards, maternity)		Target reduction, over the baseline over remaining three quarters, increasing to 25%*** in Quarter 4.	Baseline estimated at 5.85% with exclusions applied (to be confirmed)	To be confirmed	To be confirmed	To be confirmed

***25% target to be validated following development of improvement plan

[1] NHS Institute for Innovation and Improvement

5. Reviewing and refreshing the Trust's approach to patient and public partnership

The Trust has a strong record of patient and public involvement, but we recognise that this involvement is not always systematic and mainstreamed within the organisation. In 2014/15, we have committed to undertake at least two significant pieces of work, one of which will focus on the experience of a 'seldom heard' patient group, and use these as a basis for developing a new model of engagement for wider implementation.

In Quarter 1, a four step approach to achieving this objective has been agreed. This entails:

- **Defining scope:**
  The scope of the work has been defined to include how we work with people in specific service developments, Trust-wide initiatives and strategic development with an eye to an emerging system wide approach across the BNSSG health community. Our focus will be on:

  a) understanding what we already do in this field
  b) developing a systematic approach to working with patients, our members and the wider public
  c) refreshing and developing the systems, processes and methodologies we use to engage and involve people
  d) developing ways in which we can demonstrate that the information, intelligence and ideas we gather are used to inform our decisions making

- **Development:**
  During Quarters 2 and 3 and **i**n consultation with our partners, we will develop and agree a preferred option for our new approach to working with patients, our members and the wider public. This will include our approach to patient and public involvement both at a strategic and service delivery level. Informal expressions of interest have been received from Healthwatch and the Patients Association in contributing to this work. In addition, a current review of the work of INVOLVE (a national advisory group that supports greater public involvement in NHS, public health and social care research) and the growing patient and public involvement partnership hosted by the West of England Academic Health Research Network offer insights into current thinking on this issue.

- **Practice learning:**
  As part of our commitment to deliver the patient and public involvement aspects of our Patient Experience & Involvement action plan for 2014/15, we will develop and deliver PPI activities relating to patients with, for example, learning disabilities, specifically to inform the methodologies we use to engage people in our work. Preparations are in place to work with adolescent grown up congenital heart patients with learning disabilities to inform new approaches to involving patients and their carers in our work.

- **Implement:**
  During Quarter 4 we will publish our new approach to working with patients, our members and the wider public establishing the mechanisms by which this will be implemented starting in Quarter 1, 2015/16.

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Council of Governors Meeting to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 7 – Governors' Log of Communications
Purpose
The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications added or modified since the previous Council of Governors meeting.
Abstract
The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governor Log – Items since the previous meeting.

ID Governor Name

95 Mo Schiller **Title: Ward staffing levels**

Query 11/07/2014

The recent information regarding staffing levels on wards needs greater clarification as it is not clear how this can be interpreted. The public need to have assurance that all wards have the correct compliment of trained/untrained staff.

Response 22/07/2014

Assigned to Executive Lead 22 July 2014.

94 Wendy Gregory **Title: Self-medication - supplementary question to Item ID88**

Query 21/05/2014

I have just one supplementary if possible and that is:-
To conclude , what proportion of the total bed stock have the facility to self medicate trust-wide by the end of May and are we happy that 90 minutes delay to administer patients own medication on the ward, if one adds the potential delay of an A&E stay, is satisfactory? I still have an element of concern for those patients who have the capacity to self-administer and may well suffer severe breakthrough of pain during that 90 minute window.

Response 13/06/2014

Response from Deputy Chief Executive & Director of Strategic Development:

1.Self administration of medicines
'what proportion of the total bed stock have the facility to self medicate trust-wide?'

It is of important note that a proportion of the hospital beds would be very unlikely to adopt self-administration of medicines as a process; such areas include the intensive care unit, high dependency unit, cardiac intensive care and HDU beds, coronary care unit and the majority of wards in the Bristol Childrens' Hospital. Secondly there are some wards that have a small number of 'self-administration' lockers and they can place these at the bedside for the selected patients for whom medicines self-administration would be helpful. For example, the 60 beds at South Bristol Community Hospital have a small number of lockers that are available to be used in this way.

It is calculated that 375 beds have self-administration lockers. Bearing in mind the second point above, the facility is therefore available for more than 375 patients, but it is difficult to calculate the proportion of the total relevant bed stock but it is the vast majority of beds where it is appropriate to have such arrangements.

The key focus currently is to enable better uptake through supporting nursing staff with the process, therefore making best use of the available cabinets. A number of short training sessions are being scheduled in July, run jointly by Pharmacy and Nursing staff who are regularly involved in the self-administration process.

2.Delays in administration of medicines
'are we happy that 90 minutes delay to administer patients own medication on the ward, if one adds the potential delay of an A&E stay, is satisfactory?'

This is an important point and reflects the recommendation concerning medicines that is raised in the Francis report:
242 Medicines administration
In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.

The 90 minute 'window' is not the expected delay but an estimation of the realistic time for nursing staff to safely administer medicines to patients on their wards. Clearly medicines should be administered in a timely fashion, and it would be unacceptable for patients to wait for analgesia when in pain. Patients in pain on A&E would receive analgesia. I do not envisage such delays in practice, and am aware that nursing staff rightly prioritise the administration of analgesia and complaints about lack of appropriate analgesia is not a theme.

93 Mani Chauhan **Title: Feasibility study for potential new car park**

Query 14/05/2014

There was mention of a potential new car park. I appreciate this is sensitive however is there a report or feasibility study on the proposal we can look at?

Will any future car park charges be capped and will they be set by a private operator?

Response 21/05/2014

Response from Deputy Chief Executive & Director of Strategic Development:
The Trust Board will receive the Estates Strategy at its June Board which will confirm the intention to provide enhanced car parking provision on the campus. This strategy will seek Board support for an Outline Business Case to be developed by the end of September 2014 when further detail on the car park provision will be available.

Work to confirm the model of operation and charges has yet to be undertaken.

92 Clive Hamilton **Title: Guidance on nurse staffing levels**

Query 17/05/2014

Directors will be aware the The National Institute for Health and Care Excellence have recently issued guidance on nurse staffing levels. The recommended minimum level recommended is 1 nurse for every 8 patients. Are the Non-Executive Directors assured that this minimum level is met throughout the Trust and that nurse staffing is at a safe level in intensive care environments such as High Dependency? Do Non-Executive directors subscribe to the recommendation that the level of safe nursing cover in each ward should be displayed for visiting public and patient reference?

Response 13/06/2014

Response from Chief Nurse: I can confirm that the Trust has done a risk assessment against delivery of the 10 expectations of the NQB which was presented in the public board in May, which includes displaying staffing information outside all inpatient areas by end of June 2014. The Trust is signed up to some principles for setting staffing levels in adult and children's services for day and night shifts these are within the recommended minimum level of 1 nurse per 8 patients.

91 Clive Hamilton **Title: Targets for 18-week wait time for non-admitted patients - Opthalmology and Paediatric Cardiology**

Query 07/05/2014

The action plans outlined in the Extraordinary board meeting on the 14th April contain an undertaking to bring the 18 week wait time for non-admitted patients back to 95% target by October 2014. There were 2 notable outliers - Ophthalmology and Paediatric Cardiology carried over to target achievement as late as January 2015. Have the Non-Executive Directors received assurance that this is the earliest date possible and if so, why is this?

Response 20/06/2014

Response from Chief Operating Officer: The plans detailed in the Board pack describe the improvement plan to reduce the waiting time for first outpatient appointments. This will support both the delivery of the non-admitted and admitted performance by shortening the time patients wait on the first part of their pathways. This then allows more time along the 18 weeks pathway for diagnostics, further follow ups and admission, if required.

In the case of Ophthalmology, this is a high volume specialty and there are capacity constraints both in terms of physical location and resources to increase capacity. There are also some specific capacity constraints at sub-specialty level. Recruitment in underway to increase resources to support reductions in waiting times but this will take until the end of the calendar year to deliver the improvements.

For Paediatric Cardiology, the reduction in waiting times for first outpatient appointment is reliant on the recruitment of two additional consultants. This will increase capacity in the service to match demand. It is expected that these two posts will be recruited to by October 2014. Once these posts are in place, it will take time for the increased capacity to result in the required improvements in waiting times for the service.

All plans have been critically reviewed to ensure they are challenging yet robust. Delivery against the plans is monitored weekly and divisions continue to look for opportunities to accelerate the recovery plans where possible.

The plans for delivery of improved waiting times in Ophthalmology and Paediatric Cardiology do not present a risk to the improvement in overall Trust's performance, as assessed by Monitor.

90 Clive Hamilton **Title: Progress of programme to rationalise and standardise in-house documentation**

Query 07/05/2014

When Alison Moon was Chief Nurse, there was a proposed programme to rationalise and standardise in house documentation to reduce confusion and the burden of document entry. Has this programme been completed and do the Non-Executive Directors have assurance that all administrative entry systems are standardised and necessary?

Response 16/05/2014

Response from Chief Nurse: Some of this work has progressed – the programme is yet to be completed.

Actions taken to date: Development and implementation of an e-handover document. Nursing Admission documentation has been reviewed/developed and is being implemented. A Care Log has been developed and is in Trust-wide use which evidences interventions for patients at specific risk of falling, developing pressure ulcers, having poor nutritional intake or of infection. A risk assessment booklet has been developed for assessing all patients on admission and is in use.

89 Clive Hamilton **Title: Paediatric Intravenous Phlebitis Assessment controls**

Query 22/05/2014

Controls for Paediatric Intravenous Phlebitis Assessment include information which is supposed to accompany a patient with an imbedded cannula on ward transfer. Is there assurance that this is being done consistently. Has this process been audited and if so, what information is available about the effectiveness of controls.

Response 08/05/2014

Assigned to Executive Lead

88 Wendy Gregory **Title: Self-medication**

Query 25/04/2014

[These are supplementary questions following Wendy Gregory's query about self-medication at the January Council of Governors meeting and the response from Stephen Brown, Head of Pharmacy, on 22/04/14.]

Thank you for this response. I am encouraged by the following points.
a) that self-medication, where appropriate is to be encouraged- How widespread is this practice at this stage -a question to note?
b) that patients' own medication can stay with them locked away for medical staffs administration if appropriate
c) there should not be a substantial time delay for new medication to be administered.
I would like to ask how one would define "substantial" as with certain drugs such as Amatrypcyline, Baclofen, Tramadol etc a delay can cause breakthrough of pain which is very difficult to get on top of and can cause a set-back to patients recovery and well being.

Response 16/05/2014

Response from Deputy Chief Executive & Director of Strategic Development:
Self-medication:

We recognised in 2012 that the self-medication (or self-administration) process was not being suitably utilised as the Trust's stock of bedside medicines cabinets in many areas had deteriorated and so could not be used for this purpose. Pharmacy therefore led an operational capital proposal for 2013/14 to replace many of the bedside lockers in order to provide suitable cabinets that are fit for purpose, for safe storage of, and appropriate access to, patients medicines. Initially there were suitable cabinets available in some areas such as the Bristol Heart Institute, and so the other ward areas were prioritised and installation of the new cabinets has been progressed in three batches. The first two batches are installed, with good feedback from nursing staff and patients, and the third batch is being installed before the end of May. The wards were prioritised depending on the condition of their current storage for patients' own medicines. In phase 1 cabinets were provided to wards 10, 2, 61, and 15; phase 2 covered wards 5B, 6, 7, 9 and 11; phase 3 will cover wards 78, 11 and 4. Small numbers cabinets have also been provided to wards 100, 200 and 35. There has therefore been an important focus on enabling patient self-administration of medicines through provision of suitably designed hospital bedside medicines cabinets.
Some areas of the Trust that have suitable bedside medicines cabinets are routinely enabling patient self-administration of medicines, such as adult haematology on ward 62 and for Cystic Fibrosis patients on ward 54. All of the wards with new cabinets (detailed above) are using the process for some patients, but it has been recognised that this is still limited. Refresher sessions are therefore currently being scheduled in the coming weeks (being led by Pharmacy and the nursing staff who regularly enable self-administration) to ensure nursing staff are confident when applying the Trust policy and procedures. These sessions are focussing on the self-administration process and the nursing staff assessment of the capacity of patients to safely administer their own medicines.

Time delays:

We have a target that all medicines should be administered within 90 minutes of the specified prescribed time, apart from medicines for Parkinsons disease which should be administered at the actual time specified on the prescription.

87 Mani Chauhan **Title: Cancer treatment targets**

Query 15/04/2014

These questions refer to the matters discussed at the Extraordinary Board Meeting on Monday 14 April 2014.

Question 1: With regards to Cancer 62-day GP analysis. The opening statement reads "85% of patients referred by their GP with a suspected cancer to be treated within 62 days."
Where does this 62 day period come from - is it an overall NHS strategy?

Question 2: How do you define treated - actual treatment or do you mean "an appointment"?

Question 3: If it is actual treatment - how long does it take on average for a patient to be seen for an initial appointment to the hospital after that first GP referral where cancer is suspected? I'm concerned with how many sleepless nights a patient has to suffer before they know they have cancer or not.

Response 08/05/2014

Response from Chief Operating Officer:
Question 1: The 62 day target is nationally defined, and all NHS providers are expected to meet the target. The target (along with the other cancer waiting times targets) is laid out in the NHS Operating Framework and its importance is reinforced in the Department of Health policy 'Improving Outcomes: A Strategy for Cancer'

Question 2: The 62 day standard measures time from referral to start of treatment, not simply an appointment. There is extensive guidance from the Department of Health on how to apply the Cancer Waiting Times standards, including how to define a treatment. Usually a treatment is the start of an active treatment (surgery, chemotherapy or radiotherapy most commonly) or of palliative care/active monitoring if that is the only course of management being pursued.

Question 3: There is a separate standard for first appointments: a maximum of two weeks to first appointment after a suspected cancer 'fast track' referral from a GP is received. The national target is for this to be met for 93% patients. We consistently achieve this standard at UH Bristol and any 'breaches' are usually due to patients electing to wait longer than the two week period (which we cannot adjust for). In quarter 4 2013/14 the average (mean) waiting time from referral to first appointment for GP fast track referrals was 9.8 calendar days. We are currently working towards reducing the waiting time for first appointment down to one week (7 calendar days) for appropriate specialities, to further reduce the time for diagnosis and treatment, as well as improve patient experience. There will be some areas where this isn't appropriate, for example where patients attend 'one-stop' clinics that enable multiple tests on the same day, which is more convenient for the patient and usually results in a faster overall time to diagnosis.

86 Ken Booth **Title: On-street drop-off parking for volunteer drivers**

Query 14/04/2014

Response from Chief Operating Officer:
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 13/05/2014

It is agreed by everyone that the dropping off provision for our city centre hospitals is less than ideal. The hospital sites are very constrained as they are largely covered with buildings, so we sought to discuss with Bristol City Council how the parking spaces on the public highway in and around the precinct could be better used. In addition, representatives of the various volunteer driver organisations sought to have these spaces identified for their exclusive use.

Discussions have taken place with the city council department responsible for the highway and who operate the statutory controls over parking across the city. This included site visits with their manager to look at each of the locations in Lower and Upper Maudlin Street as well as Horfield Road. Among other things we discussed the desirability of reducing the maximum period of stay, to increase turnover and in effect permit more people to make short duration stops outside the hospitals.

The outcome of the discussion and site visits was then considered internally within the Transport Department and fed back to the Trust at a meeting with their manager.

What was then advised to us was that the Council would not be minded to make changes to these areas at this time as they fell into the current city centre CPZ area. The process for making a change is formal and protracted, as we understood it, and would require a consultation process and at this time the council did not wish to pursue that course of action as the previous consultation was lengthy and contentious.

They did not reject the idea of our request when the area comes up for routine review which might be in a couple of years' time.

Bearing in mind that these car parking spaces are on public highway, and are therefore theoretically available for any tax or rate payer, we got the impression that reserving them for purely one interest group i.e. for volunteer drivers, was unlikely to obtain council support. However that view was not formally confirmed as such.

The Executive team will consider how best to re-open these issues with the Council and how to win the support of the Mayor.

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 16/05/2014

Response by Head of Human Resources:
UH Bristol does not provide any direct financial support to fund staff for 3 years to undertake their training.

The training programme at the University of the West of England (UWE) provides all pre-registered nursing places that Health Education South West pay tuition fees for, students depending on their personal circumstances can apply for bursaries but this is unlikely to be able to support them in replacing a salary. Student hardship funds are available from UWE however this is not much and is for a short term crisis and would no way cover salary costs.

Students are able to work on the bank as Health Care Assistants during their training to support them financially, however at present there is no funding available to cover salary costs either from UH Bristol or other bodies.

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 19/06/2014

Response from Chief Operating Officer:
The Access Policy and Outpatient Standards currently set out timeframes for sending letters when booking appointments:

'All patients will be sent a confirmation letter for any agreed appointment or admission date, unless the appointment is within 3 working days and any such letter cannot be guaranteed to arrive ahead of the appointment date.'

No equivalent guidance exists for when appointments are cancelled so the Outpatient Standards & the Access Policy will be updated to reflect this omission.

ID	Governor Name		
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 **19/06/2014**

Response from Chief Operating Officer:
The Trust is still in the process of centralising appointment booking – mainly to the Appointment Centre with separate smaller booking centres for the Eye and Dental Hospitals currently. This problem should not happen once appointment booking is through the three appointment centres as patients are placed in a queue if no-one is available to take their call, rather than going to voicemail. Where booking calls take place outside of these centres, patients may end up leaving voicemail messages.

A recent review of the Outpatient Standards across the Trust also identified the issue of slow responses to voicemail messages. The standards are in the process of being revised and reissued with updated guidance to all booking teams. The Transformation Team is also offering additional training to Divisions on these standards. However, the existing standard is a response within one working day and this will be re-emphasised.

University Hospitals Bristol NHS
NHS Foundation Trust

Nominations and Appointments Committee Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 9 - Nominations and Appointments Committee Report

Purpose

The purpose of this report is to provide the Council of Governors with an update on the activities of the Governors' Nominations and Appointments Committee.

Abstract

The Nominations and Appointments Committee is a formal Committee of the Council of Governors established for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Recommendations

The Council of Governors is asked to **note** the report and **approve** the recommendation to appoint Emma Woollett as Senior Independent Director for one year.

Report Sponsor or Other Author

Sponsor: Trust Secretary

The Nominations and Appointments Committee has held **one** meeting since the last Council of Governors meeting.

Nominations and Appointments Committee: 27 June 2014

Governors present: Sue Silvey, Mo Schiller, Anne Skinner, John Steeds, Phil Mackie, Florene Jordan, and Jeanette Jones.

Others present or in attendance: John Savage – Chairman and Sarah Murch – PA/Administrator.

Topics discussed:

Senior Independent Director Appointment:

- Governors were asked to consider appointment of a new Senior Independent Director, following the departure of Iain Fairbairn from the Trust on 31 May at the end of his term of office as Non-executive Director.
- After some consideration, Governors agreed with the Chairman's recommendation that Emma Woollett (the current Vice-Chair), was the best candidate for the role at this time.
- The Chairman assured governors that there were precedents of the same person taking on the dual role of Vice-Chair and Senior Independent Director in other Trusts. Governors however asked that the appointment be re-considered in one year's time.
- It was agreed therefore to recommend to the Trust Board of Directors and Council of Governors the appointment of Emma Woollett as Senior Independent Director for one year.

Page *2* of *2* of a Nominations and Appointments Committee Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Board Sub-Committees:

Governors noted an update on the Non-executive Director membership of the Board Sub-Committees as follows:

- **Finance Committee** – Lisa Gardner (Chair), David Armstrong, Jill Youds, and John Savage.
- **Audit Committee** – John Moore (Chair), Emma Woollett, Alison Ryan and Lisa Gardner.
- **Quality and Outcomes Committee** – Alison Ryan (Chair), Julian Dennis, Jill Youds and David Armstrong.
- Non-executive Director representative on the **Clinical Ethics Committee**: Julian Dennis.

Governors noted that following Iain Fairbairn's departure, Julian Dennis would now become a Non-executive Director, instead of a Non-executive Observer.

Non-executive Director Activity Reports

The Committee noted the activity reports of Non-executive Directors and Non-executive Observers from December 2013-May 2014.

The next meeting of the Nominations and Appointments Committee will take place on Friday 19 December 2014 at 13:30-14:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

A Governor Development Seminar Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Governor Development Seminar Report

Purpose

To provide the Council of Governors with an update on the governor development programme.

Abstract

The governor development programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively. The programme was co-created with governors using self-assessment and short-life task and finish groups.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

There has been **one** Governor Development Seminar since the last Council of Governors meeting.

This Seminar was an Induction Seminar, and as such was open only to newly-elected and newly-appointed governors, and to governors who had been elected or appointed last year but had been unable to attend the June 2013 Governor Development Seminar.

Governor Induction Seminar (Module 1): 11 June 2014

Governors attending: Sue Silvey (Lead Governor), Brenda Rowe, Bob Bennett, Graham Briscoe, Angelo Micciche, Nick Marsh, Karen Stevens, Thomas Davies, Marc Griffiths.

Others present or in attendance: John Savage – Chairman, Ray Tarling – Adviser from DAC Beachcroft LLP, Julie Dawes – Interim Trust Secretary, Debbie Marks – Membership Administrator, Sarah Murch – Membership PA/Administrator.

Topics discussed:

NHS Overview: Ray Tarling, Adviser from DAC Beachcroft LLP, gave a presentation on the duties of directors and governors with particular reference to the structure of the NHS, the challenges of finance and quality, and to explain what NHS Foundation Trusts are and why they are important.

Julie Dawes, Interim Trust Secretary, gave a presentation covering:

- **Governance Structure of Foundation Trusts**: the role of the Trust Board, Council of Governors, Non-executive Directors and Members.

Page 2 of 2 of a Governor Development Seminar Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

- **Governor Role and Responsibilities**: the duties of the Council of Governors, and the role and responsibilities of governors.
- **Role of the Regulators:** the role of Monitor and the Care Quality Commission.
- **Meeting Structure:** governor meetings at UH Bristol and available support

Sue Silvey, Angelo Micciche and Marc Griffiths talked about their experiences as governors, and new governors took part in group discussion. Chairman John Savage hosted a question and answer session to close the seminar.

Future Seminars:

- The next Governor Development Seminar (including Module 2 of the Governor Induction Seminar) will be held on 13 August 2014 from 10:00-16:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.
- It is intended that the Governor Development programme will be a standing item on the Constitution Project Focus Group programme so that governors can continue to give their input into developing a comprehensive induction, training and development programme for consideration and approval by the Council of Governors.

University Hospitals Bristol NHS
NHS Foundation Trust

Annual Plan Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11a - Annual Plan Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Annual Plan Project Focus Group.

Abstract

The Annual Plan Project Focus Group provides an opportunity for engagement with governors to develop the Monitor Annual Plan and to contribute to the Trust's strategic objectives.

Aidan Fowler has just taken over from Deborah Lee as the Executive Lead for the Annual Plan Project Focus Group, and it is chaired by David Relph. The Lead Governor for the group was Anne Ford until 31 May 2014 and is now Wendy Gregory. There are usually 6 meetings a year, and they are open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for Annual Plan Project Focus Group

The Annual Plan Project Focus Group has held **two** meetings since the last Council of Governors meeting.

Annual Plan Project Focus Group: 8 May 2014

Governors attending: Anne Ford *(Lead Governor for the Focus Group)*, Sue Silvey, Mo Schiller, Pam Yabsley, Peter Holt, John Steeds, Anne Skinner, Wendy Gregory, Clive Hamilton, Pauline Beddoes and Joan Bayliss.

Others present or in attendance: David Relph – Head of Strategy and Business Planning *(Focus Group Chair)*, and Debbie Marks – Membership Administrator.

Topics discussed:

- **Update on the submission of the Trust Operating Plan for Monitor:** David Relph reported to governors that the 2-year operating plan had been completed and was submitted to Monitor on 4 April, and the 5-year plan would be submitted at the end of June.
- **Brief on the work plan to produce the Trust Strategic Plan for Monitor**: The work plan included engagement across the local health economy, a focus on the sustainability of services and the key strategic initiatives in the next 5 years.
- **Discussion of the Draft Trust Strategy**: Governors discussed ideas for publicising the Trust Strategy, and noted that a public event, organised by Tony Watkin, was being held on Thursday 5 June to give Foundation Trust members and members of the public an opportunity to comment on the Trust Strategy.

Page *2* of *2* of an Annual Plan Project Focus Group Meeting Account for a Council of Governors Meeting to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Annual Plan Project Focus Group: 19 June 2014

Governors attending: Sue Silvey, John Steeds, Wendy Gregory, Bob Bennett, Nick Marsh, Thomas Davies, Marc Griffiths, Angelo Micciche and Brenda Rowe.

Others present or in attendance: David Relph – Head of Strategy and Business Planning *(Focus Group Chair)*, Anne Ford – former governor and formerly Lead Governor for the Annual Plan Project Focus Group, and Debbie Marks – Membership Administrator.

Topics discussed:

- **Discussion of the Draft Trust Monitor Strategic Plan**: This included a discussion on the Workforce strategy which would be presented to the Trust Board of Directors in July. Also, David Relph presented a paper to governors on 'The Monitor Strategic Plan – The Sustainability of our Services and our Key Strategic Initiatives'. The paper focused on two key sections of the Plan – a declaration of sustainability and a summary of the Trust's key strategic initiatives.

An easy-read version of the Strategic Plan will be produced in due course.

Lead Governor for the Group: Following Anne Ford's end of term of office on 31 May, Wendy Gregory, Patient Governor, will now be Lead Governor for the Annual Plan Project Focus Group.

The next meeting of the Annual Plan Project Focus Group will be on **Wed 8 October 2014 from 14:00-16:00** in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Quality Project Focus Group Meeting Account for a Council of Governors Meeting, to be held at 14:00 on 30 July 2014 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11b - Quality Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Quality Project Focus Group.

Abstract

The objectives of the Quality Project Focus Group are to provide:

a) engagement with governors to develop the Board's Annual Quality Report;
b) regular support to enable governors to understand and interpret the Board Quality and Performance Report;
c) regular support to enable governors to understand and interpret reported progress on the Board's Quality Objectives; and,
d) opportunities for input from governors on quality matters.

The group is jointly chaired by Sean O'Kelly and Carolyn Mills (previously Deborah Lee), and its Lead Governor is Clive Hamilton. Meetings are held bi-monthly and open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for the Quality Project Focus Group

The Quality Project Focus Group has held **two** meetings since the last Council of Governors meeting.

Quality Project Focus Group Meeting: 6 May 2014

Governors attending: Clive Hamilton (Lead governor for the group), John Steeds, Mo Schiller, Lorna Watson, Pam Yabsley, Peter Holt, Anne Skinner, Wendy Gregory, Marc Griffiths, Florene Jordan, Jeanette Jones and Sue Milestone.

Others present or in attendance: Deborah Lee – Director of Strategic Development *(Focus Group Chair)*, Sean O'Kelly – Medical Director, Carolyn Mills – Chief Nurse, Chris Swonnell – Head of Quality (Patient Experience and Clinical Effectiveness), Anne Reader – Head of Quality (Patient Safety), Stuart Metcalfe – Clinical Audit and Effectiveness Manager, Dr Anne Frampton – A&E Consultant, Cat McElvaney – Outpatients Improvement Lead, Debbie Marks – Membership Administrator.

Topics discussed:

- **Staff morale at Bristol Royal Hospital for Children:** The group discussed a paper on this issue from Jill Foster (Interim Deputy Chief Nurse).
- **Clinical Audit:** Stuart Metcalfe and Dr Anne Frampton gave governors a presentation explaining Clinical Audit at UH Bristol.
- **Trust Board Quality and Performance Report:** Governors discussed the Trust Board

Quality and Performance Report, and Clive Hamilton talked the group through his paper titled 'Summary of Performance to date – 06 05 2014 Quality Project Focus Group – Quality & Access Standards from the Board Report Dated 28-04-2014'.

- **Histopathology update**: Sean O'Kelly updated the group on the Mischon paper and recruitment update.
- **Draft Quality Report 2013/14:** The draft report was circulated to governors. Of 16 quality objectives from 2013/14, 11 had been achieved, four partially achieved and one was not achieved. Chris Swonnell asked for feedback and informed governors that the report would be approved by the Trust Board at the end of May.
- **Outpatient Productivity** Cat McElvaney presented 'Productive Outpatients Update' to the group. The main purpose of this programme was to improve patient experience, improve productivity/efficiency of clinics and to transform how we deliver services.

Quality Project Focus Group Meeting: 11 July 2014

Governors attending: Clive Hamilton *(Governor Lead for this group)*, Sue Silvey, John Steeds, Mo Schiller, Lorna Watson, Pam Yabsley, Anne Skinner, Wendy Gregory, Florene Jordan, Jeanette Jones, Pauline Beddoes, Bob Bennett, Angelo Micciche and Karen Stevens.

Others present or in attendance: Sean O'Kelly – Medical Director *(Chair)*, Carolyn Mills – Chief Nurse, Anne Reader – Head of Quality (Patient Safety), Aidan Fowler – Fast Track Executive Director), Debbie Marks – Membership Administrator.

Topics discussed:

- **Quality Strategy 2014-2017:** The Quality Strategy was circulated to Governors. Carolyn Mills introduced it and answered governors' questions.
- **Trust Board Quality and Performance Report:** Governors discussed the Trust Board Quality and Performance Report, and also Clive Hamilton's governor review of the Trust's performance**.**
- **Patient Safety Strategy:** The group discussed a paper presented by Anne Reader, on the Patient Safety Strategy: a programme which aims to achieve a reduction in mortality by 15% over 5 years and adverse events by 30% over 5 years.
- **Patient Experience and Complaints report:** Governors were provided with the quarterly Patient Experience report and the quarterly Complaints report for information.
- **Draft Quality Focus Group programme for 2014-2015:** Governors discussed agenda items for future meetings.
- Governors also received an update on the Histopathology action plan and discussed the Governors' Log of Communications.

The next meeting of the Quality Project Focus Group will be held on Wed 3 September 2014, 15:00 – 17:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**.**

University Hospitals Bristol NHS
NHS Foundation Trust

Constitution Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11c – Constitution Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Constitution Project Focus Group.

Abstract

The objectives of the Constitution Project Focus Group are to provide:

(i) engagement with governors in drafting Constitutional changes;

(ii) assessing the membership profile; and,

(iii) advice from governors on communications and engagement activities for Foundation Trust members.

The group meets quarterly and is open to all governors. The Chair of the Group is Julie Dawes, Interim Trust Secretary, and the Lead Governor for the Group is Sue Silvey.

Recommendations

The Council of Governors is asked to **note** the update.

Report Sponsor or Other Author

Sponsor: Trust Secretary/Lead Governor for the Constitution Project Focus Group

The Constitution Project Focus Group has held **one** meeting since the last Council of Governors meeting.

Constitution Project Focus Group Meeting: 4 June 2014

Governors attending: Sue Silvey *(Focus Group Governor Lead)*, Clive Hamilton, Mo Schiller, Anne Skinner, Wendy Gregory, Florene Jordan, Ben Trumper, Angelo Micciche, John Steeds, Tony Rance and Jeanette Jones.

Others present or in attendance: Julie Dawes – Interim Trust Secretary *(Focus Group Chair)*, Debbie Marks – Membership Administrator, Sarah Murch – Membership Administrator.

Topics discussed:

- Changes to the Constitution – Governors discussed the proposed changes to the Foundation Trust Constitution.
- Meeting attendance – There was a discussion about governor attendance at meetings.

Future activity: This focus group will henceforth include in its work programme:

Page *2* of *2* of a Constitution Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

- the Trust's membership strategy
- Governor induction, training and development
- Monitor Code of Governance compliance
- Annual Effectiveness Reviews
- The process for future Constitutional Reviews.

The next meeting of the Constitution Project Focus Group will be held on Thursday 11 September 2014 from 10:00-12:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

A Staff Governors meeting report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11d – Staff Governors meeting report

Purpose

To provide the Council of Governors with an update on a recent Staff Governors' Meeting.

Abstract

This is the first of monthly meetings requested by staff governors to help them to shape their strategy for the coming year.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary / Florene Jordan on behalf of staff governors

Report

There has been **one** Staff Governors' meeting since the last Council of Governors meeting.

Staff Governors Meeting: Tuesday 8 July 2014 at 1pm-2pm

Attending: Florene Jordan (Staff Governor – Nursing & Midwifery), Karen Stevens (Staff Governor – Non-Clinical), Nick Marsh (Staff Governor – Non-Clinical), Ben Trumper (Staff Governor – Nursing & Midwifery), Julie Dawes (Interim Trust Secretary), and Sue Silvey (Lead Governor)

Apologies: Thomas Davies (Staff Governor – Clinical) and Ian Davies (Staff Governor – Medical & Dental).

Action Points from meeting:

- Better internal engagement with staff is needed.
- Staff governors should add value.
- What is the role of staff governors – think about and publicise.
- Voices magazine – next issue will include article about what staff governors can offer and contact details.
- Updated Poster of governors' photos and details to be displayed in departments and wards.
- 'Awareness' campaign – could include drop-in sessions
- Governors' communication with stakeholders / engagement strategy – all governors including staff.
- Monthly staff governor meetings will be arranged, to include Trust Secretary and Lead Governor.

University Hospitals Bristol NHS
NHS Foundation Trust

An Annual Members' Meeting Working Group meeting report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11e – Annual Members' Meeting Working Group report

Purpose

To provide the Council of Governors with an update on a recent meeting of the Annual Members' Meeting Working Group.

Abstract

Aim of the group – to produce a proposal on how to showcase the work UH Bristol Trust has achieved in the past 12 months.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsors: Trust Secretary and Lead Governor

Report

There has been **one** Annual Members' Meeting Working Group meeting since the last Council of Governors meeting.

Annual Members Meeting Working Group Meeting: Tuesday 22 July 2014 at 10:00-11:00.

Attending: Julie Dawes (Interim Trust Secretary), Sue Silvey (Lead Governor), Graham Briscoe (Public Governor), Mo Schiller (Public Governor), Louise Morley (General Manager for Diagnostics & Therapies), Hannah Allen (Assistant Press Officer), Marcella Pinto (Web Communications Assistant) , Sarah Murch (Membership Administrator) and Debbie Marks (note taker).

Action Points from meeting:

- The Annual Members' Meeting will be jointly led by Chairman and Lead Governor. The group gave their views on the agenda, which will include:
  - Annual Review
  - Patient Safety/Quality
  - Finance Performance Review
  - Independent Audit Report
  - Council of Governors update including Membership, Elections and Constitution.
  - Guest speaker to talk about the new developments around the Trust.
- The group suggested potential topics for display stands (including displays for membership/dementia/infection control/blood pressure/Research & Innovation)
- Ideas for publicity were discussed.

Meetings of this group will be held fortnightly.

University Hospitals Bristol NHS
NHS Foundation Trust

Governor Activity Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11f – Governor Activity Report

Purpose

To provide the Council of Governors with a summary of governor and membership activity since the last Council of Governors meeting on 28 April 2014.

Abstract

Governors fulfil their statutory responsibilities through involvement in various meetings and other activities. The Trust also has a responsibility to consult with governors on key issues and to engage with its Foundation Trust membership. A summary of recent activities is below.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

Date	Event
Feb-June 2014	Governor Election - *involvement of governors and Foundation Trust (FT) members in election events and voting.*
6 May 2014	Quality Project Focus Group meeting
7 May 2014	Nurses Day Celebrations - *governors invited to attend.*
8 May 2014	Annual Plan Project Focus Group meeting
14 May 2014	Patient-Led Assessments of the Care Environment (PLACE Assessments) at the Bristol Heart Institute – *governors involved*
19 May 2014	Chair and Chief Executive Divisional Walk-round – Women's and Children's Division – *Tony Rance and Tony Tanner.*
19 May 2014	Congenital Heart Review of cardiac departments (St Michaels, Children's Hospital and Bristol Heart Institute) – *Sue Silvey and Brenda Rowe accompanying.*
27 May 2014	- Governors' Informal meeting - Chairman's Counsel meeting with Governors and Non-executive Directors.
28 May 2014	Meeting of the Trust Board held in Public
1 June 2014	Newly-elected and appointed governors take up office.
3 June 2014	'Voices' magazine sent to all members. 'Voices' is produced by the Communications team with input from governors, and 3 times a year

Page 2 of 2 of a Governor Activity Summary Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

	is sent to all members.
4 June 2014	Constitution Project Focus Group meeting
4 June 2014	Chair and Chief Executive Divisional Walk-round – Medicine Division – *Sue Milestone and Tony Tanner*
5 June 2014	'Our Hospitals, Our Future' Event *Governors and FT members were invited to this event to inform the future direction of the Trust's Hospitals and its Strategic Plan for the next five years (organised by the Patient and Public Involvement team.)*
11 June 2014	Governor Induction Seminar for new governors
12 June 2014	Foundation Trust Governors Association (FTGA) New Governors Event – London - *Angelo Micciche*
19 June 2014	Annual Plan Project Focus Group meeting
27 June 2014	- Governors' Informal Meeting (including a talk from Ellen Devine, Healthwatch Development Officer, and Pat Foster, General Manager, Care Forum, about Healthwatch's role and function as an organisation) - Chairman's Counsel meeting with Governors and Non-executive Directors.
27 June 2014	Nominations and Appointments meeting
30 June 2014	Meeting of the Trust Board held in Public
1 July 2014	Chair and Chief Executive Divisional Walk-round – Specialised Services – *Karen Stevens and Edmund Brooks*
2 July 2014	Health Matters Event: Heart Talks from Tom Johnson (Consultant Cardiologist) on coronary artery disease, and Steven Gray (Director in Information Management and Technology) and Paul Mapson (Director of Finance and Information) on the use of IT in Patient Care. *Hosted by Governors and attended by 65 FT members and members of the public.*
8 July 2014	Staff Governors meeting
10 July 2014	Interviews for Trust Secretary -*Sue Silvey, Brenda Rowe, John Steeds involved in focus groups.*
11 July 2014	Quality Project Focus Group meeting
22 July 2014	Annual Members' Meeting Working Group meeting - *Mo Schiller, Sue Silvey and Graham Briscoe.*
22 July 2014	South West Governor Exchange Network meeting - Taunton (*several governors attending)*
30 July 2014	Meeting of the Trust Board held in Public
30 July 2014	Council of Governors meeting

University Hospitals Bristol NHS
NHS Foundation Trust

Project Focus Groups Membership Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12 – Project Focus Groups Report – Membership

Purpose

The purpose of this report is to seek clarification from the Council of Governors about membership of Project Focus Groups.

Abstract

There are three Project Focus Groups focussing on key areas of governors' responsibilities. Currently, each group has a Lead Governor and 2 other 'standing members'. All meetings of all project focus groups are, however, open to all governors.

Recommendations

The Council of Governors is asked to **discuss** whether the concept of 'standing members' of these groups requires review.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Group	*Objectives*	*Standing Members*
Annual Plan Project Focus Group	The objective of the Annual Plan Project Focus Group is to provide engagement with governors to develop the Monitor Annual Plan and to contribute to the Trust's strategic objectives.	Wendy Gregory (Lead), Pam Yabsley, and 1 vacancy
Quality Project Focus Group	The objectives of the Quality Project Focus Group are to provide: a) engagement with governors to develop the Board's Annual Quality Report; b) regular support to enable governors to understand and interpret the Board Quality and Performance Report; c) regular support to enable governors to understand and interpret reported progress on the Board's Quality Objectives; and, d) opportunities for input from governors on quality matters.	Clive Hamilton (Lead), Tony Tanner and Anne Skinner
Constitution Project Focus Group	The objectives of the Constitution Project Focus Group are to provide: a) engagement with governors in drafting Constitutional changes; b) assessing the membership profile; and, c) advice from governors on communications and engagement activities for Foundation Trust members.	Sue Silvey (Lead), Wendy Gregory and Ben Trumper

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting, to be held on 30 July 2014 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 13: Annual Review of Governors' Interests

Purpose

The purpose of this report is to present the Governors' Register of Business Interests for the Council of Governors to **note**.

Abstract

The Standing Orders for the Council of Governors, as set out in the University Hospitals Bristol NHS Foundation Trust Constitution, require that:

5.1 Declaration of Interests *– in accordance with paragraph 21 of the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.*

5.2 *A Governor must declare to the Secretary:*

5.2.1 *any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and*

5.2.2 *any interests which are relevant and material to the business of the Trust.*

The Standing Orders also require that a Register is maintained:

5.12 Register of Interests *- the Secretary shall record any declarations of interest made in a Register of Interests kept by him in accordance with paragraph 36 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.*

The attached Register of Governors' Interests reflects the entries provided by Governors at the request of the Trust Secretariat up to Tuesday 22 July 2014.

Members should note that in accordance with best practice, the Register of Interests will be published on the Trust's website in due course. It is therefore the responsibility of governors to keep the Trust Secretary informed of any future changes.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor

Trust Secretary

Appendices

Appendix A: Register of Governors' Interests

Governors' Register of Business Interests

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Abbas	Akram	Governor - Appointed, Youth Council	n/a	None	n/a	18/07/14
Pauline	Beddoes	Governor -Public, South Gloucestershire	n/a	None	n/a	07/07/14
Bob	Bennett	Governor - Public, Bristol		Independent Hospital Manager, The Priory Group	Yes - when attending patient reviews.	24/06/14
Graham	Briscoe	Governor - Public, North Somerset	n/a	None	n/a	04/07/14
Edmund	Brooks	Governor - Patient, Local	n/a	None	n/a	18/07/14
Mani	Chauhan	Governor - Public, Rest of England and Wales	1994-ongoing	- Director/Shareholder East Park Investments (Leics) Ltd. - Director/Shareholder Makan Developments Ltd	No	11/07/14
Glyn	Davies	Governor - Public, Bristol	n/a	None	n/a	05/07/14
Ian	Davies	Governor - Staff, Medical and Dental	n/a	None	n/a	21/07/14
Thomas	Davies	Governor - Staff, Other Clinical Healthcare Professionals	n/a	None	n/a	18/06/14
Wendy	Gregory	Governor - Patients, Carers (patients 16 years and over)	2012/3 - ongoing	Carers Support Centre Bristol and South Gloucestershire	No	08/07/14
Marc	Griffiths	Governor - Appointed, University of the West of England	n/a	None	n/a	11/07/14
Sue	Hall	Governor - Appointed, Avon & Wiltshire Mental Health Trust		- PJH Management Consulting Ltd Raregift Ltd (T/A Alison Miles Couture) - Pound Arts Centre Trust – NED/Treasurer - Pound Café (Community Interest Company) – Board	Yes	11/07/14

Governors' Register of Business Interests

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
				Member/Director - Resources Director - AWP		
Clive	Hamilton	Governor - Public, North Somerset	n/a	None	n/a	05/07/14
Jeanette	Jones	Governor - Partnership, Joint Union Committee	n/a	None	n/a	07/07/14
Florene	Jordan	Governor - Staff, Nursing and Midwifery	n/a	None	n/a	08/07/14
Philip	Mackie	Governor - Patients, Carers (patients under 16 years)	n/a	None	n/a	08/07/14
Nick	Marsh	Governor - Staff, Non-clinical Healthcare Professional	n/a	None	n/a	12/06/14
Lukon	Miah	Governor - Appointed, Youth Council	n/a	None	n/a	15/07/14
Angelo	Micciche	Governor - Patients, Local		Current employee – Manager of North Bristol Trust	Yes	10/07/14
Sue	Milestone	Governor - Patients, Carers (patients 16 years and over)		*No form yet received*		
Bill	Payne	Governor - Appointed, Bristol City Council	May 13-ongoing	- Bristol City Council – Labour Councillor for Frome Vale - Trustee and Board Member for the Haemophilia Society - Chair of the Management Committee of the Bristol Hospital Education Service.		17/07/14
Tim	Peters	Governor - Appointed, University of Bristol	2011-ongoing	Employee of the University of Bristol	Yes	08/07/14
Jim	Petter	Appointed, SW Ambulance Service NHS FT		Director – College of Paramedics - UK Paramedics Professional Body	No	09/07/14
Tony	Rance	Governor - Public, Rest of England and Wales		- The Toastmaster Partnership – Managing Partner	Yes	15/07/14

Governors' Register of Business Interests

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
				- Tony Rance Toastmaster – Sole Trader - Rance Regalia - Proprietor	Yes Yes	
Brenda	Rowe	Governor - Public, Bristol	n/a	None	n/a	09/07/14
Mo	Schiller	Governor - Public, Bristol	n/a	None	n/a	11/07/14
Sue	Silvey	Governor - Public, Bristol	Linkage: 2013 - ongoing RSVP West: 2012 -ongoing	- Linkage - Charity preventing social isolation in older people. Member of the Management Executive Committee. - RSVP West - Volunteer recruitment charity for over 50s. Bristol Surgery Schemes Organiser	No No	08/07/14
Anne	Skinner	Governor - Patients, Local	n/a	None	n/a	14/07/14
John	Steeds	Governor - Patients, Local	n/a	None	n/a	07/07/14
Karen	Stevens	Governor - Staff, Non-clinical Healthcare Professional	n/a	None	n/a	26/06/14
Tony	Tanner	Governor - Public, South Gloucestershire	n/a	None	n/a	12/07/14
Ben	Trumper	Governor - Staff, Nursing and Midwifery	n/a	None	n/a	16/07/14
Lorna	Watson	Governor - Patients, Carers (patients under 16 years)	n/a	None	n/a	16/07/14
Elliott	Westhoff	Governor - Patients, Local	May 2013 - ongoing	Service Manager at North Bristol NHS Trust for Renal, Transplant and Outpatients	Paid employment full time	15/07/14
Pam	Yabsley	Governor - Patients, Local	n/a	None	n/a	11/07/14