University Hospitals Bristol NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC

Date: Monday 30 July 2014
Time: 10.30 am – 13.00
Venue: Conference Room, Trust Headquarters

Distribution:

Chair:	John Savage	Trust Chairman
Board Members:	David Armstrong	Non-executive Director
	Kelvin Blake	Non-executive Director
	Julian Dennis	Non-executive Director
	Lisa Gardner	Non-executive Director
	John Moore	Non-executive Director
	Guy Orpen	Non-executive Director
	Alison Ryan	Non-executive Director
	Emma Woollett	Non-executive Director
	Jill Youds	Non-executive Director
	Robert Woolley	Chief Executive
	Sue Donaldson	Director of Workforce and Organisational Development
	Deborah Lee	Director of Strategic Development and Deputy Chief Executive
	Paul Mapson	Director of Finance and Information
	Carolyn Mills	Chief Nurse
	Sean O'Kelly	Medical Director
	James Rimmer	Chief Operating Officer
In attendance:	Julie Dawes	Interim Trust Secretary
	Pauline Holt	Management Assistant to Trust Secretary (Minutes)
Apologies:	Deborah Lee	Director of Strategic Development and Deputy Chief Executive
	Lisa Gardner	Non-executive Director
	Guy Orpen	Non-executive Director
Observers:	Penny Hilton	NHS Fast-Track Executive
	Members of the Council of Governors	
Copy for Information:	Members of Council of Governors	
	Heather Ancient*	PwC – External Auditor
	Aiden Fowler	NHS Fast-Track Executive
	Jenny McCall*	Audit South West – Internal Auditor

*Agenda and Minutes only

Contact for apologies or any enquiries concerning this meeting should be made to:

Pauline Holt, Management Assistant to Trust Secretary, Trust Headquarters. Telephone: 0117 34 23702
Email: pauline.holt@uhbristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received.	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any pecuniary or non-pecuniary interests relating to any item on the Agenda.	Chairman	5
3. Minutes from Previous Meetings To consider the Minutes the Trust Board of Directors held on 30 June 2014 for **approval.**	Chairman	6
4. Matters Arising To review the status of actions agreed for **assurance.**	Chairman	21
5. Chief Executive's Report To receive this report from the Chief Executive to **note.**	Chief Executive	23
Delivering Best Care		
6. Patient Experience Story To receive the Patient Experience Story for **review.**	Chief Nurse	26
7. Quality and Performance Report To receive the Quality and Performance Report for **assurance.** a. **Performance Overview – Director of Strategic Development** b. **Quality & Outcomes Committee Chair's Report** c. **Board Review – Quality, Workforce, Access.**	Director of Strategic Development and Deputy Chief Executive	30
8. Corporate Quality Objectives – Quarter 1 Update To receive this report by the Chief Nurse for **assurance.**	Chief Nurse	111
9. Infection Control Annual Report To receive this report from the Chief Nurse for **assurance**.	Chief Nurse	116
10. Infection Control Quarterly Report To receive this report from the Chief Nurse for **assurance.**	Chief Nurse	135

Item	*Sponsor*	*Page*
11. Quality Strategy 2014-2017 To receive this report from the Chief Nurse for **approval.**	Chief Nurse	144
12. Patient Safety Strategy 2014-2017 To receive this report from the Medical Director for **approval.**	Chief Nurse	154
13. Annual Complaints Report 2013/14 To receive this report from the Chief Nurse for **assurance.**	Chief Nurse	155
14. Transforming Care Report – Quarter 1 2014/15 To receive this report by the Chief Executive for **assurance.**	Chief Executive	175
15. Item withdrawn		*(181-184)*
Delivering Best Value		
16. Finance Report To receive this report by the Director of Finance and Information for **assurance.**	Director of Finance and Information	185
17. Finance Committee Chair's Report To receive this verbal report by the Chair of the Finance Committee for **assurance.**	Director of Finance and Information	
Renewing our Hospitals		
18. Quarterly Capital Projects Status Report To receive this report by the Director of Strategic Development and Deputy Chief Executive for **assurance.**	Director of Strategic Development and Deputy Chief Executive	203
Corporate Governance		
19. Item Withdrawn		(209)
20. Risk Assessment Framework Monitoring and Declaration – Quarter 1 2014/15 Report To receive this report by the Chief Executive for **approval.**	Chief Executive	210

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Item	*Sponsor*	*Page*
21. Board Assurance Framework – Quarter 1 Update To receive this report from the Chief Executive for **assurance.**	Chief Executive	235
22. Corporate Risk Register To receive this report from the Chief Executive for **assurance.**	Chief Executive	243
23. Governors' Log of Communications To receive this report from the Chairman to **note.**	Chairman	254
Information and Other		
24. Communications to the wider organisation To **agree** any Board decisions requiring communication to the Trust	Chief Executive	
25. Any Other Business *(Should only normally include any matters previously notified to the Chairman at least 48 hours prior to the date of the meeting)*	Chairman	
26. Date of Next Meeting: Annual Members Meeting, 18 September 2014 at 17:00 Lecture Theatre 1, Education Centre. Trust Board meeting held in public, 30 September 2014 at 10:30 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.	Chairman	

Name	Title	Interest Role	Interest Organisation	Remunerated	First Declaration Date	Last Update	End Date	Modified
Armstrong, David	Non-executive Director	Director	Chartered Quality Institute	Y	14/04/2014			02/06/2014 14:09
Blake, Kelvin	Non-executive Director	Programme Director	BT	Y	21/04/2011	14/04/2014		23/04/2014 15:53
Blake, Kelvin	Non-executive Director	Board Member	BT South West	Y	21/04/2011	14/04/2014		23/04/2014 15:53
Blake, Kelvin	Non-executive Director	Trustee	Spinal Injuries Association	N	21/04/2011	19/04/2012	17/05/2013	17/05/2013 13:31
Blake, Kelvin	Non-executive Director	Trustee	Vassall Centre Trust	N	21/04/2011	17/05/2013		17/05/2013 13:33
Blake, Kelvin	Non-executive Director	Governor	Knowle West Childrens Centre	N	21/04/2011	20/03/2012	19/04/2012	23/04/2012 12:23
Blake, Kelvin	Non-executive Director	Board Member	Bristol Cultural Development Partnership	N	10/11/2011	17/05/2013		17/05/2013 13:33
Blake, Kelvin	Non-executive Director	Trustee	Knowle West Media Centre	N	19/04/2012	19/04/2012		17/04/2013 12:22
Dennis, Julian	Non-executive Director	Visiting Professor	Visiting Professor, University of Bath: Water Science and Engineering	Y	14/04/2014			23/04/2014 16:11
Donaldson, Sue		None	Nil		14/04/2014			23/04/2014 16:08
Gardner, Lisa	Non-executive Director	Director	Watershed Arts Trust	N	20/03/2012	14/04/2014		23/04/2014 15:54
Gardner, Lisa	Non-executive Director	Shareholder, Associate	Richard Bunker & Company Limited Chartered Accountants	Y	20/03/2012	17/04/2013	17/04/2013	24/05/2013 14:41
Gardner, Lisa	Non-executive Director	Director	Watershed Trading Limited	N	17/04/2013	17/04/2013		24/05/2013 14:41
Gardner, Lisa	Non-executive Director	Interim Director of Finance	Above and Beyond (Charitable Trust UH Bristol)	Y	14/04/2014			23/04/2014 15:56
Lee, Deborah	Director of Strategic Development	None	None	N	05/04/2011	14/04/2014		23/04/2014 16:05
Mapson, Paul	Director of Finance	None	None	N	05/04/2011	14/04/2014		23/04/2014 16:06
Mills, Carolyn	Chief Nurse	None	Nil		14/04/2014			23/04/2014 16:08
Moore, John	Non-executive Director	Management Consultant	ReAlignment Limited.	Y	08/04/2011	17/05/2013		20/05/2013 09:25
Moore, John	Non-executive Director	Director	Carbotech Wheels GmbH, (Salzburg)	Y	08/04/2011	04/09/2012	04/09/2012	24/05/2013 14:42
Moore, John	Non-executive Director	Trustee	Bristol Community Family Trust.	N	08/04/2011	04/09/2012	12/04/2013	17/05/2013 11:46
O'Kelly, Sean	Medical Director	None	None.	N	16/04/2012	14/04/2014		23/04/2014 16:07
O'Kelly, Sean	Medical Director	Expert Advisor on Clinical Governance	World Health Organisation	N	14/07/2014	20/06/2014		14/07/2014 11:44
O'Kelly, Sean	Medical Director	Specialist Advisor	Care Quality Commission	N	14/07/2014			14/07/2014 11:46
Orpen, Guy	Non-executive Director	None	Employee of the University of Bristol - Member of the Senior Management Team at the University of Bristol as Pro Vice Chancellor for Research and Enterprise.	Y	06/09/2012	14/04/2014		23/04/2014 16:04
Orpen, Guy	Non-executive Director	Director	Bristol 2015 Company	N	30/05/2014	01/07/2014		01/07/2014 14:50
Orpen, Guy	Non-executive Director	Trustee	Cambridge Crystallographoc Data Centre since May 2008	N	01/07/2014	01/07/2014	01/11/2014	01/07/2014 14:52
Rimmer, James	Chief Operating Officer	None	None	N	14/07/2011	14/04/2014		23/04/2014 16:07
Rimmer, James	Chief Operating Officer	Trustee	Changing Tunes wef 22/04/14	N	15/07/2014			15/07/2014 15:19
Rimmer, James	Chief Operating Officer	Trustee	St Matthews Parochial Church Council, Kinbgsdown, Bristol wef 14/04/14	N	15/07/2014			15/07/2014 15:19
Ryan, Alison	Non-executive Director	CEO	CEO - Weldmar Hospicecare Trust Director - Weldmar Hospicecare Enterprises Ltd Director - Weldmar Hospicecare Trading Ltd	Y	15/04/2014			23/04/2014 16:03
Savage, John	Chairman	Executive President	GWE Business West	Y	13/04/2011	05/09/2012	05/09/2012	24/05/2013 14:43
Savage, John	Chairman	Board Member	South West Regional Development Agency	Y	13/04/2011	05/09/2012	05/09/2012	24/05/2013 14:43
Savage, John	Chairman	Chairman	South West Regional Skills Forum	N	13/04/2011	18/04/2013	01/04/2014	10/07/2014 10:26
Savage, John	Chairman	Chairman	Destination Bristol	N	13/04/2011	14/04/2014		23/04/2014 15:44
Savage, John	Chairman	Chairman	The Churches Council for Industrial and Social Responsibility	N	13/04/2011	18/04/2013	01/04/2014	10/07/2014 10:26
Savage, John	Chairman	Financial Director	Bristol Cultural Development Partnership Limited	N	13/04/2011	14/04/2014		23/04/2014 15:45
Savage, John	Chairman	Board Member	South West Chambers of Commerce Limited	N	13/04/2011	14/04/2014		23/04/2014 15:48
Savage, John	Chairman	Secretary and Treasurer	Bristol Society	N	13/04/2011	05/09/2012	05/09/2012	24/05/2013 14:43
Savage, John	Chairman	Chairman	The Station (My Place - Youth Centre Development)	N	13/04/2011	18/04/2013	18/04/2013	24/05/2013 14:43
Savage, John	Chairman	Executive Chairman	Bristol Chamber of Commerce and Initiative	Y	05/09/2012	14/04/2014		23/04/2014 15:42
Savage, John	Chairman	Chairman	Learning Partnership West	N	05/09/2012	14/04/2014		23/04/2014 15:45
Savage, John	Chairman	Vice Chairman	Wessex Water Customer Scrutiny Group	N	05/09/2012	18/04/2013	01/02/2014	10/07/2014 10:25
Savage, John	Chairman	Vice Chairman	Bristol Water Customer Scrutiny Group	N	05/09/2012	18/04/2013	01/02/2014	10/07/2014 10:25
Savage, John	Chairman	Trustee	The Creative Youth Network	N	05/09/2012	18/04/2013	01/04/2014	10/07/2014 10:24
Savage, John	Chairman	Director	Price Associates Limited	Y	05/09/2012	14/04/2014		23/04/2014 15:43
Savage, John	Chairman	Chairman	The Bristol Initiative Charitable Trust wef April 1989.	N	14/04/2014	10/07/2014		10/07/2014 10:22
Savage, John	Chairman	Lay Canon	Bristol Cathedral Chapter wef March 2014	N	14/04/2014	10/07/2014		10/07/2014 10:23
Savage, John	Chairman	Patron	Bristol Refugee Rights wef May 2014	N	14/04/2014	10/07/2014		10/07/2014 10:24
Woollett, Emma	Non-executive Director (Vice Chair)	Management Consultant	Woollett Consulting	Y	11/04/2011	14/04/2014	12/04/2013	23/04/2014 15:59
Woollett, Emma	Non-executive Director (Vice Chair)	Trustee	Above and Beyond	N	11/04/2011	12/04/2013	12/04/2013	24/05/2013 14:43
Woollett, Emma	Non-executive Director (Vice Chair)	Management Consultant	KPMG		22/11/2013	14/04/2014		30/06/2014 16:09
Woolley, Robert	Chief Executive	Advisory Group Member	Science City Bristol	N	06/04/2011	18/04/2012	18/04/2012	23/04/2014 17:25
Woolley, Robert	Chief Executive	Advisory Group Member	Common Purpose Bristol	N	06/04/2011	24/09/2012	24/09/2012	24/05/2013 14:43
Woolley, Robert	Chief Executive	Board Member	Health Education South West – Board Member of the Governing Body (appointed 1 September 2013 for a period of three years	N	16/09/2013	14/04/2014		23/04/2014 16:22
Woolley, Robert	Chief Executive	Director	West of England AHSN Ltd	N	14/04/2014			23/04/2014 16:21
Youds, Jill	Non-executive Director	Non-Executive Director	Hoople Ltd	Y	01/01/2014	02/06/2014		02/06/2014 16:37
Youds, Jill	Non-executive Director	Managing Director	Cresco Business Solutions Ltd	Y	10/06/2013	02/06/2014		02/06/2014 16:38
Youds, Jill	Non-executive Director	Executive Director	Senior HR Leaders EMEA Forum, Executive Networks	Y	05/12/2013	02/06/2014		02/06/2014 16:40

University Hospitals Bristol NHS
NHS Foundation Trust

Unconfirmed MINUTES of a Meeting of the Trust Board of Directors to be held in Public on 30 June 2014 at 10:30 in The Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

Board Members Present	
• John Savage – Chairman • Robert Woolley – Chief Executive • Deborah Lee – Director of Strategic Development and Deputy Chief Executive • Paul Mapson – Director of Finance & Information • Carolyn Mills – Chief Nurse • Sean O'Kelly – Medical Director • James Rimmer – Chief Operating Officer • Sue Donaldson – Director of Workforce and Organisational Development	• Julian Dennis – Non-executive Observer • Lisa Gardner – Non-executive Director • John Moore – Non-executive Director • Guy Orpen – Non-executive Director • Alison Ryan – Non-executive Director • Emma Woollett – Non-executive Director
Others in Attendance	
• Julie Dawes – Interim Trust Secretary • Xanthe Whittaker – Head of Performance Assurance & Business Intelligence/ Deputy Director of Strategic Development • Alex Nestor – Deputy Director of Organisational Development • Fiona Reid – Head of Communications • Sue Silvey – Public Governor (Lead governor) • Mo Schiller – Public Governor • Clive Hamilton – Public Governor • Brenda Rowe – Public Governor • John Steeds – Patient Governor • Anne Skinner – Patient Governor • Tony Tanner – Public Governor • Karen Stevens – Staff Governor • Graham Briscoe – Public Governor	• Wendy Gregory – Patient Governor • Sue Milestone – Patient Governor • Florene Jordan – Staff Governor • Marc Griffiths – Appointed Governor • Jeanette Jones – Appointed Governor • Angelo Micciche – Patient Governor • Bob Bennett – Public Governor • Edmund Brooks – Patient Governor • Bob Skinner – Foundation Trust member • Daphne Havercroft – Member of public • Neil Havercroft – Member of public • Matthew Hill – Health Reporter, BBC Points West • Pauline Holt – Management Assistant to Trust Secretary
Item	
1. Chairman's Introduction and Apologies Apologies had been received from Kelvin Blake, Jill Youds and David Armstrong.	

2. Declarations of Interest

In accordance with Trust Standing Orders, all Board members (including observers) present were required to declare any conflicts of interest with items on the Meeting Agenda.

No declarations of interests were received.

3. Minutes and Actions from Previous Meeting

The Board considered the Minutes of the Meeting of the Trust Board of Directors held on 28 May 2014 and **approved** them as an accurate record, subject to the following amendment:

Section 10 Finance Report – final sentence – "still failing service of continuity rating" should read "still be achieving a satisfactory continuity".

4. Matters Arising

Actions:

Action 221 – The Chief Executive reported that work to deliver the Board's stated agreed ambition for the delivery of an integrated service of cellular pathology in Bristol was proceeding well, with a business case working through a financial appraisal. The Medical Director of North Bristol Trust had reported back at the last Partnership Programme Board that a physical integration should be achievable by Spring 2015.

Action 263 –The Chief Executive wished to assure the Board that considerable thought was being put to culture change within the organisation and that work to bring a fuller report was underway for July.

Action 282 – Item placed on the Forward Planner for Audit Committee – date to be advised.

Action 294 – The Chief Executive advised that Governors and staff had been informed of the 23 June launch date for the review; information is also available on the website. A general call for evidence, from those interested in giving evidence, had been made by Eleanor Grey who confirmed that the information gathering stage would conclude by the beginning of winter.

Action 295 – The Chief Executive to update the Board as new information is available.

Action 218 – National Cancer Survey and Action Plan - update to QOC in July.

Action 277– Item taken to the Board Development Seminar – Item closed.

Actions 279/280/281 Infection Control - report to QOC in July - Item closed.

Action 297 – The Chief Nurse reported that boards, detailing the number of staff on duty in all wards, are in situ. A review of the whiteboard comment to be made in July.

Action 161 – The workforce strategy and plan is on the agenda for the Board Development Seminar in July. Item closed.

Action 296 – Report on bank and agency is contained in the performance report - Item closed.

Action 299 – Directors to update their interests; new register to Board in July - Item closed.

There were no further Matters Arising.

5. Chief Executive's Report

The Chief Executive provided the Board with updates on the following matters:

- Monitor visited the Trust on 16 June 2014 and met members of the Board in relation to the

consideration of the Trust's regulatory position for governance. Written reports, detailing action plans for recovery of access targets, had been requested and their decision was expected to be announced on 22 July 2014.

- Monitor was to participate with NHS England in a review of the urgent care system in Bristol, particularly around A&E in the Bristol Royal Infirmary. There had been a review by the Emergency Care Intensive Support Team and details of this are to be circulated in due course. The Chief Executive said that its recommendations included everything the Board would expect to see, regarding system working and the need for greater system leadership of urgent care in Bristol. A meeting is to be held with Monitor, the NHS England Area Team and the Clinical Commissioning Group to assess the resilience of the system and what is required prior to the winter.
- The Department of Health have issued a new approach to winter planning, known as System Resilience Planning, taking in both urgent care and elective care. A national amount £250m non-recurrent is available to allow Trusts to deal with waiting list backlogs before the winter.
- NHS England had published their Patient Safety Dashboards taking into account safer staffing figures. The data for the Trust was shown on the NHS Choices website as a blue rating for open and honest reporting, infection control and staff recommendation to friends and family as a place for treatment. A green rating had been received for blood clot management and responding to patient safety alerts. Staff levels were shown as positive in all sites across the Trust with the exception of South Bristol Community Hospital where a possible data issue had been identified as the cause for lower figures.
- The Chief Executive made an announcement to staff that Weston Area Health NHS Trust had announced that it was now seeking to either merge with another NHS Trust, or be acquired by an NHS Foundation Trust within a 50 mile radius. A 'NHS only' merger/acquisition programme had been agreed. An open market procurement process had commenced, three NHS Trusts had expressed an interest, namely Taunton and Musgrove Park NHS Foundation Trust, Somerset Partnership Foundation Trust and University Hospitals Bristol. Current indications suggest that the timescale for the proposed open market procurement process would run from 3 July to18 August and the announcement of the successful bidder by Autumn 2014; Members acknowledged the extremely challenging timetable and it was agreed that the Board and Governors would be kept fully informed of any developments

There being no questions the Chief Executive concluded his report.

Delivering Best Care

6. Patient Experience Story

The Board received and reviewed this report from the Chief Nurse.

The Chief Nurse introduced a film for the Patient Experience story. She explained that this was part of the Board Development Toolkit and showed the lives of two people who were affected by hospital acquired infection. She said that the Board should view the film in the context of the huge amount of work undertaken surrounding anti biotic prescribing and the Trust's improvement of C difficile figures. She informed the Board that the NHS had recognised C difficile as an infection that sometimes resulted from antibiotic prescribing and a document had been produced that would allow the Trust, in conjunction with the Clinical Commissioning Group, to validate C difficile infections in cases where the Trust could demonstrate that the patient had received the correct treatment for their condition.

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

7. Quality and Performance Report

The Board received and reviewed the Quality and Performance Report.

Overview

Deborah Lee gave the following overview of Trust performance and quality.

- The overall health of the organisation had improved with the number of red indicators having decreased by one.
- The picture relating to pressure sores was positive despite the month having seen the Trust with one grade 3 / 4 pressure sore.
- Quality - the Trust had sustained great improvements in falls, medication errors and the Friends and Family test had continued to exceed national averages for the securing of feedback from patients, particularly in relation to A & E; an area where many hospitals struggled to obtain feedback.
- Productivity continued to make progress with one red rating for length of stay. Overall length of stay had been reduced by almost half a day which Deborah described as a 'great achievement'. Renewed focus had been placed on patients whose stay exceeded fourteen days with additional focus on patients who had been in hospital for long periods.
- Finance was green rated with the exception of delivering cash reducing efficiency savings but improvement was expected in year. The typical pattern for achievement had been 85% but she cautioned that this needed to improve as reserves declined.
- Monitor would advise in the middle/late July if they intend to escalate regulatory actions or restore the Trust to a green rating. It was noted that the Trust had worked hard to provide robust evidence to Monitor that it had taken the appropriate steps to deliver the required recovery trajectories.

Quality and Outcomes Committee Chair's Report

Alison Ryan, Chair of the Quality and Outcomes Committee, advised that a number of papers had been received by the Committee regarding complaints, nursing staffing and patient experience. She noted that this cross reporting allowed the Committee to triangulate their understanding and that the changes to the format of the Patient Experience report had been particularly appreciated.

It was reported that the quality indicators had been looked at in detail and in particular the increase to the 30- day re-admission rate. It was confirmed that the Committee had obtained the necessary assurance that each case was reviewed independently and that there were no indications that patients had been re-admitted due to early discharge.

She said that the access recovery programmes were very encouraging but that the Committee had been alerted to the fact that the RTT non admitted target was significantly at risk due to unforeseen backlogs.

Future reports were to include a report on Serious Incidents that would follow the entire process of identification and action plans.

Finally, she informed the meeting that a detailed mapping exercise of the existing committee structure at both Board and executive level was currently being undertaken, particularly around the inter-relationship of the Audit Committee and Quality and Outcomes Committee with regards to clinical and non-clinical risk. It was noted that the Committee had specifically requested clarification about where the learning from adult mortality reviews were handled and also emphasised the importance of ensuring a robust process was in place for 'closing the loop' following the publication of clinical audit results.

Workforce

Sue Donaldson advised the Board that a Quarterly Workforce report was received by the Quality and

Outcomes Committee and would also in future be submitted to the Board for consideration. She updated the Board on the following matters:

- Sickness absence management - the Trust had maintained its position and remained in amber, noting the division that raised the most concern was Women's and Children's, who were above local target. It was noted that the introduction of the Employee System Programme had assisted in helping staff and with the management of sickness absence; the Estates and Facilities division was also considered to be a concern with high sickness and turnover figures. Sue advised that concerted effort was being put into this particular staff group with a view to examining the drivers and motivators that differentiated this staff group from clinical staff, to ascertain their views of working for the Trust and to offer them appropriate support.
- Bank, agency and vacancies - the Trust had already acknowledged the need to watch the use of bank and agency and there had been some improvement. There was now an improved awareness of the need to control agency use and the need to move towards the use of bank staffing. Sue advised that the reasons for the use of agency staff was multi-faceted in the case of the Medicine division, they were struggling with capacity/activity levels but a move to substantive staffing levels had improved the position. Some problems had been experienced by Specialised Services with high levels of maternity leave and in Surgery Head and Neck division, pressures in the Intensive Care Unit were driving the use of both bank and agency staff.
- Each area had been asked to produce trajectories for expected use of bank and agency and others had employed the method of employing to 120% of substantive staff. Sue concluded that she was unsure if this method would allow enough flexibility for the future.

Action 317: Emma Woollett requested that emphasis should be placed on correct staff rostering and asked to receive assurance that this was in hand.

Board Review

Lisa Gardner noted that a review had not been issued for a case of fractured neck femur due to a bank holiday. Sean O'Kelly replied that the target was dependent upon the ability of the team to take patients to theatre when trauma patients with clinical priority caused more of a demand. He said that the team were aware of the need to manage peaks in times of demand and were working hard to meet this. He concluded that there was a possible opportunity with the transfer of vascular services to dedicate more capacity to the trauma service. The target had been achieved in June due to specific initiatives.

Action 318: Emma Woollett asked that a trajectory be produced as this target had not been met for some time (with the exception of June 2014).

John Moore noted that the data for falls and ulcers had been 'normalised' and pointed out that as the population of older people increased then so would the incidents of falls and pressure sores. He asked that analysis of age related data, as a percentage of falls and ulcers incurred by the Trust, be provided.

Action 319: The Chief Executive replied that in the context of the Trust's ambition to drive all falls and pressure ulcer incidents down, further analysis would be provided to the Board.

Governors enquired about:

- Achievement of the A&E 4 hour standard - the Chief Executive advised that the Trust were not achieving the target to Monitor's satisfaction but they fully understood that there were system issues, such as the management of demand and the ability to discharge patients into the community, and not just about the Trusts internal processes and management of people through the system. He concluded that the Trust had delivered 95% of the A & E waiting standard in June 2014 but had failed the quarter as a whole. The Chairman added that the Board did not lose

sight of the importance they placed on addressing Referral to Treatment targets and that solutions were constantly being sought.

- Themes from Serious Incidents - referring to the three falls incidents that had resulted in fractures and one never event in May 2014, the Governors asked if there was a need to look at the reporting of these incidents in terms of the time it took to learn from them. Sean O'Kelly replied that there were two mechanisms and that serious incidents always had a rapid review meeting preceding the more thorough root cause analysis; the purpose being to establish what needed to change in the light of what was immediately known from the incident. Deborah Lee assured members that the rapid review took place within 72 hours.
- Medication errors – Referring to the two incidents under investigation, the Governors asked if they could be informed of the root cause analysis when this had been completed.

Action 320 : The Chief Executive replied that further consideration was required as to how best to Governors should in future be kept informed of the actions and learning from incidents.

- Dementia care – recovery plans stated a loss of the lead dementia role and the Governors asked when the post would be reappointed. Carolyn Mills replied that the lead post had been advertised, interviewed but not appointed. It was noted that; this post has subsequently been re-advertised. Additionally, a band 7 post has been appointed with a further Band 3 post pending.

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

8. Francis Report – Implementation of Action Plan

The Board received this report from the Medical Director for assurance.

The Medical Director presented an update to the Francis Report, considered by the Board in November 2013. This described the work the Trust had done in a process of self-reflection in the wake of the Francis Report and its recommendations. This had drawn two broad areas of work, the first around the key higher themes of activity that the Trust could undertake and referenced 290 specific recommendations.

The Paper described how a number of those broader themes had been incorporated into the organisation of the Trust through operating plans, the transforming care programme and detailed in the quality report. He noted that Agenda items 10, 12 & 17 all referenced the Francis Report.

The Paper also addressed how the Trust had progressed with the management of the 83 recommendations that were applicable to the Trust and outlined where residual actions arising were being carried out.

John Moore asked if the Trust were considering inviting the Internal Auditor to advise if they agree with the Trust's view. Deborah Lee assured members that the Trust was actively engaging with a number of external stakeholders concerning the robustness of the plan, including with Commissioners and the Overview and Scrutiny Committee

In response to Emma Woollett's request for clarification about what assessments have been made in terms of the quality impact on staff and its effectiveness, Sue Donaldson replied that this would be considered in the context of the wider cultural change programme.

Action 321: Sue Donaldson to review and report back on the positon concerning staff quality impact assessments in the context of the wider cultural change programme,

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

9. Patient Experience Quarterly Report

The Board received the report for assurance from the Chief Nurse.

The Chief Nurse presented the new format report detailing the methods for gaining patient experience feedback. She described this process as being audit based with overall feedback being positive and reflected in the score received from the NHS Choices Quality Assessment.

It was reported that the division with the highest reported levels of patient satisfaction was Specialised Services, with some specific issues arising from the Friends and Family Test in the Division of Medicine. Hospital led data had shown the best experiences had been at the eye and children's hospitals, the Haematology and Oncology Centre. Slightly lower scores had been received for South Bristol Community Hospital. She concluded that it was possible to see some triangulation with the different levels of information being received.

The Chairman welcomed the new format report saying it was clear and easy to understand.

In response to Alison Ryan's question whether this data had been communicated to staff at ward level, Carolyn Mills confirmed that the information was available to the Heads of Nursing and that were also in receipt of every single comment that was fed back through patient questionnaires.

In order to improve the 'Board to Ward' reporting, Lisa Gardner suggested that a list of wards and their location, should be included as appendices in future quarterly Patient Experience reports to the Board.

Action 322: Chief Nurse to amend future quarterly Patient Experience reports to include a list of wards and their location as appendices.

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

10. Report on Staffing Levels for University Hospitals Bristol

The Board received and noted this report from the Chief Nurse for assurance.

The Board were advised that subsequent to the action plan following publication of the National Quality Board and Care Quality Commission joint guidance issued on 1 April 2014 relating to 'Hard Truths' commitments regarding the publishing of staffing data, one of the recommendations regarding the setting of safe staffing. There is a specific requirement for the report to detail how the Trust set funded establishments and monitored their delivery.

It was reported that this first presented the process, the details of workforce numbers, workload measurement tools, details of specific methodologies and guidelines used to set establishment and was provided in the context of adding further details for future discussions.

It was confirmed that the Trust's position on the ratio of registered to unregistered staff was 60/40 with higher numbers in intensive care and children's services. The ratio for the number of patients per nurse, following the national push for a proposed setting of a minimum staffing level of 1:8, the Trust worked on the basis of 1:6 and 1:8 at night.

Additionally, the report detailed how the Trust knew that wards were safe and how concerns regarding staffing were identified, escalated and mitigated, on a daily basis and published on the website.

Carolyn concluded that the report was intended to provide the Board with the necessary assurance that the Trust had the appropriate establishment and a skill mix required to support safe staffing levels. It was noted that robust processes were in place for setting that establishment and managing it on a day to day basis. She assured members that with no element of complacency, there was a recognition of the need to stabilise the workforce with a recruitment campaign and to be constantly attuned to bed numbers with staffing numbers adjusted accordingly.

The Board thanked Carolyn for a very comprehensive report and sought further clarification on a number of points, including:

- How the statistics had been benchmarked. Carolyn replied that at any review of staffing establishment, the opportunity was always taken to look at national guidance and benchmark positions outside the organisation.
- What guidance was used by the Trust to assess that they had the right numbers of staffing for other staff groups such as allied healthcare or catering. Deborah Lee responded by confirming that national service specifications had been issued, and followed, for over 130 services. These had set out standards across the disciplines against which the Trust had undertaken stock assessment against standards and knew they were compliant. Two small areas of non-compliance had been recorded on risk registers and were being addressed. James Rimmer supported earlier comments and informed the meeting that site meetings were held daily and any emerging issues concerning staffing levels were addressed promptly.

Action 323: Sue Donaldson to produce a high level source reference document for all staff groups point for consideration by the QOC meeting in October 2014.

Clive Hamilton commented that he had expected a data set ward by ward, listing safe staffing levels and variations. He explained that he did not consider the current website version to be sufficiently clear as it was based on hours. Carolyn Mills acknowledged that the website information was not as user friendly as it could be and agreed that there was scope for further improvement.

In response to Clive's request for clarification as to why certain areas fell below the expected level, Carolyn Mills replied that she was confident that wards were safely staffed but challenges were always present. She accepted his comments and explained that it was necessary to look at the overall total which included the addition of specialists on duty, adding to safe staffing levels.

The Chief Executive concluded that assurance could be taken that the Trust employed a richer skill mix and staffing as opposed to the bottom level of expectation and if there was a contingent shortage for a day or a few hours, whilst cover was secured, that was not creating a safety issue.

Action 324: Carolyn Mills to review the publication of the required safe staffing information on the Trust's website information to improve the overall presentation

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

11. Emergency Preparedness Annual Report 2013/14

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

James Rimmer introduced the paper and advised that the Trust had an obligation to meet the 2004 Civil Contingencies Act. He said the report set out how this was achieved both through internal and external audit and regular testing of the system. Additionally he advised that the Trust were part of the Avon and Somerset Local Resilience Forum.

The Key areas laid out in the report were Managing Business Continuity and Clinical Disease Planning. He advised that eight significant events had been experienced within the Trust including IM&T issues, power outages and a hospital fire. All these incidents had been subject to a debrief process and lessons had been learned as to areas for improvement.

Alison Ryan asked if there was a test for losing water supply. James Rimmer replied that the Trust had on-site water storage and was on the supplier's first call priority customer list.

Alison asked what resilience the Trust had to computer viruses. James replied that the Trust reverted to a paper based system. Paul Mapson added that the Trust had dual computer rooms and audited controls.

There being no further questions the Board approved the Emergency Preparedness Annual Report 2013/14.

12. Quarterly Patient Complaints Report

The Board received and noted this report from the Chief Nurse for assurance.

This report provided a summary of:

- complaints received by the Trust during Quarter 4 of 2013/14;
- the Trust's performance in responding to those complaints in a timely and effective manner;
- themes and patterns arising from complaints; and
- actions taken by the Trust and its Divisions to address those concerns.

Carolyn Mills drew attention to the following points:

- the Trust had received 415 complaints in Quarter 4 2013/14 which equated to 0.24% of patient activity, against a target of 0.21%. In the previous quarter, the Trust had received 333 complaints, representing 0.19% of patient activity.
- the Trust's performance in responding to complaints within the timescales agreed with complainants in Quarter 4 was 84.7% compared to 85% in Quarter 3.
- In Quarter 4, slightly fewer complainants had confirmed that they were unhappy with investigations into their concerns (14) compared to 15 in Quarter 3.

Alison Ryan, assured members that the Quality and Outcomes Committee had examined the report in detail at their last meeting in June 2014. In response to question as to whether there were any recurrent themes to the small number of cases who had indicated that they were dissatisfied with the initial response, Carolyn Mills advised that the team were encouraged to look back and check original complaints letters to ensure that all areas had been appropriately addressed.

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

Delivering Best Value

13. Finance Report

The Board received and reviewed this report from the Director of Finance and Information.

The summary income and expenditure statement showed a surplus of £0.655m (before technical items) for the first two months of 2014/15. This represented an adverse variance of £0.330m against the plan.

In summary, the position to 31 May (month 2) was described as follows:

- Clinical Divisions – adverse variance of £1.9m due to shortfalls on the Trust's Operating Plan, savings programme slippage and activity under performance;
- Corporate share of income plan increases less the share of under-performance on SLA to date – a net favourable variance of £0.6m;
- Some estimated slippage on reserves of £0.4m due to increments, scheme slippage and provisions; and
- An expected favourable variance on financing costs (depreciation and PDC Dividend) of £0.6m due to phasing of capital schemes and the District Valuer 5 year revaluation impact.

It was confirmed that the key actions which will enable the financial plan to be delivered include:

- The delivery of planned activity – particularly elective and out-patients;

- Phased savings plans coming on stream;
- Progressing as near as possible to a balanced Operating Plan;
- Improvements in control especially in nursing staff rostering; and
- Careful husbandry of overall resources including corporate reserves.

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

14. Finance Committee Chair's Report

The Board received and reviewed this report from the Chair of the Finance Committee.

Lisa Gardner, Chair of the Finance Committee, updated the Board on its activity:

- They had examined the strategic plan in detail, looked at the key assumptions and supported the executive on their recommendations.
- They had undertaken a full discussion on the estates strategy and the Committee had supported it.
- The Committee had received a presentation from the Cost Improvement Director and the Committee had identified that good progress had been made in that area.
- The Committee had been pleased to see that Specialised Services had achieved a green rating and the delivery of activity within the Division of Women's and Children's.
- The Committee had reviewed the Standing Financial Instructions, examined the changes and supported it.

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

15. Medium Term Capital Programme 2014/14 – 2018/19

The Board received this report from the Director of Finance and Information for approval of the changes as set out in the report.

The report informed the Board of the proposed changes to the Medium Term Capital Programme which included the 2013/14 outturn position, the planned disposal of the Grange, the re-phasing of the BRI Redevelopment Phase IV schemes and technology fund schemes and formed part of the Strategic Plan.

It was reported that the Medium Term Capital Programme had been previously considered by the Finance Committee at a meeting on the 27th June 2014 and had been recommended to the Board for approval.

Paul Mapson offered his congratulations to Bob Pepper and Andy Headdon for their hard work on capital schemes, delivered on time and on budget.

There being no further questions the Board approved the proposed changes to the Medium Term Capital Programme.

Renewing our Hospitals

16. Estates Strategy 2020

The Board received this report from the Director of Strategic Development and Deputy Chief Executive for approval.

Deborah Lee advised that the Board would appreciate how much development had been undertaken in last few years that was now coming to fruition with the handover of the Terrell Street Ward Block.

She said that the strategy presented set out the next stages and described a number of assumptions that were implicit, including the intention to work up two outline business cases which would be submitted to the Board in the Autumn. It was noted that some aspects of non-clinical care had been included, particularly those that added an enhanced patient experience, such as car parking.

The Plan considered how to develop the estates either side of Marlborough Hill to address some of the needs at the heart of the Master Control Plan with the possible retaining of key areas of land for future research ambitions.

Deborah described the Old Building as a 'great opportunity for the Trust' with a proposal to develop an outline business case to develop the site for possible proposals. This was also to be submitted to the Board in the autumn.

It was noted that embedded in the document was the recognition that as the site was developed, there were areas that had not received attention for some time. The Programme therefore allowed for £2m of capital investment, over the next five years, with emphasis on refurbishment of those areas that received high patient traffic.

The Chairman advised the Board that the Finance Committee had reviewed the Estates Strategy on 27th June and recommended it to the Board for approval.

The Governors asked:

- if the Trust had aspirations for a restaurant/catering facility on site. The Chief Executive replied that the Senior Leadership Team was considering the specification for a facility on level 9 of the Queens Building to open in the spring of 2015.
- if the Trust has a vision for a therapy pool for inpatients and potentially outpatients. James Rimmer replied that the hydrotherapy pool had recently been upgraded.

There being no further questions the Board approved the Estates Strategy 2020.

Leading in Partnership

17. Monitor Five Year Strategic Plan (2014-19)

The Board was recommended to approve the Strategic Plan 2014-2019 for submission to Monitor and in doing so support the declarations of sustainability in respect of the one, three and five year periods covered by the plan.

Deborah Lee advised the Board that Monitor had required, for the first time, the submission of the Trust's Five year Plan which took a longer term view building on the two year operational plan submitted earlier in the year. The Five year plan put a new emphasis on the sustainability of Foundation Trusts.

A key requirement of the Board's approval was the confirmation that the Trust would be sustainable in one, three and five year time horizons. The plan confirmed the broadly sustainable nature of the Trust's services having considered financial, clinical, operational and workforce sustainability. It also noted the key assumptions which underpinned the declaration, notably that national efficiency, conveyed through tariff deflation, would not exceed 2% from years 2 to 5 of the plan.

Deborah advised that the Trust was going into the timeline in a relatively strong position compared to other trusts in the sector and had spent the last year reviewing the approach to strategy and the strategic direction, with a stronger sense of where opportunities lay, to address some of changes that were to

cross the Trust.

She concluded that she was happy to recommend this realistic plan to the Board. It had been developed with the views of Governors who had informed the plan and helped to make it more robust.

The Governors asked:

- if the key points from the Estates Strategy would be placed in an Executive Summary and issued to Members. Deborah advised that this was in process and would be issued in due course; and
- to be reminded that it had previously been agreed that carers would be a named group and not noted as representatives. Deborah thanked them for their observation and advised that the Plan would be amended prior to submission.

The Board thanked Deborah Lee for a detailed paper and there being no further questions, approved the Plan for submission to Monitor subject to the minor amendment agreed at the meeting.

18. Strategic Objectives 2014-5

The Board received this report from the Director of Strategic Development and Deputy Chief Executive for approval.

Deborah Lee presented the Strategic Objectives setting out the key strategic milestones that the Trust needed to deliver to meet the Annual Plan and noted that the progress against these items would be routinely monitored. Deborah explained that the Board could see the flow from the Vision, signed off as part of earlier strategic work and see a capture of some of the 'big issues'. It was noted that these were to follow through to the Strategic Implementation Plan that would allow the Clinical Strategy Group to monitor progress over and above the Board Assurance Framework.

The Board welcomed the improved format for the Board Assurance Framework and formally approved the Trust's Strategic Objectives for 2014/15.

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

Corporate Governance

19. Board Corporate Governance Statement – Board Self-Certification of Compliance

The Board received this report from the Chief Executive for approval.

It was reported that as a condition of Monitor's Provider Licence and in conjunction with the submission of the Trust's Five Year Strategic Plan to Monitor on 30 June 2014 (Minute no. 17 refers), the Board is required to make an annual self-certification of its compliance, risks to that compliance and mitigations.

The Chief Executive advised the Board that for this their first statement, the Trust had focussed on generic risks to forward compliance and compared them to the mitigation already in place. It was the intention to develop the approach for the future to enable the Board to monitor their compliance on a continuous basis throughout the year. He asked the Board if they recognised the evidence and assurance offered and if they were prepared to approve the Statement for submission to Monitor.

The Board welcomed and approved the Board Corporate Governance Statement –Board Self-Certification of Compliance for submission to Monitor.

20. Monitor's Letter Regarding University Hospital Bristol's Performance in Q4 2013/14

The Board received this report from the Chief Executive to note.

The Chief Executive presented Monitor's response and feedback on the Annual Operating Plan submission and the Quarter 4 Board self -certification. He advised that Monitor had reflected back the Trust's own self- assessment of a continuity of service risk of 4 and, under the governance risk rating had noted that the Trust remained investigation. It was noted that Monitor would inform the Trust the outcome their review in July.

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

21. Audit Committee Chair's Report

The Board received this verbal report by the Chair of the Audit Committee, for assurance.

John Moore advised the Board that the Audit Committee had met on 24 June and was quorate. Items covered included:

- Progress on outstanding actions from previous meetings;
- Internal Auditor Annual Report;
- Annual Report on Counter-Fraud;
- Clinical Audit Quarterly Review and Forward Plan; and
- Risk Management Quarterly Report.

He informed the Board that the Committee had received assurance that all financial flows between UH Bristol and University of Bristol were well controlled and fully covered by either purchase order or agreement and had encouraged ongoing review of IT security and guidance to staff, with regard to cloud and mobile device management.

The Internal Auditors Annual Report summarised their findings during the past year and there were no high risk or red rated reports. The Committee were pleased to note green reports on

- Friends and Family Test (procedures and data quality) and the Information Governance Toolkit;

(Amber ratings had been received for three items which the Committee had reviewed and were reassured by the action plans.);

- Business Continuity Planning (particularly refresher training in some areas);
- Financial Efficiency Planning, due to the level of non-recurring cash reducing efficiency savings in some divisions; and
- Prescribing of Insulin and the training needed in some areas to implement the new Department of Health guidance.

The Counter Fraud Annual Report had revealed that in 2013/14 there were eight cases that required investigation of which seven were staff related. Four of these were staff employed elsewhere whilst on sick leave from the Trust and others included drug misuse, visa fraud and ordering personal goods on Trust accounts. These investigations had led to one resignation and three dismissals.

The Clinical Audit Report had shown ongoing improvement in the management of clinical audit projects and the Committee received the 2014/15 Plan and welcomed the prioritisation process being adopted. They encouraged the Clinical Audit leadership to monitor the timely completion of projects.

Finally, he advised that the Committee had requested that greater detail be provided in the Risk Management Group Reports that were received quarterly by the Committee.

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

22. Standing Financial Instructions and Scheme of Delegation

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

The report informed the Trust Board of proposed changes to the Trust's current Standing Financial Instructions and Scheme of Delegation following the required annual review process. It was noted that these changes had been considered by the Finance Committee at their meeting on the 27th June 2014.

There being no questions the Board approved the Standing Financial Instructions and Scheme of Delegation as presented to the meeting.

23. Governor's Log of Communications

The Board received this report from the Chairman, to note.

The Chairman reported that the reply process was a bit slow and that steps were being taken to speed up the process for replies on the log which was considered to be a good mechanism for addressing any questions raised by Governors.

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

24. Register of Seals

The Board received this report from the Trust Secretary and noted its contents.

Information and Other

25. Any Other Business

In response to a request from a member of the public to ask a question at the meeting concerning the National Audit Office, the Chairman advised that the meeting of the Board of directors was a meeting held in public and not a public meeting. He clarified the position by saying that it was not a requirement for the Board to allow comments or take questions from either members of the public or members of the Trust at such meetings. He explained that the appropriate forum for asking questions was the Council of Governors meetings which are normally held on a quarterly basis at which members of the public are welcome to attend and participate.

Following the questioner's request for further clarification on the Trust's current position, it was agreed that in the spirit of openness and transparency, a short explanatory document would in due course, be published on the Trust's website concerning how members of the public in the future, can raise questions at Board meetings.

In response to the questioner's request for clarification on the Trust's current position, it was agreed that in the spirit of openness and transparency, a short explanatory document would be published in due course on the Trust's website on how members of the public can in future raise questions at Board meetings

Action 325: Publication of the Trust's protocol on how members of public can raise questions at Board meetings.

James Rimmer notified the Board of the retirement of Bob Pepper, Director of Facilities and Estates. James, on behalf of the Board, offered a note thanks to Bob for his sterling work over the last ten years.

There being no further business the Chair thanked everyone for attending and closed the meeting at 13:17.

26. Date of Next Meeting

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

Action by	ID	Meeting Date	Public / Private	Minute number & title	Description (minute)	Action to be Taken	Date to Report Back
Chief Executive	**263**	27/03/2014	Public	Patient Experience Story	The Chief Executive concluded that the Board were pinpointing the need for the Executive to consider the application of empathy in a systematic and more visible way, considering the specific features of the organisation and its staff, communicating with families who have serious concerns or who are bereaved or about to be bereaved. He said that the executive would report back to the Board.	**30/06/14 The Chief Executive wished to assure the Board that considerable thought was being put to culture change within the organisation and that work to bring a fuller report was underway for July.** 28/05/14 Jill Youds, Non-executive Observer, reiterated that she would still like to receive a response from the Executive Team about the culture of empathy throughout the organisation. The Chief Executive agreed that a proposal would be presented at a future Board meeting about how the Board could best address patient experience and issues associated with compassionate care. He added that the Trust had agreed to bring in a senior executive from the retail industry who had been placed with the Trust from the NHS Leadership Academy, and who would work specifically on this agenda. 27/03/14 Report back at future Board meeting	**30/07/2014**
Chief Executive	**282**	28/04/2014	Public	10.3 National Institute for Health Research Clinical Research Network, West of	John Moore asked for further details of the flow of funding and asked to see the governance structure for the flow and for that of procurement, for the organisations that managed the funding.	**30/06/14 item to be placed on the Forward Planner for Audit Committee – date to be advised.** 28/05/14 The Chief Executive reported that further details would be brought back in due course to the Audit Committee as requested. 28/04/14 The Chief Executive said that there was a case for describing to the Audit Committee at its next meeting how the Trust operated hosting across all the institutions that it was a host for	**30/07/2014**
Chief Executive	**295**	28/05/2014	Public	4. Chief Executive's Update	4.1 The Trust hosted a visit last week from the New Congenital Heart Disease Review team. This was a national review undertaken by NHS England following the demise of the Safe and Sustainable Review into children's heart surgery, and the new review looked at children's and adults' services together. The team visited the Trust's facilities and discussed services provided with staff, directors, governors, patients and families. They would report back in due course, and the Chief Executive would keep the Board updated.	**30/06/14** **The RW to update the Board as and when information available.** 28/05/14 Chief Executive to update the Board	**30/07/2014**
Chief Executive	**320**	30/06/2014	Public	7. Quality & Performance Report - Board Review	Medication errors – the two incidents under investigation. The governors asked if they could be informed of the root cause analysis, when this had been completed.	**30/06/14 The Chief Executive replied that he would consider how best to carry this forward and think how to best advise governors the actions and learning from incidents.**	**30/07/2014**
Chief Executive	**325**	30/06/2014	Public	25. AOB	Mrs Havercroft requested that a statement be published on the Trust website that made the policy clear regarding questions from the public and members. She added that a precedent had been set in that questions had been accepted in the past at board meetings. She felt that 'in the spirit of openness and transparency' changes of policy needed to be notified to the public and she made the request that the minutes of the meeting reflected her request for clarification of the policy.	**23/07/14 Minutes reflected Mrs H request.** 30/06/14 The Chairman replied that her request would be dealt with and the minutes would reflect this.	**30/07/2014**
Chief Nurse	**218**	28/11/2013	Public	6. National Cancer Survey & Action Plan	Wendy Gregory stressed the importance of Cancer Nurse Specialists and asked for reassurance that the lack of a nurse specialist for Melanoma would be addressed. Ruth Hendy advised that a strategy was being discussed by divisions for cross-working as people progressed on their pathways and would form part of divisional operating plan.	**25/07/14 Paper provided to QOC** 30/06/14 Update to QOC in July 25/07/14 Paper provided to QOC 28/5/14 The Chief Nurse reported progress on the recruitment of a melanoma nurse specialist. The post had been approved, and had been advertised three times, but had not been appointed to yet. The post would sit across the Divisions of Medicine (Dermatology) and Specialised Services (Oncology). 28/11/13 Emma Woollett suggested an update to the Board be provided after six months.	**30/07/2014**
Chief Nurse	**298**	28/05/2014	Public	Implications of National Quality Board Guidance – Guidance to nurse, midwifery and care staffing – Capacity and Capability	Guy Orpen, Non-executive Director, asked that the opportunity be taken to update noticeboards to address other issues, such as informing patients how to give feedback on quality of service, or how to raise complaints (both areas in which the Trust scored poorly in the CQC's 2013 National Inpatient Survey). Carolyn agreed to look into this, adding that it would be helpful to have governors' views on the kind of information that could usefully be provided on ward noticeboards.	**28/05/14 Carolyn to update to Board**	**RED 30/06/2014**

Chief Nurse	**317**	30/06/2014	Public	7. Quality & Performance Report - Workforce	Sue Donaldson had advised that each area had been asked to produce trajectories for expected use of bank and agency and others had employed the method of employing to 120% of substantive staff. Sue concluded that she was unsure if this method would allow enough flexibility for the future.	**30/06/14 Emma Woollett requested that emphasis be placed on correct rostering and asked for assurance that this was in hand.**	**30/07/2014**
Chief Nurse	**319**	30/06/2014	Public	7. Quality & Perfornce Report - Board Review	John Moore noted that the data for falls and ulcers had been 'normalised' and pointed out that as the population of older people increased then so would the incidents of falls and pressure sores. He asked that analysis of age related data as a percentage of falls and ulcers incurred by the Trust be provided.	30/06/14 The Chief Executive replied that it the context of the Trust's ambition to drive all falls and pressure ulcer incidents down, analysis would be provided to the Board	25/09/2014
Chief Nurse	**322**	30/06/2014	Public	9. Patient Experience Quarterly Report	Lisa Gardner suggested a list of wards and their location, be placed in the appendices of future reports.	30/06/14 Chief Nurse to amend report for the future.	25/09/2014
Chief Nurse	**324**	30/06/2014	Public	10. Report on Staffing Levels for UHB	Clive Hamilton said that he had expected a data set ward by ward, listing safe staffing levels and variations. The Website version was not clear as it was based on hours and he asked why some areas fell below the expected level.	30/06/14 Carolyn Mills accepted that the website information was not as user friendly as it could be and said thought would be put to improvement.	25/09/2014
Director of Workforce and Organisational Development	**321**	30/06/2014	Public	8. Francis Report	John Moore asked if the Trust were to consider inviting the internal auditor to advise if they agreed with the Trust's view. Deborah Lee replied that other eyes were on the plan with Commissioners regularly reviewing the action planning progress and the Overview and Scrutiny Committee having sight of the process. Emma Woollett asked if assessments had been made of the impact on staff and its effectiveness.	30/06/14 Sue Donaldson replied that she would consider in the light of the cultural change programme what could be done around cultural not audit assessment. Verbal report to October to describe intentions.	27/10/2014
Director of Workforce and Organisational Development	**323**	30/06/2014	Public	10. Report on Staffing levels for UHB	Carolyn concluded that the report was to give the Board assurance that Bristol had establishment and a skill mix that was set to support safe staffing levels. Robust processes were in place for setting that establishment and managing it day to day. With no element of complacency there was recognition of the need to stabilise the workforce with a recruitment campaign and to be constantly attuned to bed numbers with staffing numbers adjusted accordingly.	30/06/14 Sue Donaldson offered to pull together a source document at a high level for all staff groups as a reference point. To be produced at the October QOC meet.	27/10/2014
Medical Director	**318**	30/06/2014	Public	7. Quality & Performance Report - Board Review	Lisa Gardner noted that a review had not been issued for a case of fractured neck femur due to it being a bank holiday. Sean O'Kelly replied that the target was dependent upon the ability of the team to take patients to theatre when trauma patients with clinical priority caused more of a demand. He said that the team were aware of the need to manage peaks in times of demand and were working hard to meet this. He concluded that there was a possible opportunity with the transfer of vascular services to dedicate more capacity to the trauma service. The target had been achieved in June due to specific initiatives.	30/06/14 Emma Woollett asked that a trajectory be produced as this target had not been met for some time (with the exception of June).	25/09/2014

University Hospitals Bristol NHS
NHS Foundation Trust

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

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

APPENDIX A

TRUST MANAGEMENT EXECUTIVE

REPORT TO TRUST BOARD – JULY 2014

1. INTRODUCTION

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

2. COMMUNICATIONS

The Trust Management Executive **noted** the monthly reports on the activities of the Communications Department. In particular it was noted that the Recognising Success Awards 2014 had opened to nominations and SLT were reminded of the importance of role modelling positive leadership behaviours.

3. QUALITY, PERFORMANCE AND COMPLIANCE

The group noted the Quarter 1 2014/2015 position in respect of performance against Monitor's Compliance Framework. The 4-hour emergency target, Referral to Treatment Non-Admitted and 62-day GP/Screening cancer standards had not been achieved.

The Senior Leadership Team **supported** the recommendation to declare the standards failed in quarter 1 to be, the Referral to Treatment Non-Admitted standard, the accident and emergency 4-hour standard and the 62-day GP cancer standard. The forecast failure of the Referral to Treatment non-admitted and 62-day GP cancer standards, in line with the agreed recovery trajectory, should be flagged with Monitor as part of the narrative that accompanies the declaration. The declaration should note further work was in hand to assess the regulatory implications of the national initiative to further reduce admitted referral to treatment backlogs throughout quarter 2 and at this stage a planned failure was predicted for July and August. Further assessments of the plan for September onwards were in hand.

The group **received** an update on progress in respect of essential training and noted significant risks remained to the delivery of the agreed recovery plan.

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

The group received a report following the review of risk management in the Children's Hospital and **agreed** an approach for responding to the recommendations which were both corporate and divisional in nature.

The group received a detailed analysis of complaints received during 2013/2014 and **supported** its onward submission to the Quality and Outcomes Committee and Trust Board.

4. STRATEGY AND BUSINESS PLANNING

The group received and **approved** the Quality Strategy 2014-2017 for onward submission to the Quality and Outcomes Committee and Trust Board.

The group received and **approved** the Patient Safety Strategy 2014-2017, subject to some amendments being made, for onward submission to the Quality and Outcomes Committee and Trust Board.

The group received and **supported** a bid by the Bristol Medical Simulation Centre, in collaboration with the University of Bristol/Versalius, to the Ministry of Defence to deliver Military Operational Surgical Training by way of simulated scenarios, for the next three years, with an option of a fourth year, subject to some final checking around licensing and security.

5. RISK, FINANCE AND GOVERNANCE

The group received and **approved** a Standard Operating Procedure for management of equipment and/or environmental defects following the external reviews commissioning in response to the previous power outage incidents in Q3 2013.

The group received and **approved** proposed changes to the process of management of serious incidents.

The group received and **approved** revised terms of reference for Senior Leadership Team, subject to some amendments.

The group received and **approved** the Board Assurance Framework Quarter 1 update report, for onward submission to the Trust Board.

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

The group received and **supported** the recommendations from the Internal Audit report around the procedural document management framework.

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

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

6. RECOMMENDATIONS

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

Deborah Lee
Deputy Chief Executive
July 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

6. Patient Experience Story

Purpose

To share with the Board members a patient story to support the triangulation of the Board's quality assurance role.

Abstract

The story is an un-edited written summary of Mrs X and her husband's lived experience of accessing services at University Hospitals Bristol. The attached experience written by Mrs X was used by her, to support her sharing her story at a meeting she had requested with the Chief Nurse, to discuss her and her husband's experiences of receiving health services provided by University Hospitals Bristol.

Mrs X was part of a randomly selected group of people who had complained about the service they had received, and who agreed to take part in some focus group work commissioned by the Trust with the Patients Association to get feedback on the Trust's Complaints Service from a user perspective. During this work Mrs X wanted the opportunity to share her experiences more widely within the Trust, to raise awareness of the very positive impact on patient carer experience of good communication and the devastating impact of poor communication and she was offered the opportunity to meet with the Chief Nurse. She wanted to share her and her husband's story more widely and make people aware of the key issues which would not have changed the outcome for her husband but would have made the experience so much better.

The story highlights a number of key issues:

1. Impact of good communication
2. Impact of poor communication/lack of compassion (sensitivity & kindness)
3. Impact of feeling a loss of control/ability to influence
4. Impact of being treated as "stupid"

This is not the experience that the Trust would want anyone accessing our services to live through.

Our thanks to her for sharing her and her husband's story with us.

The Chief Nurse and Medical Director will share this story with the named individuals for them to understand the impact their behaviours have on patients and carers experiences. The story has also been shared with the relevant divisional management teams for dissemination and learning within their division and will be presented to the Patient Experience Group.

Recommendations

The Board is recommended to receive the report for review

Report Sponsor

Carolyn Mills, Chief Nurse

Appendices

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
					PEG August meeting

[redacted] *was diagnosed with a Hiatus hernia approx. 20 years ago*
Had at least 2 endoscopy's in previous years

17th May	*Our GP Dr [redacted] arranging appointment for endoscopy*
24th May	*Saw Dr [redacted] – had pains in stomach – no joy*
25th May	***Rang 111** – Saw [redacted] At Clevedon hospital – didn't even look at his stomach as he was going to have an endoscopy of 6th June – told to take paracetamol*
6th June 2013	*Endoscopy at Westbury Clinic* *Good Results – no signs of any cancer or polyp's*
12th June 2013	*Sent bowel test*
17th June 2013	*Results came back clear with no signs of cancer*
14th July	*Stomach very uncomfortable and swollen*
18th July	*Dr [redacted] sent [redacted] to BRI directly– bypassing A&E* *Waited hours in a considerable amount of pain I asked a young doctor for some paracetamol but she couldn't find the medicine trolley and then no water so I gave [redacted] paracetamol which I had in my handbag. Sat in a room for many hours waiting to be seen by another doctor* *Much later that day he had x-rays and was admitted to Ward [redacted] for overnight stay*
19th July	*Had CT first thing – in the afternoon Staff nurse and 2 young doctors came around the bed – and gave us devastating results - pneumonia / suspected lymphadenopathy, renal and hepatic lesions - require investigations?* ***No privacy and the whole ward could hear everything that was being said. Should have been taken into an office – SENT HOME*** *– We were informed the hospital would be in touch for scan / oncology –* ***(ACTUALLY HAD AN APPOINTMENT WITH ONCOLOGY 10TH SEPTEMBER)***
20th July	*[redacted] in considerable pain and didn't know what to do with himself*
21st July	*Rang Ward [redacted] and they informed me to take [redacted] to A&E as he couldn't come back on the ward and would have to be treated as a new patient – had to go through all the history again – they did not look at their records*
21st July	***Got [redacted] to the hospital at approx. 7.30 am – two drunks only in the A&E department this is when [redacted] received appalling treatment for the triage nurse who didn't want me in the room and told me to be quiet as he only wanted to talk to [redacted] [redacted] at this stage in a very distressed state. This person didn't assess the seriousness of the illness until I interrupted = much to his annoyance and put the release report given to [redacted] 36 hours earlier pointing out expected terminal cancer. Back in Ward [redacted]***
23rd July	*[redacted] had a Colonoscopy*
24th July	*Dr [redacted] confirmed bowel cancer and tumour needed removing*
25th July	*CT Scan followed by an Operation to remove bowel and replaced with a stoma bag - Unable to remove tumour as it was too large.*

Stoma Nurse on holiday for 2 weeks – we had no instructions on what to do .

31st July	*[redacted] allowed home after 10 days in hospital suffering with very* ***bad pressure sores*** *on his bottom - no checks for pressure sores taken while in hospital*

We were told that the oncology would be in touch the following week with the view to receiving chemotherapy. I rang the hospital after a week to find out when [redacted] would be seen – I was told we would be notified but he would have to have a MRI scan before the appointment – news to us.

7th August *MRI scan at BRI - Had to walk from Trenchard St Car Park with stoma bag very uncomfortable – Nowhere to park near the hospital for patients.*

8th August *Appointment with [redacted] – Stoma Nurse – excellent treatment and chased up appointment. By the time we got home [redacted] had left a message on the answer phone saying she had contacted the consultant and apologised about the poor treatment [redacted] had received.*

Received a letter from Dr [redacted] for chemo sessions - [redacted] in the meantime had developed awful pains in his stomach and our G.P thought it may have been an infection so prescribed strong antibiotics and told me to cancel the chemo until the antibiotic course had been completed and [redacted] in less pain.

I rang the BRI to say [redacted] was unwell and to cancel the appointment – the secretary asked me why I was ringing her as [redacted]n was not one of Dr [redacted]s patients. I told her I had the letter in front of me with the dates arranged for chemo and follow up appointments with Dr [redacted] She said [redacted] had been sent the letter in error and that it should have gone to another patient. I then rang Dr [redacted] secretary to arrange the appointment.

4th September *Received an appointment for a PET scan at Cheltenham Cobalt hospital – very good hospital and treated with care*

10th September *First Appointment with Dr [redacted] – [redacted]*
We arrived 5 minutes before our appointment time.
Overcrowded waiting room - not enough seats for everyone – needs comfortable seating and drinks should be offered to patients as it was very hot in the waiting room
Every patient waited at least one hour before being seen - there were patients waiting who were clearing in discomfort and should not have had to wait so long to be seen.
*When we saw Dr [redacted] – absolutely appalling way in which he just asked 'how much do you want to know – it's not good news – **cancer now in liver and bones'** nothing much we can do – totally indifferent about telling someone they were going to die . He said he would let [redacted] have a course of chemo although it was just palliative treatment. He turned to his computer and printed off 12 x A4 sheets of the drugs which would be used – during this time he did not talk or give us any advice of what to expect. This appointment lasted less than 15 minutes to be told [redacted] he was going to die. There was not an ounce of human compassion, [redacted] was treated as a number and not a person. We were dismissed absolutely devastated.*

14th October 2013 *First and last chemotherapy treatment -*

As [redacted] was allegedly an expert in cancer treatment it is my opinion that he should never have put [redacted] through this awful treatment. [redacted] was so terribly ill from the moment we left the hospital and he endured every side effect possible from these drugs and slowly deteriorated.
He was given 14 days of chemo tablets (8 tablets each day) on the 12th day we stopped the tablets as these were obviously killing him. He had every side effect possible with these two drugs

29th October 2013
Struggled to walk from the car into see Dr [redacted] and waited another hour to see this man. I asked the nurse could he be seen on time as [redacted] could hardly walk and she said they were very busy - Saw Dr [redacted] and he said well we tried it so just go home and enjoy what life he had left.

29 October until 16th December the day [redacted] died we had wonderful care from our Doctor, District Nurses and St Peters Hospice Nurse.

Home with pressure sores so very bad that the District Nurse had to use iodine pads every day which were very painful.

(6th Jan 2014) *I sent a letter to Professor [redacted] asking why this hadn't been detected on this test and the previous test June 2011 which also came back normal. – the reply was [redacted] was just unfortunate. I have completed a form removing my name from the list as I feel this is an absolute waste of money and time for the NHS.*

I was a volunteer at St Peters Hospice for several years and saw the care and dedication of the nursing staff there. This treatment should be adopted at the BRI. It appears that there is an absolute lack of training in the care of terminally ill patients.

[redacted]

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

7. Quality & Performance Report

Purpose

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

Abstract

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

Recommendations

The Board is recommended to receive the report for assurance

Report Sponsor

'Overview' – Deborah Lee (Deputy Chief Executive/Director of Strategic Development)
'Quality' – Carolyn Mills (Chief Nurse) & Sean O'Kelly (Medical Director)
'Workforce' – Sue Donaldson (Director of Workforce & Organisational Development)
'Access' – James Rimmer (Chief Operating Officer)

Authors

- Xanthe Whittaker (Head of Performance Assurance & Business Intelligence / Deputy Director of Strategic Development)
- Anne Reader (Head of Quality (Patient Safety))
- Heather Toyne (Assistant Director of Workforce Planning)

Appendices

-

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
		25/07/14			

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

July 2014

CONTENTS

CONTENTS

SECTION A – Performance Overview

Summary

The overall 'health' of the organisation has remained similar to that of last month, with the same number of RED rated and GREEN rated indicators as the previous period. Within this overall steady state there were some notable changes in individual indicators, including the level of complaints increasing and moving this indicator to a RED rating. However, both the number of hospital acquired pressure sores (grade 3 and 4) and the number of Inpatient Falls showed improvements in the period, with the former being restored to a GREEN rating. Sustained improvements also continue to be seen across a range of quality indicators including, overall pressure ulcer incidence, medication errors, and the level of Harm Free Care, as measured by the NHS Safety Thermometer.

One of the three measures of efficiency, overall length of stay, remains RED rated, with Theatre Productivity having maintained its GREEN rating in the period and the Outpatient Appointment Hospital Cancellation Rate showing an improvement for the fifth successive month. The overall Length of Stay of patients discharged in the month increased by 0.05 days relative to the previous month, and remains above the RED threshold. The increase in length of stay reflects a higher proportion of long stay patients being discharged in the month. However, for the first time since the end of March, there were more patients in hospital at month-end that had stayed over 14 days. Positively, despite this deterioration in the flow of patients out of hospital, the national 95% A&E 4-hour waiting time standard was achieved in the period, for the first time since November. Other improvements in patient flow were also observed, such as a reduction in the number of days patients spent as an outlier, and also ambulance hand-over delays.

Three of the four measures of financial performance maintained a GREEN rating in the period. The level of Savings achieved against plan showed a small improvement but remains RED rated, reflecting delays in the divisional plans taking effect at this early stage in the financial year. Whilst the current ratings for CQUINs achievement assume delivery of the plan, the year-end forecast for Contract Penalties has deteriorated, with the main variances from plan including lower than expected performance against the 6-week diagnostic wait, further details of which can be found in the Exception Report provided in the Access section. Staff sickness increased in the period, and this indicator was RED rated for the first time since March. This important indicator of staff wellbeing and productivity continues to be the focus of significant attention. The rate of staff turn-over remains amber rated. Both indicators of the Trust's Research activities continue to be GREEN rated.

The Trust currently has a draft Service Performance score of 3.0 against Monitor's Risk Assessment Framework for quarter 1, which equates to a GREEN rating. This score reflects the failure to achieve the A&E 4-hour standard, Referral to Treatment Time (RTT) Non-admitted standard, and 62-day GP/Screening Cancer Standard for the quarter. Whilst the total number of reported cases of *Clostridium difficile* in the quarter was above the limit that had been set, only one case was deemed to be avoidable by the Trust, following the review of cases by our commissioners. Monitor has confirmed following its regional board meeting early this month that the Trust has been restored to a GREEN rating for quarter 4 2013/14. A formal investigation into repeated failures of the A&E 4-hour, RTT Non-admitted and 62-day GP cancer

standards will only be triggered if the Trust fails to adhere to its planned recovery trajectories.

SECTION B – Organisational Health Barometer

Providing a Good Patient Experience

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
A01	Patient Experience Tracker Score	89	92	N/A	Green: >= 86 Red: < 85	↑	Current month is May 2014.
A02	Patient Complaints as a Proportion of Activity	0.226%	0.277%	0.248%	Green: <0.21% Red: >0.25%	↑	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	0	0	Green: 0 Red> >0	→	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	1	0	1	Green: 0 Red: >= 1	↓	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	5.18	4.28	4.75	Green < 5.6 Red: >= 5.6	↓	

Keeping People Safe

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
C01	Number of Serious Incidents (SIs)	7	5	17		↓	
C02	Cumulative Number of C.Diff cases	1	1	1	Below Trajectory		This indicator now shows the number of commissioner agreed avoidable C. diff cases for the perdio, against a limit for the year to date of 10.

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	91.8%	90.1%	91.2%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	0	1	1	Green: 0 Red: >=2	↑	Previous is confirmed Q3. Current is confirmed Q4. Q1 to be reported at the beginning of August. YTD is Q1, Q2, Q3 and Q4.
D03	A&E 4 Hour Standard	94.30%	95.21%	94.67%	Green: >=95% Red: <95%	↑	

PERFORMANCE OVERVIEW

Being Effective

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
E01	Summary Hospital Mortality Indicator (SHMI) - In Hospital Deaths	59.8	66.6	63.3	Green: <65 Red: >=75	↑	Previous is April 2014 and Current is May 2014. Data now uses the "2013 Baseline" rather than the "2012 Baseline". Target thresholds have been changed to reflect benchmark performance
E02	30 Day Emergency Readmissions	289	317	606	Below 13/14 Readmission Rate	↑	Previous is April's discharges where there was an emergency Readmission within 30 days. Current is May's discharges. Threshold changed to be based on 2013/14 data.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.20	4.25	4.36	Green: <= Quarterly target 3.79 Red: >= Quartrely target 3.79	↑	The target for 2013/14 and 2014/15 for this overall indicator of Length of Stay has been derived from the Trust's bed model.
F03	Theatre Productivity - Percentage of Sessions Used	90.6%	91.2%	90.4%	Green: >= 90% Red: < 90%	↑	
F04	Outpatient appointment hospital cancellation rate	9.5%	9.4%	9.8%	Green: <=6.0% Red: >=10.7%	↓	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	11.2%	11.5%	11.3%	Green: < target Red: >=10% above target	↑	
G02	Staff Sickness	3.7%	4.1%	3.8%	Green: < target Red: >=0.5 percent pts above target	↑	

Promoting Research

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
H02	Cumulative Weighted Recruitment	10,361	13,393	13,393	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Mar 2014 and Current is Jan-Apr 2014
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	52.0%	53.6%	53.6%	Green: >=30% (Upper Quartile) Red: <27.7% (Median)	↑	Current is Q1 2013/14 – Q4 2013-14. Previous is Q4 2012/13 - Q3 2013/14. Updated Quarterly.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	5	3	N/A	Green: < 4 Red: > = 4	↓	Previous shows the Q4 poisition. Current shows the draft position for quarter 1.

Delivering Our Contracts

The Previous column represents Month 2. Current (and YTD) represents Month 3 2014/15.

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£9.68	£6.60	£6.60	> 50% Green < 50% Red	↓	This is Potential year-end rewards. To date, no assessment of performance has been carried out, however in Month 3 the year end assessment has been updated to reflect assumed performance at the level of currently assumed baseline (c68%). To be updated when estimate of actual performance is known.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	-£0.01	£0.17	£0.17	Green: Below Plan Red: Above Plan	↑	Data is variance above (+) or below (-) plan, with a higher negative value representing better performance.YTD and Current is variance reported for June, which refelects assessments available so far for all penalties except EMTA, which is assumed on plan - to be updated when estimate of actual performance is known.

Managing Our Finance

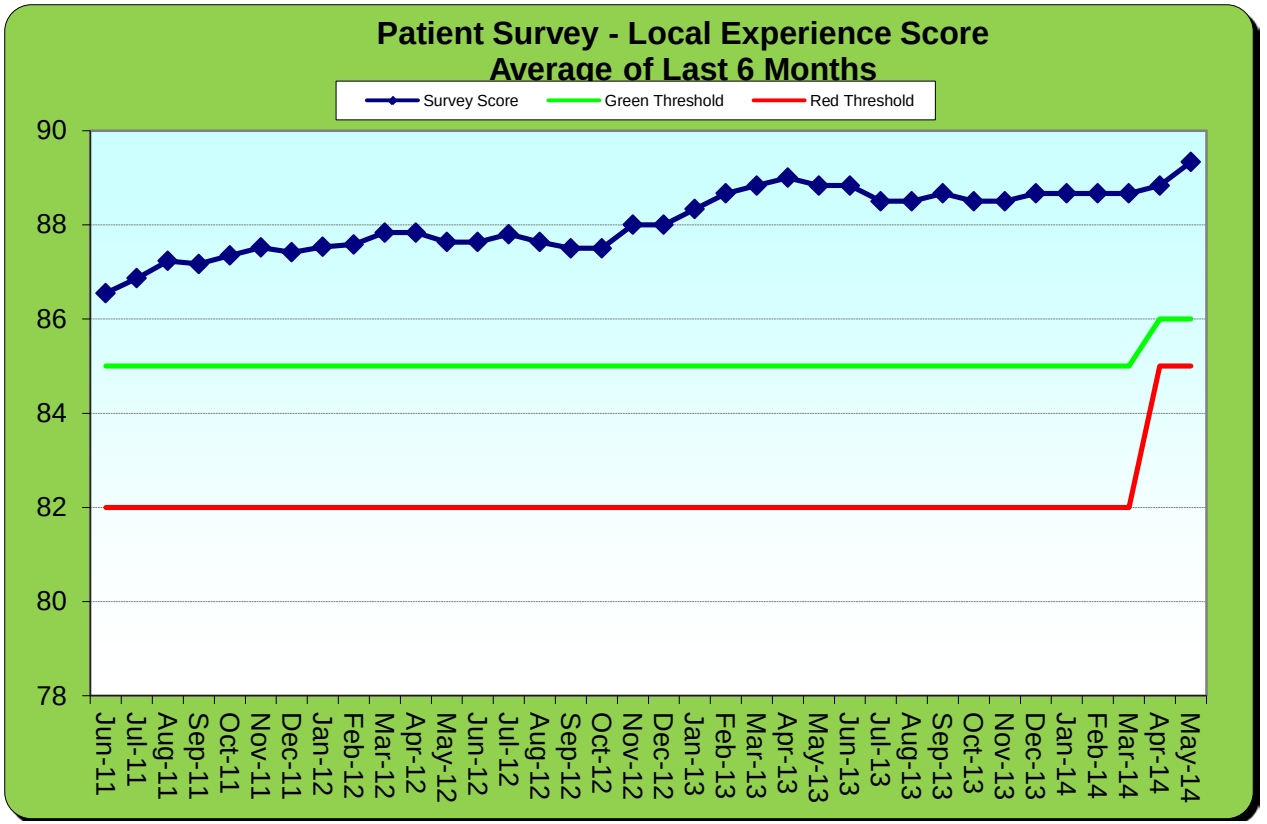
ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
L01	Monitor Continuity of Service	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	For financial measures except CRES, Current and YTD is Current Year To Date. For CRES there is a separate total for latest month and YTD. Previous is previous month's reported data.
L02	Liquidity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	
L03	Capital Service Capacity	4.0	4.0	4.0	Green: >=3.0 Red: <2.5	→	
L04	Savings plan achievement	66%	67%	66%	Green: >=90% Red: < 75%	↑	

Notes

Unless otherwise stated, Previous is May 2014 and Current is June 2014

YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2014 up to and including the current month

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


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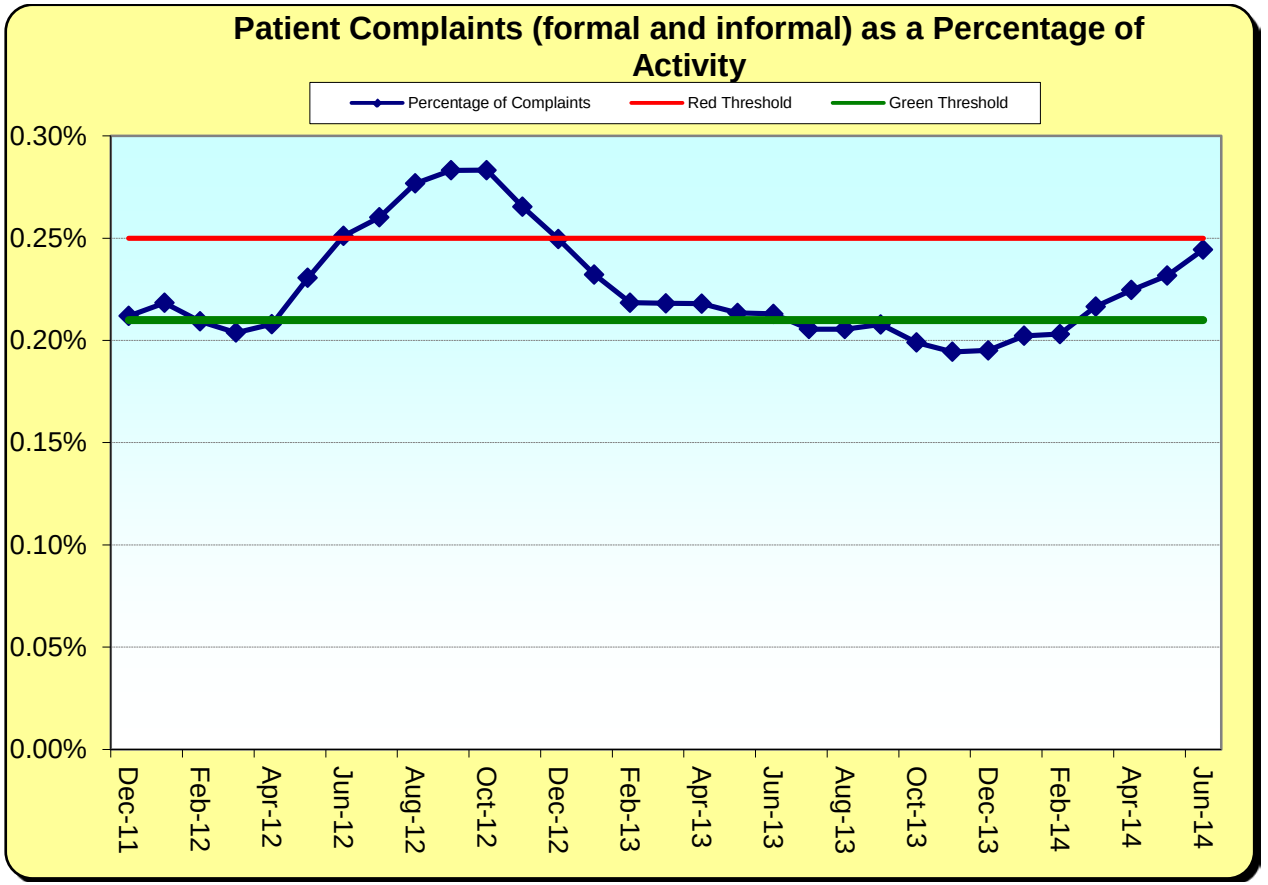
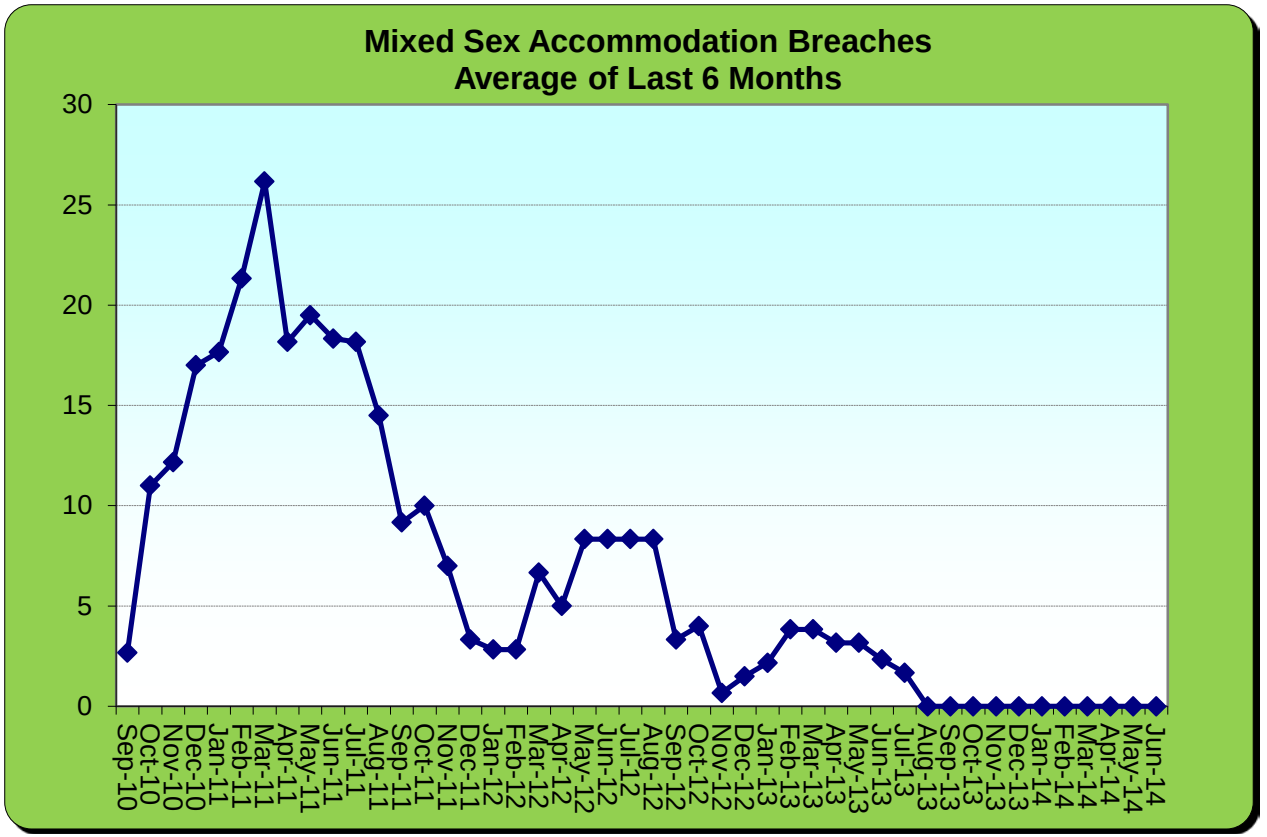
Apr-14
May-14


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


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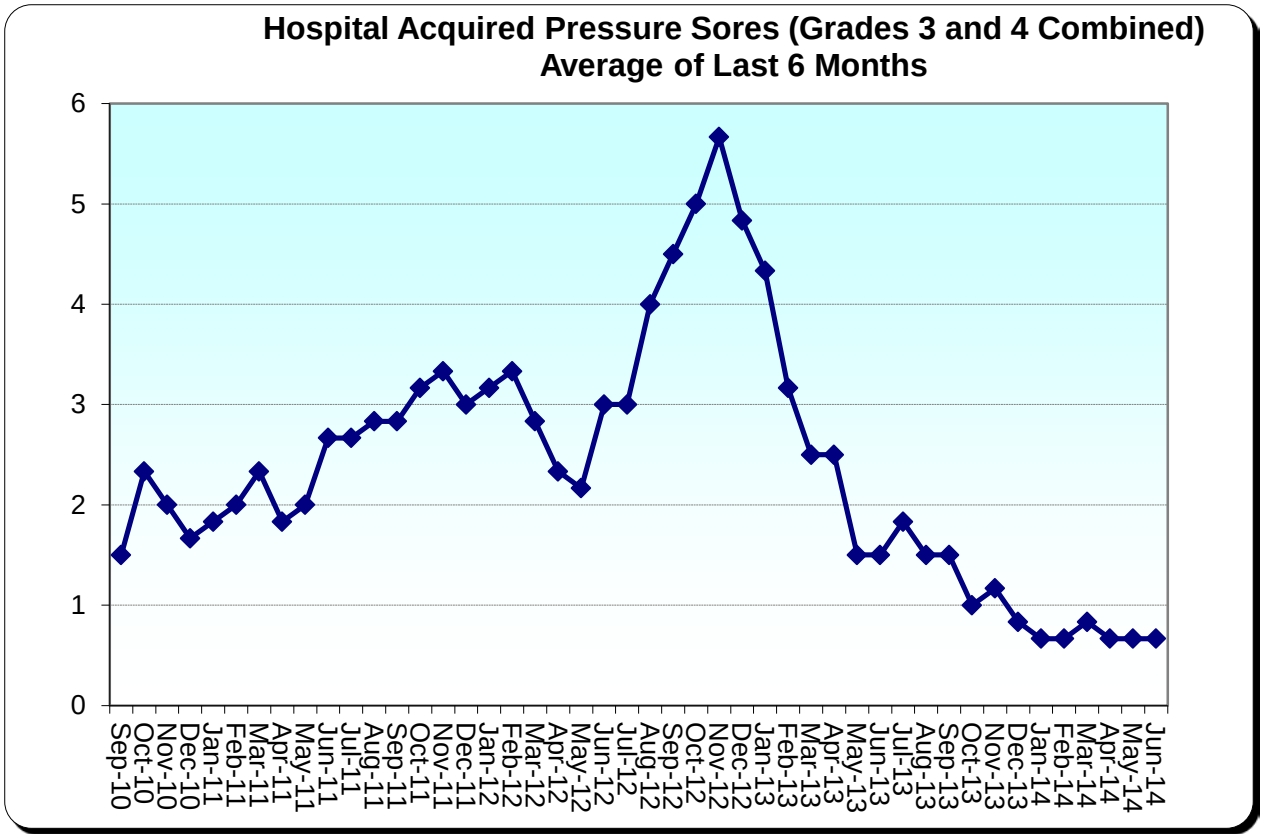
May-14
Jun-14


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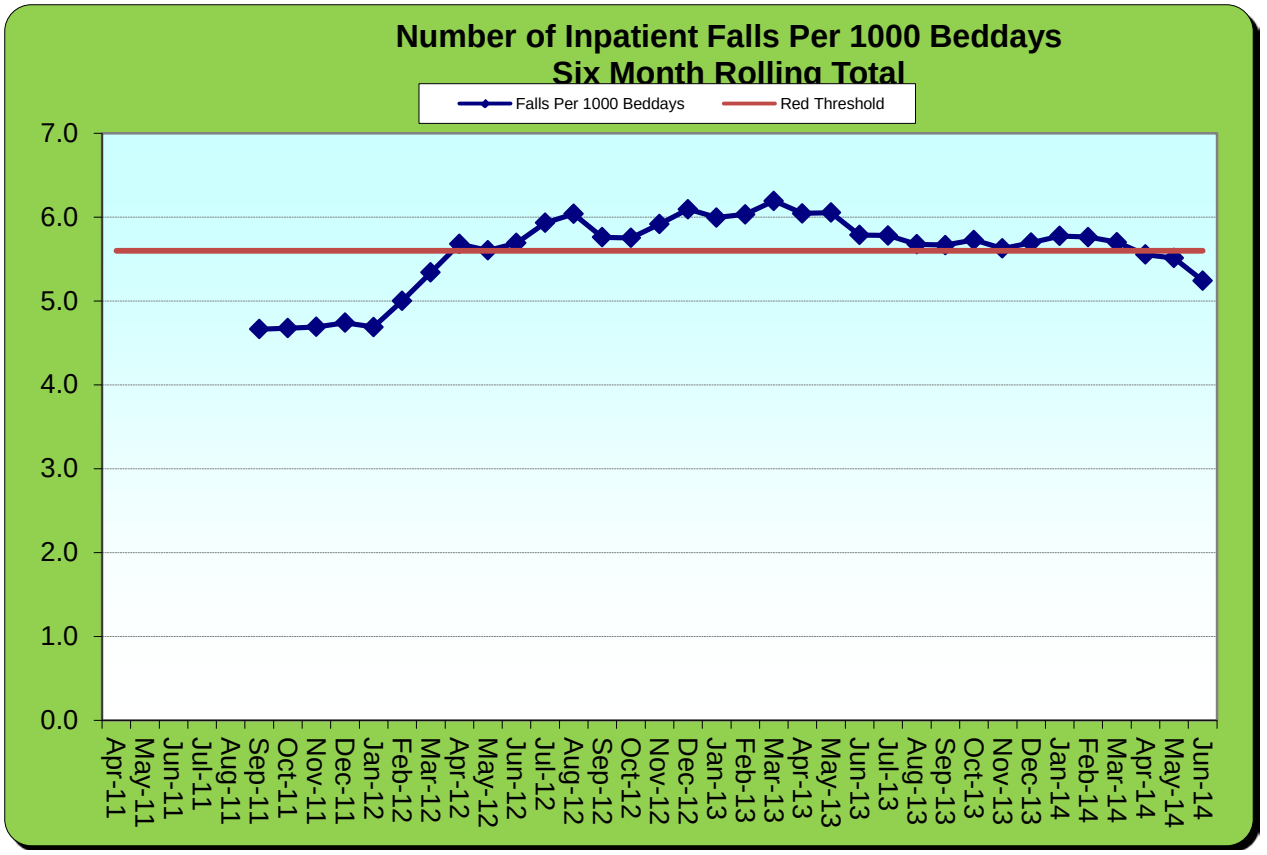
May-14
Jun-14


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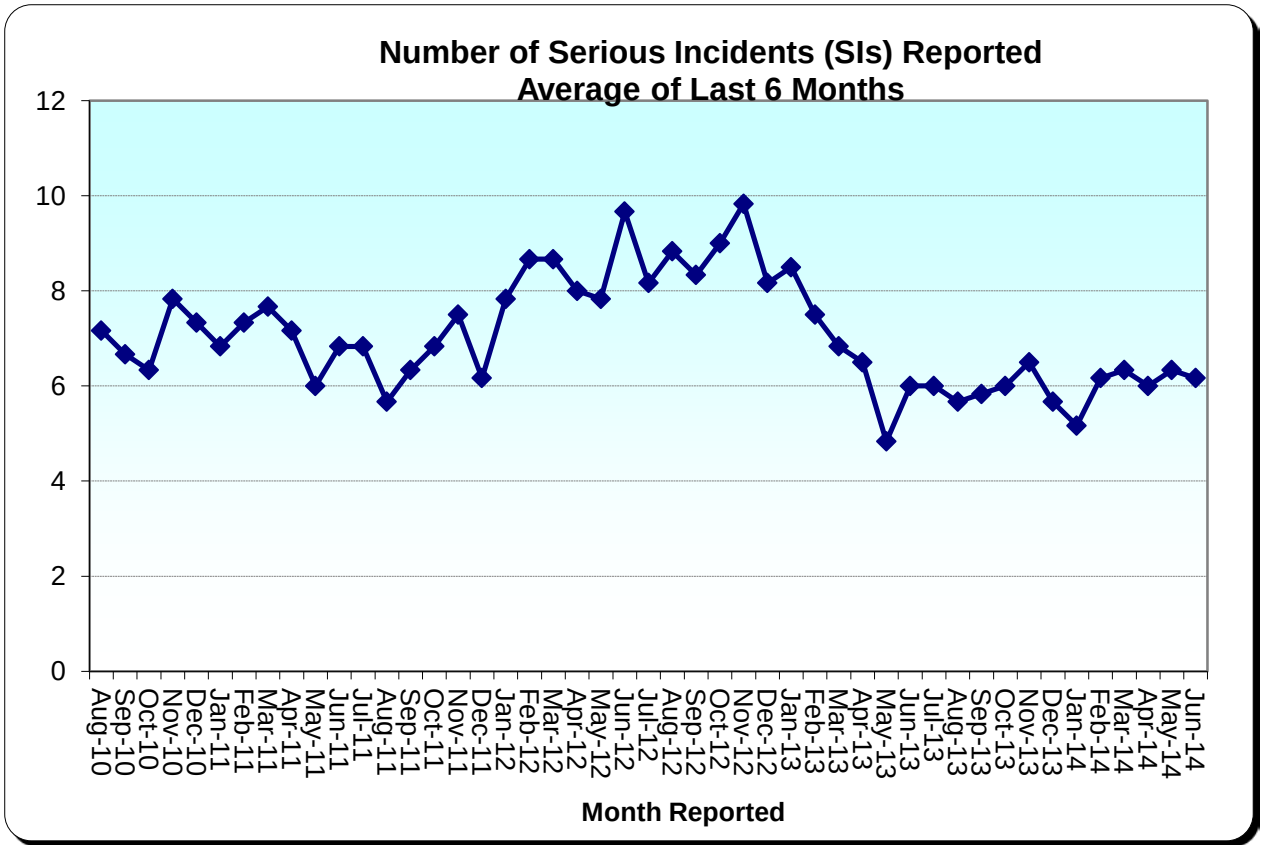
May-14
Jun-14


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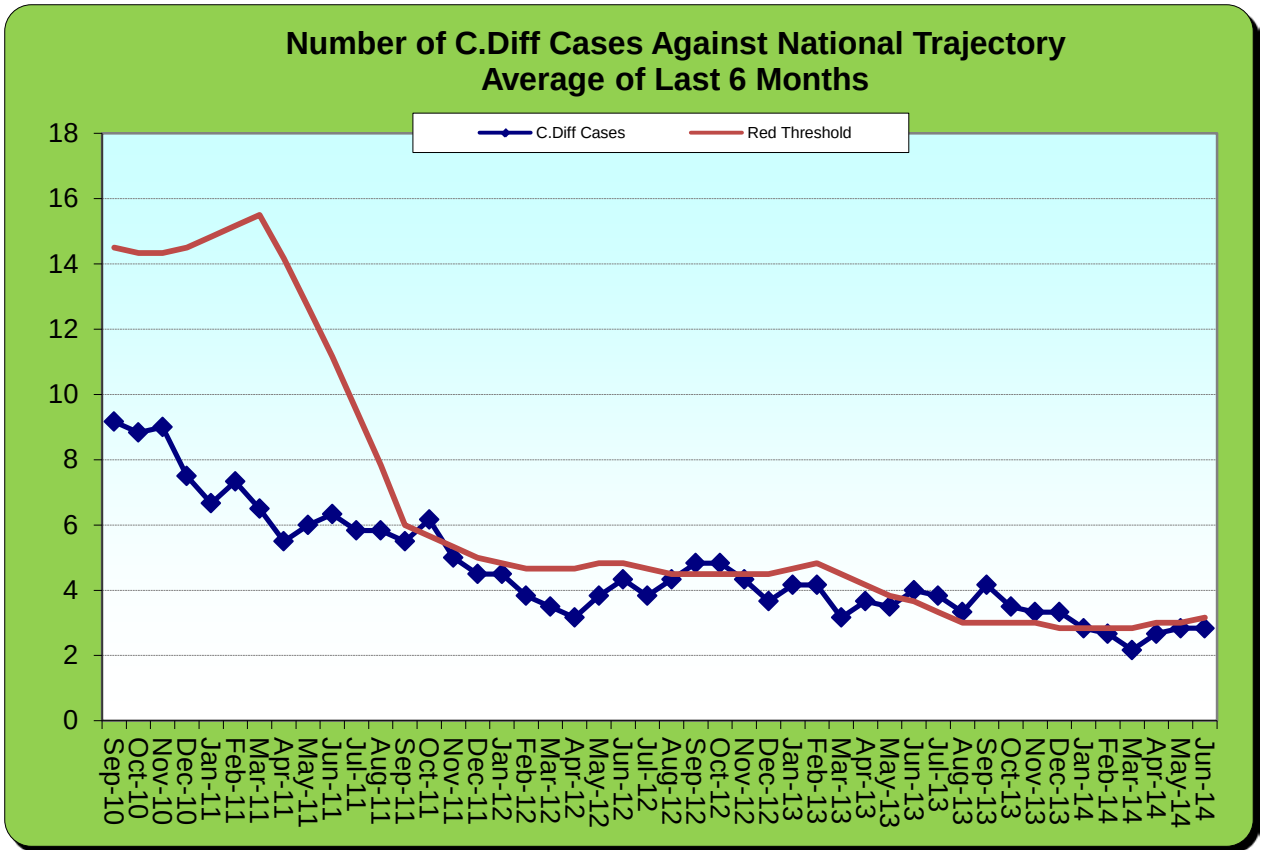
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Month Reported


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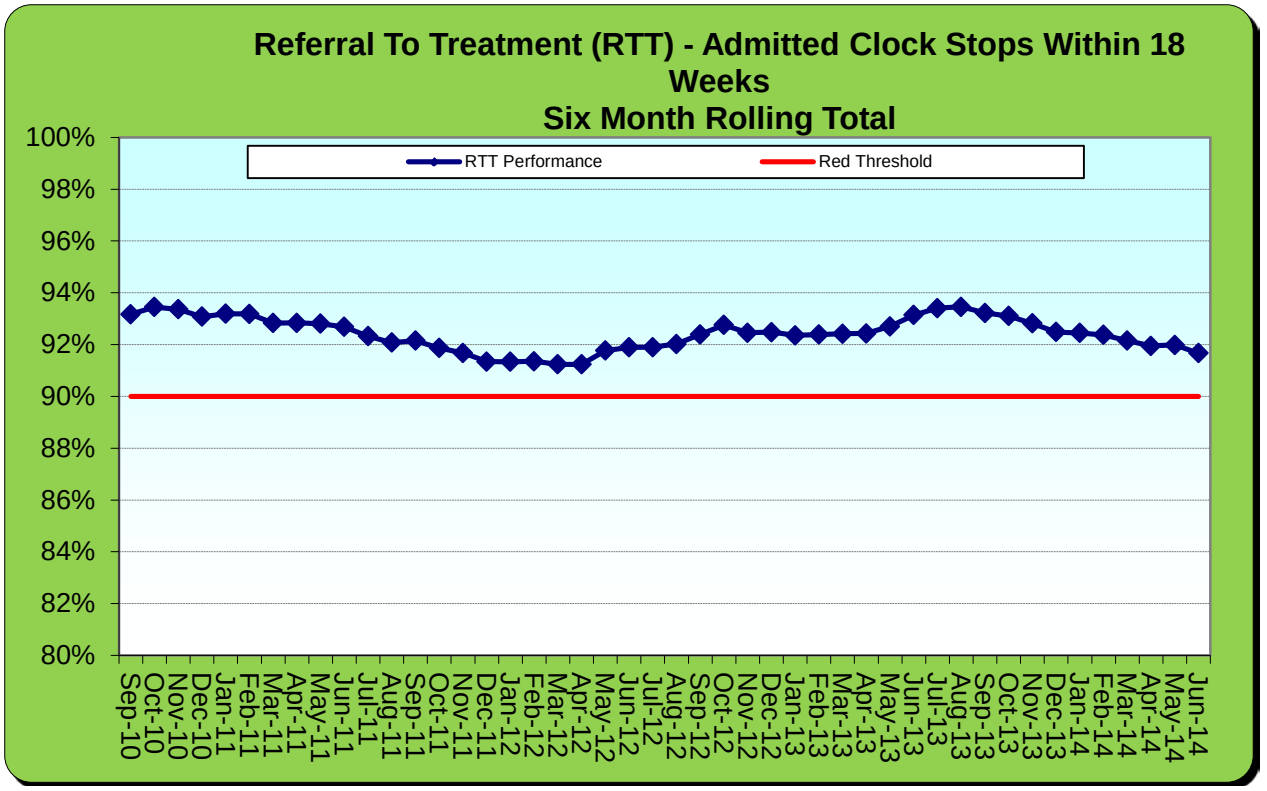
Apr-14
May-14
Jun-14


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
Six Month Rolling Total
RTT Performance
Red Threshold
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
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Apr-12
May-12
Jun-12
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Feb-13
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Apr-13
May-13
Jun-13
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Jan-14
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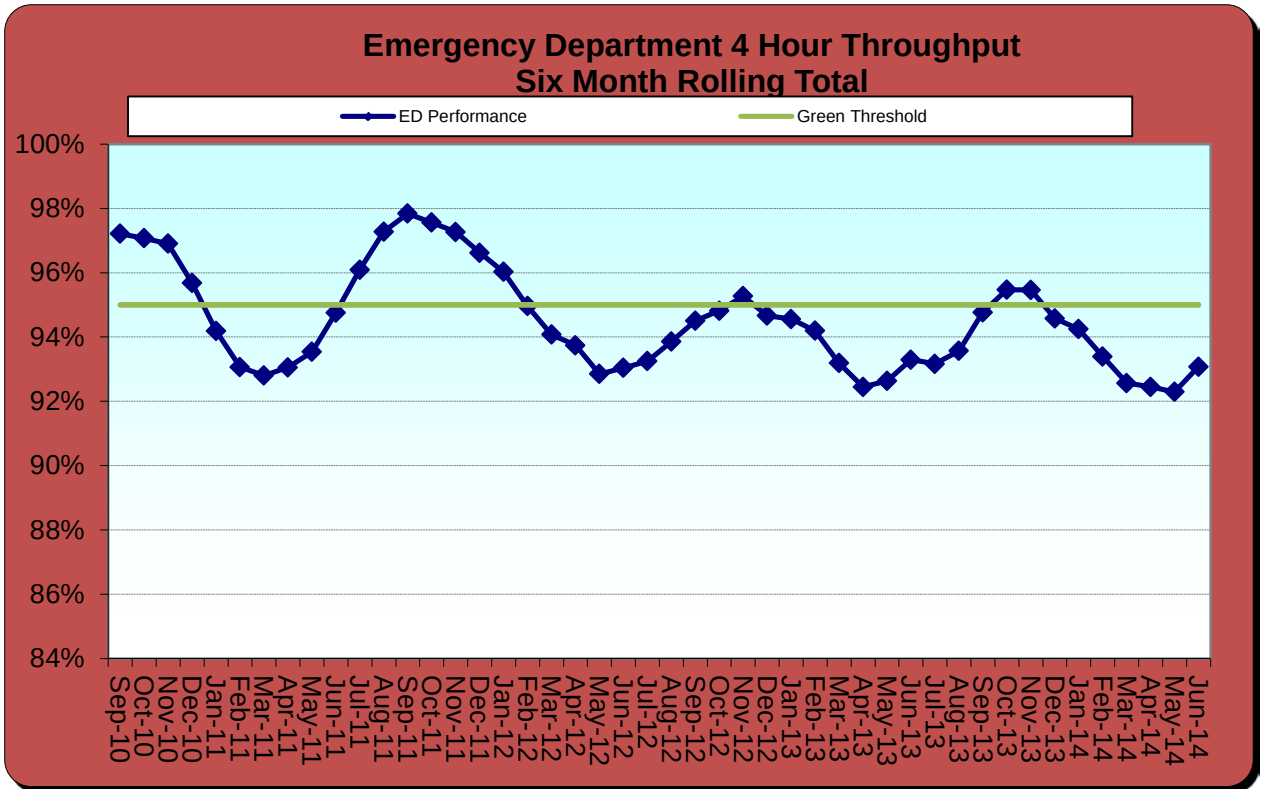
Mar-14
Apr-14
May-14
Jun-14


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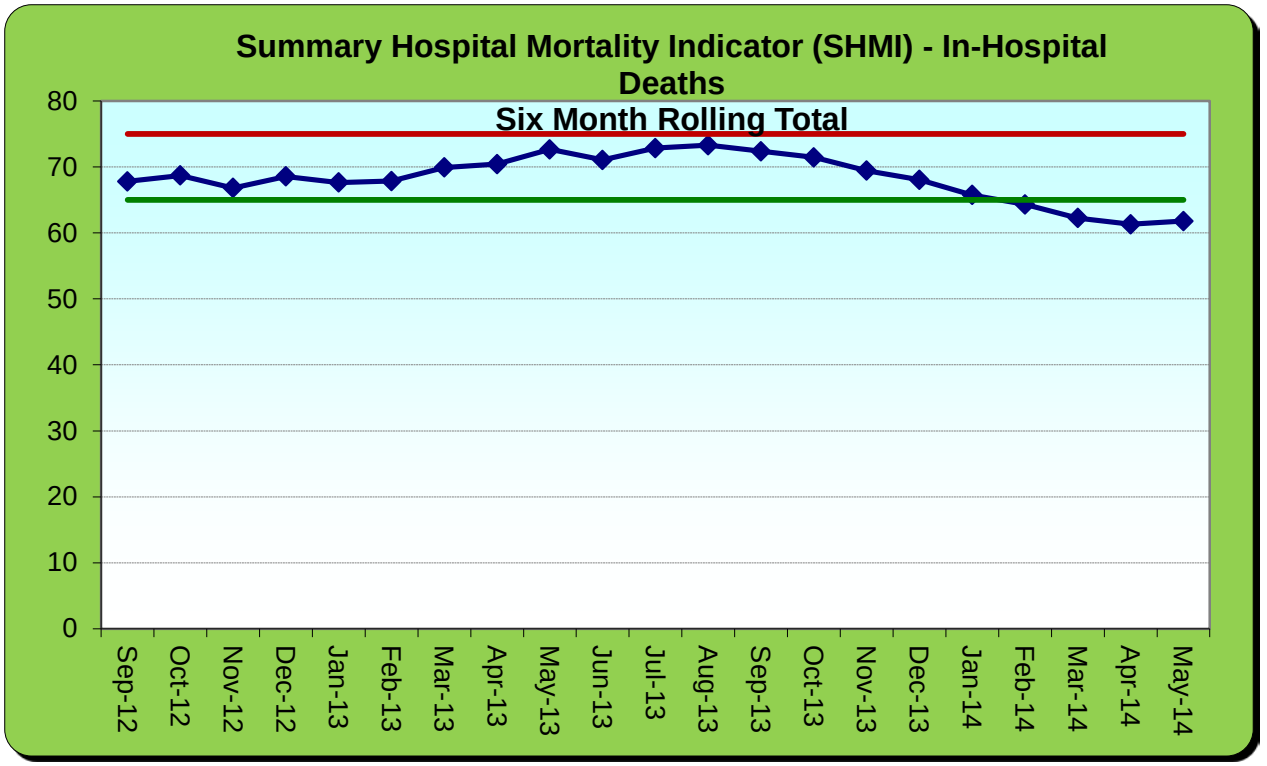
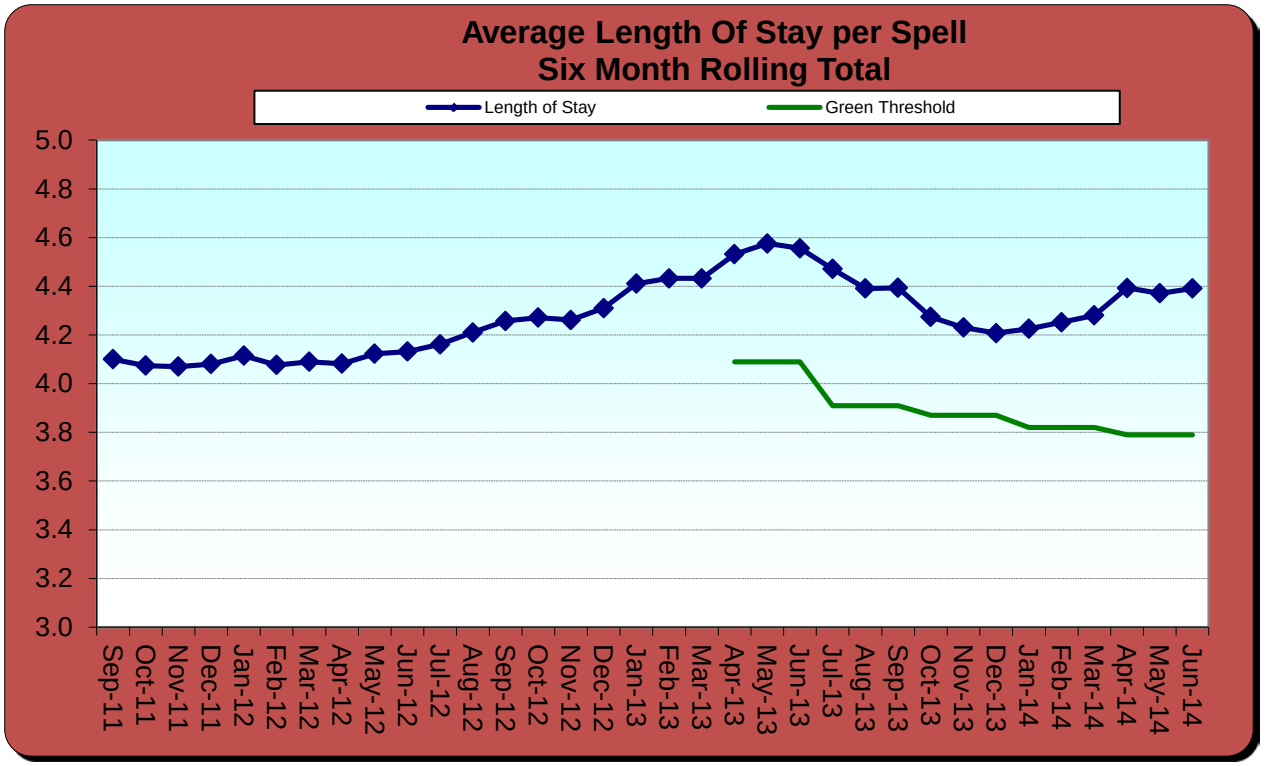
May-14
Jun-14


Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
80
70
60
50
40
30
20
10
0
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14


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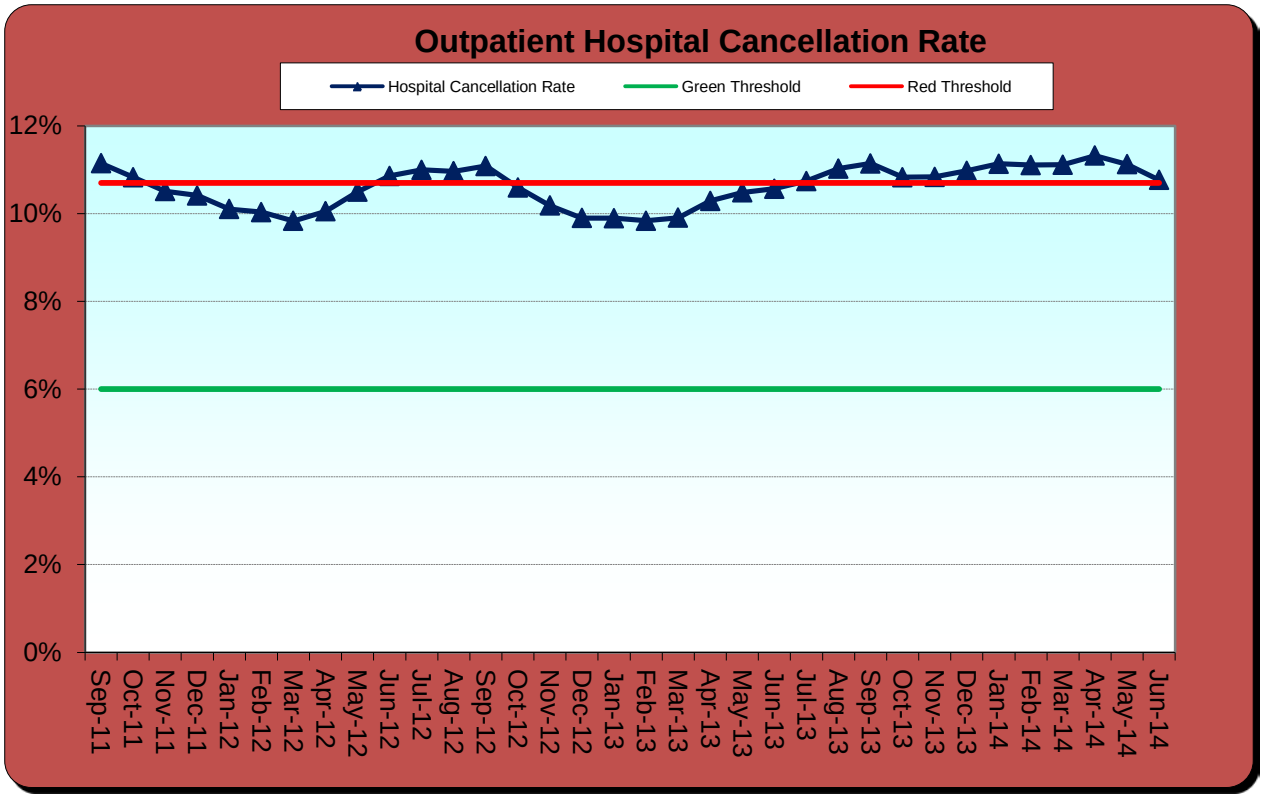
May-14
Jun-14


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

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Patient complaints as a proportion of activity	In the *Quality* section of this report	
30-day emergency readmission	In the *Quality* section of this report	
Overall Length of Stay	See *Overview section*	
Staff sickness	In the *Workforce* section of this report	
Contract penalties above plan	See *Overview section*	
Savings Plan Achievement	See separate Finance Report.	

SECTION C – Monitor's Compliance Framework

For quarter 1 as a whole the Trust failed to meet three of the standards in Monitor's 2014/15 Risk Assessment Framework. Exception reports are provided for these three standards, which are:

- A&E 4-hour maximum wait (1.0) – *Access section*
- RTT Non-admitted standard (1.0) – *Access section*
- 62-day Referral to Treatment GP/Screening Cancer standard (1.0) – *Access section*

Whilst the total number of reported cases of *Clostridium difficile* in the quarter was above the limit that had been set, only one case was deemed to be avoidable by the Trust, following the review of cases by our commissioners.

Overall the Trust has a draft Service Performance Score of 3.0 against Monitor's Risk Assessment Framework, reflecting the three standards not met for the quarter. This equates to a GREEN risk rating. Monitor has confirmed following its regional board meeting early this month that the Trust has been restored to a GREEN rating for quarter 4 2013/14. A formal investigation into repeated failures of the A&E 4-hour, RTT Non-admitted and 62-day GP cancer standards will only be triggered if the Trust fails to adhere to its planned recovery trajectories.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 1 2014/15.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Compliance Framework Q1 13/14	Compliance Framework Q2 13/14	Risk Assessment Framework Q3 13/14	Risk Assessment Framework Q4 13/14	Risk Assessment Framework Q1 14/15*	Q1 Actual quarter-end*	Notes	Q1 Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	1	×	×	×	×	1	✓	1 unavoidable case against a limit of 10, as agreed by commissioners	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	100.0%	✓	✓	✓	✓	99.4%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	95.6%	✓	✓	✓	✓	94.9%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	98.4%	✓	✓	✓	✓	97.0%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	78.1%	✓	×	✓	×	81.3%	×	62-day GP standard not achieved for the quarter. The screening standard is below the 90% standard due to the management of pathways at other providers.	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	89.9%	✓	✓	✓	✓	89.7%	×		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	91.2%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	91.2%	✓		Achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	93.4%	Achieved each month	Not achieved	Not achieved	Not achieved	93.4%	×	Standard failed in April and May so failed for the quarter as a whole.	Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.4%	Achieved each month	Achieved each month	Achieved each month	Achieved each month	92.4%	✓		Achieved
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	97.9%	✓	✓	✓	✓	96.7%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	97.1%	✓	✓	✓	✓	96.6%	✓		Achieved
	8b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
	9	A&E Total time in A&E 4 hours	1.0	95%	94.7%	×	✓	×	×	94.7%	×	95% standard not met in April or May.	Not achieved
	10	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Actions implemented	Not applicable	Not applicable	Not applicable		Achieved
					rating	AMBER-RED	AMBER-RED	GREEN	GREEN	GREEN	GREEN		3.0 GREEN

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

***Q1 Cancer figures based upon reported figures for April and May, and draft figures for June. The C diff figures is shown as the cumulative position against the quarter-end target with exclusions agreed with commissioners applied.**

1.1 QUALITY TRACKER

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Quarterly Totals 13/14	Quarterly Totals 13/14	Quarterly Totals 13/14	Quarterly Totals 14/15
Patient Safety																						
Infections	DA01a	MRSA Cumulative Cases Against National Trajectory	0	1	2	3	1	1	1	1	1	1	1	2	2	1	1	3	1	1	2	3
	DA03a	C.Diff Cumulative Cases Against National Trajectory	40	40	38	13	17	20	25	27	30	34	34	36	38	5	9	13	25	34	38	13
	DA02	MSSA Cases Against Trajectory	25	25	27	4	2	1	5	3	3	3	1	2	2	1	0	3	8	9	5	4
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	DD02	MRSA Emergency Screenings	95%	80%	94.8%	95.4%	92.3%	93.9%	94.8%	95.2%	94.9%	95.2%	95%	95.2%	95.3%	96%	95.5%	94.9%	93.6%	95.1%	95.2%	95.4%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.8%	97.4%	98.1%	92.4%	97.8%	96.4%	96.1%	96%	98.3%	98.3%	97.2%	97.5%	96.9%	97.8%	96%	96.2%	97.8%	97.4%
	DB02	Antibiotic Compliance	90%	80%	88%	89.4%	88.3%	85%	86.5%	85.9%	86.5%	86.5%	88.6%	90.1%	90.7%	91.8%	88%	87.9%	86.7%	86.2%	89.9%	89.4%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	95%	70%	95%	96%	95%	96%	94%	95%	95%	94%	94%	94%	96%	96%	95%	96%	95%	95%	95%	96%
	DC02	Cleanliness Monitoring - Very High Risk Areas	95%	95%	96%	96%	96%	98%	96%	95%	96%	96%	95%	96%	96%	95%	97%	95%	97%	96%	96%	96%
	DC03	Cleanliness Monitoring - High Risk Areas	95%	70%	95%	96%	96%	95%	95%	94%	96%	95%	95%	95%	96%	96%	96%	96%	95%	95%	95%	96%
Serious Incidents	S02	Number of Serious Incidents Reported	0	0	73	17	9	3	4	7	5	6	6	9	5	5	7	5	16	18	20	17
	S02a	Number of Confirmed Serious Incidents	0	0	70	4	8	3	4	7	5	6	6	9	4	2	2	-	15	18	19	4
	S02b	Number of Serious Incidents Still Open	0	0	1	13	-	-	-	-	-	-	-	-	1	3	5	5	-	-	1	13
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	83.6%	70.6%	66.7%	100%	25%	85.7%	100%	83.3%	100%	88.9%	100%	80%	57.1%	80%	62.5%	88.9%	95%	70.6%
	S04	Percentage of Serious Incident Investigations Completed Within Timesca	80%	80%	92.4%	82.4%	100%	100%	100%	87.5%	100%	100%	87.5%	75%	100%	100%	50%	83.3%	100%	93.8%	89.5%	82.4%
Never Events	S01	Total Never Events	0	1	2	2	0	0	0	0	0	1	0	0	0	1	1	0	0	1	0	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	0	0	12090	1822	1134	914	922	1064	1052	958	1060	954	986	897	925	-	2970	3074	3000	1822
	S06a	Patient Safety Incidents Per 100 Admissions	0	0	9.25	8.33	10.05	8.38	8.45	9.09	9.57	9.41	9.43	9.28	9	8.37	8.3	-	8.97	9.35	9.24	8.33
	S07	Number of Patient Safety Incidents - Severe Harm	0	0	44	10	3	1	3	7	3	3	3	7	6	4	6	-	7	13	16	10
Patient Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.68	4.85	5.64	5.76	5.8	5.96	5.42	5.59	6.1	5.67	5.46	5.08	5.18	4.28	5.73	5.66	5.74	4.85
	AB06a	Total Number of Patient Falls Resulting in Harm	24	25	27	8	2	1	3	1	4	2	2	4	2	1	5	2	6	7	8	8
Falls (CQUIN Improvement)	AB07a	Number of Inpatient Falls	429	429	-	374	-	-	-	-	-	-	-	-	-	129	136	109	-	-	-	374
	AB07b	Inpatient Falls - Improvement from Baseline	0	0	-	-55	-	-	-	-	-	-	-	-	-	-12	-8	-35	-	-	-	-55
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	0.656	0.363	0.788	0.755	1.078	0.706	0.526	0.555	0.69	0.417	0.417	0.433	0.343	0.314	0.871	0.596	0.51	0.363
	DE02	Pressure Ulcers - Grade 2	0	0	184	27	18	18	26	17	12	14	17	9	10	11	8	8	62	43	36	27
	DE03	Pressure Ulcers - Grade 3	0	1	13	1	2	1	0	1	1	0	1	1	1	0	1	0	3	2	3	1
	DE04	Pressure Ulcers - Grade 4	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	96%	95%	98%	98.6%	96.6%	98.1%	97.9%	98%	98.5%	98.2%	98.6%	98.7%	98.5%	98.9%	98.7%	98.1%	97.5%	98.2%	98.6%	98.6%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	90%	93.4%	94.9%	91.6%	92.5%	95.6%	94.6%	95.1%	97.1%	94.9%	96.6%	94.5%	96.4%	94.3%	94%	93.2%	95.6%	95.3%	94.9%
Nutrition	tbc	Nutritional Screening Completed																				
	WB03	Nutrition: Food Chart Review	90%	85%	82.5%	89.5%	72.3%	92.4%	80.9%	83.8%	76.9%	84.1%	91.2%	91.8%	78.2%	94.7%	87.4%	87.7%	81.8%	82.1%	87.7%	89.5%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.6%	99.6%	99.7%	99.5%	99.5%	99.6%	99.5%	99.7%	99.9%	99.6%	99.6%	99.7%	99.6%	99.4%	99.6%	99.6%	99.7%	99.6%
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2%	0.68%	0.61%	0.74%	0%	0.7%	0.61%	0.56%	0%	1%	0.54%	0%	1.3%	0%	-	0.49%	0.41%	0.52%	0.61%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	97.9%	98.1%	99.1%	98.3%	99%	99.1%	100%	100%	99.1%	99%	100%	98.6%	100%	95.6%	98.8%	99.7%	99.4%	98.1%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	92%	96.1%	93.3%	97.5%	89.1%	89.5%	90.8%	83.3%	85%	100%	100%	98.8%	99.1%	90.9%	93.6%	88.1%	94.1%	96.1%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.5%	2%	1.91%	0.68%	1.91%	2.1%	1.19%	2.75%	2.32%	2.6%	1.08%	0.91%	1.66%	1.18%	0.55%	0.38%	1.74%	2.56%	1.23%	0.68%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	95.6%	92.8%	94.1%	96.1%	91.9%	95.2%	94.5%	93.5%	95.8%	95%	95.6%	96.2%	95.2%	95.7%	96.7%	96%	93.9%	94.7%	95.7%	96.1%
	AK04	Safety Thermometer - No New Harms	98.2%	97%	97.2%	98.3%	95.9%	97.3%	98.3%	96.7%	97.4%	97.9%	98.5%	97.8%	97.6%	98.2%	98.4%	98.5%	97.2%	97.3%	98%	98.3%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	95%	90%	85%	88%	79%	85%	80%	85%	82%	76%	91%	86%	88%	89%	83%	91%	82%	81%	89%	88%
	CC01	Number of Verified Crash Calls from Adult General Wards	96	108	-	13	-	-	-	-	-	-	-	-	-	3	5	5	-	-	-	13
Discharges	TD04	Out of Hours Discharges			9%	8.9%	9.8%	10%	9.2%	8.7%	8.8%	8.6%	8.1%	10%	9.8%	9.5%	9%	8.2%	9.7%	8.7%	9.3%	8.9%

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15	Monthly Totals Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Quarterly Totals 13/14	13/14	13/14	14/15
Clinical Effectiveness																						
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital D	65	75	67.2	63.3	70.8	69.9	73.7	65.4	64.3	64.7	57.6	60.8	60.9	59.8	66.6	-	71.5	64.8	59.7	63.3
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	-	-	94.7	-	-	-	95.7	-	-	-	-	-	-	-	-	-	95.7	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI)	80	90	75.7	70.3	82.1	76.2	80.3	69.8	66.8	78.7	65.4	75.3	73.1	69.8	70.7	-	79.5	72	71	70.3
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	80%	50%	83.9%	93.8%	50%	100%	88.2%	100%	95%	77.8%	95%	90.5%	92.3%	100%	78.9%	100%	73.7%	91.7%	92.6%	93.8%
Readmissions	C01	Emergency Readmissions Percentage	2.7%	2.7%	2.71%	2.77%	2.61%	2.49%	2.76%	2.7%	2.69%	2.83%	2.89%	2.93%	2.86%	2.71%	2.83%	-	2.62%	2.73%	2.89%	2.77%
Maternity	G04	Percentage of Normal Births			61.7%	61.7%	60.7%	60.9%	61.6%	61.2%	63.9%	62.7%	59.9%	62.6%	61.4%	63.6%	58.9%	62.4%	61.1%	62.6%	61.3%	61.7%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	90%	90%	77.4%	78.9%	75.9%	77.1%	96.6%	90.5%	95.5%	87.8%	55.9%	92.6%	85.7%	88.9%	70%	82.6%	82.8%	90.5%	76.4%	78.9%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	90%	90%	78.8%	94.4%	62.1%	68.6%	75.9%	81%	95.5%	100%	97.1%	100%	100%	94.4%	93.3%	95.7%	68.8%	94%	98.9%	94.4%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	61.7%	74.6%	44.8%	54.3%	69%	71.4%	90.9%	87.8%	52.9%	92.6%	85.7%	83.3%	66.7%	78.3%	55.9%	84.5%	75.3%	74.6%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	50%	50%	55.1%	52.8%	60%	53.7%	62.2%	58%	36.1%	66.7%	62.2%	56.8%	63.9%	52.3%	53.6%	-	58.5%	55.2%	60.8%	52.8%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	84.2%	93.1%	91.1%	82.9%	89.2%	86%	83.3%	87.5%	86.7%	79.5%	86.1%	90.9%	96.4%	-	87.8%	85.8%	84%	93.1%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	55.8%	48.3%	35.3%	62.5%	71.4%	73.3%	40%	61.1%	50%	45.5%	50%	60%	30%	57.1%	55.3%	63.2%	48.8%	48.3%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	67.7%	52.6%	80.1%	86.2%	86.6%	83.4%	74.9%	49.7%	46.6%	45.3%	46.9%	57.1%	52.3%	49%	84.5%	68.7%	46.3%	52.6%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	60.6%	70.3%	40.4%	52.9%	53.4%	59%	57.7%	66.7%	75.5%	78%	66.7%	71.7%	78.3%	59.5%	49.2%	60.7%	73%	70.3%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	65.4%	42.4%	66.7%	62.5%	62.5%	75%	75.9%	61.5%	57.9%	38.5%	52.4%	47.6%	56.5%	22.7%	63.6%	70.7%	48.5%	42.4%
	AC04	Percentage of Dementia Carers Feeling Supported			-	69.7%	-	-	-	-	-	-	-	-	-	60%	62.5%	90%	-	-	-	69.7%
Outliers	J05	Ward Outliers - Beddays			10622	2419	661	698	517	846	755	1064	1302	1246	960	683	927	809	1876	2665	3508	2419
Patient Experience																						
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	-	-	88	89	89	88	89	89	88	89	89	89	92	-	89	89	89	90
	P01g	Patient Survey - Kindness and Understanding	-	-	-	-	94	93	94	93	93	93	93	91	94	94	94	-	93	93	93	94
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	25%	25%	29.6%	41.6%	17.4%	21.4%	38.2%	42.2%	45.2%	37.4%	37.9%	43.8%	46.7%	45.9%	39.5%	39.5%	25.1%	41.6%	42.7%	41.6%
	P03b	Friends and Family Test ED Coverage	15%	15%	13.3%	18.7%	10.5%	11.7%	16.2%	19.1%	18.6%	11.6%	13.8%	16.4%	26.4%	15.7%	21.1%	19.2%	12.7%	16.6%	19.1%	18.7%
	P04a	Friends and Family Test Score - Inpatients	70	64	75.9	75.2	81.2	75	73.8	76.5	75.7	74.4	75.5	76.5	76.1	78.4	73.3	73.5	75.9	75.6	76	75.2
	P04b	Friends and Family Test Score - ED	51	42	70.1	71.8	70.5	72.3	73.9	71.6	70.8	66.3	70.3	70.1	68.7	75.8	71.4	69.3	72.4	70.1	69.5	71.8
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.212%	0.248%	0.162%	0.232%	0.202%	0.192%	0.185%	0.199%	0.214%	0.227%	0.282%	0.238%	0.226%	0.277%	0.198%	0.192%	0.241%	0.248%
	T03a	Complaints Responded To Within Trust Timeframe	95%	85%	76.4%	86.3%	80.3%	77.2%	87.8%	84.9%	82.2%	88.1%	76.1%	92%	88.7%	93.1%	82.5%	83.3%	81.4%	85%	84.7%	86.3%
	T03b	Complaints Responded To Within Divisional Timeframe			71.1%	86.9%	74.6%	93%	83.7%	69.9%	66.7%	57.1%	77.6%	86%	75.5%	82.8%	86%	91.7%	83.1%	65.6%	79.4%	86.9%
	T04a	Complainants Disatisfied with Response			62	21	6	11	1	7	2	6	6	3	5	6	4	11	18	15	14	21
Ward Moves	J06	Average Number of Ward Moves			2.3	2.3	2.2	2.2	2.3	2.3	2.4	2.3	2.4	2.3	2.4	2.3	2.3	2.3	2.2	2.3	2.4	2.3
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.02%	1.02%	1.15%	0.85%	0.72%	0.65%	0.94%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	1.1%	0.91%	0.85%	1.17%	1.02%
	F01a	Number of Last Minute Cancelled Operations	0	0	690	172	69	47	40	40	54	47	70	78	52	54	54	64	156	141	200	172

1.2 SUMMARY

Of particular note this month is the significant improvement in falls metrics, both overall incidence (from 5.18 in May to 4.28 falls per 1000 bed days in June) and in the actual number of falls (from 136 in May to 109 in June). In addition the number of falls resulting in moderate or major harm has reduced and there were 35 fewer falls than the age adjusted baseline. Whilst it is too early to say whether this is a trend, it is an encouraging set of figures this month.

On the other hand, three of our infection control metrics have exceeded their red thresholds in the month: *Clostridium difficile*, MRSA (Meticillin Resistant Staphylococcus aureus) and MSSA (Meticillin Sensitive Staphylococcus aureus) bacteraemias, and the dementia metrics have also deteriorated. We have, however, introduced a new metric based on our surveys of carers of people with dementia, which encouragingly shows that 90% of carers feel supported. Recovery plans for red rated metrics are provided in the relevant exception report.

We have agreed our Commissioning for Quality and Innovation (CQUIN) targets with our commissioners and have introduced two new metrics into the dashboard: reduction in falls against baseline, and reduction in cardiac arrest calls from adult general ward areas, both of which are currently meeting the green threshold. We continue to refine thresholds for existing metrics and have made further changes as planned in the explanatory report provided last month as an addendum to the quality report.

 **Achieving set threshold (36)**	 **Thresholds not met or no change on previous month (6)**
- MRSA (Meticillin Resistant Staphylococcus aureus) screening – elective - Hand Hygiene Audit - Cleanliness monitoring: 1) overall Trust score, 2) very high risk areas and 3) high risk areas - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescales - Never Events - Inpatient falls incidence per 1,000 bed days - Falls resulting in harm - Falls improvement from baseline - Total pressure ulcer incidence per 1,000 bed days - Number of grade 3 hospital acquired pressure ulcers - Number of grade 4 hospital acquired pressure ulcers	- MRSA screening – emergency - Antibiotic prescribing compliance - Percentage adult in-patients who received thrombo-prophylaxis - 72 hour Food Chart review - Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - Summary Hospital Mortality Indicator (SHMI) in-hospital deaths

QUALITY

- Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Medicines reconciliation performed within one day of admission (Assessment and cardiac wards) - Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards) - Non-purposeful omitted doses of listed critical medication - Reduction in medication errors resulting in moderate or severe harm - NHS Safety thermometer- harm free care - NHS Safety thermometer-no new harms - Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas - Summary Hospital Mortality Indicator (SHMI) including out of hospital-deaths within 30 days of discharge - Risk Adjusted Mortality (Hospital Standardised Mortality Ratio equivalent) - Learning disability (adults)-percentage adjustments made - Stroke care: percentage receiving brain imaging within 1 hour - Stroke care: percentage spending 90% + time on a stroke unit - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Ward outliers bed-days - Patient experience local patient experience tracker - Monthly patient survey: kindness and understanding - Friends and Family Test (FFT) coverage: Inpatients - Friends and Family Test (FFT) coverage: Emergency Department - FFT Score: Inpatients - FFT Score: Emergency Department	
Quality metrics not achieved or requiring attention (15)	**Quality metrics not rated (12)**
- MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory - Clostridium difficile cases against national trajectory - MSSA (Meticillin Sensitive Staphylococcus aureus) cases against	**Data not yet available** - Nutritional screening: will report from July **Thresholds to be agreed**

QUALITY

trajectory - WHO surgical checklist compliance - 30 day emergency re-admissions - Fractured neck of femur patients treated with 36 hours - Fractured neck of femur patients achieving Best Practice Tariff - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours - Dementia admissions-case finding applied - Dementia admissions-assessment completed - Dementia admissions-referred on to specialist services - Patient complaints as a proportion of all activity - Percentage of complaints resolved within agreed timescale - Number of complainants dissatisfied with our response (not responded in full) - Last minute cancelled operations: percentage of admissions	- Dementia-carers feeling supported - Out of hours discharges - Average number of ward moves - Number of normal births **Metrics for information** - Number of serious incidents - Confirmed number of serious incidents - Total number of patient safety incidents reported - Total number of patient safety incidents per 100 admissions - Number of patient safety incidents severe harm - Number of grade 2 hospital acquired pressure ulcers - Number of falls - Number of last minute cancelled operations

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

The CQUINs monitored in the quality dashboard for 2014/15 are:

1.3.1 Deteriorating patient:

The rescue of deteriorating patients is one of our quality objectives for 2014/15. It aligns with the Trust's existing proactive adult patient safety improvement programme.

We have agreed a two-part CQUIN with our commissioners relating to this area of quality:

- Adult patients with an Early Warning Score (EWS) of 2 or more to have an appropriate response according the escalation protocol. Our improvement target is 95% by Quarter 4. In June the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 91% against an improvement target of 95%;
- Reduction in cardiac arrest calls from general ward areas for confirmed cardiac or respiratory arrests. This has been identified as an outcome measure of identifying and responding to deterioration earlier. The target is a 5% reduction from a baseline of Q4 2013/14, to be measured at the end of 2014/15, which equates to no more than 91 cardiac arrest calls for the whole of 2014/15. In June the number of cardiac arrest calls was 5 against a target of 7.

1.3.2 NHS Safety Thermometer improvement goal

We have agreed a two-part CQUIN with our commissioners:

- A reduction in the number of inpatient falls of five fewer per month on average over the whole of 2014/15, against a monthly age-adjusted baseline. In June there were 35 fewer falls against a target of 5 fewer than baseline;

- To implement five actions to enable closer working with our community partners to help reduce harm from pressure ulcers and improve infection prevention and control across the healthcare system;

  We have completed one of the two infection control actions by setting up a database to collect information relating to patients identified as having *Clostridium difficile* (but not attributed to the Trust) and sharing this with our commissioners to enable them to focus their risk reduction actions accordingly. The second action, which involves the delivery of training sessions for GP surgeries and Nursing Home Managers, has a planned delivery date of the end of December 2014;

  There are three pressure ulcer prevention actions of which two are complete. We have aligned our pressure ulcer wound assessment, action and treatment review documentation with that for Bristol Clinical Commissioning Group (CCG) and Bristol Community Health. This is being implemented from 21st July 2014. We have also opened-up access to our wound care training to our community partners and advertised this to

Bristol Community Health and Charlton Farm Children's Hospice, and we have provided a bespoke to training session to Charlton Farm. Our third action is to develop a pan-Avon dressings formulary. This is partially complete: the formulary has been agreed and a tendering process is underway via NHS Supply Chain at the time of writing. Once this is complete the final formulary will be developed.

1.3.3 Friends and Family Test

We will report on two elements of the national Friends & Family Test CQUIN, achievement of which will be tracked via the quality dashboard: increasing response rates for Inpatients and the Emergency Departments. The targets are 25% in Quarter 1 rising to 30% in Quarter 4 for inpatients, and 15% in Quarter 1 rising to 20% in Quarter 4 for Emergency Departments.

Performance in June was 39.5% against a target of 25% for inpatients, and 19.2% against a target of 15% for Emergency Departments.

1.3.4 Dementia

We will continue to report the dementia case finding metrics as in 2013/14:

- Patients admitted with dementia:
    1. Percentage of patients aged over 75 years identified with a clinical diagnosis of delirium or who have been asked the dementia case finding question - performance in June was 49% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in June was 59.5% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in June was 22.7% against a target of 90%

The results of our carers survey in June showed that 90% of carers looking after people with dementia said they felt supported.

1.4 CHANGES IN THE PERIOD

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

- MSSA (Meticillin Sensitive Staphylococcus aureus) cases up ↑ from 0 in May to 3 in June.
- Falls incidence per 1000 bed days significantly down ↓ from 5.18 in May to 4.28 in June.
- Non-purposeful omitted doses of listed critical medication down ↓ from 0.55% in May to 0.38% in June;
- Number of complainants dissatisfied with our response up ↑ from 4 in May to 11 in June.

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

*Please note that an exception report is **not** provided for the percentage of last minute cancelled operations because this is a quarterly measure which is subject to monthly variation, but was achieved for Quarter 1 as a whole.*

1. MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory
2. Clostridium difficile cases against national trajectory
3. MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory
4. WHO surgical checklist compliance
5. 30 day emergency re-admissions
6. Fractured neck of femur patients treated with 36 hours
7. Fractured neck of femur patients achieving Best Practice Tariff
8. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hours
9. Dementia admissions-case finding applied
10. Dementia admissions-assessment completed
11. Dementia admissions-referred on to specialist services
12. Patient complaints as a proportion of all activity
13. Percentage of complaints resolved within agreed timescale
14. Number of complainants dissatisfied with our response (not responded in full)

QUALITY

Q1. EXCEPTION REPORT: Meticillin Resistant Staphylococcus aureus (MRSA) cases against trajectory	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Positive blood cultures taken from patients in hospital for more than 2 days. The Trust has a zero tolerance for avoidable MRSA bacteraemia. There are no financial penalties and this does not contribute to the Monitor compliance framework.

Performance in the period, including reasons for the exception:

There were two Trust apportioned case of MRSA bacteraemia in June 2014.

Division	Monthly Objective	Number of cases in the month
Specialised services	0	0
Surgery Head and Neck	0	0
Women's and Children's	0	2
Medicine	0	0

Widespread screening for MRSA is undertaken in the Trust.

Recovery plan, including expected date performance will be restored:

Post Infection Reviews have been undertaken. One case was a pre-48 hour case and would not normally be attributed to the Trust. However, on investigation it was shown there had been issues with the discharge process and it was felt this case should be attributed to the Trust. This case was reported as a Serious Incident and a Root Cause Analysis was also undertaken. Action plans have been developed and will be monitored by Infection Control group and the Division of Women's & Children's.

QUALITY

Q2. EXCEPTION REPORT: *Clostridium difficile*	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

Patients in hospital for more than 3 days, who have unexplained reasons for diarrhoea and test positive for *Clostridium difficile.*

Monitor measurement: Cumulative year-to-date trajectory, reported quarterly. The national objective set centrally is a limit of 40 cases in the year, with reporting to Monitor against a limit of 10 per quarter (cumulative limits: quarter 1 = 10; quarter 2 = 20; quarter 3 = 30; quarter 4 = 40). Financial penalties are linked to the national objective.

Performance in the period, including reasons for the exception:

There were four apportioned cases of *Clostridium difficile* in June 2014 against an internally set limit for the month of three. There have been thirteen reported cases for the quarter, against the nationally set limit of ten. However, twelve of the thirteen cases have been agreed by our commissioners to be unavoidable according to the criteria that have been set.

Division	**Divisional Limit**	**Number of cases**
Medicine	2	1
Surgery, Head & Neck	1	1
Women's & Children's	0	1
Specialised Services	1	0

Recovery plan, including expected date performance will be restored:

- All cases of *Clostridium difficile* infection are visited by the Director of Infection Prevention & Control (DIPC) /Infection Control Doctor/ Microbiologist, Infection Control Nurse and pharmacist within one working day. Each case is assessed to ensure there have been no lapses in care;
- Focused care and management of *Clostridium difficile* positive patients continues on the cohort ward with daily monitoring of patients by the Infection Control Team;
- GP study morning has been set up for September. This will include training on the management and antibiotic prescribing for *Clostridium difficile* cases.

QUALITY

Q3. EXCEPTION REPORT: Meticillin Sensitive Staphylococcus aureus (MSSA) cases against Trust limit.	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The number of MSSA cases of patients in hospital for more than 2 days. The limit is set at 25 cases in the year. This limit has no financial penalties and does not contribute to the Monitor compliance framework.

Performance in the period, including reasons for the exception:

There were three Trust apportioned cases of MSSA in June 2014. This is one over the Trust's limit for June of two cases.

Actions to prevent MSSA are similar to those for MRSA although at present widespread screening for MSSA is not recommended nationally. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA. The overall limit for quarter one is six cases. The actual number of cases at the end of quarter one was four.

Recovery plan, including expected date performance will be restored.

- All post-48 hour cases are investigated by the clinical team with learning shared at the Infection Control Group bimonthly meeting, chaired by the Chief Nurse;
- MSSA screening continues in Cardiac and Renal services.

QUALITY

Q4. EXCEPTION REPORT: WHO Surgical Safety Checklist	RESPONSIBLE DIRECTOR: Medical Director

Description of how the standard is measured:

The measure of compliance of this standard is all three elements of the WHO Surgical Safety checklist: Sign In, Time out, Sign Out are completed and recorded on the Medway system by theatre staff. Data is pulled from the Medway system for all theatre visits across adult and paediatric theatres.

All three sections need to be completed with 'Yes' response for an overall 'Yes' to be achieved. This data is reviewed both weekly and monthly, retrospectively, by the Senior Manager for Theatres and within the Perioperative Patient Safety Group.

Performance in the period, including reasons for the exception:

Since the last exception report the compliance has been in the amber range (above 99.5%). In June there was a decrease in compliance with the WHO checklist, as measured by the three elements. On review of the data it is evident that the main area for reduced compliance is in Queens Unit Theatres (94.71%).

Recovery plan, including expected date performance will be restored:

- Manager and staff in Queens Unit Theatres to be made aware of drop in compliance and to instigate refresher training for staff;
- Ensure staff are aware that all procedures which take place in theatres, including Endoscopy/Trans-oesophageal Echocardiogram/varicose vein surgery, need to have a WHO checklist performed;
- Implementation of Standard Operating Procedure and new format (poster on wall) for completion of WHO checklist;
- Weekly review of non-compliant theatre visits to review and amend as appropriate;
- Monthly review of WHO checklist compliance data at Perioperative Safety Work-stream meeting with Theatre representatives;
- Observations of WHO checklist completion to assess quality of checklist.

QUALITY

Q5. EXCEPTION REPORT: 30-day emergency readmissions	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

The number of emergency readmissions within 30 days of a previous discharge, rated against a target measured as a percentage of all discharges in the period. The target is an improvement on the previous year's level of emergency readmissions (i.e. 2013/14), which for 2014/15 equates to an emergency readmission rate of 2.70%

Performance in the period, including reasons for the exception:

In May there were 317 emergency readmissions within 30 days of discharge, which equates to 2.83% of discharges. This is 0.13% above the target level of readmissions of no more than 2.70%. The rate of readmissions in the period remains lower than in any month in quarter 4 2013/14, but is higher than the same period last year. There are at this stage no dicernable patterns of increasing readmissions.

Recovery plan, including expected date performance will be restored:

- Reviews of the causes of any specialties identified as having a high emergency readmission rate, relative to the national average and clinical peer group, to continue to be commissioned by the Quality Intelligence Group. These reviews include the following:
    - Clinical coding review of the readmissions (including an assessment of whether the type of admissions has been correctly classified) that happened during any period for which levels of readmissions were identified as being statistically high;
    - Following any amendments to clinical coding, the revised data to be reviewed to assess whether the specialty is still showing as an outlier from the national average and clinical peer group level, with the corrected data;
    - Where the clinical coding data changes have not addressed the variance, the initiation of a formal clinical review of the readmission cases, to determine what the causes of readmissions were and whether there are any themes, in terms of avoidable reasons for readmission which need to be addressed.

QUALITY

Q6-Q7. EXCEPTION REPORT:	RESPONSIBLE DIRECTOR: Medical Director
• **Fractured neck of femur patients treated with 36 hours** • **Fractured neck of femur patients achieving best practice tariff**	

Description of how the standard is measured:

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

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

Performance in the period, including reasons for the exception:

June's Best Practice Tariff performance was 78.3%. This is under the 90% target due to all eight standards not being met for five out of twenty three patients. The details of the patients are:

- Four patients were not operated on within 36 hours
  - Two patients were cancelled on the same operating list due to lack of time. There was a backlog of trauma and patients were treated in chronological order from admission;
  - One patient breached due to three hip fracture admissions occurring within 12 hours, and the lack of trauma time within the next 36 hours to complete all surgery;
  - One patient breached because they were clinically unwell and needed a cardiac condition stabilised prior to having surgery.
- One patient breached as time to ortho-geriatric review exceeded 72 hours; this was due to annual leave following a weekend admission.

Recovery plan, including expected date performance will be restored:

- Continued daily monitoring of trauma waiting times and escalation within the Division to identify additional theatre capacity when required;
- 'Golden Case' protocol aimed at improving times to theatres now in place and progress is being monitored;

QUALITY

- The Division is reviewing the theatre timetable post-October 2014 when vascular surgery is planned to transfer to NBT. This may provide opportunities to improve the scheduling of trauma operating sessions and increase total operating hours.

QUALITY

Q8. EXCEPTION REPORT: High Risk Transient Ischaemic Attack (TIA) starting treatment in 24 Hours	RESPONSIBLE DIRECTOR: Medical Director

Description of how the target is measured:

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

Performance during the period, including reasons for exception:

Performance against the 60% standard was 57.1% in May, with six out of fourteen high risk patients failing to be treated within the 24-hour target. These are identified high risk patients and are part of a larger volume of other lower risk patients who need to be seen within 7 days. The reason for not being able to treat these high risk patients within 24-hours is as follows:

- For one patient there was no clinic available to book them into, due to medical staff leave;
- One patient was not referred by the Emergency Department when they should have been;
- For one patient a MRI scan slot was not available;
- For one patient the faxed referral was not proceeded in a timely way by the clinic;
- One patient was referred late, ten days post symptoms;
- One patient required multiple scans which could not be completed within the 24 hour timeframe.

Recovery plan, including expected date performance will be restored:

- Ongoing stroke pathway work is in progress. The issued with MRI slots previously reported has improved and did not contribute to any breaches in May, and only one in June. The Division of Diagnostics & Therapies are involved in the pathway work;
- Capacity and cancellation of clinics relates to consultant capacity. The revised Acute Model of Care will address this;
- The administrative delay with processing the fax has been addressed within TIA team;
- The Emergency Department remain part of the stroke pathway work. We are building electronic clinic slot access for Emergency Department staff and the Clinical Site Managers to book clinic slots following Emergency Department attendance.

QUALITY

Q9-11. EXCEPTION REPORT: Dementia Stage 1 - Find Stage 2 – Assess & Investigate Stage 3 – Referral on to GP	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

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

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

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

Performance in the period, including reasons for the exception:

Stage 1- Find – status RED

Performance in June for stage 1 was 49%, compared with 52.3 % in May.

Divisional performance

Medicine 55.7%; Surgery Head & Neck 41.3%; Specialised Services 30.2%

Stage 2 – Assessment and Investigation – status RED

Performance in June for stage 2 was 59.5% against a target of 90%, compared with 78.3% in May.

QUALITY

Divisional performance

Medicine 25%; Surgery Head & Neck 100%; Specialised Services 100%

Stage 3 – Referral on to GP – status RED

Performance in June for stage 3 was 22.7% compared with 55.6% in May.

Divisional performance

Medicine 25%; Surgery Head & Neck 0%; Specialised Services 0%

During March and April 2014 the Trust team focused on improving compliance for stage 1 (asking the dementia case finding question) within the admission areas, which resulted in a 12% increase. This improvement was not sustained in May, despite a continued focus. This is in part due a change at junior doctor level covering the Medical Assessment Unit during this time.

Recovery plan, including expected date performance will be restored:

The following steps have been taken or are in progress to improve compliance of all three stages on the CQUIN FAIR process;

- Recruitment process commenced for Lead Dementia role, which has been vacant since June 23rd. Interviews are taking place on August 6th;
- Development of an IM&T system to flag, record and monitor all stages of the FAIR process. This system is expected to be in place by the autumn 2014 at the latest;
- Successful bid to the Clinical Commissioning Group (CCG) for two dementia project posts:
    i. Band 7 WTE two year secondment / fixed term project post to focus on the admission areas (MAU; OPAU; STAU) to ensure the timely screening, assessment and referral on where appropriate. This post will ensure that this process is embedded into daily clinical practice. Post holder commences July 14th, earlier than anticipated;
    ii. Band 3 WTE two year secondment / fixed term clinical support post to support lead nurse for Dementia and related project posts in the achievement of the National Dementia CQUIN and best practice. Interviews held 16th June 2014. Post not filled. To be re-advertised.
- A sticker has been developed to place in the medical records to prompt medical staff on next steps following a ‘yes’ answer to the dementia case finding question. This will be implemented by the Band 7 project post across the admission areas;
- A care plan (‘Caring for people with cognitive impairment ‘) has been developed and disseminated. This will be implemented Trust-wide by the end of June 2014 and audited from July 2014. An electronic audit capture tool has been developed. The care plan will prompt completion of the FAIR process and guide staff on delivering best practice (identified action from CQC inspection January 2014).

Divisional support has been requested via the Heads of Nursing to support the CQUIN.

QUALITY

Q 12. EXCEPTION REPORT: Percentage of complaints per patient attendance in the month	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

In June 2014, complaints received represented 0.28% of clinical activity (approximately one in every 350 patient episodes of care). This compares to 0.23% in May. 166 complaints were received, 64 of which are being progressed through formal resolution.There was a notable increase in the number of complaints received by the Division of Medicine and the Division of Women's and Children's services.

- The Division of Medicine received 31 complaints in June 2014 (22 in May), representing 0.24% of patient activity. Four of these complaints were about the Emergency Department (the same number as in May and April). No other discernible trends were noted;
- The Division of Women's & Children's Services received 30 complaints in June 2014 (18 in May) representing 0.23% of patient activity. Twenty of these complaints related to Bristol Royal Hospital for Children (compared with 11 in May) and 10 were for St Michael's Hospital (compared with 7 in May). Five of the complaints received for St Michael's Hospital were for Gynaecology (4 outpatients and 1 for Ward 78). Four of the complaints received by the Children's Hospital were received by Paediatric Orthopaedics. There were no other discernible themes or trends noted, with the complaints shared across various departments within each hospital site;
- The Division of Specialised Services received 28 complaints in June 2014 (26 in May), representing 0.36% of activity, which is similar to May 2014 (although a significant increase from 0.25% in April). Within this total, 9 complaints were received by the Bristol Haematology & Oncology Centre (BHOC) (compared to 8 in May) and 19 by the Bristol Heart Institute (BHI) (compared with 18 in May). Of the complaints received by BHOC, the Chemotherapy Day Unit/Outpatients Department received five complaints. In the BHI, just two complaints were about the Outpatients Department (compared to nine in May 2014);
- The Division of Surgery Head & Neck received 59 complaints in May 2014 (50 in May), representing 0.23% of patient activity. Ten of these complaints related to care at Bristol Eye Hospital (13 in May and 6 in April). A further 12 complaints related to Trauma & Orthopaedics (6 in May and 10 in April). Thirteen complaints were made about the Ear, Nose & Throat Outpatient Clinic (compared to 9 in May and 6 in April).
- The Division of Diagnostics & Therapies received 8 complaints in June 2014 (6 in May) – this is not recorded as a percentage of patient activity for this Division, due to the low numbers involved. Four of the 8 complaints were about Radiology (3 for Adult X-Ray and 1 for Breast Screening).

QUALITY

Recovery plan, including expected date performance will be restored:

- June complaints data will be discussed in detail by Heads of Nursing at the Trust's Patient Experience Group meeting on 14th August, and actions agreed accordingly.

QUALITY

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

Description of how the standard is measured:

The number of complaints which are resolved within the timescale originally agreed (or subsequently renegotiated) with the complainant. The target for the percentage to be resolved within the formal timescale is 95% each month with effect from June 2014 (formerly 98%).

Performance in the period, including reasons for the exception:

In June 2014, 50 responses out of the 60 which had been due in that month were posted to the complainant by the date agreed (83.3%). This represents a slight improvement in performance compared with 82.5% in May 2014.

Ten breaches were recorded in total for June (the same number as in May).Of these 10 breaches, 6 were attributable to delays in Divisions (3 in the Division of Women's & Children's, 2 in the Division of Medicine and 1 in the Division of Surgery, Head & Neck). The remaining 4 cases breached due to delays during the Executive sign-off process.

The Divisions of Specialised Services, Diagnostics & Therapies and Facilities & Estates recorded zero breached deadlines in June.

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

Recovery plan, including expected date performance will be restored:

- Each breached deadline is validated by the Patient Support & Complaints Team and the relevant Divisional Complaints Co-ordinator: as well as being a validation of the breach (data quality check), this also ensures that the Division can look at how the delay could have been avoided and therefore how they will learn from this for the future;
- Key Performance Indicators are now in place in respect of performance against response deadlines for the Divisions, the Patient Support & Complaints Team and the Executives;
- Performance is discussed and monitored at the Patient Experience Group, chaired by the Chief Nurse;
- All written responses must be received by the Patient Support & Complaints Team four working days before the response is due with the complainant: this is to allow time for the response to be checked prior to Executive sign-off.

QUALITY

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

In June 2014, 11 complainants told us that they were dissatisfied with our response to their complaint; this is a significant increase on the four cases in May and six cases in April 2014. The 11 cases related to complaints in the following Divisions:

- Division of Surgery, Head & Neck – five cases
- Division of Medicine – three cases
- Division of Specialised Services – two cases
- Division of Women's & Children's – one case

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

In the cases from Surgery, Head & Neck, four complainants disputed the information contained in the original response and one complainant felt that the response did not resolve the issues raised.

In the Medicine cases, all three complainants disputed the information provided in the response letter.

In the cases from Specialised Services, one complainant felt that not all of the issues raised had been addressed and the other disputed the information contained in the response letter.

In the case from Women's & Children's, the complainant did not feel that the response adequately addressed all of their concerns.

Recovery plan, including expected date performance will be restored:

- A system has now been implemented to formally verify details of all dissatisfied cases with the Division. This ensures data accuracy and requires the Division to consider whether anything could have been done differently when the initial response was written – for purposes of future learning;
- The corporate Patient Support & Complaints Team continues to monitor response letters to ensure that all aspects of a complaint have been fully

addressed; amendments are requested from Divisions if necessary;

- There is also rigorous checking of response letters by the Chief Nurse, to ensure responses are complete and adequate before being sent to the complainant.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the Division of **Surgery, Head & Neck**.

As a Division we feel strongly that quality is at the top of our agenda in every aspect of care we deliver, we have had some notable successes but wanted to start with this comment about the Bristol Eye Hospital that was posted on the Trust's website in early July this year:

"I don't quite know how to say we were absolutely delighted with every aspect of my son's care and surgery for his detached retina. Every aspect of our experience of this hospital was as close to perfection as is humanly possible, from the receptionist to the Consultant Surgeon, the surgeon, the doctors, the nurses, the care staff and the admin - everybody worked together with good humour and absolute professionalism to make his stay in the ward and his surgery as painless and perfect as possible. The most impressive thing, apart from the surgery, (which you expect to be perfect) was the communication and efficiency of staff working together and the care and attention given to our son and ourselves. Of course minor surgery gets delayed, that is what makes it possible for emergencies such as my son's to jump straight to the top of the priority list."

Please see below some of the many quality achievements within the division:

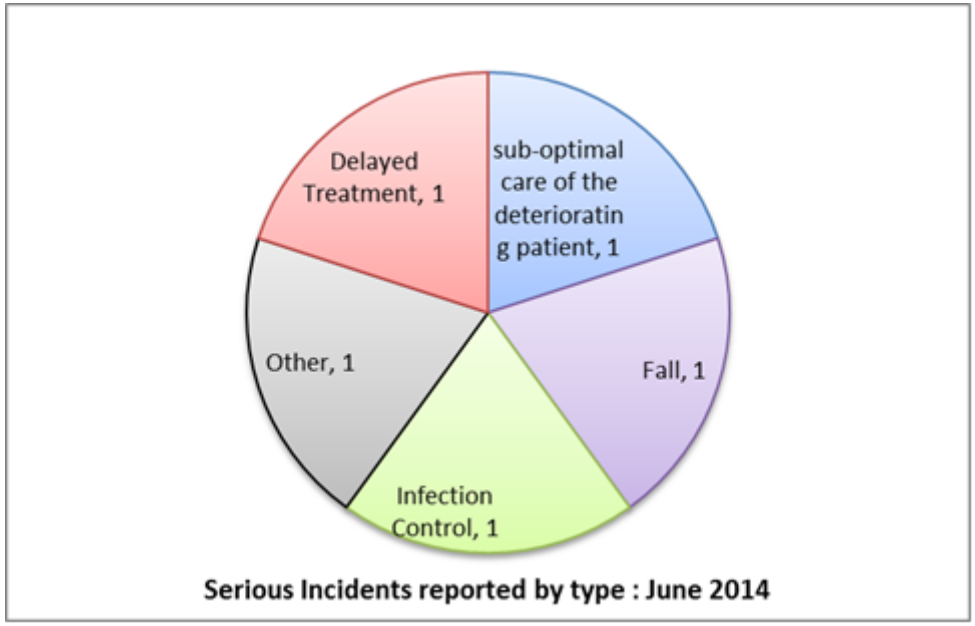
- Pre-Operative Assessment (POA) has started to use Skype as a form of communication to pre operatively assess their patients. This initiative is being led by Claire Dowse, Consultant Anaesthetist, with the POA nursing team. This reduces the amount of times patients from a long distance have to make a journey to the hospital. It is proving very successful with patients and staff;
- The Division has set up a divisional mailbox: SH&N.management@UHBristol.nhs.uk for all staff to send in ideas about raising standards. This initiative supports the Clinical Strategy that has been developed in the Division. This strategy concentrates on the delivery of high quality patient care, teaching and research;
- The nursing teams have managed to sustain a continued improvement in the prevention of pressure ulcers for our patients: In June we had only one grade 2 pressure ulcer. This is one too many, but a marked improvement has been achieved over the last 12 months;
- John Bell and Chris Summers (Charge nurses in the Intensive Therapy Unit - ITU) have been shortlisted and selected to present their work around reducing the incidence of pressure ulcers caused by non-invasive ventilation masks (which are often a problem across patients' noses in ITU) at the national conference for Innovation and Developments in Critical Care in London;
- The Divisional quality achievements are measured and monitored via the Clinical Quality Dashboard and validated by the monthly safety thermometer audit. In June there continues to be downward trend in patient falls in the surgical areas after a small spike in May. Reassuring results on the following metrics: falls risk assessment 95.5%; pressure ulcer risk assessment 95.8%; nutritional assessment 95.5%; Early Warning Scores correctly recorded 99.3% ; Early warning scores acted upon: 100% SBAR Communication; 100%.

QUALITY

- Dr Rachel Craven, Consultant Anaesthetist has been awarded the Pask Certificate of Honour by the Association of Anaesthetist's of Great Britain and Ireland in recognition of her voluntary work overseas for Medicine Sans Frontiers in areas where there is terrible conflict and danger. The Pask award was instituted, in 1977 after the Moorgate underground disaster. The award was instituted to enable those who have rendered distinguished service, either with gallantry in the performance of their clinical duties, in a single meritorious act or consistently and faithfully over a long period. A fantastic achievement.

1.6.2 SERIOUS INCIDENT THEMES

There were five serious incidents reported in June as shown below:



Further details are provided in the table below:

Date of Incident	SI Number	Division	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
04/05/2014	2014 17903	Medicine	Yes	Open	Delay in seeking medical review. Patient subsequently died.	Unclear until investigation complete	Investigation underway

QUALITY

Date of Incident	SI Number	Division	Reported within 48 hours	Status	Incident Details	Initial assessment of harm	Investigation
30/05/2014	2014 18060	Medicine	No	Open	Inpatient fall	Major	Investigation underway
12/06/2014	2014 19283	Women and Children	Yes	Open	MRSA bacteraemia	Moderate	Investigation underway
11/06/2014	2014 19307	Women and Children	Yes	Open	Cardiac arrest during cardiology procedure	Major	Investigation underway
13/06/2014	2014 21006	Surgery, Head and Neck	Yes	Open	Glaucoma patient lost to follow up. Patient returned 2 years later having lost her eyesight.	Major	Investigation underway

WORKFORCE

2.1 SUMMARY

The six indicators included in the monthly performance review are summarised in the dashboard below.

 **Achieving (1)**	 **Underachieving (2)**	 **Failing (3)**
- Workforce numbers - compared with budgeted establishment	- Workforce expenditure - compared with budget - Turnover - compared with target	- Bank and agency usage - compared with target - Vacancies - compared with target - Sickness absence – compared with target

2.2 EXCEPTION REPORTS

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

- Bank and agency usage – red rated against target
- Vacancies– red rated against target
- Sickness – red rated against target

Key Performance Indicators in the quarterly report will include appraisal, essential training, health and safety measures and junior doctor new deal compliance, in addition to those which form part of the monthly performance report. Targets for sickness absence, turnover and bank and agency are agreed with divisions as part of the Operating Plan process. For those targets which are failing, exception reports are provided which detail performance against target, and against the previous month. Graphs in the Supporting Information section are continuous from the previous year to provide a rolling perspective on performance.

WORKFORCE

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

Description of how the standard is measured:

Bank and agency usage in Full Time Equivalents (FTE) compared with targets set by Divisions for 2014/15.

Performance in the period, including reasons for the exception:

The variance in pay and staff in post compared with budget improved this month, with both being within the agreed threshold. As a percentage of total staffing numbers, there is little change in the proportion of temporary staffing utilised. During June, temporary staffing comprised 6.3% of total staffing numbers (FTE) compared with 6.4% last month, and an average over the last year of 5.8%. Within this figure, agency staffing accounted for 1.3% of total staffing numbers for June, close to the average for the year of 1.2%.

Usage of bank and agency continues to be for the following reasons:

- Workload and clinical needs, extra capacity and administrative workload – this reduced to 30.4% of overall usage, compared with 35.4% last month;
- Cover for vacancies – this increased to 29.5% compared with 27.4% last month;
- Cover for sickness absence – this increased to 15.4% compared with 14.3% last month, which aligns with the slight increase in sickness absence during June;
- Nursing assistant one-to-one care – this reduced this month, from 7.7% to 6.4% of usage.

An overview by Division is as follows:

Bank and Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Actual June 2013	393.0	13.3	135.8	44.2	78.3	55.5	34.9	31.1
Actual June 2014	429.8	14.4	118.3	59.3	79.8	72.6	30.9	54.5
Target June 2014	320.7	16.2	86.8	37.8	56.9	72.4	31.3	19.1
	25.4%	-13.1%	26.6%	36.2%	28.7%	0.3%	-1.4%	64.9%

WORKFORCE

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

General actions to reduce use of bank and agency are focussed on recruitment to vacancies (see Vacancy Exception Report W2 for progress) and targeting sickness absence (see Sickness Absence Exception Report W3).

Divisional action plans, in addition to the focus on recruitment and reducing sickness absence, aim to target nursing bank and agency by more efficient rostering, effective controls and the development and implementation of an Enhanced Observation policy to reduce the use of Nursing Assistant one to ones.

Divisional operating plans are currently being reviewed; as part of this process, Executives are scrutinising future workforce plans including the use of temporary staff.

WORKFORCE

W2. EXCEPTION REPORT: Vacancy Levels	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

The vacancy Key Performance Indicator (KPI) is the difference between the full time equivalent budgeted establishment and the full time equivalent substantively employed, represented as a percentage. The Trust-wide vacancy KPI threshold is 5%.

Performance in the period, including reasons for the exception:

There is a slight overall increase in vacancy levels from 5.5% to 5.6% this month. This compares with vacancy levels of 7% a year ago. Vacancies by Division are shown in the table below.

Vacancy Levels by Division	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
WTE	436.5	33.2	56.7	50.9	83.1	91.4	55.1	66.1
Percentage	5.6%	3.4%	5.2%	6.2%	4.9%	5.3%	8.1%	8.8%

There is little change in levels reported last month for Facilities & Estates, Trust Services, Women's and Children's and Medicine and the reasons continue to be the following:

- Vacancies in Facilities & Estates are due to the ongoing impact of the BRI Redevelopment and the transfer of Specialist Paediatrics;
- Nursing and Midwifery vacancies in Women's and Children's Division remain at 7%, largely due to vacancies in theatres, Paediatric Emergency Department and the Paediatric Intensive Care Unit resulting from the transfer of Specialist Paediatrics, for which recruitment is underway;
- Ward 21 in Medicine included funded establishment during June, but was staffed largely by bank staff, resulting in apparent vacancy levels of 55%, but the Division also has nursing vacancies in other wards;
- There are workforce changes and vacancies across a range of cost centres within Trust Services, including Medical Records, Information Management & Technology and Human Resources.

In addition, this month Specialised Services is reporting junior doctor vacancies in Cardiac Surgery, which are currently being covered by agency, and Haematology & Oncology, for which new recruits have been appointed but are pending start dates. There are also nursing vacancies in specific areas such as Coronary Intensive Care Unit and Coronary Care Unit, which are being recruited to as part of the nursing recruitment programme. Vacancy levels in this Division are expected to reduce during the next three months.

WORKFORCE

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

Progress on recruitment to the two staff groups with the highest numbers of vacancies is described below:

Ancillary Recruitment

As part of an ongoing recruitment campaign, 12 domestic assistants were recruited in June, and 8 left in the same period. In addition, 7 were recruited to the Trust Bank. Domestic Assistant vacancies, including for the BRI Redevelopment, currently stand at 62.4 FTE. These vacancy numbers will fluctuate between now and April 2015, as a result of staff consultations and recruitment being undertaken. Recruitment initiatives incorporate creative advertising, including optimising the use of social media, open day events, and close partnership with the Job Centre. Vacancies within this staff group has been a long-standing issue, and given the increased demand resulting from the BRI Redevelopment combined with turnover, vacancies are anticipated to continue for some time. Bank, agency and overtime will continue to be used over the coming months to ensure effective services are sustained.

Nurse Recruitment

Similarly, our rolling recruitment campaign for nursing staff continues. Highlights are as follows:

- There were 215 applications received in total from new graduates from the University of the West of England and other universities. 123 interviews resulted in 95 offers to date, of which 86 have accepted and a third of these have already have final offers of appointment. 38 were in the Division of Women's and Children's, with a further 6 where the decision is still pending, 22 in Specialised Services, 15 in Medicine and 9 in Surgery, Head & Neck;
- 2 further nursing assistant assessment centres were held in June. Since the end of May, when the new recruitment approach commenced, 27 conditional offers have been made;
- In total, between April and June 2014, 218 final offer letters were issued to new starters, 127 were to registered nurses and 91 to Nursing Assistants;
- Plans for future recruitment include the Royal College of Nursing recruitment fairs in Manchester (July 2014) and London (September 2014);
- Recruitment in key areas in the Division of Women's and Children's associated with the transfer of Specialist Paediatrics is proceeding to plan; 8 staff have been appointed to theatres with start dates between July and September, by which time, vacancies are anticipated to reduce.

WORKFORCE

W3. EXCEPTION REPORT: Sickness compliance	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured: Sickness absence figures are shown as percentage of available FTE (full time equivalent) absent.

Performance in the period, including reasons for the exception:

Absence has increased to 4.1% in June, compared with 3.7% in the previous month and 3.7% in June 2013. This is 0.7 percentage points above the monthly target of 3.4%. Monthly targets contribute to an overall target for 2014/15 of 3.5%. UH Bristol sickness absence was 4% for 2013/14, which is slightly higher than the average for all Acute Teaching Trusts (3.9%).

Detail by Division is provided in the following table.

	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Absence June 2013	3.7%	3.2%	4.5%	4.0%	3.3%	3.2%	3.1%	4.9%
Target June 2014	3.4%	2.3%	3.9%	3.7%	3.2%	3.2%	2.2%	5.2%
Absence June 2014	**4.1%**	**2.7%**	**4.5%**	**4.2%**	**4.0%**	**3.8%**	**3.1%**	**6.9%**
Cumulative absence June 2014	3.8%	2.2%	4.3%	3.8%	3.7%	3.7%	3.0%	6.7%
Variance from target:	0.7%	0.4%	0.5%	0.5%	0.7%	0.6%	0.9%	1.7%

Performance on sickness absence prior to June only exceeded the agreed threshold on one other occasion in the last year. The increase this month is associated with increased long term absence, particularly related to back and psychological problems. There has been a 4.9% reduction in days lost due to short term sickness and long term absence increased by 13.6%. Anxiety, stress and depression continue to be the highest cause of absence, resulting in a loss of 1954 days, an increase of 7.4% compared with the previous month. Sickness absence related to back problems has increased by 19% this month, largely due to an increase in Medicine Division. Reasons for absence vary by Division, for example, in Specialised Services, pregnancy related absence accounts for 10% of days lost, and in Facilities & Estates, 20% of days lost are due to musculo-skeletal absence. The top five reasons for absence are included in the supporting information, see section 2.3.1.

WORKFORCE

Progress against recovery plan:

The following Trust-Wide initiatives continue as part of our comprehensive health and well-being work:

- Programmes to focus on stress related absence include the following:
  - "Lighten up", an accredited health and wellbeing programme comprising workshops and supporting materials, started in July as a three-month pilot. The programme, delivered by the Avon Partnership NHS Occupational Health Service, provides coping strategies to improve quality of life, both at work and home, thus improving health and wellbeing;
  - Avon Occupational Health Service has expanded the provision of one to one counselling by bringing in newly qualified counsellors onto work placements, and has been involving counsellors in team mediation and support across the Trust;
  - An online social club was launched in June on Connect, the Trust intranet, to encourage staff to develop social support outside of work.
- Physio-Direct continues to provide a service to prevent back related and musculo-skeletal absence;
- Programmes of work to target pregnancy related absence include the new series of 4 monthly 'Working in Pregnancy Workshops' commenced in June. The workshops are intended to generally support health and well-being and are also anticipated to reduce levels of pregnancy-related sickness absence;
- Occupational Health referral times are now down to one week for a nurse appointment, and are within the 10 day standard for doctor appointments;
- The recommendations of the Sickness Audit Report, published six months ago, continue to be implemented, which include improving the completeness and accuracy of sickness absence data by ensuring the list of nominated contacts who return the information is up to date.

Divisional Business Partners and Employee Services continue to work with managers to support them in implementing the Supporting Attendance Policy. Division specific initiatives include the following:

- *Women's and Children's***:** a 12-month initial contract to provide an Employee Assistance Programme has now been agreed, which will include face-to-face, 24-hour telephone and online counselling;
- *Facilities & Estates:* the Division continues to implement their action plan; recent progress includes the following:
  - Sickness review meetings with Facilities Assistant General Managers to prevent and reduce sickness absence;
  - Fast-tracking referral for back, musculoskeletal or stress, anxiety and depression related absence through occupational health
  - Exploring ways of rewarding attendance, including financial recompense;
  - A return to work audit is expected to report at the end of July, to ensure that the appropriate processes on return from absence are undertaken;
  - Analysis, by the end of July, of new starters to review evidence of high rates among new recruits.
- *Medicine Division:* a centralised hotline was introduced in June as a three-month pilot, to target weekend sickness.
- *Specialised Services:* a programme of work is underway including "return to work" audits combined with focus groups for staff and training for managers.

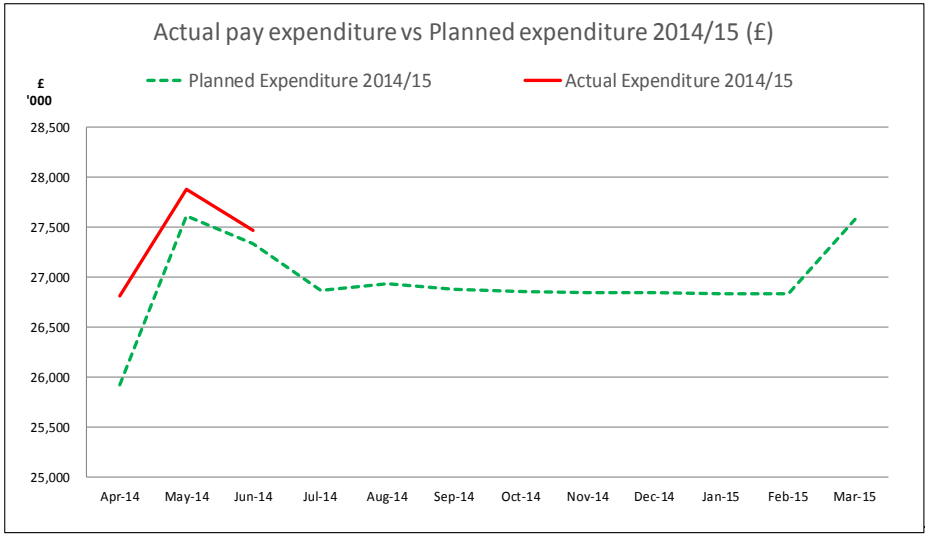
Divisions will continuously share good practice and sickness absence will be closely monitored over the next two months to assess whether the increase

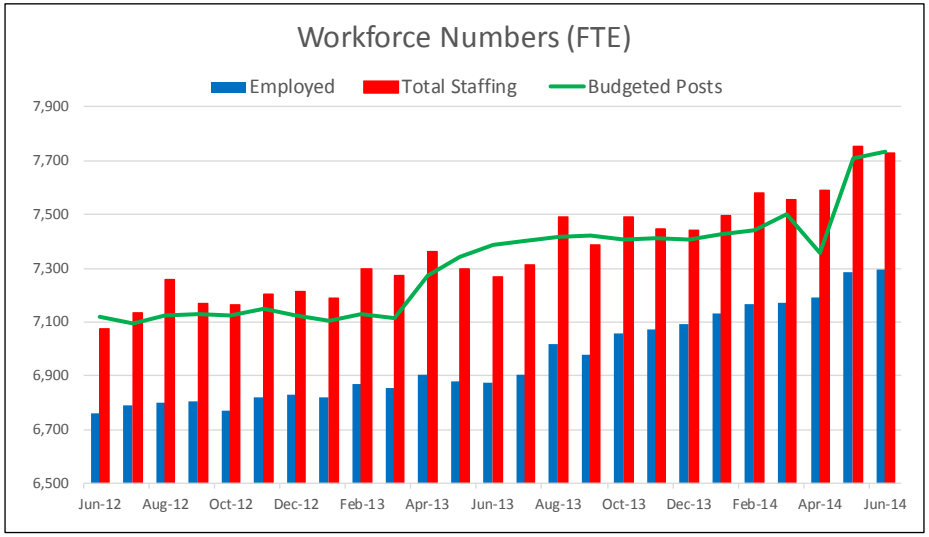
is associated with a longer term trend which would require the trajectory to achieve 3.5% to be revised.

2.3 SUPPORTING INFORMATION

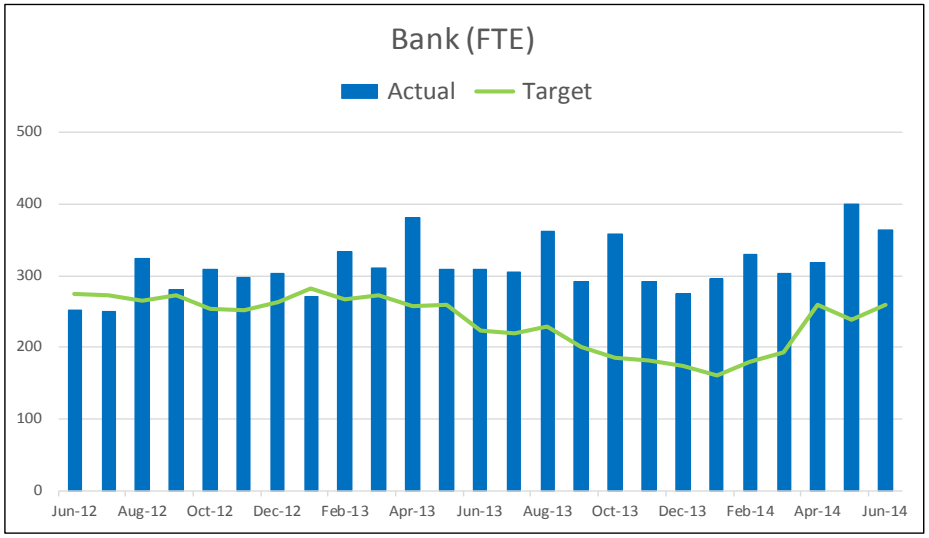
2.3.1 Performance against key workforce standards

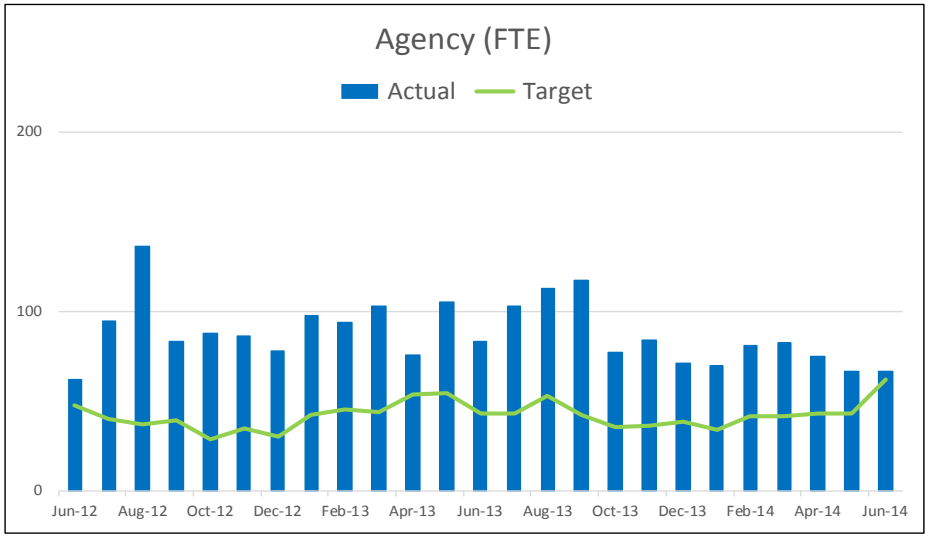
This section provides an outline of the Trust's performance against workforce indicators for workforce expenditure, workforce numbers, and bank and agency usage, with an additional chart to show how the variance against target for agency usage has reduced. There are also graphs to show nursing agency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





WORKFORCE


Bank (FTE)
Actual
Target
500
400
300
200
100
0
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14


Agency (FTE)
Actual
Target
200
100
0
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
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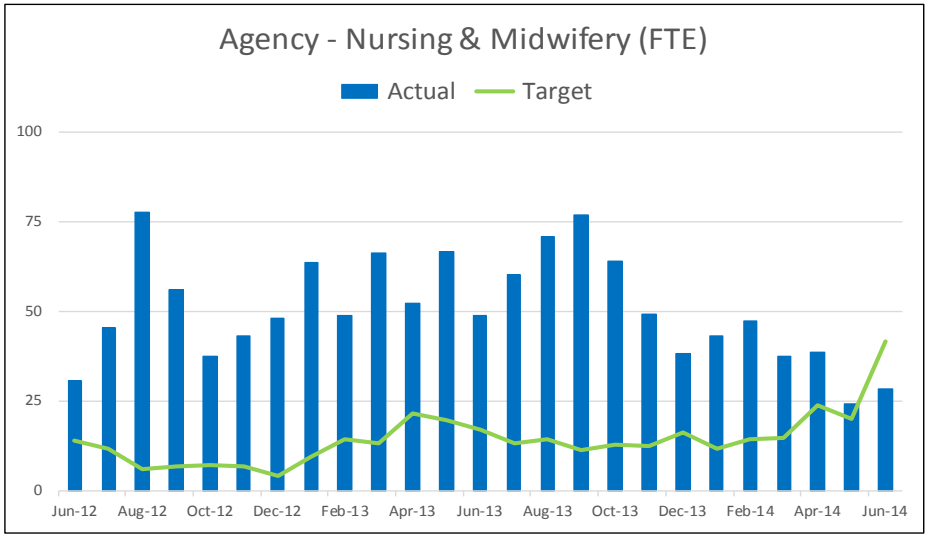
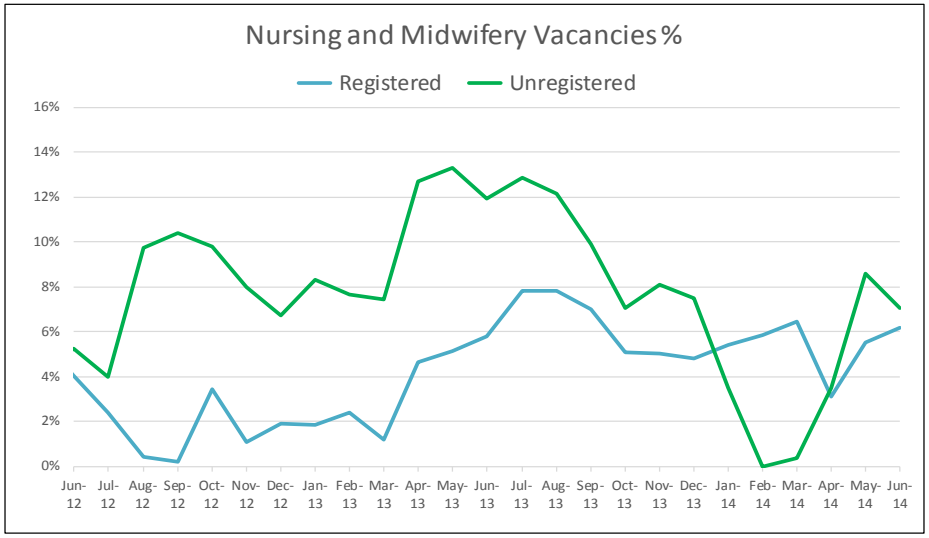
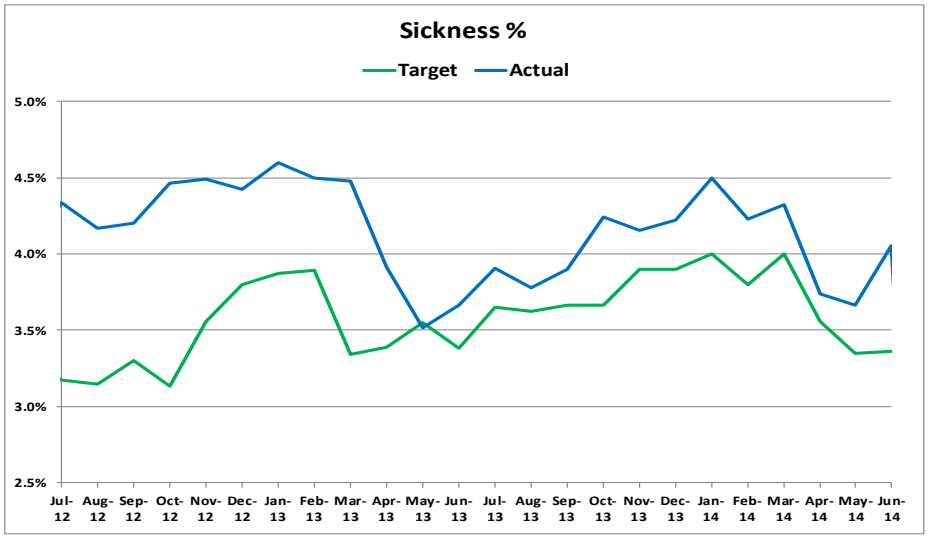
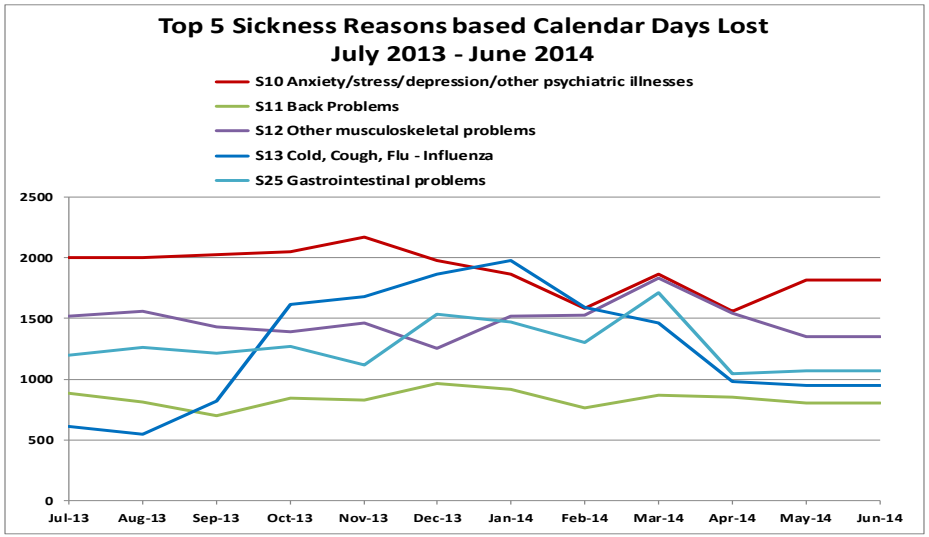
Dec-13
Feb-14
Apr-14
Jun-14

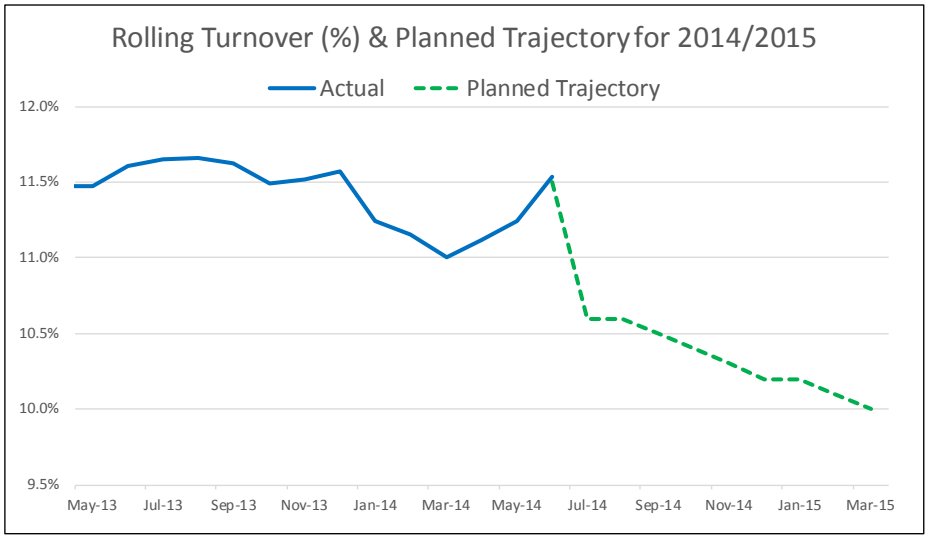

Agency - Nursing & Midwifery (FTE)
Actual
Target
100
75
50
25
0
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14


Nursing and Midwifery Vacancies %
Registered
Unregistered
16%
14%
12%
10%
8%
6%
4%
2%
0%
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14

WORKFORCE

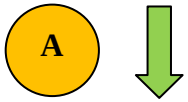
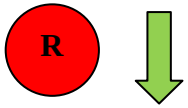
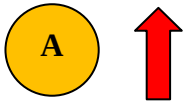
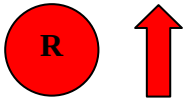

Sickness %
Target
Actual
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14


Top 5 Sickness Reasons based Calendar Days Lost
July 2013 - June 2014
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
2500
2000
1500
1000
500
0
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14


Rolling Turnover (%) & Planned Trajectory for 2014/2015
Actual
Planned Trajectory
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15

2.3.3 Changes in the period

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

Indicator	RAG Rating[1]	Commentary	Notes
Workforce Expenditure (£)		Workforce expenditure adverse variance from budget reduced from 0.95% to 0.49% in month compared with May 2014.	See summary and supporting information.
Workforce Numbers (FTE)		Total workforce numbers including bank and agency reduced by 0.3% (26.2 FTE) compared with the previous month. Workforce numbers were 0.1% below budgeted FTE. This compares with June 2014, which was 0.6% above budgeted establishment.	See summary and supporting information.
Bank/ Agency (FTE)		Agency reduced by 0.5% (0.3 FTE) and bank reduced by 9.2% (36.7 FTE) in June 2014 compared with the previous month.	See summary, supporting information and exception report.
Sickness absence (%)		Sickness absence in April was 4.1% compared with a target of 3.4%, 0.7 percentage points above target, and compares with 3.7% in May.	See summary, supporting information and exception report.
Turnover (%)		Rolling turnover (with exclusions) increased to 11.5% compared a target of 10.8%. 7.8% above the turnover target trajectory for June and up 0.3 percentage points compared with May.	See summary and supporting information.
Vacancy (%)		The vacancy target is 5% or less. Vacancies increased from 5.5% last month to 5.6%	See summary, supporting information and exception report.

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

2.3.4 Monthly forecast and overview

Measure	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	June 14 Target
Budgeted Posts (FTE)	7387.6	7399.9	7415.6	7420.3	7408.3	7411.1	7406.4	7424.8	7442.0	7499.3	7355.2	7709.5	7732.9	7714.0
Total Staffing (FTE)	6872.9	6905.5	7017.4	6979.7	7056.7	7071.7	7093.7	7130.2	7167.3	7170.6	7193.7	7285.6	7296.4	7720.4
Bank (FTE) Admin & Clerical	71.7	75.1	95.3	67.1	80.0	63.9	58.4	59.0	67.4	64.9	71.3	89.2	83.7	66.5
Bank (FTE) Ancillary Staff	27.3	29.8	37.6	27.4	36.7	27.0	25.6	30.7	35.2	34.6	38.0	54.6	51.8	20.4
Bank (FTE) Nursing & Midwifery	200.2	189.6	217.1	188.6	232.2	194.5	184.2	197.0	220.2	197.4	203.6	249.5	220.8	145.8
Agency (FTE) Admin & Clerical	11.3	18.2	19.9	27.3	12.2	14.8	17.4	13.5	27.1	25.7	23.4	22.4	21.1	10.5
Agency (FTE) Ancillary Staff	13.7	12.2	10.5	-0.5	-10.0	10.7	10.5	3.7	0.0	8.3	0.0	6.8	4.9	2.7
Agency (FTE) Nursing & Midwifery	48.7	60.3	70.9	76.9	64.1	49.4	38.1	43.1	47.2	37.5	38.5	24.1	28.3	21.0
Overtime	59.3	62.1	71.1	96.1	67.7	55.8	58.2	60.1	54.7	83.7	76.4	48.2	62.3	46.7
Sickness absence[1] Rate (%)	3.7%	3.9%	3.8%	3.9%	4.2%	4.2%	4.2%	4.5%	4.2%	4.3%	3.7%	3.7%	4.1%	3.4%
Appraisal (%)	86.1%	85.9%	86.1%	85.5%	86.1%	87.3%	88.8%	88.5%	87.9%	85.9%	87.1%	86.3%	87.2%	85.0%
Consultant Appraisal[5] (%)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	89.1%	89.2%	80.3%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	18.7%	15.9%	18.7%	18.5%	18.4%	18.3%	18.3%	17.9%	18.0%	17.8%	17.8%	18.0%	18.3%	
Rolling Average Turnover[3] (with exclusions) (%)	11.6%	11.7%	11.7%	11.6%	11.5%	11.5%	11.6%	11.2%	11.2%	11.0%	11.1%	11.2%	11.5%	10.7%
Vacancy[4] Rate (%)	7.0%	6.7%	5.4%	5.9%	4.7%	4.6%	4.2%	4.0%	3.7%	4.4%	2.2%	5.5%	5.6%	≤5%

1. Sickness absence is expressed as a percentage of total whole time equivalent staff in post.
2. Turnover measures the number of leavers expressed as a percentage of the average number of staff in post in the period. Turnover (all reasons) excludes bank, locum and honorary staff.
3. Turnover (with exclusions) excludes bank, locum, honorary and fixed term staff together with junior doctors.
4. Vacancy measures the number of vacant posts as a percentage of the budgeted establishment.
5. Consultant appraisal process allows 14 months before counting as non-compliant.

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of June 2014**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 1)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (14)	**Underachieving (1)**
- 31-day diagnosis to treatment cancer standard - *first treatment* - 31-day diagnosis to treatment cancer standard - *subsequent drug* - 31-day diagnosis to treatment cancer standard – *subsequent radiotherapy* - 31-day diagnosis to treatment cancer standard - *subsequent surgery* - 2-week wait urgent GP referral cancer standard - Referral to Treatment Time for admitted patients - Referral to Treatment Time for incomplete pathways - Genito-Urinary Medicine (GUM) 48-hour access - A&E Left without being seen rate - A&E Time to Initial Assessment + A&E Time to Treatment - A&E Unplanned re-attendance - Ambulance hand-over delays over 30 minutes (year-on-year reduction) - Reperfusion times (door to balloon time of 90 minutes)	- Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved*
Failing (8)	**Not reported/scored (0)**
- A&E Maximum waiting time (4-hours) - Delayed Discharges - Referral to Treatment Time for non-admitted patients - 62-day referral to treatment cancer standard – *GP + Screening referred* - Last-minute cancelled (LMC) operations + 28-day readmission following LMC - 6-week wait for key diagnostic tests	

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

3.2 ACCESS DASHBOARD

Access Standards - dashboard

		Thresholds		Previous YTD	Year to date (YTD)	Month												Quarter			
	Target	Green	Red			Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	96.8%	97.1%	96.6%	95.7%	97.2%	95.0%	96.3%	98.0%	95.4%	98.0%	98.4%	97.1%	97.0%	Cancer standards report two months in arrears	96.5%	96.4%	97.4%	97.1%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	98.1%	97.9%	99.4%	96.5%	94.3%	96.9%	99.5%	97.6%	96.2%	94.0%	97.8%	97.9%	97.9%		96.7%	98.0%	96.0%	97.9%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	99.3%	100.0%	100.0%	100.0%	100.0%		100.0%	99.7%	99.7%	100.0%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	92.9%	95.6%	96.1%	95.2%	89.3%	100.0%	93.5%	95.0%	93.5%	97.6%	91.8%	97.9%	93.2%		94.2%	96.9%	94.1%	95.6%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	98.9%	98.4%	97.8%	98.1%	97.1%	97.1%	97.6%	99.0%	92.3%	99.5%	95.6%	97.9%	98.9%		97.7%	97.8%	95.7%	98.4%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.9%	78.1%	76.6%	77.9%	82.7%	85.6%	83.1%	85.2%	72.9%	77.4%	74.8%	75.3%	81.1%		78.9%	84.6%	75.1%	78.1%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	92.7%	89.9%	95.3%	100.0%	93.9%	91.8%	84.2%	97.6%	98.0%	94.9%	88.9%	89.6%	90.5%		96.6%	90.5%	94.4%	89.9%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	100.0%	92.0%	94.3%	88.2%	100.0%	86.7%	84.2%	93.1%	79.3%	75.6%	97.0%	97.5%	86.1%		94.2%	88.3%	85.3%	92.0%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	93.7%	91.2%	93.0%	92.8%	92.2%	92.9%	91.6%	92.1%	92.8%	92.4%	90.5%	91.9%	91.8%	90.1%	92.7%	92.3%	92.0%	91.2%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	95.7%	93.4%	92.5%	91.5%	91.3%	92.4%	91.3%	94.0%	92.0%	92.7%	93.1%	93.6%	94.0%	92.8%	91.8%	92.5%	92.6%	93.4%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.5%	92.4%	92.2%	92.3%	92.6%	92.9%	93.1%	92.2%	92.6%	92.4%	93.1%	92.7%	92.5%	92.1%	92.4%	92.7%	92.7%	92.4%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	94.1%	94.7%	93.8%	95.6%	97.1%	95.1%	95.4%	90.8%	91.6%	90.1%	92.1%	94.5%	94.3%	95.2%	95.4%	93.7%	91.3%	94.7%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	38	12	14	13	12	13	13	14	12	24	15	14	12	11	13	13	14	12
	A&E Time to treatment decision (median) - in minutes	60	60	53	55	54	47	49	53	53	53	46	55	54	53	57	55	50	53	51	55
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	2.1%	2.4%	0.6%	0.7%	0.6%	2.3%	2.2%	3.0%	2.8%	2.5%	2.4%	2.7%	2.2%	2.4%	0.6%	2.5%	2.5%	2.4%
	A&E Left without being seen	5%	5%	1.6%	1.6%	1.8%	1.7%	1.8%	2.2%	2.1%	2.1%	2.0%	1.8%	1.7%	1.5%	1.9%	1.4%	1.7%	2.1%	1.8%	1.6%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.14%	1.02%	1.15%	0.85%	0.72%	0.65%	0.96%	1.02%	1.18%	1.44%	0.92%	0.98%	0.96%	1.10%	0.91%	0.85%	1.17%	1.02%
	28 Day Readmissions	95%	85%	86.0%	91.3%	88.9%	88.4%	93.6%	95.0%	95.0%	92.6%	93.6%	88.6%	89.7%	94.2%	85.2%	94.4%	90.1%	94.0%	90.3%	91.3%
	6-week wait for key diagnostics	99%	99%	98.1%	97.4%	97.7%	98.2%	98.5%	98.9%	99.5%	98.8%	98.0%	99.2%	99.2%	98.3%	96.6%	97.3%	98.1%	99.1%	98.8%	97.4%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	77.3%	78.4%	89.7%	84.4%	65.0%	86.2%	91.2%	81.6%	77.5%	82.9%	77.1%	78.6%	78.3%		81.5%	86.1%	78.9%	78.4%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	90.9%	94.6%	96.6%	90.6%	95.0%	96.6%	97.1%	89.5%	90.0%	91.4%	91.7%	96.4%	93.5%		93.8%	94.1%	91.1%	94.6%
	Delayed discharges (Green to Go List)	30	41	Not applicable	55.0	58	60	65	57	50	52	60	73	58	56	51	58	61.0	53.0	63.7	55.0
	Ambulance hand-over delays (over 30 minutes) - *year-on-year reduction*	20%	10%	132.7	91.7	123	52	44	63	70	120	94	137	105	96	100	79	73.0	84.3	112.0	91.7

Please note:
Where the threshold for achieving the standard has changed between years, the latest threshold for 2014/15 has been applied in the Red, Amber, Green ratings.
The thresholds for Ambulance hand-over delays are a percentage reduction on the same period last year, in order to take account of seaonal changes in demand.
The standard for Primary PCI 150 Call to Balloon Time only applies to direct admissions - the local target is shown as the GREEN threshold and the national target as the RED.
All **CANCER STANDARDS** are reported nationally two months in arrears. Monthly figures are indicative, until they are finalised at the end of the quarter. The figures shown are those reported as part of the National Cancer Waiting Times data-set. They do not reflect any breach reallocation for late referrals, which is only allowable under Monitor's Compliance Framework.

3.3 CHANGES IN THE PERIOD

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

- A&E 4-hour maximum waiting times standards ↑ (up from 94.3% in May to 95.2% in June)
- 31-day diagnosis to treatment cancer standard *– subsequent surgery* ↓ (down from 97.9% in April to 93.2% in May) *– but expecting to be confirmed as achieved for the quarter as a whole*
- 62-day referral to treatment cancer standard – *screening referred* ↑ (up from 89.6% in April to 90.5% in May)
- Ambulance hand-over delays ↓ (down from 100 in May to 79 in June)

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

3.4 EXCEPTION REPORTS

Exception reports are provided for seven of the RED rated performance indicators.

Please note that the number of Delayed Discharge patients in hospital at month-end is now reported as one of the access key performance indicators, along with Ambulance hand-over delays over 30 minutes. As a key measure of patient flow, performance against the Delayed Discharges operational target will be reported as part of the A&E 4-hour Exception Report, in months where the 95% standard isn't achieved.

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

ACCESS STANDARDS

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

Description of how the target is measured:

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

This standard remains part of the NHS Constitution.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

There were 64 last-minute cancellations (LMCs) of surgery in June (1.10% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in June were as follows:

- 31% (20 cancellations) were due to an emergency patient being prioritised on the day
- 14% (9 cancellations) were due to no ward bed being available to admit a patient to
- 14% (9 cancellations) were due to the morning theatre list running-over and/or another patient in theatre being more clinically complicated than expected
- 6% (4 cancellations) were due to the lack of nursing staff support for a dermatology day-case theatre list
- 5% (3 cancellations) were due to a dermatology consultant being taken ill
- 30% (19 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging

Of the 64 cancellations, 29 were day-cases and 35 were inpatients (45% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher rate of inpatient cancellations reflects the high cancellation rate due to emergency patients needing to take priority, which is more likely to impact inpatient than day-case procedures. There were, unusually, a total of seven cancellations in June for dermatology procedures, which were due to the lack of nursing staff and consultant sickness.

Unlike the previous two months, ward bed availability was not the single highest cause of cancellations this month. This reflects the improvements seen in patient flow in the period. In May, the lack of a critical care bed was one of the top three causes of cancellations in the month. However, there was only one cancellation attributed to the lack of a critical care bed in June, confirming as expected that the problems experience in the previous month was due to a short-term increase in demand.

In June, 94.4% of patients cancelled in the previous month were readmitted within 28 days of the cancellation. There were 3 breaches of standard in the month. One of these patients was due for readmission to the Bristol Children's Hospital and could not be re-admitted within 28-days due to more urgent patients taking priority. The remaining patients were due for surgery within the Bristol Royal Infirmary and were not re-admitted within 28-days due to more urgent patients taking priority.

ACCESS STANDARDS

Recovery plan, including expected date performance will be restored:

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

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability (see A&E 4-hour Exception Report – A6);
- Escalation of all LMCs not re-booked within 7 days of cancellation (ongoing); patient list now also being reviewed at the weekly or fortnightly Referral to Treatment Time (RTT) meetings with Divisions;
- Monthly validation of all potential LMCs re-established, to ensure we are not inappropriately reporting last-minute cancelled operations, or failures to re-admit within 28 days, and that we understand the reasons for cancellations (ongoing);
- Outputs of the weekly scheduling meeting are reviewed by Surgery, Head & Neck team, to be clear on the accountability for making sure theatre lists are appropriately booked (i.e. will not over-run), and the necessary equipment/staffing are available (ongoing);
- Weekly reviews of future week's operating lists continue, to ensure the demand for critical care beds is spread as evenly as possible across the week; daily reviews of current demand for critical care beds, and flexible critical care bed-usage across Divisions to minimise cancellations (ongoing);
- Daily e-mails circulated of all on-the-day cancellations within the Bristol Royal Infirmary by the nominated Patient Flow Co-ordinator, to help ensure patients are re-booked within target (ongoing);
- In addition to the opening of the twentieth ITU bed, a further review of critical care capacity is being undertaken, as part of the 2014/15 Operating Model, which is being led by the Senior Leadership Team.

Progress against the recovery plan:

The 0.8% national last-minute cancelled operations standard was not achieved in June. This was primarily due to emergency pressures on theatres, with almost a third of cancellations being due to emergency patients having to take priority.

Performance against the 28-day readmission standard was 94.4%, which represents a significant improvement on May's performance of 85.2%. The ability to re-admit patients following their cancellation was primarily affected by a combination of emergency pressures and other more urgent patients needing to be prioritised. Reducing the level of ward-bed related cancellations remains critical to the achievement of both the last-minute cancelled operations and the 28-day readmission standards, even though in June the 0.8% would not have been achieved even if the Trust had had no ward bed-related cancellations. Delivery of the objectives of the 2014/15 Operating Model should reduce levels of last-minute cancelled operations and improve performance against the 28-day readmission standard.

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A3-A4. EXCEPTION REPORT: 62-day referral to treatment for GP and Screening referred patients	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients with confirmed cancers treated within 62 days of referral, as a percentage all cancer patients treated during the period under that standard. There are separate targets for GP and Screening referred patients, although Monitor treats this as a combined standards for the purposes of scoring

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

Performance during the period, including reasons for exceptions:

62-day GP referred

Draft performance for June is 87.2%, with performance for the quarter expected to be confirmed as 81.3% against the 85% standard. These figures are subject to further validation and reporting, which will take place early in August. The recovery trajectory target of 65.0% was achieved for the month. The recovery target for the quarter of 75.3% was also met.

Performance in May was reported as 81.1% against the 85% standard, although the latest refreshed data, which will be submitted as part of the end of quarter submission shows that performance improved to 81.7%. Breach analysis has shown the reasons for the breaches to be as follows:

Breach reasons	May breaches	Percentage of breaches
Late referral	4.5	33%
Delayed admitted diagnostic procedure	2.5	19%
Elective capacity	2.0	15%
Medical deferral/Clinical complexity	2.0	15%
Admin delay/pathway planning issue	1.0	7%
Patient choice to delay	1.0	7%
Other reasons	0.5	4%
	13.5	**100%**

Fifty-five percent (55%) of breaches were due to primarily unavoidable reasons, including late referral, clinical complexity and patient choice.

There were 6 breaches (44%) relating to internally managed pathways and 7.5 breaches (15 pathways x 0.5 accountability) relating to shared pathways.

The transfer of breast and urology services to North Bristol Trust has left the Trust with a challenging group of pathways to meet the 62-day GP standard. This is because breast cancers are relatively easy to treat within 62-day of referral because the diagnostic pathways are simple and patients are usually fit enough to proceed to treatment without further intervention. In quarter 4 2013/14, the 85% standard was only achieved for breast and

skin cancers at a national level, and national average performance overall for all tumour sites was 84.6%. The Trust is now the only acute provider in the country that provides neither breast nor urology cancer outpatients or surgical services.

An improvement working group was established in October 2013, focusing primarily on the 62-day cancer pathways. Improvements in performance at a tumour-site level were realised between quarter 2 and quarter 3 2013/14. This is especially evident when comparing the Trust's performance against the national average reported for the same quarter. However, the volume and proportion of unavoidable breaches has increased since then, meaning that further improvements now have to be made to offset these additional breaches that are largely outside of the Trust's control.

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

62-day Screening

Draft performance for the quarter is 89.7%. But this is still subject to final validation and reporting by treating providers. A total of 7.5 breaches of standard have been incurred during the quarter, 7.0 of which were incurred for breast screening pathways, due to delays at receiving providers following timely referral by the Trust.

Recovery plan, including expected date performance will be restored:

A fortnightly cancer steering group is taking forward further improvement priorities which have identified from the most recent breach analysis and learning from other providers. The key actions are as follows:

62-day GP referred actions:

- Implement new management for tertiary thoracic surgery peripheral clinics to reduce delays to referrals from other providers (impact from Q4 onwards); following agreements with North Bristol Trust (NBT), surgical review of patients to be conducted on the same day as the Multi-Disciplinary Team discussion of the patient's case, from July, which should reduce the thoracic pathway by 9 days; discussions with Yeovil District Hospital, Gloucester Hospitals and Taunton & Somerset trusts ongoing, to agree the adoption of a similar approach;
- Reduce maximum wait for 2-week wait step to 7 days (excluding skin and paediatrics, for which the wait to first appointment will not have a material impact on breach volumes) for 90% of patients (planned for end July, but timescales under review); demand modelling undertaken for each tumour site; additional clinic capacity established in head & neck, lung and gynaecology, and being planned in other specialties; monitoring report now available;
- Establish 2.5 additional ENT theatre sessions per week from October 2014 onwards, to reduce the majority of panendoscopy delays; additional capacity currently being sought to bring forward this action (ongoing);

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- Implement new approach to critical care cancellations and booking of cases to minimise impact of residual cancellations; action completed; critical care cancellations continue to be tightly managed, with pro-active cancellations taking place as necessary and back-fill of sessions with cases that do not require a critical care bed, to ensure theatre and surgeon capacity is not wasted;
- Establish additional thoracic and hepato-billiary theatre sessions from October 2014, when Vascular service moves to North Bristol Trust; review being undertaken as to whether additional short-term capacity can be established before October;
- Range of options being implemented for increasing thoracic surgical capacity between July to September;
- Revise the pre-operative assessment management process in order to ensure potential issues for patients on cancer pathways can be identified quickly and tests expedited; new protocol-based process established and being monitored;
- Schedule additional elective cancer surgery slots in December 2014, when activity levels are low and breaches can result in quarter 4

62-day Screening referred actions:

- Maintain close dialogue with treating providers, escalating concerns with delays in treatments;
- Continue to proactively manage internally delivered screening pathways.

Progress against the recovery plan:

62-day GP

The following improvement trajectory has been agreed, on the basis of the actions identified and expected impact of these actions. The figures below are expected to be confirmed on final national reporting early in August. Performance for the quarter is significantly above trajectory.

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Q3	Jan-15	Feb-15	Mar-15	Q4
Trajectory	75.7%	80.5%	65.0%	75.3%	79.9%	82.1%	81.8%	81.3%	86.4%	85.1%	84.1%	85.3%	84.8%	85.4%	87.0%	85.8%
Actual	75.0%	81.7%	87.2%	81.3%												

31-day first definitive

The 31-day first definitive treatment standard was achieved in quarter 4. But due to the narrow margin of achievement against the 96% standard in quarter 4 2013/14, the following trajectory has been agreed and progress with achieving this trajectory will be reported to the Board on a monthly basis. The figures below are expected to be confirmed on final national reporting early in August. Performance for the quarter is above trajectory.

	Apr-14	May-14	Jun -14	Q1	Jul -14	Aug -14	Sep -14	Q2	Oct -14	Nov-14	Dec -14	Q3	Jan -15	Feb -15	Mar-15	Q4
Trajectory	95.9%	96.4%	96.7%	96.3%	96.8%	96.7%	96.8%	96.7%	97.2%	97.2%	96.7%	97.0%	97.2%	96.9%	97.2%	97.1%
Actual	98.0%	97.9%	94.3%	96.7%												

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

Description of how the target is measured:

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

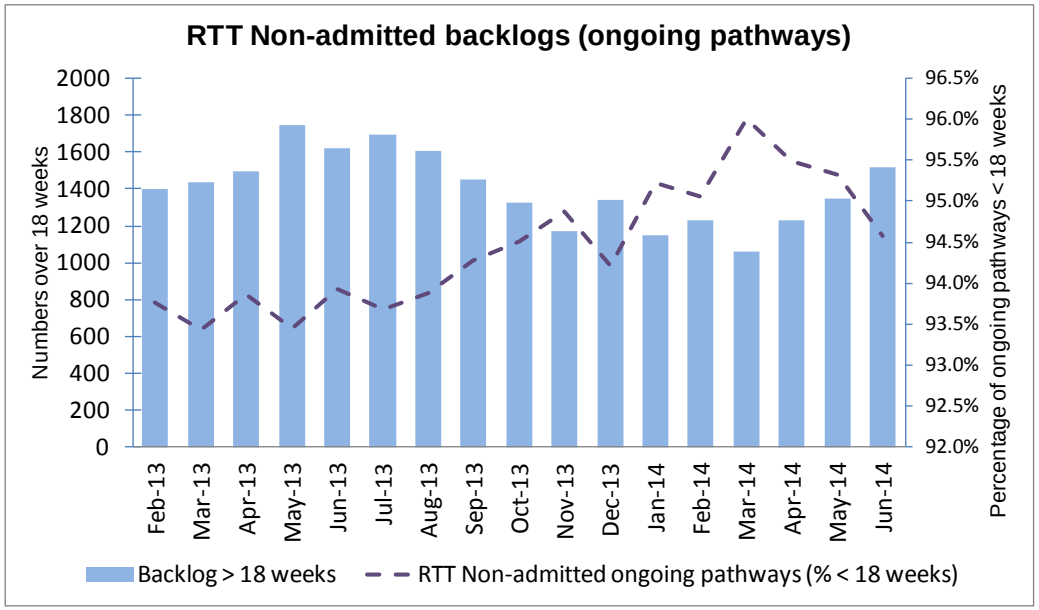
Performance is assessed by Monitor at an aggregated Trust level.

Monitor measurement period: Monthly achievement required but quarterly monitoring

Performance during the period, including reasons for exceptions:

Performance in June was 92.8% against the Non-admitted standard, which is a deterioration on the May position of 94.1%, and 1.3% below the target trajectory.

The failure to achieve the RTT Non-Admitted standard was forecast following the Head & Neck service transfer from North Bristol Trust, due to the number of patients already waiting over 18-week for their first outpatient appointment, at the point of transfer. The forecast failure was flagged to Monitor in the Annual Plan, and re-stated as part of the quarter 2 declaration of compliance. In combination with increases in referrals from GPs, which has resulted in waits for first outpatient appointments lengthening, this led to a failure of the standard in quarter 4, and the Trust flagging to Monitor the potential failure of the standard in quarters 1 and 2 of 2014/15, as part of the 2014/15 Annual Plan.



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

The percentage of patients on a non-admitted ongoing pathway that are waiting under 18 weeks at each month-end was above 95% between January and May, but dipped below 95% in June. This rise in the backlog is due to a 'bulge' in the number of patients waiting for a dental first outpatient appointment, moving through the waiting list. Action was taken in June to establish 1600 additional dental outpatient appointments during June to

September, to address the additional waiters now progressing through the waiting list. Overall non-admitted RTT activity (treatments) in June increased by 908 relative to May (13.5% up). This included an additional 150 breach patients being treated in June, 115 of which were dental in dental specialties. For this reason the original RTT Non-admitted recovery trajectory target for the month, of 94.1%, was not met.

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

- Forty-nine percent of the patients treated in the month who had waited over 18 weeks for treatment were in dental specialties, which is an increase of 10% over the previous month and reflects the additional activity undertaken to reduce the number of long waiters;
- Additional patients that had waited over 18 weeks from referral being seen for first outpatient appointments within the adult Ear, Nose & Throat and Oral Surgery services following transfer of the waiting list from North Bristol Trust; this is now mainly due to increases in referral volumes beyond that expected as part of the transfer;
- Lengthening outpatient waiting times for first appointments in a range of specialties, following increasing volumes of referrals, especially from GPs

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

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	149	19	168	**88.7%**
Cardiothoracic Surgery	18	1	19	**94.7%**
Dermatology	535	13	548	**97.6%**
E.N.T.	564	45	609	**92.6%**
Gastroenterology	33	4	37	**89.2%**
General Medicine	188	0	188	**100.0%**
Geriatric Medicine	56	0	56	**100.0%**
Gynaecology	549	11	560	**98.0%**
Neurology	85	1	86	**98.8%**
Ophthalmology	1068	19	1087	**98.3%**
Oral Surgery	250	30	280	**89.3%**
Other	3082	368	3450	**89.3%**
Rheumatology	127	3	130	**97.7%**
Thoracic Medicine	217	4	221	**98.2%**
Trauma & Orthopaedics	112	26	138	**81.2%**
TOTAL	**7033**	**544**	**7577**	**92.8%**

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In June, eight of fifteen specialties achieved the 95% standard, compared with ten in May.

Recovery plan, including expected date performance will be restored:

- To improve performance for non-admitted Referral to Treatment (RTT) pathways, a three phase project plan has been developed that focuses on immediate actions required to bring performance back in line as well as more medium / longer term sustainability improvements;
- A working group was established in February, and has developed the recovery plan for reducing waiting times for first outpatient appointments. This group has been meeting weekly and has developed the activity and waiting list trajectories for reducing outpatient waiting times throughout 2014/15. Weekly monitoring of activity against the plan is now taking place and any deviations from plan are being identified so that mitigating actions can be taken;
- A monthly RTT Steering Group has also been set-up to oversee the progress of the working group as well as to provide a more strategic oversight of RTT performance. This group is responsible for ensuring all the milestones of the project are met as well as overseeing risks, reviewing benchmarking information, providing cross divisional oversight and recognising / promoting best practice;
- To provide external assurance that our recovery plan is 'fit for purpose', the national Elective Care Intensive Support Team (IST) was asked to undertake a review of our action plan, to ensure it is robust as well as to share best practice from other organisations. Following the original visit in April and further visits to the Trust in June and July, final reports are now available. Plans are now being developed to implement the key recommendations of the review. Initial planning will be undertaken in August by the RTT Steering Group.

Progress against the recovery plan:

Weekly activity plans are being implemented, to further reduce the number of patients waiting over 18 weeks. The modelling which has been undertaken of the impact of shortening first outpatient waits forecasts achievement of the 95% standard from October 2014, as shown in the trajectory below. June's target was not achieved in the month, for the reasons detailed above. The trajectory for July to October has been revised to reflect the number of additional breach patients expected to be treated in each of the next three months.

Non-admitted Trajectory	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Patients above target outpatient wait	2,940	2,483	1,998	1,454	844	505	364	207	98	98	0	0	0
Forecast performance against RTT Non-admitted standard	93.1%	93.4%	93.7%	94.1%	89.5%	88.0%	92.5%	95.0%	95.0%	95.0%	95.1%	95.1%	95.1%
Actual performance against the RTT Non-admitted standard	93.1%	93.6%	94.0%	92.8%									

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

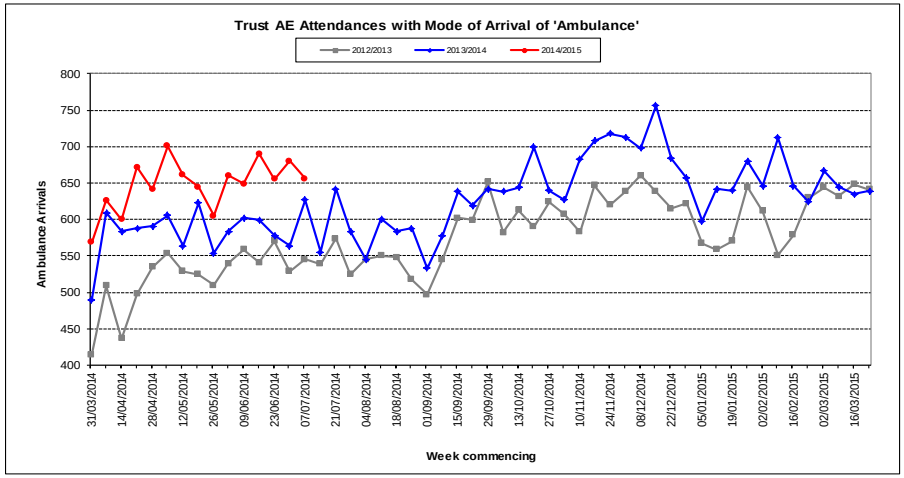
Description of how the target is measured:

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

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

Trust-level performance against the 4-hour standard was 95.2% in June, with the 95% national standard being achieved for the first time since November 2013. However, the improvement in performance in the period was not sufficient to support achievement for the quarter. Performance against the 4-hour standard at the Bristol Children's Hospital was above the 95% standard and improved by 1.1% relative to May, to 97.7%. Performance within the BRI remained below the 95% standard, but also improved by 1.0% relative to May, to 92.4%. The Bristol Eye Hospital achieved 99.7% against the 95% national standard.



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

Ambulance arrivals into the Trust remain high and for the BRI were 11.2% higher in June than the same period last year. In quarters 2 and 3 2013/14 emergency admissions stayed at similar levels to previous years despite an increase in ambulance arrivals. This was attributed to the work of the Ambulatory Care Unit. In contrast to April and May, there was only a small rise in emergency admissions (4.4%) in June, despite a significantly higher increase in ambulance arrivals. Based upon the Trust's planning assumptions, the majority of this rise in emergency admissions is attributable to the closure of the Frenchay Emergency Department (ED).

The Bristol Children's Hospital experienced a 19.6% increase in ambulance arrivals in June, relative to the same period last year. There was also a 31.9% increase in the level of emergency admissions. A relatively small proportion of this increase in emergency admissions is solely attributable to the closure of the Frenchay ED, based upon the original planning assumptions.

There was an increase in length of stay for patients discharged in the month, reflecting a higher proportion of long stay patients discharged in the period. However, the number of long-stay patients in hospital at month-end increased. This is in part due to an increase in the number of delayed

discharges (see Table 1 below). There has been further focus on reducing the number of long stay patients in hospital during the first half of July, and a reduction in the total number of long waiters is expected at month-end.

Table 1 – Number of Delayed Discharges on the Green to Go list at the end of June compared with the previous six month-ends

Month	Total number of Green to Go (Delayed Discharge) patients at month-end
November 2013	50
December 2013	52
January 2014	60
February 2014	73
March 2014	58
April 2014	56
May 2014	51
June 2014	58

Recovery plan, including expected date performance will be restored:

The Senior Leadership Team is overseeing the delivery of the 2014/15 Operating Model. This covers a programme of seven projects which are targeting improvements in patient flow. Progress updates for the projects are provided in the table below.

Project	Project Aims	Progress on delivery
Breaking the Cycle Together	During week commencing Monday 31st March the Trust ran an initiate a "Breaking the Cycle Together" (BTCT) week with our partner organisations; Bristol Community Health, Clinical Commissioning Group, Commissioning Support Unit and Social Services, to focus on: • To reaffirm and consolidate our standards of patient care; • Using a Major Incident approach to rapidly address barriers to adherence with these standards; • Align our whole organisation's attention from the very top down, to focus and fix issues which get in the way	Divisions have piloted changes to daily operational routines which aimed to replicate the methods used in the BTCT week. The learning from the pilots has been taken into a set of agreed standards for these routines which are being adopted in the Divisions as business as usual. A further audit against these standards will take place in late July, and any further actions required will be overseen by Service Delivery Group.

	of the quality of care we aim to deliver; • This initiative will be run over a full 7 days, and will include all inpatient activity.	
Integrated discharge hub and supporting discharge processes	To co-locate staff from the three key Organisations responsible for managing patients with complex care needs; Bristol City Council, Bristol Community Health and University Hospitals Bristol; to improve efficiency of discharge processes; improve communication, reduce duplication and create an integrated discharge policy and process.	• Detailed plans are now advanced for the joint Integrated Discharge workshops with Bristol City Council and Bristol Community Health which will develop integrated ways of working. These workshops will take place over the 3rd and 4th weeks of July and will specify detailed changes to be implemented over the following 1-3 months
Out of hospital solution	To commission further out of hospital transitional care beds to reduce the number of bed days consumed by 'Green to Go' (delayed discharge) patients, thereby reducing Length of Stay (LOS) and bed occupancy to improve patient flow.	• Potential beds identified. Proposal prepared for the Better Care Fund programme board to agree funding arrangements (**completed**). • A detailed analysis of current provision and occupancy has been developed and tracking of Key Performance Indicators in place. Further work to plan provision for the winter is scheduled for September
Early Supported Discharge **(ESD)**	Effective early supported discharge pathways in place for patients which are provided by either a community partner or UH Bristol, or a combination of both which leads to better patient outcomes, better patient experience and a reduced Length of Stay.	• This work will be advanced by the multi-agency workshops later in July who will use the ESD approach to facilitate the discharge of relevant patient cohorts
Trust wide review of Critical Care	The project is still being scoped, but will address issues of flow and capacity in adult critical care facilities.	• Improvements to short term capacity management are embedded within the protected beds method (below). The long term capacity review is in planning stage.
Weekend discharge – diagnostic and solution	To understand the issues needed to even out patient flow across the seven days of the week and increase the number of discharges that take place at the weekend.	• The Information Technology tool to identify patients for discharge action over weekend has been implemented in several areas and an evaluation of its impact will take place in July and August.

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Protected Beds	To develop an operating model that will support elective and urgent tertiary activity to proceed unhindered by periods of high demand for acute medical care through the Emergency Department. This will ensure that all our patient flows are supported, both planned and unplanned care.	• The detailed operating model to support Protected Beds, along with operational procedures and training plan has been developed. This will be presented to Senior Leadership Team for sign-off in August and implementation across initial wards early in September

Progress against the recovery plan:

Performance against the 4-hour standard improved in June, with the 95% standard being achieved for the first time since November 2013. Key milestones for the achievement of the aims of the Operating Model programme of work have been defined and will be used to inform an improvement trajectory for sustainable achievement of the 95% national standard in quarters 3 to 4. The new patterns of emergency admissions following the Frenchay Emergency Department closure are still emerging. In addition, the Trust is continuing to see increasing numbers of ambulance arrivals, which in conjunction with the increasing ago-profile of patients admitted to the Trust, pose risks to achievement of the 95% standard over the winter which need to be mitigated effectively.

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A7. EXCEPTION REPORT: 6-week wait for key diagnostic tests	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

The number of patients waiting over 6 weeks for one of the top 15 key diagnostic tests at each month-end, shown as a percentage of all patients waiting for these tests. The figures include patients that are more than 6 weeks overdue a planned diagnostic follow-up test, such as a surveillance scan or scoping procedures. The national standard is 99%.

Monitor measurement period: Not applicable; the monitoring period nationally is monthly.

Performance during the period, including reasons for exceptions:

Performance in June was 97.3% against the 99% national standard for 6-week diagnostic waits. This is a 0.7% improvement of May's performance of 96.6% There were 187 breaches of the 6-week standard at month-end, of which 107 were for MRI scans (a reduction from 112 in May), 25 were for gastrointestinal endoscopies (a reduction from 61 in May) and 53 were for Cardiac Stress Echocardiograms (a slight rise from 51 in May). There were also 2 breaches of standard for patients awaiting neurophysiology tests.

The increase in long waiters for MRI scans in June follows a period of heightened demand, in combination with the loss of capacity in some areas, such as the paediatric MRI service, with a number of sessions being lost due to bank holidays and the lack of anaesthetic cover.

The original dip in performance against the 6-week wait standard in 2013/14 resulted from demand for the gastrointestinal endoscopies outstripping available service capacity. This was due to a significant rise in demand for the procedures, which is a pattern that has been seen both regionally and nationally. The rise in demand could not be responded to quickly due to delays in the opening of additional facilities at South Bristol Community Hospital. However, a remedial action plan was developed which addressed this and the backlog of adult endoscopy cases was cleared at the end of May 2013. In May, there were 38 breaches of 6-week standard for adult endoscopies, but none in June following actions taken by the Division to address the small backlog which had built-up. The 25 gastrointestinal paediatric endoscopy breaches of standard reported in June were for routine paediatric patients. The numbers of long waiters remain similar to that of previous months, with sustainable changes in capacity planned during quarter 3.

Demand for Cardiac Stress Echocardiograms also remains high due to changes in NICE guidance for patients with cardiac problems. Capacity is also restricted due to the limited number of staff able to undertake these diagnostic tests.

Recovery plan, including expected date performance will be restored:

The following actions are being taken to improve performance against the 6-week wait standard in quarter 1. *Please note: actions completed in*

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previous months have been removed from the following list:

- Future paediatric MRI scanning capacity is being reviewed and plans for additional sessions are being taken forward;
- All appropriate adult patients continue to be offered MRI scans at another local provider (however, under waiting times rules, where patients decline to be seen elsewhere their waiting times cannot be adjusted); the Trust's own MRI scanners continue to be run at weekends, to increase capacity;
- A mobile MRI scanner will be based at South Bristol Community Hospital from mid July to provide further routine capacity and to reduce the likelihood of a backlog building-up again;
- The recruitment of an Echo Cardiographer Radiographer/Technician has been approved, and a locum is being sought from an agency until the post can be recruited to substantively; additional sessions with current staff are also being run in July and August;
- A plan has been developed to clear the backlog of adult endoscopy long waiters, and to ensure maximum waiting times are maintained thereafter (Action complete);
- A long-term solution is being put in place to support sustainable waiting times for paediatric endoscopies (by the end of quarter 3);

Progress against the recovery plan:

The 99% standard wasn't achieved in June, although there was an improvement in performance as planned. Additional capacity continues to be put in place to reduce the number of long waiters for a number of different types of diagnostic test. Achievement of the 99% standard was forecast for July month-end, although there is slippage against this trajectory due to some plans needing to change. A further improvement in performance is, however, expected based upon progress in the month to date.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

8. Corporate Quality Objectives – Quarter 1 Update

Purpose

To brief the Board 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

The Board is recommended to receive the report for assurance

Report Sponsor

Chief Nurse

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
		25/7/14			

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Quarter 1 update on Corporate Quality Objectives**

Report to: **Quality and Outcomes Committee**

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

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

9. Infection Control Annual Report

Purpose

To brief the Board on the Infection Control Annual Report. For compliance with the Hygiene Code the Director of Infection Prevention and Control is required to produce a report and release it publicly annually. The content of the report is dictated by expectations from the department of health and the care quality commission and summarises performance in infection prevention and control matters for the year.

Abstract

The report outlines progress against compliance with the hygiene code, in which full compliance was achieved. The corporate objective to further reduce rates of Infection was partially achieved. The annual infection control programme was, overall achieved. We have also :

- Applied the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code)
- Report and investigated cases and outbreaks of healthcare associated infection as mandated
- Reduce further the incidence of infections, specifically Meticillin Resistant Staphylococcus Aureus (MRSA) and Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections and Clostridium Difficile (C. diff).
- Maintained a clean and appropriate environment. The average score across the Trust in all risk categories was maintained at 95%.
- Developed study sessions for Nursing home staff and General Pratitioners to help them understand the management of patients with particular infections. E.g., Clostridium difficile

We will continue for the year 2014/15 to :

- Comply with the Code of Practice and related guidance in the prevention and control of infections.
- We will continue to strive to reduce further the incidence of infections, specifically MRSA and MSSA blood stream infections and Clostridium difficile.

Statistics on specific infections and outbreaks are included as are standing sections on decontamination, cleaning services and the Matrons report. The objectives for 2014/15 are outlined.

Recommendations

The Board is recommended to receive the report for assurance

Report Sponsor

Chief Nurse

Appendices

- Infection Control Annual Report

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
		25/7/14			

University Hospitals Bristol NHS
NHS Foundation Trust

Infection Control Annual Report 2013/14

STATEMENT FROM THE CHIEF NURSE

High standards of infection control are crucial to ensure prevention of infection in healthcare facilities. The organisation has a statutory responsibility under the Health and Social Care Act, 2008 (the Hygiene Code) to produce and publish an infection control annual report.

This report summarises the key Infection Prevention and Control (IPC) activities carried out on behalf of University Hospitals Bristol NHS Foundation Trust from April 1st 2013 to March 31st 2014. It provides an overview of all IPC activities in the past year, highlights service achievements and progress made against national and local priorities related to infection control.

Our focus on working to reduce the incidence of hospital acquired infections is continuous. I would personally like to thank all staff for their efforts and support in this important area of clinical care.

Carolyn Mills
Chief Nurse

CONTENTS

1. OVERVIEW OF PROGRESS FOR 2013/14

Our goal in 2013/14 was to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this we identified the following six objectives:

1. To comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code)
2. To report and investigate cases and outbreaks of healthcare associated infection as mandated
3. Reduce further the incidence of infections, specifically Meticillin Resistant Staphylococcus aureus (MRSA) and Meticillin Sensitive Staphylococcus aureus (MSSA) blood stream infections and *Clostridium difficile* (C. diff).
4. Develop the Infection Prevention and Control Master class Training Programme
5. To implement a programme for sharps injury prevention to meet requirements of Directive 2010/32/EU.
6. To develop a system in conjunction with Occupational Health and Human Resources (HR) for identifying members of staff who have been visiting (on annual leave/secondment) a high risk Pulmonary Tuberculosis (TB) country for more than 3 months or who have worked and lived with TB patients for more than one month

2. COMPLIANCE TO THE HYGIENE CODE

Have systems in place to manage and monitor the prevention and control of infection, using risk assessment to consider individual and environmental risks.

- We have a fully established infection control team that consists of an Infection Control doctor, seven infection control nurses, an antimicrobial pharmacist, an analyst and administrative support. An Intravenous Access coordinator that was originally in post for one year. This post has been made a permanent part of the team.
- The Director of Infection Prevention and Control leads the team and reports directly to the Chief Nurse and Medical Director.
- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times in 2013/14 and includes Governor and partner organisation representatives. It has been decided that from April 2014 the group will meet on a bi monthly basis.
- The Trust Board has received monthly Infection Control reports within the Quality Report and a quarterly detailed report. Detailed quarterly reports are available on the Infection Control Group workspace.
- The Infection Control Group has monitored all relevant risks at each meeting
- The Infection Control Group quarterly assessed compliance to the hygiene code.
- Hygiene code and Care Quality Commission outcome 8 compliance.

Compliant	Minor concerns	Moderate concerns
50	3	2

Assessment of compliance with the hygiene code shows there are two moderate concerns. These relate to isolation and the availability of hand hygiene facilities. This status will change when the new ward block has been completed as isolation hand hygiene facilities will increase in the new build. The minor concerns relate to occupational health and the screening of staff who have worked in high risk areas of TB and immunisation records. This is included in the general report.

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

Provide and maintain a clean and appropriate environment:

- Trust wide cleanliness audits continue on a monthly basis. If scores fall below 95%, audits are repeated weekly until the area returns to 95% for four consecutive weeks.
- Across all the Very High risk category areas in the Trust the average score has been 96% continuously for the past twelve months. All sites are averaging scores of 94% or above.
- Audit score sheets have been updated to include columns which identify the reasons for failures. The infection control team are notified when areas who have scored a red or amber rating.
- Hand hygiene practice monitoring scores have achieved 98% against the 95% standard over the year.

Provide suitable and accurate information on infections to service users and their visitors.

- All patient and visitor Infection Prevention and Control Information leaflets have been updated as required.
- General Practitioner and patient letters for Meticillin Resistant Staphylococcus aureus have been updated after a patient raised concerns with the content. More clarification of what patients should do when they receive positive results by post has been included.

Provide suitable and accurate information on infections to any person concerned with further support including nursing/medical care in a timely manner.

- Adult and Paediatric patients that have been discharged and have a positive Meticillin Resistant *Staphylococcus aureus* (MRSA) and positive *Clostridium difficile* result are informed by letter of their result. Their General Practitioners (GP) are also informed.
- A re audit looking at discharge summaries to see that the infection status of patients is completed is in progress and will be reported on later in the year.

Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care:

- An assessment for risk of infection is carried out for all patients when they are admitted
- We ensure the clinical teams are informed of any positive results.

- We follow up positive MRSA and C diff patients, ensuring appropriate treatment is commenced.
- Management of the cubicle tracker by the infection control team and clinical site team ensures patients are isolated appropriately.
- We screen elective and emergency patients before surgery for MRSA. Our target is 100% for elective patients and 90% for emergency patients.
- We screen inpatients every 14 days for MRSA.
- A pilot study was undertaken in the Trust. Patients who came through the Pre Op Assessment Unit who did not have a date for surgery within two weeks were given swabs to take home and an information leaflet. The patients were given a box to send the swabs back for processing in the laboratory through the post. Initial results were positive; however the pilot is going to be repeated on a bigger scale to ascertain if there are benefits in continuing this.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
MRSA Pre-Op Elective Screenings	100%	100%	100%	99.6%	99.2%	100%	99.1%	100%	100%	100%	100%	100%
MRSA Emergency Screenings	96.99%	95.81%	97.09%	96.91%	95.49%	95.82%	96.44%	96.24%	95.99%	95.11%	95.70%	95.27%

Ensure all staff are fully involved in the process of preventing and controlling infection

- All Divisions have leadership for infection control through the Heads of Nursing (for the Division of Diagnostics and Therapies it is the Lead Allied Health Professional), a designated medical lead and Matrons. Divisions all have effective link nurse systems
- All Infection Prevention and Control mandatory and update training has been reviewed. All training includes staff responsibilities, for example, what action they are required to take if they are unwell or, suspect they have pulmonary Tuberculosis (TB).
- Training has been reviewed quarterly to reflect target requirements and achievements. E learning packages have been developed and all clinical updates including paediatrics will be delivered through this route, from October 2014. Non clinical staff will have a mixture of e learning and face to face sessions. Medical staff will continue with face to face sessions.
- A joint annual Infection Prevention and Control study day is held and includes staff from North Bristol Trust.

Provide adequate isolation facilities

- A negative pressure room has been commissioned in the Trust. This allows Multi drug resistant TB patients to be managed in the Trust and not transferred outside the city.
- Isolation facilities have been planned into the new Bristol Royal Infirmary build; increasing isolation facilities from 12% to 33% these include areas with negative pressure facilities.

Secure adequate access to laboratory facilities

- Laboratory services are provided by Public Health England laboratory in line with the expected contract.

Have and adhere to policies that will prevent and control infection

- All Infection Prevention and Control policies have been monitored and updated with national guidelines and up to date evidence as required. Clinical guidelines have been developed after consultation with staff to ensure management of patients with infections guidance is easy and practical to follow.
- We have audited hand hygiene compliance monthly with a standard of 98% achieved at the end of year, against a target of 95%.
- The annual audit of sharps management has been completed by Daniel's, the company that supply the sharps bins to the Trust. The results are broken down into department, ward and area. Results and recommendations are fed back to the Divisions. Results from the audits can be obtained by contacting the infection control team.
- Environmental and equipment audits have been carried out by the infection control team Trust wide. Results and recommendations are fed back to each ward area. Results from the audits can be obtained from the infection control team.

Ensure that healthcare workers are free of and protected from exposure to infections and that all staff are suitably educated in the prevention of cross infection. To develop a system in conjunction with Occupational Health and Human Resources (HR) for identifying members of staff who have been visiting (on annual leave/secondment) a high risk Pulmonary Tuberculosis (TB) country for more than 3 months or who have worked and lived with TB patients for more than one month.

- All staff are screened for infection when they begin work at the Trust and are offered appropriate vaccinations against infectious disease
- The Occupational Health department use the eOPAS system (Occupational Health IT system) to remind staff when their immunisations are due.
- Staff immunisation status is now included in staff appraisals.
- Additional health screening continues for staff that spends long periods in specific countries abroad for either work of personal reasons.
- We have continued to place specific focus on providing infection control induction and update training for all staff.

3. STATUTORY AND NATIONAL REQUIREMENTS

Further reduce the incidence of infections, (specifically MRSA and MSSA blood stream infections and *Clostridium difficile.*

Clostridium difficile

2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
286	99	94	54	48	38

- The standard is measured by the number of *Clostridium difficile* cases for patients in hospital for more than 3 days. The national reduction target set centrally for 2013/14 was 35 cases in the year; 38 cases were recorded by the end of the year.
- The Trust was 10 cases lower than the previous year.
- Procalcitonin testing was introduced into the Medical Assessment Unit and the Elderly Assessment Unit. Preliminary results show that 58% of antibiotics have been stopped or not given due to low Procalcitonin levels.
- A new antibiotic called Temocillin was added to the formulary. There is less risk of patients developing *Clostridium difficile* when being treated with this antibiotic
- An antibiotic guideline smart phone application (App) is available in the Trust.
- Screening of BMT *Clostridium difficile* positive patients on admission was introduced.
- A large study was undertaken in Oxford looking at reducing cases of *Clostridium difficile.* The results have shown that there needs to be more management in the community to help prevent patients coming into hospital with the disease. In light of this study a study morning took place for General Practitioners and Nursing home managers to help them understand the management and prevention of *Clostridium difficile.* Both sessions were well attended and there are sessions booked for 2014/15.
- All isolates are being sent to the Anaerobic Laboratory in Cardiff for sensitivity testing to allow us to understand the distribution of resistance and allow adjustments to antibiotic guidelines. The typing of faecal sample has shown a wide variety of types and no evidence of in- hospital transmission.
- The Infection Prevention and Control team undertook a bench marking exercise with ten other Trusts who had reduced their cases of *Clostridium difficile.* We looked to see if there were any further improvements that could be introduced that would help to reduce our cases. The Trusts that were contacted asked for our documentation as they felt it was clear and informative. The exercise showed there were no new actions that need to be introduced within the policies and protocols that were already in place.

MRSA Bacteraemia

Number of cases

2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
17	09	5	4	10	2

- The standard is measured by patients in hospital for more than 2 days. The target for 2013/14 was 0 tolerance to avoidable MRSA bacteraemia. This target has no financial penalties but does contribute to the Monitor compliance framework. By the end of March 2014 the Trust had two MRSA bacteraemia attributed to them. The cases were investigated and reported as per national requirement. One case was a blood culture contaminant, there was no patient infection. However this still is attributed to the Trust and an investigation was instigated to ensure there were no failures in the Trust policies or protocols.
- The new Public Health England reporting and investigation process was implemented in the Trust in April 2014. The investigation takes the form a Post Infection Review (PIR).
- The Trust IV Access Co-ordinator has been in post since August 2013; this post was originally a twelve month secondment but has now been made a permanent post.
- A vascular access group has been set up. This is a multidisciplinary group who will facilitate a multidisciplinary approach to improvements in vascular access and provide a forum for collaboration across neighbouring Trusts and specialities.
- Work is continuing to develop one data base in the Trust to record line insertion, removals and any incidences that occur whilst the line is in situ.
- Audits looking at Aseptic Non Touch Technique (ANTT) and cannula documentation have been completed and action plans are in place.
- It has been agreed that ANTT will be incorporated into the induction training for new clinical employees.
- The IV catheter related sepsis protocol has been developed and rolled out in the Trust.
- The yellow dot system has been reintroduced on the Medway system and on the wards to give staff a visual reminder when patients have an infection.
- All elective and emergency patients where possible are asked to have a chlorhexidine wash prior to surgery.

MSSA Bacteraemia

The standard is measured by patients in hospital for more than 2 days. The Trust target was no more than 29 cases in the year. This target has no financial penalties and does not contribute to the Monitor compliance framework. The Trust reported 27 cases. This was less than the number of cases recorded in 2012/13. The actions to reduce MSSA are the same as for MRSA because both organisms are responsible for intravascular access and surgical site infections.

E. Coli

There has been no target set for E. coli bacteraemia. However we report these blood stream infections to Public Health England. This is a National requirement.

Report and investigate cases of healthcare associated infection and outbreaks.

- For some infections (e.g. chickenpox) staff or patients are infectious before they show any sign of the infection. When a staff member or patient develops such infections we look carefully at any patients or staff they have been in contact with, and may be at risk of getting the infection. In 2013/14 a patient was admitted with multidrug resistant Enterobacter cloacae. There was extensive screening of patients during a three week period. No spread of infection occurred.
- During the last two weeks of November and the first two weeks of December 2013 there was a high number of Respiratory Syncytial Virus in the children's hospital. These pressures were also felt by neighbouring Trusts.
- A patient diagnosed with multi drug resistant TB instigated contact screening of patients.

NOROVIRUS OUTBREAK ACTIVITY

April 2013 – March 2014

During the year the Trust experienced a number of outbreaks of Norovirus. There were 16 whole ward closures and 32 part and bay only closures there were a total of 218 patients and 47 staff affected with symptoms of diarrhoea and or vomiting. Samples are sent to the Virology laboratory at Myrtle road and there were 101 positive Norovirus results reported. Bed days lost during this period was 524. The Trust complies with the National Norovirus tool kit in the management of outbreaks.

4. DEVELOPMENTAL OBJECTIVES

Establish in-house infection prevention and control master class training programme.

- We have continued to undertake ad hoc training when required
- We developed a training day for General Practitioners and Nursing Home managers which were well attended. These study days will be repeated in 2014/15. The GP's will be able to use these days as part of their Continual Professional Development.
- The annual Infection Prevention and Control study day was held for the ninth year in conjunction with North Bristol Trust. One hundred and eighty delegates attended.

Implement a programme for sharps injury prevention

- The Trust working group has bought together a diverse range of staff to work with the directive. The most recent development is the completion of the tender for safety cannula that has been rolled out in all areas (except Paediatrics).
- The only outstanding area that the group has identified and are actioning is the use of insulin needles and patient own insulin pens. There is currently a community trial underway with one device and UH Bristol are reviewing another with Procurement and the Trust diabetic team.
- The group would wish to continue for a further 12 months to continue the identification and promotion of safer devices

5. ANTIBIOTIC PRESCRIBING

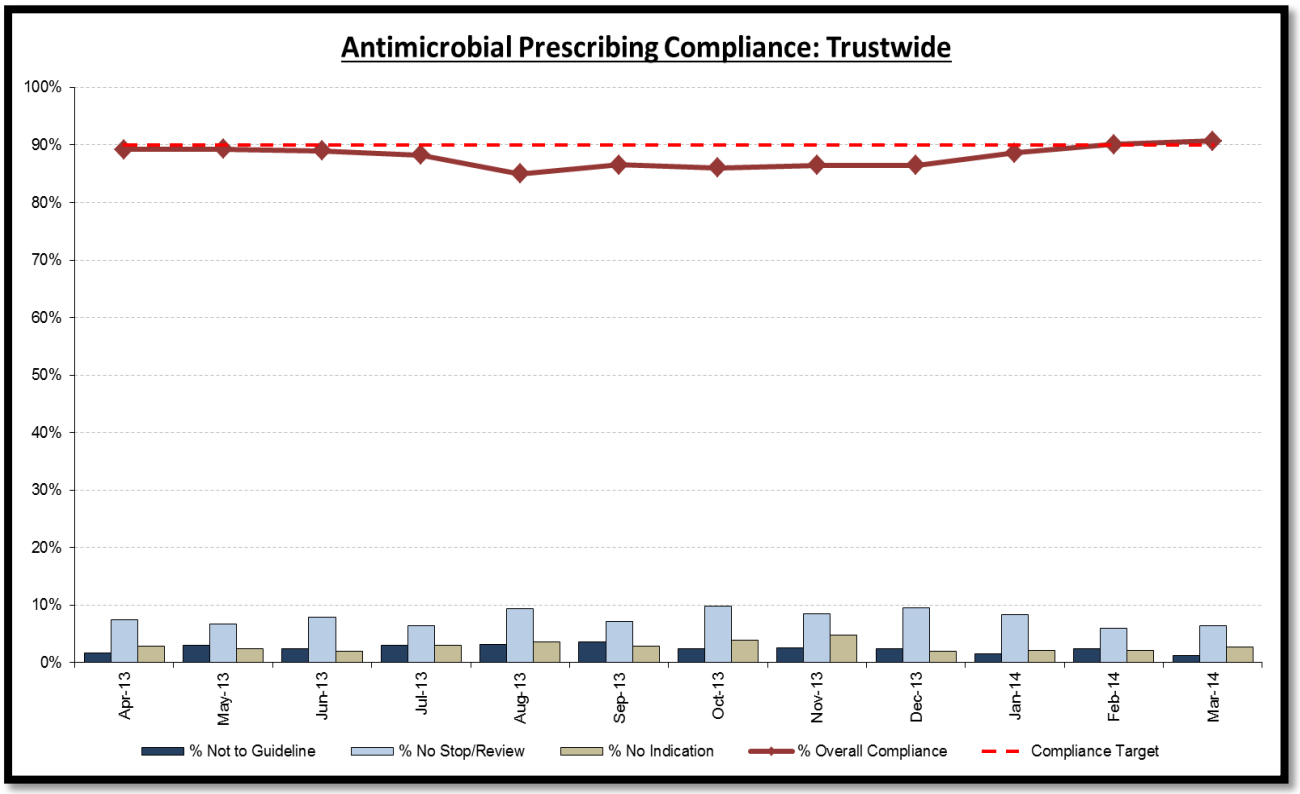
Antibiotic Lead Structures

The Trust Anti-infective Committee has continued to meet under the leadership of Dr Sean O'Kelly with representatives from each division, microbiology and pharmacy. The Committee is responsible for the antibiotic stewardship within UHBristol.

Antibiotic Ward Reviews

Antibiotic ward reviews continue across the trust. There has been an increase in joint reviews with microbiology and pharmacy totalling 24 wards per week; with all other wards reviewed fortnightly by an antimicrobial pharmacist. On a weekly basis, divisions receive a summary report of compliance by ward and monthly by specialist teams.

The tables below summarise the Trust wide results.



The compliance with the antibiotic prescribing care bundle continued to rise during the year with the 90% target being achieved and maintained since February. Work continues to ensure continued improvement in 2013/14.

Antibiotic Guidelines

A continued review of antibiotic guidelines has been undertaken, with all areas covered by a guideline or having a guideline under production. February saw the launch of our microguide, an antimicrobial app, making all our antimicrobial guidelines more accessible.

6. DECONTAMINATION

Risks

- Recurrence of the presence of mycobacteria in final rinse water of the Automated Endoscopic Re-processors at Day Surgery Endoscopy Unit at South Bristol Community Hospital. Many actions have been undertaken to rid the machines of these bacteria and at this moment in time (June 2014) we have clear results. The risk with this issue is more about interruption to service delivery than harm to patients. UHBristol Microbiologists have assured the Trust that the presence of mycobacteria is not harmful to the patient groups undergoing endoscopic procedures in the unit.
- Failure of Reverse Osmosis (RO) plant – Bristol Dental Hospital. Due the age profile of the existing plant (12 years +) and recent machine performance, capital monies have been applied for and been awarded in order for us to purchase new plant. This is in order to support the workings of the decontamination equipment and thus the dental service delivered in the dental hospital.
- Failure of Automated Endoscopic Reprocesses in Queens Day Unit. Due to the age profile of the existing machines (7-8 years) and increased machine breakdowns, capital monies have been applied for and are awarded in order for us to purchase new plant. This is in order to support the workings of the decontamination equipment and thus the endoscopy service delivered by the Queens Day Unit.
- Failure of Reverse Osmosis plant – level 3, Bristol Children's Hospital (BCH). Due to the age profile (12 years +) and the demands placed upon it due to now serving BCH theatres, this machinery needs replacing urgently. Capital monies were applied for but were not successful this year. A fully comprehensive service and maintenance contract that includes emergency call outs is in place, but the plant and hence the service remains vulnerable.
- Ability to maintain sterilising service in Theatre Sterile Supplies Unit (TSSU), BEH due to 1 x steriliser being condemned. Department currently managing to provide a service with only 1 steriliser instead of 2. Short-term contingency would be to sterilise items either at BDH or Kingsdown building whilst a more long-term solution is worked up. Possibility that TSSU service at Bristol Eye Hospital may need to close earlier than originally planned (2016).

Project of works

- Replacement of QDU RO plant – autumn 2014
- Replacement of QDU Automatic Endoscopy Repressor's – winter 2014
- Replacement of BDH RO plant – autumn/winter 2014
- Purchase of additional AER ENT OPD's – autumn 2014
- Purchase of 3 HEPA filtered drying cabinets QDU – autumn 2014
- Purchase of 1 new AER for BCH day case theatres, new build – summer 2014
- Refurbishment of CSSD – year 2, ongoing.
- Purchase of an automated decontamination machine for radiology – summer/autumn 2014.

Successes for year 13 - 14

- Up-grade to BCH decontamination room following Authorised Engineer Decontamination annual report– now compliant with decontamination guidelines
- Creation of decontamination room, level C, SMH for the manual decontamination of ultrasound probes
- Up-grade works to ventilation system in QDU and application of film to windows in order to reduce heat gain – thus making the decontamination working environment much more pleasant and compliant to decontamination guidelines
- Installation of 7 new washer-disinfectors in Sterile Services that has led to an improved cycle time of 45 minutes as oppose to 70. This in turn has led to a significant improvement to the management of the decontamination room in terms of production.
- Installation of a new RO plant and new raw water tank in CSSD to support the new washers.
- Installation of a new condense line in CSSD in support of the new washers.

7. CLEANLINESS REPORT

Current Year (2013-14)

1.1. The Facilities department has made continual improvements to performance and working strategy to ensure the best patient environment experience. Actions and initiatives during 2013/14 included:

- During 2013/14, Hotel Services within the Children's have successfully managed the changes and maintained the cleaning standards throughout the Centralisation Specialised Paediatrics project.
- Successful implementation of a new ride-on machine for cleaning the floors in the corridors within the BRI/BHI, which has improved efficiencies and enhanced cleaning standards.
- Completion of standardising the cleaning chemicals throughout the Trust to ensure a constant approach across the Trust and provide more flexibility in the workforce.
- Successful completion of the Patient Led Assessment of the Care Environment (PLACE) 2014. Scores to be released August 2014. The assessments included clinical, facilities and estates representatives whilst being led by patient representatives including governors, volunteers, patients, HealthWatch and the Youth Council.
- Implementation of a change of finishing times for the Heath Service Assistant's at BHI, which brought the finishing times in line with the rest of BRI without affecting the current levels of cleaning and food service.
- Successful implementation of the cleaning of the Welcome Centre, which included the purchase of a new stand on machine for cleaning floors in this area.
- Reviewed the market in identifying the best monitoring system for adenosine triphosphate (ATP). This is a method to assess the cleanliness of environmental surfaces in real time, and the system detects the presence of organism residue in addition to microorganisms which have been left on surfaces after cleaning. Trialled system, however lack of support from the supplier regarding the trial, and therefore will need to go back out to the market again to identify an alternative supplier.

- The Patient Environment Operational Group (PEOG) oversees the standards and protocol development and implementation and senior facilities representatives attend relevant infection control strategic and operational meetings.

1.2. As set out in the NHS Cleaning Manual guidance cleaning schedules and frequencies are agreed and publicly displayed in each area. Regular audits of cleanliness are undertaken by facilities management and supervisory staff which are reported to the Ward Managers and Matrons with remedial actions agreed where needed.

1.3. Cleanliness monitoring audits are carried out around the Trust by an independent audit team. Each area is assigned a risk category (very high, high, significant or low risk) and a RAG rating (red, amber or green). High risk areas such as intensive care units and theatres (where patients are more vulnerable to infection) are categorised as very high risk and audited on a monthly basis. A green rating is applied when audit scores are 95% or over. When audit scores do not achieve a green rating a remedial action plan is completed by the Hotel Services Management Team and re-audits take place.

1.4. The refurbishment of Tyndall's Park Training Centre has provided an improved training venue for new Hotel Service Assistants to practice their skills within a comfortable training room and realistic patient areas comprising of a 5 bedded ward area, sluice room, ward kitchen, toilets and shower room. On completion of the comprehensive programme all staff complete a competency test to measure their skills and knowledge. The facility is also available for existing staff to refresh their practical skills.

1.5. The facilities team continue to support infection prevention and control with deep cleans of bed spaces, cubicles, rooms and whole ward areas. This cleaning is in addition to regular cleaning and is carried out in response to individual cases of infection as well as outbreaks. The number of deep cleans performed in 2013/14 totalled 4,358, an increase of 2.5% from the previous year. During 2013/14 the deep clean team have used Hydrogen Peroxide Vapour machines for disinfection of an area 328 times, averaging up to 6 usages per week.

1.6. The Actions arising from the 2013 Patient Led Assessments of the Care Environment have been completed and presented to the Trust's Service Delivery Group in May 2014.

Next Financial Year (2014-15)

1.7. During 2014/15, in line with the Trust cleaning strategy, we plan to build further on the improvements made in the standard of cleanliness achieved Trust-wide by:

- During 2013/14 (April to March) the average cleanliness score across all risk categories (very high, high, significant and low) for the Trust was 95%, achieving an average score of 96% for very high and 95% for high risk category areas across the Trust. An audit report tracks the scores achieved throughout the year. The Trust is working towards adopting the National Standards for Cleanliness risk ratings in full. This will mean that the site scores will incorporate four elements (cleaning, nursing, contractors/estates and catering) and be implemented mid-2014.
- Introducing a new micro-fibre mop system to Terrell Street building (August 2014) to improve efficiencies and offer a more effective cleaning method
- To implement new HSA rotas in the Queens Building to provide a more efficient way of working (October 2014-April 2015).

8. MATRON REPORT

- The principle philosophy underpinning the Matron's Charter is that cleanliness is everyone's responsibility. Throughout the past year the matron's have:
- Worked closely with Facilities in the development and implementation of the cleaning responsibilities framework.
- The Matrons have worked closely with facilities to ensure specific roles and responsibilities for cleaning are clear.
- The matron's and the facilities department have worked together to ensure that cleaning routines will be clear, agreed and well publicised within the clinical areas.
- Matrons participated in the PLACE visits and are working and supporting the estates department to minimise the disruption to clinical areas during the refurbishment and building projects around the Trust.
- Matrons have been throughout 2013/14 working with the Senior Nurse for quality ensuring the new quality in care tool is implemented.
- They have been focused on working with the infection prevention and control team reducing peripheral line infections and reducing the cases of *Clostridium difficile. Each case of Clostridium difficile* is reviewed by the divisional matron.

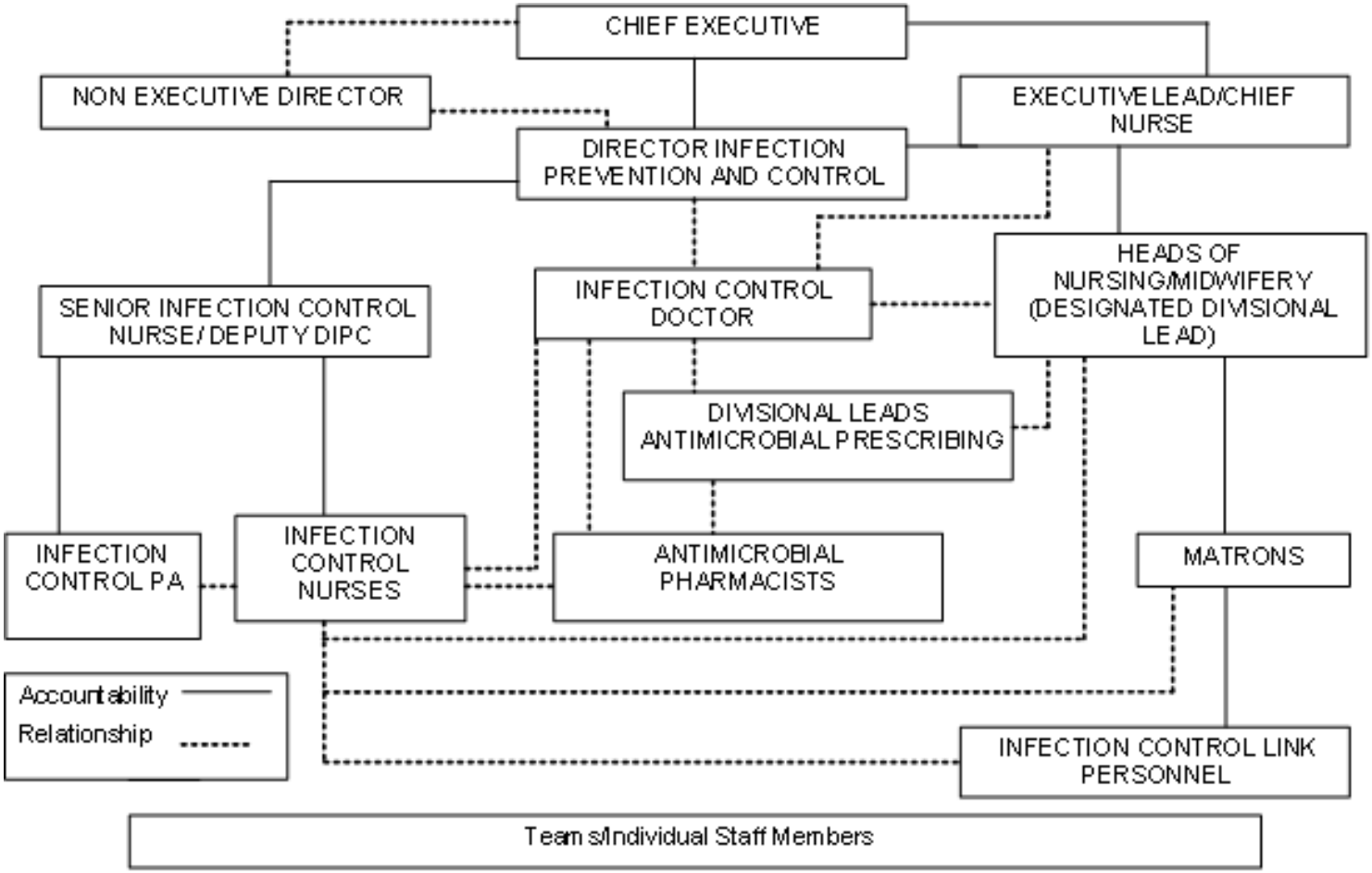
9. NEXT STEPS

Our goal in 2014/15 remains to ensure that patients who receive care within the organisation are assured that every effort is taken to reduce their risk of infection as well as to ensure the Trust meets statutory and national requirements related to healthcare associated infection. To achieve this we have identified the following five objectives:

1. We will comply with the Code of Practice on the Prevention and Control of Infections and Related Guidance (Hygiene Code).
2. We will report and investigate cases and outbreaks of healthcare associated infection as mandated.
3. We will reduce further the incidence of infections (specifically MRSA and MSSA blood stream infections and *Clostridium difficile*).
4. Develop a Surgical Site Infection surveillance programme.
5. Develop working and supportive relationships with our community colleagues.
6. Monitor Carbapenemase producing Enterobacteriaceae (CPE) and ensure appropriate control measures are in place.

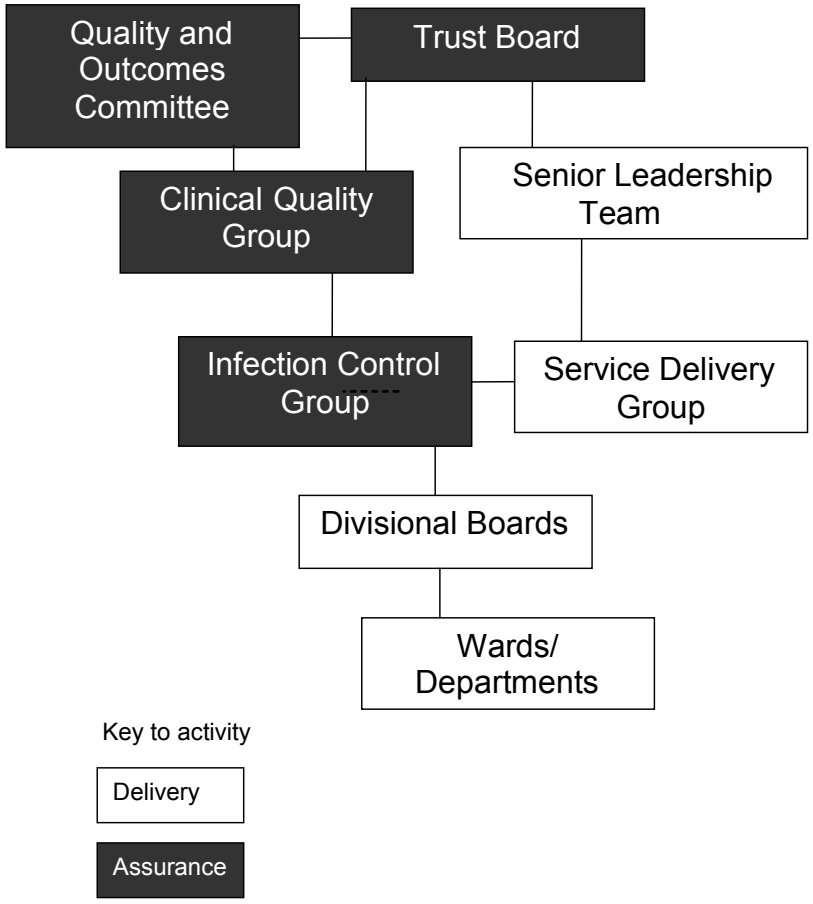
APPENDIX A

Infection Control Organogram



APPENDIX B

Infection Prevention and Control Reporting/Governance Structures



- The Chief Nurse is the Executive Lead and chairs the Infection Control Group, which has met four times and includes Governor and partner organisation representatives.
- The Trust Board has received infection control reports within the quality report monthly and a detailed report quarterly.
- The Infection Control Group has monitored all relevant risks at each meeting and has assessed compliance to the hygiene code quarterly at each Infection Control Group. The Trust Infection Prevention and Control risks include training compliance. There is a Trust wide action plan and this plan is being monitored at Service Delivery group. Isolation capacity, which will be removed from the risk register once the new ward block has been completed and opened. Norovirus outbreaks which is an ongoing risk and will continue to be monitored. Occupational Health Clearance regarding immunisations and infectious diseases which has ongoing monitoring and actions in place.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

10. Infection Control Quarterly Report
Purpose
To update the Board on Infection Prevention and Control Activities for the months of April May and June.
Abstract
• Clostridium difficile numbers at the end of the quarter were 13, against a limit of 10. Still waiting confirmation from the CCG of how they will judge avoidable and non-avoidable cases. • There have been three MRSA bacteraemia in the children's hospital during the first quarter. Post Infection reviews have been undertaken. • A patient with Carbarbapenamase Producing Enterobacteriacea (CPE). Was admitted to the children's hospital. Screening has been undertaken. • Infection Prevention and Control training for clinical staff will go to E learning in October.
Recommendations
The Board is recommended to receive the report for assurance
Report Sponsor
Carolyn Mills, Chief Nurse
Appendices
Infection Control Quarterly Report

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
		25/07/14			

INFECTION PREVENTION AND CONTROL QUARTERLY REPORT (April-June 2014)

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

Clostridium difficile:

	April	May	June
LIMIT	4	3	3
ACTUAL	5	4	4

- The first quarter total was 13 cases of *Clostridium difficile* against a limit of 10**.** One case below for the same period last year.
- The patient is visited by the DIPC or Infection Control Doctor, Infection control nurse and pharmacist and management assessed within one working day of receiving the positive result.
- Timelines are undertaken for each case to investigate if there were any common themes or if further actions need to be implemented.
- A meeting to discuss any issues is held with the matron for the area, the ward sister/charge nurse, Infection Prevention and Control Nurse and the DIPC/Infection Control Doctor.
- Patients with active disease continue to be nursed and managed on the cohort ward.

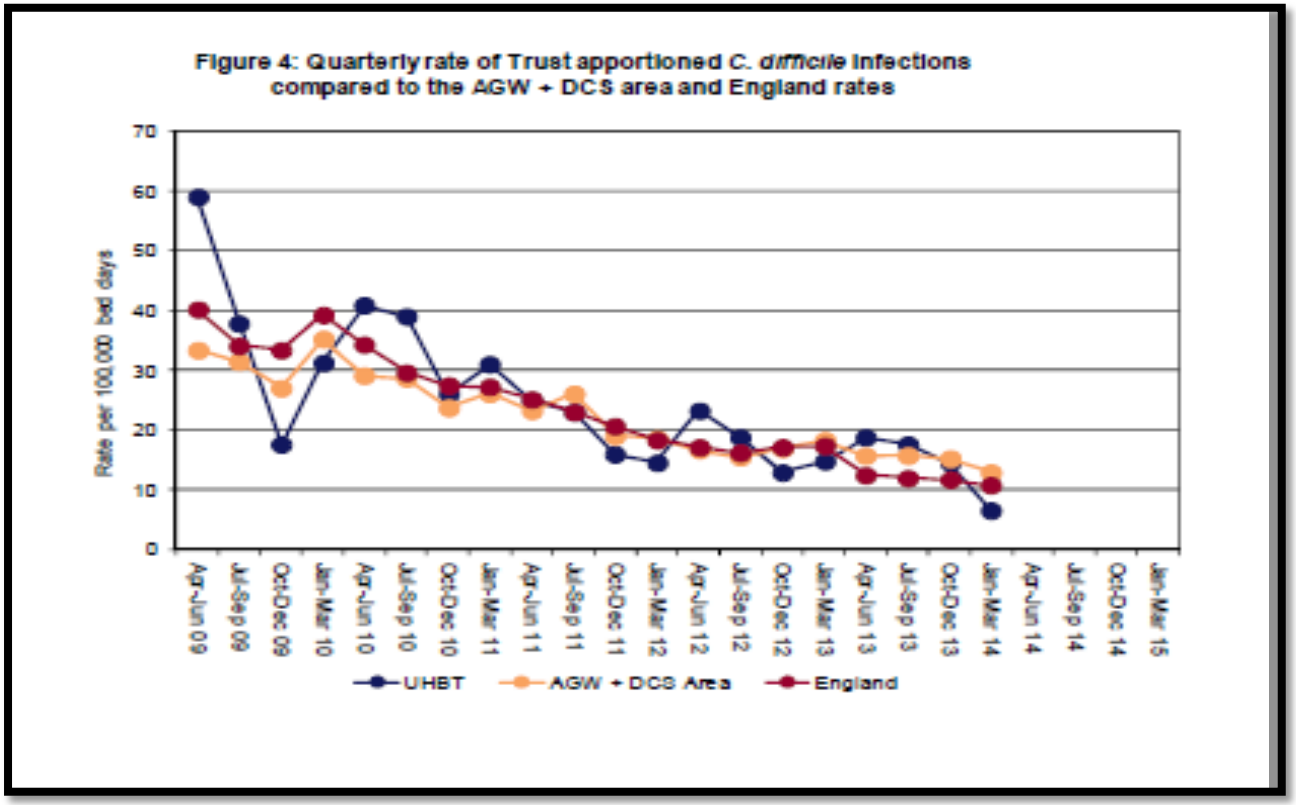
Common Themes

After investigation of the cases for this quarter, no common themes have emerged. Specimens are sent for Ribo typing; to ensure no cross infection has occurred.

The Clinical Commissioning Group is still deciding the criteria they will use to decide if the cases are avoidable or non-avoidable.

Comparative data – Figure 1

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

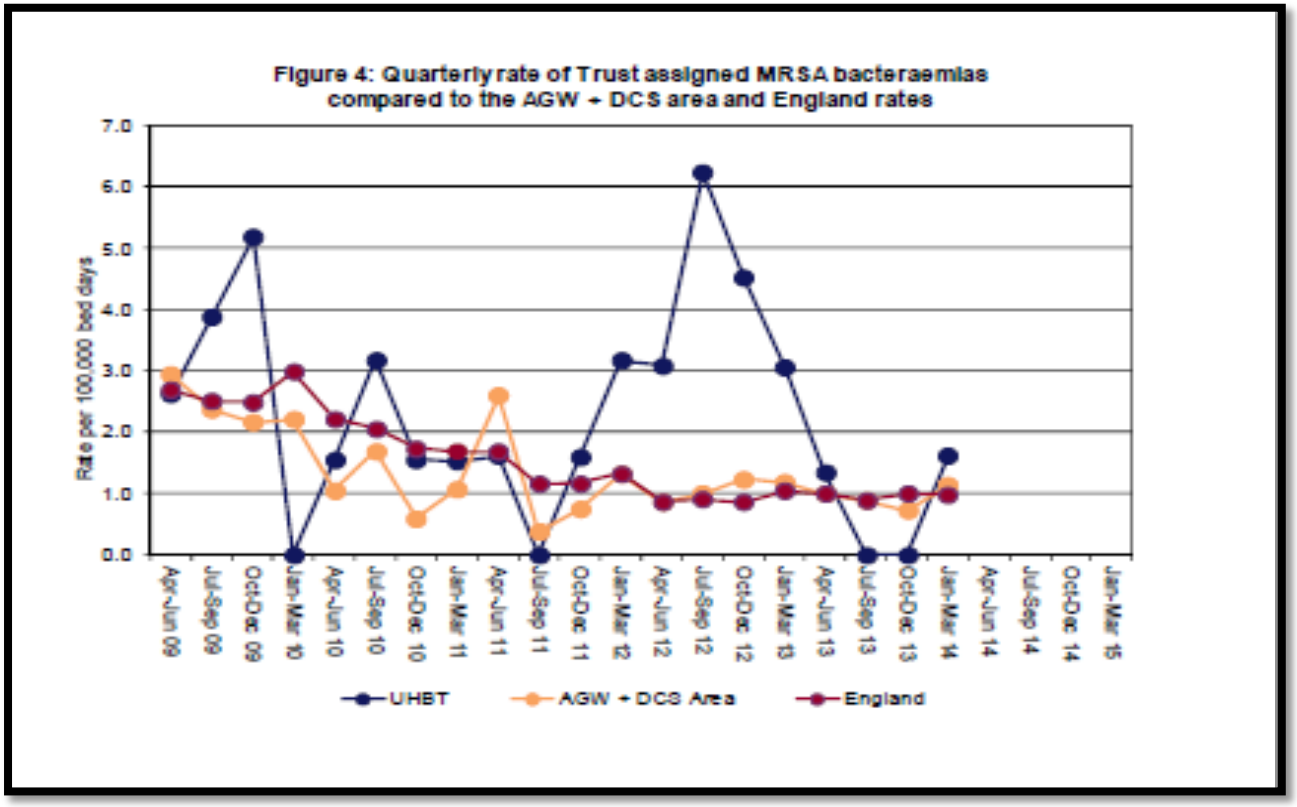


MRSA BACTERAEMIA

April	May	June
1	0	2

There have been three cases of MRSA bacteraemia during the first quarter of the year. All cases have been within the Women's and Children Division. There have been Post Infection Reviews undertaken as per National guidance. One case had a culture taken within the first 48 hours of their admission. This case would not normally be attributed to the Trust. However after investigation it was shown that there were issues with regards to the discharge of the patient and results not being acted upon during a previous admission The case was also reported as a Serious Incident and a Root Cause Analysis undertaken. An action plans have been developed by the Division and will be monitored at Infection Control Group and the Division of Women's and Children.

Comparative data – Figure 2



Carbarbapenamase Producing Enterobacteriacea (CPE).

There has been confirmed case of CPE during May. This patient is a frequent attender for a chronic renal condition in the children's hospital. The patient has been Medway alerted and all clinical teams associated with the patient aware of the need for isolation when admitted. Before the result known, five children need to be screened and parents were informed.

MSSA

	April	May	June
LIMIT	2	2	2
ACTUAL	1	0	2

The total for this quarter is three against a limit of six. There are no financial penalties associated with this limit. The actions for MSSA are the same as MRSA.

Ecoli

	April	May	June
POST 48HRS	6	5	15
PRE 48HRS	6	16	14

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

Outbreaks and Untoward Incidents: Norovirus

The High Dependency Unit (HDU) on ward 10 was closed with confirmed Norovirus. The whole of the ward was eventually closed with confirmed norovirus. Seven patients were affected during the outbreak. A bay on ward 17 was also shut due to symptoms of diarrhoea. There was no positive norovirus result.

Infection Control Training

April	May	June
75%	72%	Not available

The Trust compliance for training is set at 95%. Infection Prevention and Control training is incorporated into the Trusts induction and essential training programme. An action plan is in place to improve training attendance. From October Infection control training for clinical staff will be in the form of an E learning package. There will be E learning packages for adult and Paediatric staff. Non clinical staff will have face to face and E learning training as not all non-clinical staff have access to a computer*Clostridium difficile* training has been undertaken on wards 34 and 37.

IV Access coordinator update

The IV access coordinator post has now been made permanent. Jody Coram will remain in post. IV access data base is to be piloted on wards 34, 35 and 37. This commences on the 16th June for three weeks. Teaching sessions in the Emergency Department have been set up to cover cannulation and aseptic non touch technique (ANTT). Aseptic Non Touch Technique (ANTT) policy is in progress. It has been agreed that ANTT will be included in induction training for all new clinical staff from October 2014. E learning will be available in the future for current staff and the infection Prevention and Control Team will include a session in essential training.

Trustwide Infection Control Audits

Hand hygiene audits continue on a monthly basis, April 98%, May 97%. June data not available at the time of writing this report. Areas that fall below 95% are required to revert to weekly audits until they have achieved the required standard for four consecutive weeks. Infection control safety audits continue alongside the safety thermometer on a monthly basis. Results are fed back to individual areas. Any actions that are required are actioned by ward sisters and monitored by infection control group.

Decontamination

All Trust decontamination equipment held either on site or in the community remains compliant with annual and quarterly testing regimes. Following a JAG assessment last autumn a number of recommendations were made in order to significantly improve the working environment. The works have started and include an up-grade works to ventilation system in QDU and application of film to windows in order to reduce heat gain – thus making the decontamination working environment much more pleasant and compliant to decontamination guidelines.

The Annual Accreditation Audit has been undertaken and the auditor revisited the department on 28th May to review progress with regards to major Corrective Action Required (CARs). Two have now been closed out and four have been downgraded to minor as full closure not able to occur until after staff attend training in July. The next visit is scheduled for October when it is expected all outstanding CARs will be closed.

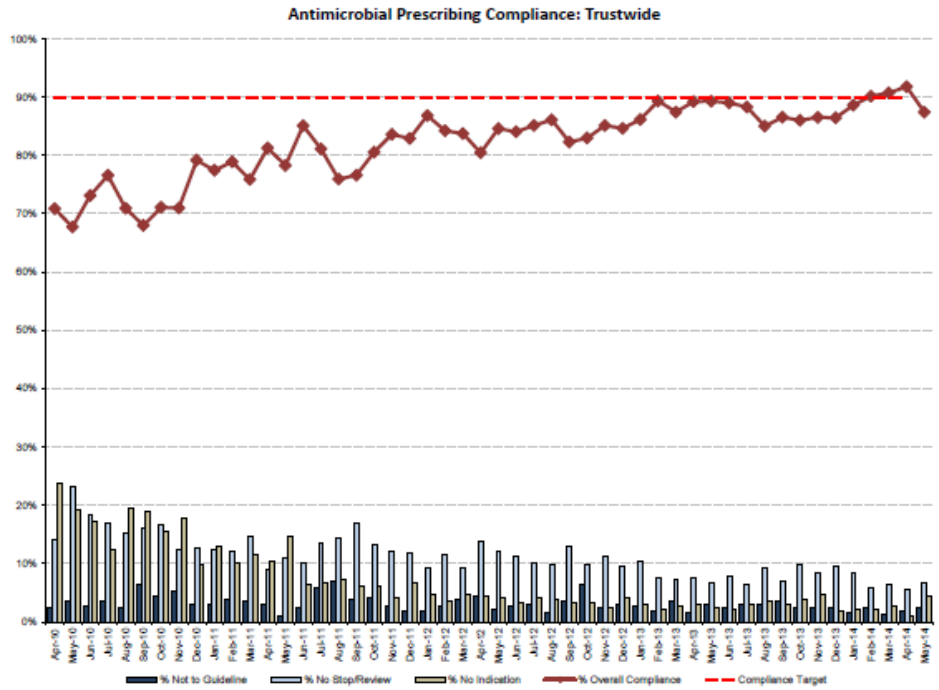
Facilities/Estates Cleaning Results

RESULTS		2013							2014				
Risk Category	Area	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
VERY HIGH													
Areas include:	B.R.I	96	95	94	96	96	96	96	88	88	88	95	88
	B.R.C.H	96	95	95	95	95	96	96	94	95	96	96	96
	S.M.H	95	96	93	96	95	96	95	93	93	95	93	95
	B.H.O.C	97	97	97	98	98	97	98	97	97	98	98	97
	B.E.H	96	98	98	98	97	96	96	94	96	98	97	97
	S.B.C.H	97	96	98	98	97	98	98	98	99	96	97	99
	Total Average	96	96	96	97	96	96	96	94	95	95	96	95
HIGH													
Areas include:	B.R.I	95	94	94	93	93	93	93	96	95	96	97	96
	B.R.C.H	96	96	95	94	95	96	94	94	95	95	97	96
	S.M.H	95	95	95	94	93	97	92	92	94	96	94	95
	B.H.O.C	96	97	97	98	99	98	97	99	98	99	98	99
	B.D.H	95	95	95	94	93	95	96	95	94	96	93	94
	B.E.H	95	97	98	98	98	97	98	95	96	96	97	96
	C.H.C	97	97	97	94	95	97	98	98	98	97	97	95
	S.B.C.H	95	96	95	94	96	96	96	94	96	96	97	97
	Total Average	96	96	96	95	95	96	95	95	96	96	96	96
SIGNIFICANT													
Areas include:-	B.R.I	91	93	90	89	93	90	87	90	89	79	93	85
	B.R.C.H	84	93	93	85	92	96	88	91	95	97	91	96
	S.M.H	97	90	96	91	88	97	91	91	91	92	94	96
	B.H.O.C	84	98	91	94	97	98	95	93	94	100	92	92
	B.D.H	90	92	95	95	89	95	90	87	93	100	86	90
	B.E.H	95	97	96	92	95	95	97	93	95	98	96	95
	C.H.C	89	96	100	88	97	97	85	96	94	97	94	91
	S.B.C.H	95	98	99	95	98	96	93	97	96	94	99	93
	Total Average	91	95	95	90	94	95	91	92	93	95	93	92
LOW													
Areas include:-	B.R.I												
	B.R.C.H												
	S.M.H												
	B.H.O.C												
	B.D.H												
	B.E.H												
	C.H.C												
	S.B.C.H		93		96								
	Total Average		93		96								
	TRUST SCORE	94	95	96	94	95	96	94	94	94	96	95	94

KEY	
	From 95% to 100%
	From 80% to 94%
	Under 80%

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

May 2014 - Antimicrobial Prescribing Compliance Report



Division	Month	Number of reviews	Percentage compliant	Number compliant	No. Not Compliant	No. not to guideline	No. with no stop or review date	No. with no indication
Medicine	Feb-14	256	89.1%	228	28	4	20	6
	Mar-14	445	89.7%	399	46	6	35	8
	Apr-14	500	90.8%	454	46	13	32	3
	May-14	462	91.6%	423	39	12	25	3
Specialised Services	Feb-14	112	91.1%	102	10	3	6	1
	Mar-14	117	91.5%	107	10	0	7	5
	Apr-14	155	96.8%	150	5	3	2	0
	May-14	127	94.5%	120	7	0	7	0
Surgery, Head & Neck	Feb-14	162	88.3%	143	19	7	11	3
	Mar-14	218	91.3%	199	19	6	10	6
	Apr-14	298	91.9%	274	24	4	17	4
	May-14	233	82.0%	191	42	9	15	22
Women's & Children's	Feb-14	129	93.8%	121	8	2	2	4
	Mar-14	166	92.2%	153	13	0	9	6
	Apr-14	188	89.9%	169	19	3	12	4
	May-14	185	78.9%	146	39	3	20	19
Trustwide Total	**Feb-14**	**659**	**90.1%**	**594**	**65**	**16**	**39**	**14**
	Mar-14	**946**	**90.7%**	**858**	**88**	**12**	**61**	**25**
	Apr-14	**1141**	**91.8%**	**1047**	**94**	**23**	**63**	**11**
	May-14	**1007**	**87.4%**	**880**	**127**	**24**	**67**	**44**

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

Green	Amber	Red
35	5	2

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

Infection Prevention and Control related risks:

Low	Moderate
2	1

The risks are reviewed at Infection Control group.

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

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

July 2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

11. Quality Strategy 2014-2017

Purpose

The purpose of the Quality Strategy is to articulate the Trust's ambition to be a leader in healthcare quality, both within the NHS and internationally. We want our patients to receive the best possible treatment, delivered with care and compassion. We will achieve this by implementing our shared values – respecting everyone, working together, embracing change and recognising success – and by learning from what our patients and staff tell us; from external review; from internal peer review and audit; and from the implementation of evidence-based treatment and care derived from high-class research.

Abstract

This document updates and refreshes the Trust's previous Quality Strategy for 2011-2014, reflecting organisational learning and a number of significant developments in the wider NHS during that period. The strategy continues to adopt the definition of quality favoured by the Next Stage Review, i.e. the core dimensions of healthcare quality are patient safety, patient experience and clinical effectiveness, but recognises that these cannot be delivered without organisational efficiency. The Quality Strategy 2014-2017 sets a direction of travel for the Trust whilst recognising that quality is a constantly moving target: our ambitions will continue to be reviewed on an annual basis and detailed annual objectives will be published via our Quality Accounts.

The Quality Strategy is effectiveness an 'umbrella' document beneath which sit three key sub-strategies:

- Patient Experience and Involvement Strategy (2012-2015)
- Clinical Effectiveness and Outcomes Strategy (2013-2016)
- Patient Safety Strategy (2014-2017)

Recommendations

The Board is recommended to receive the report for approval

Report Sponsor

Chief Nurse
Medical Director

Appendices

Quality Strategy 2014-2017

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
	16/7/14	25/7/14			Clinical Quality Group, 3/7/14

University Hospitals Bristol NHS Foundation Trust
Quality Strategy 2014-2017

1. Statement of strategic intent

The Trust Board of Directors is committed to ensuring that the University Hospitals Bristol NHS Foundation Trust is delivering services of the highest quality. Clinical effectiveness and outcomes must never be compromised. Every opportunity must be taken to improve the built environment in which these are delivered. Above all, patients must be kept safe and have the experience of being properly cared for. The Board's broad ambitions for quality are set out in this document and its three supporting sub-strategies[1].

Quality is one of five strategic enabling strategies within the Trust's overall Integrated Business Plan and Long Term Financial Model. "Quality at the heart of what we do" is also one of four Strategic Themes underpinning the Trust's current five year Clinical Services Strategy (2010-2015). This means that, as we formulate strategic plans to ensure that our three core businesses – clinical services; research and innovation; and teaching and learning – not only survive but thrive through challenging economic times, we will also maintain a clear focus on quality improvement.

The Trust Board of Directors monitors the achievement of its Objectives and associated risks through the annual cycle of Board Reporting set out in the Board Forward Planner, including the Board Assurance Framework and Risk Register.

2. Introduction

This document updates and refreshes the Trust's previous Quality Strategy for 2011-2014, reflecting organisational learning and a number of significant developments in the wider NHS during that period. The strategy continues to adopt the definition of quality favoured by the *Next Stage Review*[2], i.e. the core dimensions of healthcare quality are patient safety, patient experience and clinical effectiveness, but recognises that these cannot be delivered without organisational efficiency. The Quality Strategy 2014-2017 sets a direction of travel for the Trust whilst recognising that quality is a constantly moving target: our ambitions will continue to be reviewed on an annual basis and detailed annual objectives will be published via our Quality Accounts. The Quality Strategy has been developed by the Board in consultation with Governors and clinical Divisions.

[1] Patient Safety; Patient Experience and Involvement; Clinical Outcomes and Effectiveness
[2] *High quality care for all,* Professor the Lord Darzi of Denham, June 2008

3. Purpose

The purpose of the Quality Strategy is to articulate our ambition to be a leader in healthcare quality, both within the NHS and internationally. We want our patients to receive the best possible treatment, delivered with care and compassion. We will achieve this by implementing our shared values – respecting everyone, working together, embracing change and recognising success – and by learning from what our patients and staff tell us; from external review; from internal peer review and audit; and from the implementation of evidence-based treatment and care derived from high-class research.

4. Definition of Quality

Although there is no universally accepted definition of 'quality' in healthcare, quality in its broadest sense may be described as "the degree of excellence in healthcare". The Trust has chosen to adopt the model of quality proposed by Lord Darzi, defining quality in terms of whether patients are safe, whether their treatment achieves the best possible clinical outcome for each individual, and whether they have the best possible experience of care.

At the same time, the Trust acknowledges wider definitions of quality which embrace organisational efficiency[3]. Research previously conducted by Ipsos MORI[4] has highlighted that patients and the public tend to take clinical outcomes and clinical effectiveness as read: perceptions of quality are instead influenced by issues relating to safety, but are overwhelmingly determined by patient experience, as well as issues relating to access to services. This is why understanding and responding to patient experience must remain a prominent feature of our strategy for quality, and why access issues need to be viewed as integral to, and not separate from, quality.

[3] e.g. Institute of Medicine, *To err is human*, 1999
[4] Ipsos MORI, *Perceptions of quality in NHS secondary care: a research report for NHS West Midlands*, 2010, p2

5. The NHS context

Since our previous Quality Strategy was published, much has changed. The NHS has undergone a fundamental reorganisation; Robert Francis QC has published his report into failings at Mid Staffordshire NHS Foundation Trust (our Trust published its response to the Francis recommendations in December 2013); Professor Don Berwick published ten key recommendations to the NHS about reducing patient harm by embracing an ethic of learning[5]; and Ann Clwyd and Tricia Hart have published the findings of their Government-backed review of how NHS complaints are managed.

In 2014, Monitor has published the 'Well-led framework' for Foundation Trusts, incorporating the previous Board Quality Governance Framework, and the Care Quality Commission has introduced a new regime of hospital inspections to test the quality of services and announced an intention to publish new 'fundamental standards'. CQC inspection will provide invaluable independent insight into the quality of our services and will test whether they are safe, effective, caring, responsive and well-led. Our message to staff is clear: quality means doing it right even when nobody is watching.

The Trust has responded positively to each of these wider developments. The challenges are familiar ones and the principles of delivering quality services have not changed. Along with the rest of the NHS, our challenge is to be learning constantly from our mistakes so that they are not repeated, at the same time as we recognise, share and celebrate our successes.

6. What implementation of this strategy means for patients

Safe	Patients will: • Be kept safe from avoidable harm
Effective	Patients will: • Receive the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best achievable outcome
Caring	Patients will: • Be treated as an individual and have their individual needs addressed • Be treated with compassion, respect and dignity • Be kept fully informed in decision making about their care • Have any concerns about their care addressed as early as possible

7. Patient safety

The Trust's ambitions for improving patient safety are set out in detail in our Patient Safety Strategy (2014-2017). Our aspiration is for no avoidable harm to patients and zero 'never events'. We will review and strengthen our arrangements for the management of serious

[5] *A promise to learn – a commitment to act,* National Advisory Group on the Safety of Patients in England, 2013

incidents and continue to focus on systematic incident analysis, implementation of risk reduction actions, including across the organisation where applicable.

Plans described in the Patient Safety Strategy include developing a patient safety culture, and taking forward the legacy of the five year South West Patient Safety Improvement Programme via the emerging national Patient Safety Collaborative programme. NHS England has suggested that areas of focus in the first year of the patient safety collaborative programme will be:

- Leadership for patient safety
- Measurement for patient safety
- Pressure ulcers
- Medication errors

8. Patient experience

We know from our own local analysis of national patient survey data that there are four key factors which influence patients' overall satisfaction with the care they have received:

- The extent to which patients have confidence and trust in the staff who care for them
- Perception of cleanliness of the hospital environment
- Quality of communication between staff and patients and those who care for them
- The extent to which patients are involved in decisions about their care

The Board monitors a monthly aggregate score derived from patient feedback on these key factors. Details of this 'patient experience tracker' are also published in our annual Quality Account[6]. A level of performance is set, and reviewed annually, below which the Board will intervene (to date such intervention has not been necessary).

The Trust's ambitions for patient experience and involvement are set out in detail in our Patient Experience & Involvement Strategy (2012-2015) based around four core themes:

- Refining and developing how we measure the patient experience
- Sharing what patients have told us and using this to drive change
- Not just measuring, but involving
- Embedding patient involvement and experience activities at all levels of the Trust

One of our aspirations is to be the 'provider of choice' for patients in Bristol and the West of England. At the time of writing, the Trust's scores for the inpatient NHS Friends and Family Test (FFT)[7] are on the borderline of upper quintile performance – our aim is to be in the top 20% performing Trusts consistently for all forms of the FFT.

For 2014/15, one of the Trust's five quality objectives is to refresh and enhance our approach to patient and public involvement. Whilst we can point to examples of excellent

[6] Published as the UH Bristol 'Quality Report'
[7] The FFT asks patients whether they would recommend the Trust's services to their friends or family

practice in terms of involving people in decisions about changes to services, we want our approach to be more systematic so that 'nothing about me without me' becomes common practice across the organisation.

During the second half of 2014, the Trust will begin to develop plans for the next version of the Patient Experience and Involvement Strategy for 2015-2018. This will include plans for adding technology-based solutions (e.g. SMS messaging) to our existing range of methods of capturing patient feedback, and for increased triangulation of data-sources (including patient complaints), providing enhanced ward-level quality intelligence and enabling us to learn from the highest performing teams.

One important aspect of patient experience which currently sits separately to our Patient Experience and Involvement Strategy is how we respond to complaints about our services. The Trust has agreed a detailed work plan in response to various NHS-wide recommendations published by Ann Clwyd and Tricia Hart, the Parliamentary and Health Service Ombudsman and the Patients Association. In early 2014/15, partly in response to these challenges, the Trust committed significant additional resources to strengthen its systems for supporting complaints and concerns. During the second half of 2013/14, we also worked collaboratively with the Patients Association to improve our training in writing effective complaints responses. At the time of writing, the Patients Association are independently gathering stories from a random sample of previous complainants to present back to the Trust for our learning. We are making a commitment to continue this collaboration with the Patients Association for the duration of this Quality Strategy (i.e. until at least the year 2016/2017).

9. Clinical effectiveness

The Trust's ambitions for improving clinical effectiveness are set out in detail in our Clinical Effectiveness and Outcomes Strategy (2013-2016) based around six core themes:

- Improving our use of local clinical audit
- Implementation of evidence-based guidance, including NICE Quality Standards
- Development of local clinical guidelines
- Implementation of new clinical procedures
- Patient Reported Outcome Measures (PROMs)
- Clinical outcomes monitoring

The Care Quality Commission regularly reports that clinical outcomes are one of the least well developed aspects of quality across the NHS. In 2013/14, as part of our Clinical Effectiveness and Outcomes Strategy, we began a piece of work to scope out the use of local clinical outcome measures. We will be encouraging the use of appropriate patient reported outcome measures (PROMs) as part of this ongoing project.

Our overarching goal is to consistently maintain a hospital mortality rate which is lower than the NHS average[8].

[8] Measured as the Summary Hospital-level Mortality Indicator (SHMI) or Hospital Standardised Mortality Ratio (HSMR)

10. Quality at what price?

According to Ipsos MORI research, patients and the public "sometimes feel that financial resources and government targets are more important to senior management, than quality". There is a clear expectation across the NHS that cost improvement plans must demonstrate that their implementation will not compromise clinical quality and that appropriate consultation has taken place with clinical teams. At UH Bristol, managers are required to use a quality impact assessment tool to describe any anticipated impact that planned cost efficiencies may have on patient safety, patient experience and clinical effectiveness, and how any risk is mitigated.

The Trust will also continue to participate in the CQUIN (Commissioning for Quality and Innovation) scheme, working in partnership with our commissioners to use financial incentives to mutual benefit to support achievement of many of our quality ambitions.

We also recognise that providing a quality service does not always involve additional costs: sometimes quality is about the small things that make a difference and show that we care.

11. Quality governance

Executive responsibility for the quality agenda is shared by the Chief Nurse and Medical Director, who jointly chair the Trust's Clinical Quality Group and are jointly responsible for the activities of the Trust's quality support function (the Quality Team).

The Trust Board discharges its responsibilities for monitoring quality of services through its Non-Executive-led monthly Quality and Outcomes Committee (QOC). The QOC is responsible for ensuring that the Board meets good practice guidance asset out by Monitor originally in its Quality Governance Framework and more recently in the Well-led Framework. The QOC scrutinises a detailed dashboard of quality and performance indicators and provides challenge to management wherever standards fall below pre-agreed targets. The same data is also received at public meetings of the Board. These meetings commence with a patient story, designed to set a patient-focused tone for the various discussions that follow. Key quality issues are also discussed by Governors at meetings of the bi-monthly Quality Project Focus Group, chaired by the Chief Nurse and Medical Director and supported by the Trust's Heads of Quality.

In the context of increasing scrutiny from our own Board and from regulators and external organisations, data quality and benchmarking become ever more important. It's essential that we know:

- How good we are
- Whether we are getting better
- How we compare with the best

We have already put in place Data Quality Frameworks to assure data quality for mandated indicators published in our annual Quality Account and we will continue to focus on the

timeliness, accuracy, reliability and validity of quality data throughout the lifetime of this strategy. We will also continue to strengthen our links with external providers of benchmarking data, in particular through the activities of the Trust's Quality Intelligence Group.

Each year, the Trust publishes a Quality Report (which encompasses the requirements of a Quality Account) describing successes and challenges during the year gone and setting out specific quality objectives for the year ahead. For 2014/15, the first time, the Trust held a public engagement event to help inform its plans for that year and beyond. We are making a commitment to continue this collaboration approach as (at least) an annual event. Feedback from the event we held in January 2014 served to reinforce the central quality themes of consistently safe, high quality, compassionate care where patients are closely involved in decisions about their care.

Members of the public also placed reductions in cancelled operations and effective planning for a positive return to the community high the top of their list of quality priorities. In 2014/15, our aim is to achieve these goals through implementation of four key 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.

12. Maintaining our focus on learning

In the words of Sir Liam Donaldson, then England's Deputy Chief Medical Officer, "To err is human, to cover up is unforgiveable, *to fail to learn is inexcusable*."[9] Through a range of existing policies and initiatives, the Trust is already focused on learning from experience - both good and bad - from incidents, claims, complaints, patient and staff feedback. For example, the Complaints and Concerns Policy explains how patient complaints will be used not only for individual and team learning, but also within Divisions, across work streams for operational groups, between Divisions and throughout the organisation. But we know we need to do more and as part of our strategy for quality, the Trust is recommitting itself to the concept of being 'an organisation with a memory'.

[9] Sir Liam was speaking at the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004

13. Monitoring and measuring success

Implementation of the Quality Strategy will be delivered through the work plans associated with its three sub-strategies, i.e.:

- Patient Safety Strategy
- Patient Experience and Involvement Strategy
- Clinical Effectiveness and Outcomes Strategy

Specific annual quality objectives will be agreed and monitored by the Quality and Outcomes Committee of the Board, the Executive-led Clinical Quality Group, and by Divisions.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

12. Patient Safety Strategy 2014-2017

Purpose

The Patient Safety Strategy for 2014-17 and its associated work plan is presented to the Board for approval

Abstract

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

Since 2009, the Trust's strategy for patient safety has been enshrined in the aims and objectives of the five-year Safer Care South West, adult patient safety improvement programme and in an equivalent "Leading Improvements in Patient Safety" programme for paediatrics. The programme is due to end in 2014/15.

Our aspiration continues to be to strive for excellence in patient safety demonstrated by no avoidable harm to patients and zero never events.

The overall aim of the Patient Safety Strategy 2014-2017 is to build on the successes of previous patient safety programmes, in particular working as part of the newly constituted West of England Patient Safety Collaborative, part of a national patient safety collaborative programme arising out of the Francis and Berwick reports.

We will also "Sign up for Safety", a new government campaign which was launched in June 2014 by the Secretary of State for Health to make the NHS the safest healthcare system in the world. The campaign has set out a three-year shared objective for the NHS to save 6,000 lives and halve avoidable harm as part of its journey towards ensuring patients get harm free care every time, everywhere.

Recommendations

The Board is recommended to receive the strategy for approval

Report Sponsor

Chief Nurse

Appendices

Patient Safety Strategy 2014-2017

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
	16/07/2014	25/07/2014			Clinical Quality Group 03/07/2014 Patient Safety Group 18/06/2014 and 16/07/2014

Patient Safety Strategy
2014-2017

1. Statement of strategic intent

Over the past decade, mismanaged healthcare that harms patients has increasingly drawn public and media attention. Patients want to attend a hospital with a good patient safety record, and people want to work in such an organisation.

The Government wishes to maintain and increase the focus on safety in the NHS, especially through the reporting of patient safety incidents and ensuring that lessons are learned and implemented.

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

The Trust Board of Directors is committed to ensuring that the University Hospitals Bristol NHS Foundation Trust is providing services which are safe and that there is continual focus on reducing avoidable harm to patients. Patients expect to receive the safest possible care and have the right to be informed of the risks and benefits of any intended treatment before giving their consent.

The Board of Directors is also committed to transparency and candour by sharing information with patients and the public about the safety of the Trust's services. We have published annual Quality Accounts and Reports containing information about patient safety incidents, including serious incidents, which have occurred in our Trust as well as achievements against corporate objectives to improve patient safety. The expectation of the Board of Directors, and of this strategy, is that this commitment to transparency will continue. This expectation is reinforced by the response to the Francis Report into failings at Mid Staffordshire NHS Foundation Trust:

> "Robert Francis' report provided a stark account of an organisation that focused on targets and processes at the expense of its core responsibilities to patients. All parts of the NHS must focus on outcomes rather than processes, and on what matters most: providing safe, effective care and a positive patient experience."
>
> *Putting Patients First, 2013*

The Board of Directors needs to be assured that:

Author: Anne Reader, Head of Quality (Patient Safety)
25/07/2014

- robust arrangements are in place for the management and monitoring of patient safety activity (as defined in this strategy)
- systematic learning from analysis of patient safety incidents which have occurred is being implemented
- proactive patient safety improvement work is supporting wider transformation goals where appropriate
- the patient safety indicators and metrics it monitors via the monthly Board quality report reflect clinically-relevant priorities

The Trust Board of Directors monitors the achievement of its objectives, and associated risks through the annual cycle of Board Reporting set out in the Board Forward Planner, including the Board Assurance Framework and Risk Register.

2. Introduction

The Trust's existing Quality Strategy is based on Lord Darzi's concept of quality, expressed in terms of Patient Safety, Patient Experience and Clinical Effectiveness: patients want to be safe; they want to have a good experience of being a patient; and they want to receive the right treatment, in the right way, at the right time - and with the best possible outcome for their particular circumstances.

Since 2009, the Trust's strategy for patient safety has been enshrined in the aims and objectives of the five-year Safer Care South West[1,2] adult patient safety improvement programme and in an equivalent "Leading Improvements in Patient Safety" programme for paediatrics. The programme is due to end in October 2014 and the final evaluation will be reported in the latter half of 2014/15.

The purpose of this document is to bring together a high level plan to achieve specific safety goals for 2014-2017.

3. Aims of the strategy

Our aspiration is for excellence in patient safety demonstrated by no avoidable harm to patients and zero never events.

The overall aim of the Patient Safety Strategy is to build on the successes of previous patient safety programmes by transforming and embedding a proactive patient safety culture at every level of the organisation.

Our strategic direction for the next three years will remain the reduction of avoidable harm to patients and proactive improvement of patient safety. This is necessarily located in the context of an open and transparent culture when things go wrong and a mind-set of seeking continuous improvement. The drivers for this strategy are set out in Appendix 1.

[1] Formerly known as the South West Quality and Patient Safety Improvement Progamme
[2] Supported by the Institute for Health Improvement (IHI), Cambridge, Massachusetts, USA

The Trust's approach to delivering this strategy will include the successful transition during 2014 of the work of our existing patient safety improvement programmes in to the work streams of the emerging national Patient Safety Collaborative programme in response to the report from Don Berwick's National Advisory Group on the Safety of Patients in England which stated that:

"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

A promise to learn-a commitment to act, 2013

In addition the elements of the "Seven Steps to Patient Safety"[3] remain valid as a framework for improving patient safety and will resonate within the work programme which underpins this strategy.

1. Building the safety culture
2. Leading and supporting staff
3. Integrating risk management activity
4. Promoting reporting
5. Involvement and communication with patients and the public
6. Learning and sharing lessons
7. Implementing solutions to prevent harm.

In particular we will work in partnership with patients in developing the Trust's safety agenda, for example in the design of information and processes to reduce harm, and also within the proactive patient safety improvement work of the West of England Patient Safety Collaborative described in section 4.2.

The delivery of this Patient Safety Strategy also supports the delivery of:

1. Corporate annual quality objectives relating to patient safety
2. The Trust's responses to the Francis Report
3. Compliance with Care Quality Commission (CQC) 'Essential Standards'
4. Commissioning for Quality and Innovation (CQUIN) targets relating to patient safety
5. Divisional annual quality objectives relating to patient safety

4. Our plans

4.1 Patient Safety Culture and Being Open

There isn't a universally accepted definition of a safety culture in healthcare but it is essentially a culture where staff have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and one that encourages people

[3] National Patient Safety Agency 2004

to speak up about mistakes. It is one where staff, patients and their families feel able to raise concerns and report incidents about the safety of care being provided without fear of repercussions and in the knowledge that these will be investigated and acted on. This open culture is highlighted by Don Berwick:

"Abandon blame as a tool and trust the goodwill and good intentions of the staff"

A promise to learn-a commitment to act, 2013

In organisations with a developed safety culture people are able to learn about what is going wrong and then put things right.

For NHS organisations this means that:

- staff are open about incidents they have been involved in;
- staff and organisations are accountable for their actions;
- staff feel able to talk to their colleagues and superiors about any incident;
- NHS organisations are open with patients, the public and staff when things have gone wrong, and explain what lessons will be learned;
- staff are treated fairly and are supported when an incident happens.

What will we do?

We will build on initial pilots of patient safety culture/climate assessments tools and implement a programme of patient safety culture/climate assessments across the organisation. Learning from these assessments will be used by local teams to develop their patient safety culture. Trust wide and local action plans will be developed based on the outcomes of assessments.

4.2 Proactive Patient Safety Improvement Programmes

During 2014/15 we will come to the end of our five year proactive adult patient safety improvement programme, Safer Care South West.

At its highest level, Safer Care South West aimed to reduce in-hospital mortality by 15% and adverse events[4] by 30% over five years across the whole area served by the former South West Regional Health Authority and to raise the profile of patient safety improvement within the leadership of constituent NHS organisations. The Trust achieved and exceeded the 15% reduction in mortality in patients who use our services by the end of 2011 and the 30% reduction in adverse event rate by the end of 2012. Since then there has been focus on continuous improvements in both these overall aims and on achieving sustained improvement in all sixty four improvement measures of the programme.

[4] Adverse events are detected by case note review using a Global Trigger Tool that focuses on identifying specific types of harm as opposed to errors. An adverse event is defined by the IHI as "any noxious or unintended event occurring in relation to medical care" that directly caused harm.

Modules from a similar programme "Leading Improvements in Patient Safety"[5] were implemented for paediatric settings.

What will we do?

We want to continue our focus on proactive patient safety improvement across the organisation. The vehicle for this will be the aforementioned emerging national Patient Safety Collaborative programme. The national patient safety priorities are shown below:

National Patient Safety Priorities

Topic area	Patient Safety Topic							
The 'essentials'	Leadership			Measurement				
NHS Outcomes Framework improvement areas	Venous Thrombo-embolism	Healthcare Associated Infections	Pressure Ulcers	Maternity	Medication Errors	Deterioration in children		
Other major sources of death and severe harm	Falls	Handover and Discharge	Nutrition and hydration	Acute Kidney Injury	Missed and delayed diagnosis	Deterioration of patients	Medical Device Errors	Sepsis
Vulnerable groups for whom improving safety is a priority	People with Mental Health needs	People with Learning Disabilities	Children	Offenders	Acutely ill older people	Transition between paediatric and adult care		

Unsurprisingly, the above topics[6] are already on the patient safety radar of the Trust, and the wider NHS, in one form or another. These are largely, but not exclusively, evident within the succession of patient safety improvement programmes the Trust has been involved with since 2007, building on the principles of continuous improvement.

Locally, the West of England Patient Safety Collaborative is being established which is hosted by the West of England Academic Health Science Network. Our Trust, in common with other Trusts in the area, has representation on its Board. A key theme of the collaborative will be the engagement and involvement of patients in the patient safety agenda and cross system working (commissioners, community services, acute, ambulance and mental health providers).

[5] NHS Institute for Innovation and Improvement

[6] VTE=venous thrombo-embolism, HCAI=healthcare associated infection, AKI=acute kidney injury.

NHS England has suggested that areas of focus in the first year of the patient safety collaborative programme will be:

- Leadership for patient safety: *Delivering improvement requires leaders in every organisation to put safety first. Executive leaders and boards will be the focus in the first year.*
- Measurement for patient safety: *Using data well is crucial to all quality improvement.*
- Pressure Ulcers: *There are clear interventions that can deliver significant improvement in the burden of harm represented by pressure ulcers, but clearly they remain a significant burden, particularly outside the acute sector.*
- Medication Errors: *The prescribing, dispensing and administration of medicines is a complex area where any errors or poor practice have the potential to cause a high level of patient harm, making this a priority area for continued focussed attention.*

As the West of England Patient Safety Collaborative is in its infancy and Safer Care South West remains current for the next few months, the Trust will initially continue to focus on existing patient safety improvement measures. These are aligned with the proposed national patient safety collaborative programme framework and our quality objectives for 2014/15. This will continue until such time as the strategic direction and the resources to support the work of the collaborative are established.

"Sign up for Safety"

In June 2014 a new campaign "Sign up to Safety" was launched by the Secretary of State for Health to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group[7]. The campaign has set out a three-year shared objective for the NHS to save 6,000 lives and halve avoidable harm as part of its journey towards ensuring patients get harm free care every time, everywhere.

There are five Sign up to Safety pledges:

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.
2. Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.
3. Honesty. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

[7] A promise to learn-a commitment to act. National Advisory Group on the Safety of Patients in England August 2013

5. Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress

Key deliverables:
We will "Sign up for Safety" using the content of this strategy as the backbone of our pledges.

During 2014/15, until such time as the initial objectives of the West of England Patient Safety Collaborative are established we will:

Leadership for patient safety:

- Review and improve our patient safety executive walk rounds to support the development of our safety culture and to act on safety concerns raised by staff patient and visitors.

- In 2014/15 we will conduct at least seven executive walk rounds per month and complete all patient safety actions identified from these walk rounds within the agreed timescale.

Reduction in the burden of harm to patients:

- In 2014/15 we will achieve upper quartile performance[8] for harm free care (95.6%) and no new harms (98.2%) as defined by the NHS Safety Thermometer[9]

Falls reduction:

- In 2014/15 we will achieve a reduction in the number of in-patient falls of five fewer per month on average over the whole of 2014/15 against a monthly age adjusted baseline.

Medication errors:

- In 2014/15 we will achieve a further reduction in medication errors resulting in moderate or above harm to below 1.61%.

Deteriorating patient:

- In 2014/15 we will achieve a 5% reduction in cardiac arrest calls from adult general ward areas for confirmed cardiac or respiratory arrests. This has been identified as an outcome measure for identifying and responding to deterioration earlier.

We will also complete our "Southwest STAR" project to test two innovations designed to improve patient safety in emergency care systems as part of Shine programme supported by The Health Foundation. The Shine programme focuses on aspects of health care quality that reflect the key issues facing the UK health service and offers participating organisations the

[8] Based on Quarter 4 2013/14 performance of the NHS England National Reporting and Learning System acute teaching trust peer group.

[9] The NHS Safety Thermometer measure four types of harm: pressure ulcers, falls, venous thromboembolism and catheter associated urinary tract infections

opportunity to demonstrate the feasibility of innovation as the key driver for sustained quality improvements. Our "Southwest STAR project is focussed in the Emergency Department and comprises a safety 'checklist' to encompass safety, assessment and triage; and an information technology innovation that helps the clinical site team to place inpatients in the most appropriate bed. The team anticipate that the project will enhance patient safety and outcomes in a cost effective and demonstrable way.

4.3 Incident identification, reporting, analysis and learning

Incident identification, reporting, analysis and learning is a key pillar of patient safety which informs improvement actions and harm reduction. This is supplemented by other systematic measures such as adverse event identification and safety thermometer audits to help us know and understand when things have gone wrong, where risk reduction measures need to be focussed and to monitor the effectiveness of improvement actions.

Incident reporting rates are also an additional indicator of safety culture:

"Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are."[10]

The systematic analysis of incidents which have occurred is supplemented by in-depth root cause analysis (and serious incident panel reviews where relevant) of our most serious incidents. This is used to identify causes and contributory factors which inform the local, organisation and system-wide actions to reduce the risk of a recurrence.

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 information is used to triangulate patient safety information from other sources e.g. incident reporting, to understand the burden of harm for our patients compared to similar Trusts and to learn from those Trusts which are consistently reporting low levels of harm. We are also commencing the application of the NHS Medication Safety Thermometer which is a specialised national tool to investigate safe use of medicines in greater detail.

What will we do?

We will review our processes for working with patients and their families when things go wrong, i.e. ensure that patient safety incidents, complaints, mortality and morbidity reviews are joined up from the patient/family perspective and they have a key and clear point of contact.

We will review and strengthen our arrangements for learning from serious incidents. We will also continue to focus on encouraging incident reporting and systematic incident analysis, implementation of risk reduction actions. We will spread the breadth of our Safety Bulletins and will review and strengthen our systems for sharing organisation wide learning.

[10] NHS England National Reporting and Learning System Organisation Patient Safety Incident Reports

We will achieve year on year improvement in our NHS Safety Thermometer benchmarked position for the percentage of patients who are “harm free” and have no “new harms”. This will be measured by setting annual targets based on the upper quartile of our acute teaching trust peer group. As new safety thermometers are developed e.g. for medication, maternity and paediatrics, we will review how they can best be used within our Trust.

We will apply the learning from the NHS Medication Safety Thermometer to improve the care of our patients, particularly in the context of risks at the interface with primary care.

We will meet NHS England’s guidance on reporting and learning from medication and medical device incidents via the Trust’s two respective designated safety officers.

4.4 Never Events Prevention

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. However, they do occur.

There are currently 25 incidents that are designated as never events. Since the never events framework was established in 2010/11, seven never events have unfortunately occurred in our Trust as of the end of May 2014. Four of these occurred within the last 12 months and were related to surgical procedures, the nationally most common type of never event (in 2012/13, 329 never events were reported, of these 255 related to surgical procedures).

Surgery is an inherently risky process, and surgical systems are highly complex. A high volume of care, tailored to individual patient needs, is delivered by differently trained staff working with specialised technology in a sometimes challenging environment. Despite a genuine commitment to safe practice and a high degree of technical competence, there is ample scope for error. Evidence from across the world demonstrates that the recognised sources of error in surgery include human fallibility, miscommunication, poor co-ordination of team activity, human-technology interaction and sub-optimal management of the environment. Safer surgery depends upon reducing the scope for error from each of these sources.

What will we do?
In addition to our embedded processes for managing and leaning from serious incidents, we have set up a never events working party.

We will continue to monitor published national data on never events, including medication never events, in order to learn lessons and avoid any such potentially catastrophic incidents.

We will systematically review our arrangements for preventing never events and identify and implement any further risk reduction measures. We will prioritise our highest risk areas which will include surgical never events. In doing so we will give due regard to the standards in “Standardise, educate, harmonise. Commissioning the conditions for safer surgery” a report of the NHS England Never Events taskforce (February 2014).

4.5 Patient Safety and Quality Intelligence Alerts

Patient safety and quality intelligence alerts come from a range of external sources such as NHS England (formerly from the National Patient Safety Agency), the Medicines Healthcare Regulatory Agency and Public Health England. These fall into two broad groups:

- An alert arising from national learning from incident analyses or other patient safety information requiring proactive preventative action to be taken by all Trusts
- An alert advising of a possible problem with an aspect of our services which needs further investigating.

In addition we monitor the patient safety aspects of our services by regular review of reports extracted from our quality intelligence system to internally identify any potential problems for further investigation.

What will we do?
We will review our processes to respond to NHS England Patient Safety Alerts to ensure they are consistent with changes in national systems and can demonstrate an audit trail of completion of actions.

We will continue to respond to external alerts and take preventative action as required.

We will improve how we use our quality intelligence data to identify possible patient safety problems sooner using the latest available live data and respond accordingly.

4.6 Mortality and Morbidity Reviews

For many years we have conducted an annual mortality review of a sample of adult deaths within our Trust to identify any themes that need to be addressed in the future. In 2014 we are building on these annual sample audits by introducing a process for systematic mortality review of all adult deaths (excluding those where patients are receiving end of life care).

We also have an established system of divisional specialty based Mortality and Morbidity meetings where care of patients who have had complications or unexpected outcomes is reviewed by clinical teams to share learning and inform future practice.

We fully participate in the well-established Child Death Review process with our community partners to identify any modifiable factors and learning from such events.

What will we do?
We will evaluate our initial pilot of systematic mortality review of adult deaths and build on this for future years. We will review the approaches used across the Trust for Mortality and Morbidity meetings to ensure best practice and to maximise learning and we will reflect this is an updated policy.

4.7 Patient Safety Education and Development

Education and development in a particular area is an action that frequently arises from incident investigations and learning from all elements of patient safety e.g. an incident investigation identifies the need for a team to undertake educational activity on the latest clinical guideline to manage diabetic ketoacidosis. This strategy does not address the vast range of professional education and development either for specific learning for teams or for keeping pace with clinical developments.

What it does do is address the general education and development needs of our staff to support them in their responsibilities relating to the elements of the "Seven Steps to Patient Safety" and to raise awareness of the key themes arising from our incidents with high level reminders of key preventative actions that should be taken. More importantly it sets out a direction of travel for the next three years to educate staff about human factors as major determinates of safety.

Human factors encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work such a situational awareness, teamwork, perception and cognition. Awareness of human factors can help reduce errors caused by, for example: distractions, physical environment, teamwork, process and product design

More detailed systematic education to reduce the risks of key incidents is carried out by specialist teams e.g. pressure ulcer prevention, medicines management.

What will we do?
We will develop a human factors approach to patient safety updates over the next three years. We will continue to spread learning from our incidents across the organisation through such means as safety bulletins and face-to-face safety briefs for clinical teams. We will feed key themes into essential generic patient safety training. We will ensure essential generic patient safety training is continually evaluated and updated to reflect best practice in managing patient safety, to highlight the key patient safety risks in our Trust and the latest developments to address them. We will work with colleagues in Training and Development to improve compliance with essential generic patient safety training. We will continuously review and update root cause analysis incident investigation training provision.

5. Accountability, responsibility and enablers

Accountability for the Strategy at Board level rests with the Medical Director and Chief Nurse on behalf of the Chief Executive.

Responsibility for delivery of the Strategy is shared by:

- Clinical Chairs and Heads of Nursing
- Divisional leads for patient safety
- The Head of Quality (Patient Safety) and Associate Medical Director for Patient Safety

- Director of Pharmacy

Essential enablers, without which the strategy will not be deliverable include:

- The Trust's corporate patient safety team
- Divisional patient safety advisors/managers
- Commitment from staff at all levels of the organisation
- A governance structure for patient safety that is effective and streamlined
- Systems for measurement to inform quality and safety improvement

6. Evaluation: how we will assess whether this strategy has worked

The success of our strategy will be measured by:

- delivery of an annual patient safety work-plan that delivers the strategy
- evaluation of the Trust's existing five year proactive patient safety improvement programme Safer Care South West
- achievement of overarching patient safety objectives set out in the Trust's Quality Strategy
- achievement of specific patient safety objectives which will be identified by Divisions on an annual basis for each year of the lifetime of this strategy
- achievement of any agreed CQUINs[11]

Progress will be monitored by the Patient Safety Group, Clinical Quality Group, the Quality and Outcomes Committee of the Board, and the Board itself.

7. Integral and aligned work streams

The following work streams support this strategy:

- Review of serious incident management and key policies as outlined in the work plan in Appendix 2 including the Policy for the Management of Incidents and Serious Incident Policy.

- Review of Mortality and Morbidity meetings and associated policy and linking of learning from incident investigations with mortality reviews including the Child Death Review Procedure.

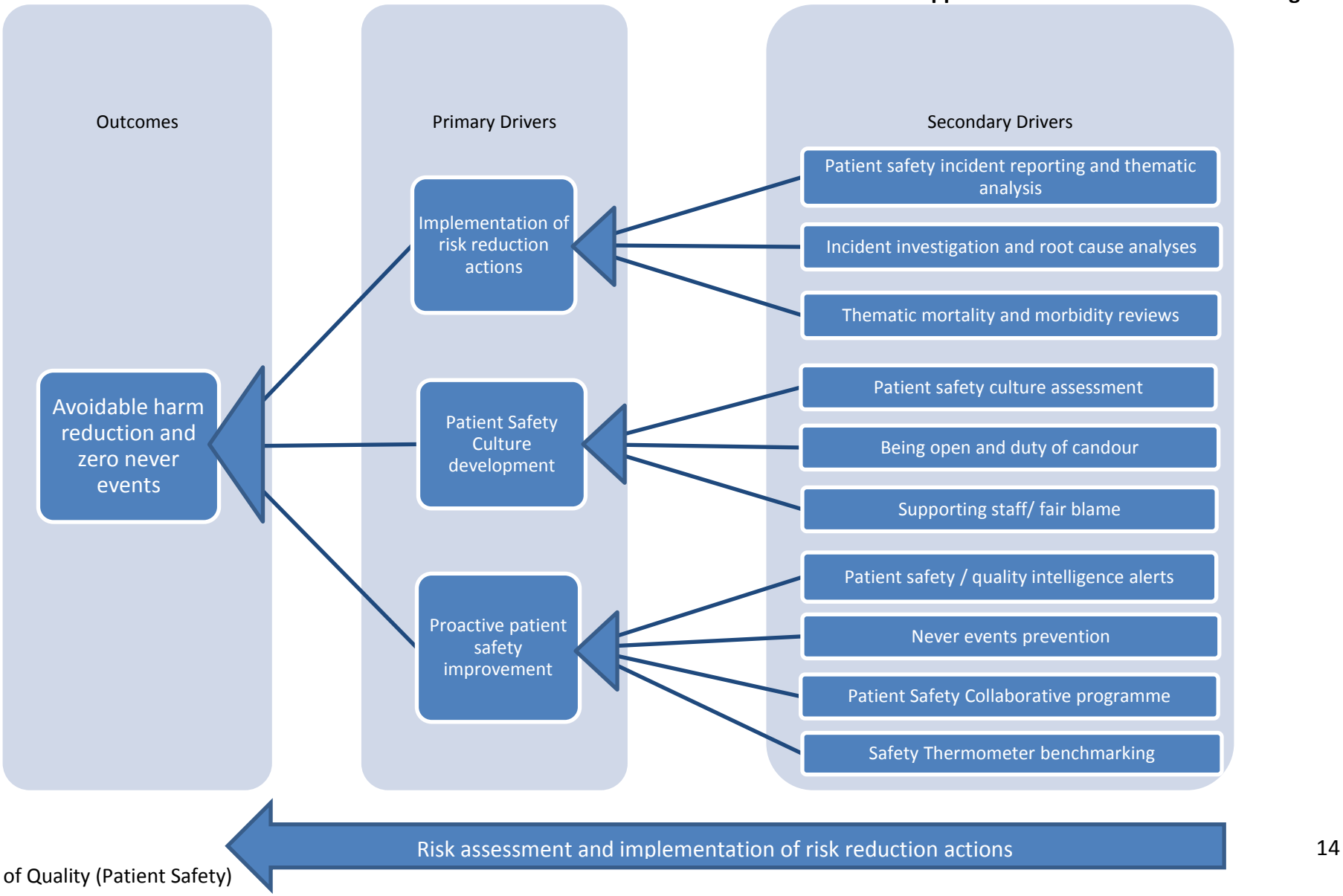
- Trust review of quality governance, including patient safety and serious incident reporting, and arrangements for the implementation of the Trust's Risk Management Policy.

- Review of procedures for the management of patient safety alerts in the light of new national requirements for medication error and medical devices incidents[12].

[11] Annual quality and innovation targets agreed with our commissioners
[12] NHS England NHS/PSA/2014/005, NHS/PSA/2014/006

- Supporting staff who raise concerns and further develop an open and just (fair blame) safety culture as defined in the Trust's Speaking out Whistleblowing Policy. This will be reflected in the revised Workforce and Organisational Development Strategy.

Appendix 1 Harm reduction driver diagram



Author: Anne Reader, Head of Quality (Patient Safety)
25/07/2014

Appendix 2 Work Plan

Objective	Action	Lead	Timescale	Measure of success
Patient Safety Culture and Being Open				
1. Assess and develop the Trust's patient safety culture	Implement a Trust wide programme of patient safety culture/climate assessments to include the Trust and Divisional Boards	Head of Quality (Patient Safety)/ Divisional patient safety advisors	Conduct assessments 30/09/2014	Completed assessments
			Analyse and feedback 31/12/2014	Feedback to teams
	Multidisciplinary teams to locally agree and implement actions to develop their patient safety culture in response to their local assessments	Ward/department Managers and speciality consultants	31/12/2015	Implemented action plans
	Divisional Boards to agree and implement actions to develop their division's patient safety culture	Clinical Chairs	31/12/2015	Implemented action plans
	Trust Board / executive team to consider the outcome of their patient safety culture assessment and agree and implement any actions relating to the conduct of their business.	Trust Secretary	31/03/2015	Changes to the conduct of Board / executive team business
	Ensure patient safety is high on the agenda of Board or management team meetings	Trust Secretary/Executive Directors/Clinical Chairs/ Divisional Directors	30/09/2014	Audit of meeting agendas
	Evaluate and modify patient safety culture assessment process	Head of Quality (Patient Safety)/ Divisional patient safety advisors	31/03/2015	Completed evaluation report

	Repeat patient safety culture assessments every two years	Head of Quality (Patient Safety)/ Divisional patient safety advisors	30/09/2017	Completed assessments
2. Sustain compliance with duty of candour and focus on developing an open culture	Conduct annual (as a minimum) audits of compliance with the contractual requirement for duty of candour (last conducted January 2014)	Head of Quality (Patient Safety)	31/01/2015, 31/01/2016, 31/01/2017	Completed audits
	Feedback results to divisions and implement any actions arising from audits	To be identified following completion of audits	To be identified following completion of audits	To be identified following completion of audits
	Review and make changes (if any required) to the Trust's policy when statutory duty of candour comes into being	Head of Quality (Patient Safety)	To be confirmed when statutory duty of candour comes into being	Review of statutory duty of candour
	Develop systems to enable patients and their families to be involved in the Trust's patient safety agenda including formulating actions in response to incidents they have been involved in if they wish to	Head of Quality (Patient Safety/ Associate Medical Director for Patient Safety /Patient Experience Lead (Engagement and Involvement)	31/12/2014	System in place
Patient Safety Improvement Programmes				
3. Achieve the aims of the Safer Care South West programme: 15% reduction in mortality, 30% reduction in adverse events and sustained improvement in each of the 64 work	Continue the existing work to achieve sustained improvement in the remaining 12 measures of the Safer Care South West programme and evaluate its success.	Head of Quality (Patient Safety)/Programme Manager/ Work stream Leads.	Currently 30/09/2014 but the programme is likely be extended until the new Patient Safety Collaborative programme is in	Final report of Safer Care South West

stream measures.			place.	
	Review and refresh executive led patient safety walk rounds	Patient Safety Programme Manager	31/07/2014	Updated guidance.
4. Actively participate in the West of England Patient Safety Collaborative -specific objectives will be determined once the programme is in place	Take forward the West of England Patient Safety Collaborative programme within the Trust	Head of Quality (Patient Safety)	To be identified once the Patient Safety Collaborative programme is in place.	To be identified once the Patient Safety Collaborative programme is in place
5. Complete the "Southwest STAR" project to test two innovations designed to improve patient safety in emergency care systems	Complete the detailed programme of work associated with this project	Associate Medical Director for Patient Safety	31/03/2015	Project evaluation report
6. Deliver deteriorating patient CQUIN for 2014/15 by building on the successful delivery in 2013/14	Deliver deteriorating patient project by implementing a change package to improve recognition and response as soon as deterioration in patients is detectable	Head of Quality (Patient Safety)/ Deteriorating Patient Project Nurse/	31/03/2015	95% compliance with appropriate response to an early warning score of 2 or more 5% reduction in cardiac arrest calls from adult general wards.
Incident identification, reporting, analysis and learning				
7. Ensure a joined up approach for patients and their families when things go wrong.	We will review our processes for working with patients and their families when things go wrong, i.e. ensure that patient safety incidents, complaints, mortality and morbidity reviews are joined up from the patient/family perspective and they have a key	Head of Quality (Patient Safety)/Head of Quality (Patient Experience/ Clinical Effectiveness)/Divisional	30/10/2014	System in place

	and clear point of contact.	Directors		
8. Sustain levels of incident reporting to remain in the upper quartile of our acute teaching trust peer group	Encouraging incident recognition and reporting, particularly near misses and specifically incident reporting by doctors, through patient safety training programmes and day to day interactions with clinical teams.	Patient Safety Manager (Incidents) and divisional Patient Safety Advisors	On-going	National Reporting and Learning System benchmark reports
9. Strengthen learning from all incidents and serious incidents including organisation wide learning	Further develop process of incident review at Patient Safety Group to improve organisation wide learning	Head of Quality (Patient Safety)/ Associate Medical Director for Patient Safety	31/07/2014	Minutes of Patient Safety Group
	Maximise use of Safety Briefs to incorporate Trust wide patient safety messages	Head of Quality (Patient Safety)/ Associate Medical Director for Patient Safety/Patient Safety Programme Manager	31/07/2014	Safety Brief documentation and compliance levels
	Convene task and finish working group to implement organisation wide systemic learning identified from incident investigations	As required.	As required.	Working Group action notes.
	Review and streamline processes for the reporting and management of patient safety incidents from the front line to executive directors	Trust Patient Safety Manager (Incidents) /Divisional Patient Safety Managers	31/10/2014	Revised processes underpinning Trust Policy for the Management of Incidents.
	Ensure a consistent robust Trust wide approach for the completion of actions/recommendations arising from incidents	Head of Quality (Patient Safety)/Divisional Directors	31/10/2014	Trust wide approach in place
	Strengthen links between incidents and monitoring of risk reduction actions through follow up audits	Trust Patient Safety Manager (Incidents)/ Divisional Patient Safety Managers	31/10/2014	Incident investigation reports and corresponding audit reports

NHS Safety Thermometer benchmarking of harm				
10. Year on year improvement in our NHS Safety Thermometer benchmarked position for the percentage of patients who are "harm free" and have no "new harms" For 2014/15 our target is	Agree with Heads of Nursing and Infection Control Team and implement a programme of work to reduce the incidence of catheter associated urinary tract infections (CAUTI) and implement it.	Heads of Nursing/ Infection Control Team	31/12/2014	Work programme. Reduction in CAUTI incidence.
	Evaluate and, if successful, spread the pilot of zero tolerance to falls.	Deputy Chief Nurse	31/12/2014	Reduction in falls incidence.
	Continue to implement the Trust wide pressure ulcer reduction action plan.	Deputy Chief Nurse/ Senior Nurse Tissue Viability	On-going	Pressure ulcer incidence.
	Continue to analyse and implement learning from all episodes of hospital associated thrombosis	VTE Project Nurses	On-going	Hospital Associated Thrombosis incidence.
	Set improvement targets each year based on the previous year's upper quartile performance of our acute teaching trust peer group.	Head of Quality (Patient Safety)/Heads of Nursing	31/03/2015	Performance against Board quality dashboard targets
11. Implementation of new NHS Safety Thermometer tools	As new safety thermometers are developed e.g. for medication, maternity and paediatrics, we will review how they can best be used within our Trust.	Director of Pharmacy/ Head of Midwifery/ Head of Nursing (Women's and Children's')	Once new tools available.	Review of new tools and, if appropriate, their implementation
Never Events Prevention				
12. Proactively assess and reduce the risk of never events happening within the Trust	Convene a Never Events Working Party and identify areas within the Trust where system wide never events could occur	Associate Medical Director for Patient Safety /Divisional and Corporate Patient Safety Managers	31/05/2014	Never events matrix
	Compile a never event risk register and identify and implement any further mitigating actions	Associate Medical Director for Patient Safety/ Divisional and	Dependent on risk assessment and identified	Never events risk register

		Corporate Patient Safety Managers	actions	
Patient Safety and Quality Intelligence Alerts				
13. Ensure systems for identifying, receiving and responding to alerts are comprehensive and robust	Review and strengthen our systems for receiving and responding to patient safety alerts in the light of changes in alert dissemination from NHS England and the introduction of the new roles of Trust Medicines Safety Officer and Medical Device Safety Officer	Head of Quality (Patient Safety)/ Director of Pharmacy/ Head of Medical Physics and Bio-engineering/ Associate Medical Director for Patient Safety/ CAS Officer	31/07/2014	Updated Standard Operating Procedures
	Develop a Standard Operating Procedure for the use of the Trust's live quality intelligence system to identify potential areas of concern in advance of official alerts to include a robust and explicit decision making process for further action.	Head of Quality (Patient Safety)/ Head of Business Intelligence and Deputy Director of Strategic Development	31/07/2014	Standard Operating Procedure
	Review Terms of Reference of the Trust's Quality Intelligence Steering Group and Quality Intelligence Working Group	Head of Quality (Patient Safety)	30/06/2014	Revised Terms of Reference
Mortality and Morbidity Reviews				
14. Ensure a proactive system for mortality review is in place and identify and implement learning arising from these	Continue to participate in the well-developed Child Death Review process in place	Women's and Children's Division	Ongoing	Child Death Review outcomes. Annual Reports from Child Death Overview Panel.
	Evaluate initial pilot of systematic mortality review of adult deaths and develop for the future	Associate Medical Director for Patient Safety	30/10/2014	Evaluation report
	Review approaches to Mortality and Morbidity meetings, update Mortality and Morbidity Policy and develop auditable standards	Head of Quality (Patient Safety)	31/08/2014	Revised policy and standards

Patient Safety Education and Development				
15. Ensure generic patient safety training sessions are comprehensive, reflect current best practice, include recent organisational learning from incidents and are of a consistently high standard	Continually review and update patient safety training session in the light of learning from incidents and local and national developments in the patient safety agenda.	Patient Safety Manager (Education and Development)	Ongoing	Session content and evaluations
	Deliver Joint Complaints, Claims and Incident Investigation Training to identified key staff required to undertake investigations	Patient Safety Manager (Education and Development)/ Head of Health and Safety Services/ Complaints Manager/ Head of Legal Services	31/12/2014	Session content and evaluations
	Incorporate a human factors approach to patient safety development activity	Patient Safety Manager (Education and Development)	31/12/2014	Session content and evaluations
16. Improve essential generic patient safety training compliance to 90%	Provide sufficient sessions to achieve compliance target	Head of Quality (Patient Safety) /Patient Safety Manager (Education and Development)/Divisional Patient Safety Managers	31/12/2014	Update session schedules
	Release of staff to attend sessions provided	Divisional Directors/Heads of Nursing/Clinical Chairs	31/12/2014	Attendance records
17. Develop quality of Root Cause Analysis Investigations	Access and secure funding for Root Cause Analysis update training for Clinical Chairs, Heads of Nursing and staff in key patient safety roles.	Head of Quality (Patient Safety)/Chief Nurse	31/07/2014	Session content, attendance records and evaluations

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

13. Annual Complaints Report 2013/14

Purpose

In accordance with NHS Complaints Regulations (2009), the attached report sets out a detailed analysis of the nature and number of complaints and contacts with the Patient Support & Complaints Team at University Hospitals Bristol NHS Foundation Trust during 2013/2014.

Abstract

In summary:

- 1,442 complaints were received by the Trust in the year 2013/2014, averaging 120 per month. Of these, 762 were managed through the formal investigation process and 680 through the informal investigation process. This compared with a total of 1,604 complaints received in the year 2012/2013, a decrease of 10%.
- The Trust had 17 complaints referred to the Parliamentary & Health Service Ombudsman in 2013/14. Eight complaints were not upheld, one was upheld and one was partially upheld. The remaining seven cases are still being considered by the Ombudsman.
- 62 complaints were re-opened due to complainants being dissatisfied with incomplete or factually incorrect responses. This compared with 20 the previous year.
- During 2013/14, the volume of complaints received by the Trust as a proportion of patient activity was 0.21%. This was a significant improvement on 2012/13, when 0.29% of patient episodes resulted in a complaint.
- In the fourth quarter of 2013/14, a backlog of enquiries to the Patient Support & Complaints Team developed, resulting in Executive approval for investment to strengthen the team's resources.

Patient stories and examples of learning from complaints have been used in staff training sessions to ensure that training is customer focused; these have been reported to the Board on a monthly basis.

Recommendations

The Board is recommended to receive the report for assurance

Report Sponsor

Chief Nurse

Appendices

Annual Complaints Report 2013/14

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
	16/7/14	25/7/14			Patient Experience Group 19/6/14

University Hospitals Bristol NHS
NHS Foundation Trust

ANNUAL COMPLAINTS REPORT 2013/2014

Author: Tanya Tofts, Patient Support & Complaints Manager - June 2014

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Appendices

Executive Summary

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the nature and number of complaints and contacts with the Patient Support & Complaints Team at University Hospitals Bristol NHS Foundation Trust during 2013/2014.

In summary:

- 1,442 complaints were received by the Trust in the year 2013/2014, averaging 120 per month. Of these, 762 were managed through the formal investigation process and 680 through the informal investigation process. This compared with a total of 1,604 complaints received in the year 2012/2013, a decrease of 10%.

- In addition, the Patient Support & Complaints Team dealt with 723 other enquiries, including compliments, requests for support and requests for information and advice, a similar figure to the 657 enquiries dealt with in 2012/2013.

- The Trust had 17 complaints referred to the Parliamentary & Health Service Ombudsman in 2013/14. Eight complaints were not upheld, one was upheld and one was partially upheld. The remaining seven cases are still being considered by the Ombudsman (as at 31/5/14).

- 62 complaints were re-opened due to complainants being dissatisfied with incomplete or factually incorrect responses. This compared with 20 the previous year.

- During 2013/14, the volume of complaints received by the Trust as a proportion of patient activity was 0.21%. This was a significant improvement on 2012/13, when 0.29% of patient episodes resulted in a complaint.

- In the fourth quarter of 2013/14, a backlog of enquiries to the Patient Support & Complaints Team developed, resulting in Executive approval for investment to strengthen the team's resources.

- Patient stories and examples of learning from complaints have been used in staff training sessions to ensure that training is customer focused; these have been reported to the Board on a monthly basis. The Patient Support & Complaints Team has continued to provide training to various staff groups in order to give them the confidence to deal with complaints as they arise and the knowledge and information required when they need to pass a complaint on.

1. Accountability for complaints management

The Board of Directors has corporate responsibility for the quality of care and the management and monitoring of complaints. The Chief Executive delegates responsibility for the management of complaints to the Chief Nurse.

The Patient Support & Complaints Manager line manages a team, which as at May 2014, consists of two full-time and one part-time complaints officer/caseworker (Band 5) and two

part-time administrators (Band 3). The total team resource, including the manager, is 4.8 WTE.

The Trust Executive has recently approved three new full-time posts to strengthen the team: a Band 6 Deputy Manager, a Band 5 caseworker and a Band 3 Administrator. Recruitment to these roles is due to be completed by September 2014.

The Patient Support & Complaints Manager is responsible for ensuring that:

- All complaints are fully investigated in a manner appropriate to the seriousness and complexity of the complaint.
- All formal complaints receive a comprehensive written response from the Chief Executive or his nominated deputy or a local resolution meeting with a senior clinician and senior member of the divisional management team.
- Complaints are resolved within the timescale agreed with each complainant at a local level wherever possible.
- Where a timescale cannot be met, an explanation is provided and an extension agreed with the complainant.
- When a complainant requests a review by the Parliamentary & Health Service Ombudsman, all enquiries received from the Ombudsman's office are responded to in a prompt, co-operative and open manner.

2. Improvements in complaints management during 2013/14

The Trust continually seeks to improve the service it offers to all patients and visitors to its hospitals and to learn from complaints. Significant developments in complaints management during 2013/14 have included:

- Joint working with the Patient Association to enhance and roll out training on how to write a good complaint response letter. The team has also worked with the Trust's Patient & Public Involvement Lead and the Patient's Association, who have carried out in-depth interviews with past complainants to assess how their complaints were dealt with and what improvements could be made to the service. The Patients Association are also hosting two focus groups in June 2014, consisting of a random selection of people who have made a formal complaint in the last six months. The Patients Association report on these activities is anticipated in July 2014.

- A comprehensive response to complaints management recommendations published in the Francis Report, Clwyd-Hart Report, and by the Parliamentary Health Service Ombudsman and Patients Association.

- Agreement by the Trust Executive to increase resourcing of the Patient Support and Complaints Team.

- Strengthening of complaints data quality including analyst support.

3. Reporting

Each month, the Patient Support & Complaints Manager provides the following information to the Board:

- Percentage of complaints per patient attendance
- Percentage of complaints responded to within the agreed timescale
- Number of cases where the complainant is dissatisfied with the original response
- Exception reports in any instances where performance deviates from target

In addition, the following information is reported to the Patient Experience Group:

- Validated complaints data for the Trust as a whole and also for each clinical Division.
- Quarterly Complaints Report
- Annual Complaints Report (which is also received by the Board)

The Quarterly Complaints Report provides an overview of the numbers and types of complaints received, including any trends or themes that may have arisen, including analysis by Division and information about how the Trust is responding. Starting with the final quarter of 2013/14, the Quarterly Complaints Report is also now being discussed by the Board and published on the Trust's web site.

A patient story is discussed at the Patient Experience Group (PEG) each month. This is an anonymised example of an issue that has resulted in learning for the department involved, for the Division, and also for the organisation as a whole. The story may be a positive or a negative one and Divisions rotate in providing the story each month. This allows learning to be shared across the Divisions, who are all represented at the group. The story discussed by PEG is usually reported to the Board the following month.

4. Total complaints received in 2013/2014

In 2013/14, our target was that the volume of complaints received should not exceed 0.21% of patient activity – in other words, that no more than approximately 1 in 500 patients complaining about our service. We achieved 0.21%, compared to 0.29% in 2012/13.

The total number of complaints received during the year was 1,442, a decrease of 10% on the previous year. Table 1 shows the number of complaints received by each Division compared with the previous year.

Compared with 2012/13, there was a decrease of 6% in the number of complaints managed through the formal investigation process and a 13% decrease in the number of complaints managed through the informal investigation process.

A formal complaint is classed as one where an investigation by the Division is required in order to respond to the complaint. This investigation typically takes 25-30 working days and a senior manager is appointed to carry out the investigation and gather statements from the appropriate staff. These statements are then used as the basis for either a written response to or a meeting with the complainant (or occasionally a telephone call from the manager). The method of feedback is agreed with the complainant and is their choice.

An informal complaint is one where the concerns raised can usually be addressed quickly by means of an investigation by the Patient Support & Complaints Team and a telephone call to the complainant. The figures below do not include informal complaints and concerns which are dealt with directly by staff in our Divisions. We are currently investigating how systems might be put in place to record and report this information in the future.

Figure 1: Monthly complaints as a percentage of patient activity 2011/12, 2012/13 and 2013/14

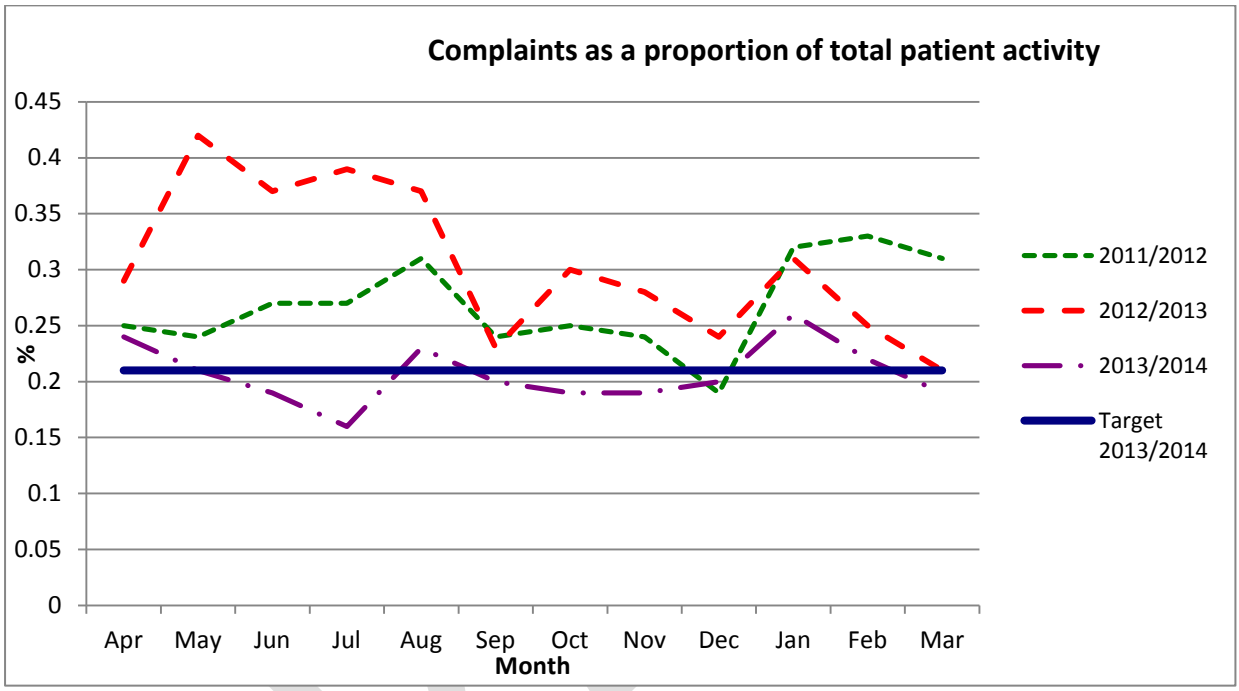


Table 1 – Breakdown of complaints by Division

Division	Informal Complaints 2012/2013	Formal Complaints 2012/2013	Divisional Total 2012/13	Informal Complaints 2013/2014	Formal Complaints 2013/2014	Divisional Total 2013/14
Surgery, Head & Neck	436	361	**797**	321 ↓	299 ↓	**620** ↓
Medicine	137	182	**319**	90 ↓	171 ↓	**261** ↓
Specialised Services	99	86	**185**	116 ↑	99 ↑	**215** ↑
Women & Children	48	134	**182**	50 ↑	118 ↓	**168** ↓
Diagnostics & Therapies	26	20	**46**	57 ↑	40 ↑	**97** ↑
Facilities & Estates	19	16	**35**	22 ↑	23 ↑	**45** ↑
Trust Services	24	16	**40**	24	12 ↓	**36** ↓
TOTALS	**789**	**815**	**1604**	**680** ↓	**762** ↓	**1442** ↓

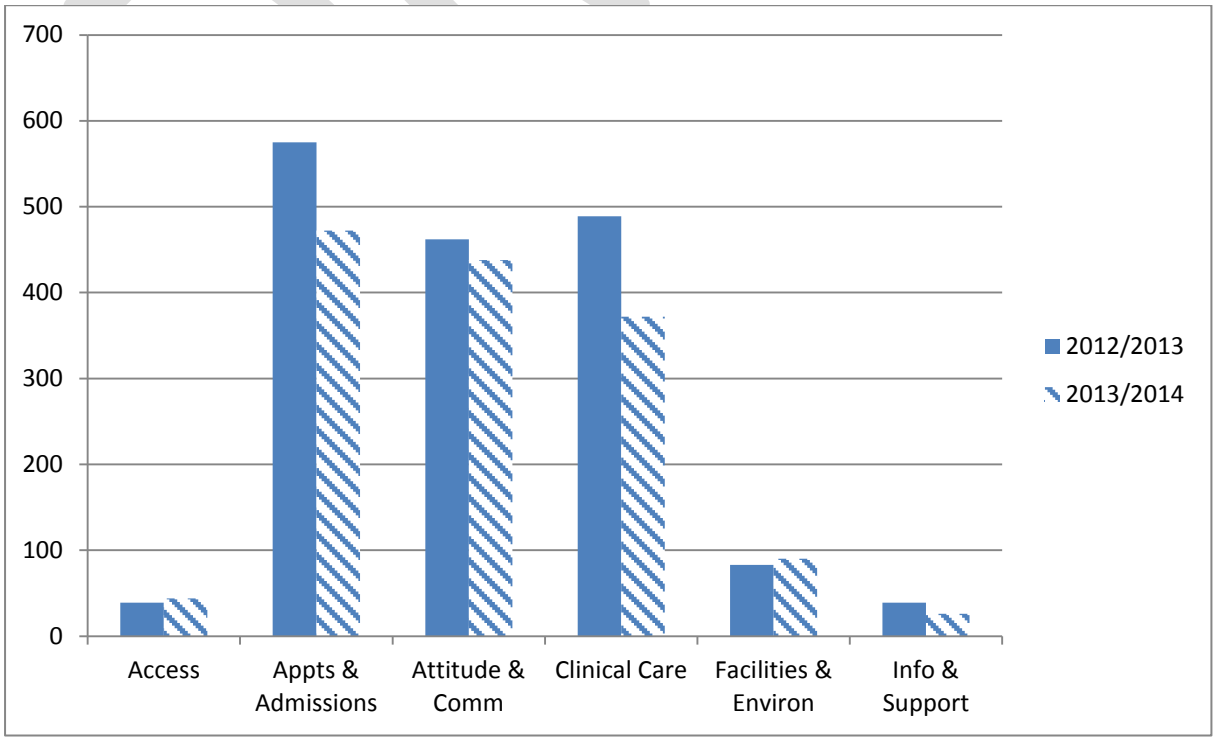
5. Complaint themes

The Trust records complaints under six main "themes" and, within each theme, by a number of specific categories. A complaint may be recorded under more than one category, depending upon the nature and complexity of the complaint. This data helps us to identify whether any trends or themes are developing when matched against hospital sites, departments, clinics and wards. Table 2 and Figure 2 show complaints received by theme, again compared to 2012/2013.

Table 2 – Complaint themes by Division

Complaint Theme	Informal Complaints 2012/2013	Formal Complaints 2012/2013	Total 2012/13	Informal Complaints 2013/2014	Formal Complaints 2013/2014	Total 2013/14
Access	21	18	**39**	24 ↑	20 ↑	**44** ↑
Appointments & Admissions	331	244	**575**	280 ↓	192 ↓	**472** ↓
Attitude & Communication	258	204	**462**	206 ↓	232 ↑	**438** ↓
Clinical Care	93	303	**396**	99 ↑	273 ↓	**372** ↓
Facilities & Environment	57	36	**93**	53 ↓	37 ↑	**90** ↓
Information & Support	29	10	**39**	18 ↓	8 ↓	**26** ↓
TOTALS	**789**	**815**	**1604**	**680** ↓	**762** ↓	**1442** ↓

Figure 2: Complaints by Theme - 2012/13 and 2013/14



In 2013/14, the total number of complaints received under the theme of Access increased by 12.8% and the total number for Facilities & Environment has increased by 8.4%. All other themes saw fewer complaints received when compared to 2012/13, with a decrease of 17.9% for Appointments & Admissions; 5.2% for Attitude & Communication; 23.9% for Clinical Care and 33.3% for Information & Support.

The decrease in Appointments & Admissions complaints was, as anticipated last year, largely due to the work carried out by the Trust's Productive Outpatients Team, which helped to reduce hospital cancellations of appointments, reduce DNAs (where the patient Did Not Attend) and improve slot utilisation by tasking Clinic Co-ordinators with not leaving any appointment slots unfilled. Work continues as part of the Trust's Transformation programme to improve the 'flow' of patients through our hospitals: the Trust's corporate quality objectives for 2014/15 are focussed on reducing numbers of cancelled appointments, minimising patient moves between wards, ensuring that patients are treated on the right ward for their clinical condition and ensuring that no patients are discharged from our hospitals out-of-hours[1].

Whilst there was a small decrease overall in the number of complaints regarding Attitude & Communication, this theme still accounts for over 30% of all complaints received by the Trust. The highest numbers of complaints under this theme were in the following categories:

- Communication with Patient/Relative - 80
- Attitude of Medical Staff – 79
- Communication (Administrative) - 75
- Attitude of Nursing/Midwifery Staff – 41

In 2014/15, the Trust will be improving its use of patient experience data. Where correlations are found between wards with a pattern of complaints coupled with lower than average patient survey feedback, including the NHS Friends and Family Test, the Trust is conducting 'deep dives' using the 15 Steps Challenge methodology and its *Face to Face* patient interview programme to gain a more detailed understanding of patient experience and to engage staff in raised standards.

5.1 Annual KO41A return

Each year, the Trust is required to submit a 'KO41A' return to the Department of Health. This is a report which gives a detailed breakdown of the number of formal complaints received and how these are spread across the various areas and departments of the Trust. The return for 2013/2014 can be found in Appendix 1.

It should be noted that the total number of formal complaints reported in the KO41A is slightly higher than the number shown in the main body of this report. This is because the data for the return was extracted from the Safeguard database as a separate report to the data used for monthly complaint reporting. This figure can sometimes change slightly throughout the course of the year due to, for example, a complaint investigation type being reclassified from "informal" to "formal" (or vice versa) following initial enquiries.

[1] Currently 10pm – 7am

5.2 Equalities data: monitoring protected characteristics

Patients' ethnicity, age and gender are recorded on the Trust's patient administration system, Medway. Where available, this information is exported into the Ulysses Safeguard database used by the Patient Support and Complaints Team. This data covers patients' age, gender and ethnic group.

Information about the age, gender and ethnicity of patients who made a complaint in 2013/14 (or on behalf of whom a complaint was made) can be found at Appendix 2. This data shows that:

- There was a broadly even distribution of complaints between men and women
- 31.6% of patients were aged 65 years or above[2]
- The overwhelming majority of people who complained, and whose ethnicity is recorded, were White British.

The pattern of complaints according to ethnic origin warrants further investigation. In 2013/14, there were 488 patients whose ethnicity was unknown. If that group of patients bore the same characteristics as the group whose ethnicity is known, it would be reasonable to conclude that the ethnic origin of people who complain about the Trust's services does not mirror the ethnicity of the population the Trust serves. This may be for cultural reasons, and partly it may reflect UH Bristol's role as a tertiary care centre (i.e. the population of the wider region is less diverse than in Bristol). However it may also raise questions about accessibility. As a starting point, we need to gather more reliable data. During 2014/15 the Patient Support & Complaints Team will commence the practice of routinely asking for the patient's ethnic group, age and gender if this data has not been pre-populated on the Safeguard system. In the meantime, the Trust will be making its Patient Support and Complaints Team 'How can we help?' leaflet available in several of the ethnic languages most commonly spoken by residents of Bristol.

6. Performance in responding to complaints

In addition to monitoring the volume of complaints received, the Trust also measures its performance in responding to complainants within agreed timescales, and the number of complainants who are dissatisfied with responses.

6.1 Proportion of complaints responded to within timescale

All complaints are acknowledged within two working days for telephone enquiries and within three working days for written enquiries. The complainant's concerns are confirmed and the most appropriate way in which to address their complaint is agreed. This is a right enshrined in the NHS Constitution. A realistic timescale in which the complaint is to be resolved is agreed, based on the complexity of the complaint whilst responding in a timely manner.

The time limit for making a complaint, as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter

[2] This includes all inpatient and outpatient complaints. However, as a point of reference, 29.4% of inpatients seen by the Trust in 2013/14 were aged 65 or above, i.e. the pattern of complaints is broadly similar.

came to the attention of the complainant. These regulations and guidance from the Parliamentary & Health Service Ombudsman indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the Trust must inform the complainant of the reason for the delay and agree a new date by which the response will be sent.

The Trust captures data about the numbers of complaints responded to within the agreed timescale. The Trust's performance target for this in 2013/14 was 98% compliance with the agreed timescale. For any months when reported performance was below 90%, the Board received an exception report summarising the total number of breaches, the reasons why these breaches occurred and what steps were being taken by the Divisions and by the Patient Support & Complaints Team to improve the situation. Over the course of the year 2013/14, 76% of responses were responded to within the agreed timescale. Performance improved steadily during the year and peaked in Quarter 4 at 85%.

In order to improve performance in providing timely responses to complaints, the following actions have been taken:

- Divisions have been reminded of the importance of providing the corporate Patient Support & Complaints Team with response letters at least four working days prior to the date that they are due with complainants.
- The Patient Support & Complaints Team continues to actively follow up Divisions if responses are not received on time. Divisional staff are also reminded of the need to contact the complainant to agree an extension to the deadline if necessary.
- Longer deadlines are agreed with all Divisions should the complainant request a meeting rather than a written response. This allows for the additional time needed to coordinate the diaries of clinical staff required to attend these meetings.
- The deadlines agreed with Surgery Head & Neck and Medicine are longer than for the other Divisions, to reflect the larger patient numbers and subsequent complaints received by these Divisions.

6.2 Numbers of complainants who are dissatisfied with our response

The Trust also measures performance in respect of the number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate (which we differentiate from follow-up enquiries where a complainant raises additional questions).

The total number of cases for 2013/14 where the complainant was dissatisfied with our response for this reason was 62, which represents 8% of all formal complaints received during the same period. This compares with the 20 cases reported in 2012/13 (which represented approximately 3% of formal complaints received). No theme or trend has been identified which would clearly explain this increase, however it is hoped that, in particular, the introduction of the new response letter template (mentioned below in procedures in place to improve performance) will help to reduce the number of complainants who are dissatisfied with the response they receive. The Trust has benchmarked its performance against other large teaching trusts: published data suggests that a dissatisfaction rate of 8-10% is typical. Nonetheless our aspiration is for nobody to be unhappy with the quality of our original response.

The cases were spread across all Divisions, approximately in line with the total number of complaints that each received during the year:

Division of Surgery, Head & Neck – 30 cases
Division of Medicine – 13 cases
Division of Women & Children – 8 cases
Division of Specialised Services – 7 cases
Division of Diagnostics & Therapies – 2 cases
Division of Facilities & Estates – 1 case
Division of Trust Services – 1 case

In order to further improve our performance, the following procedures are in place:

- Divisions are notified of any case where the complainant is dissatisfied. Cases are reviewed by a senior manager, reinvestigated where appropriate and resolved either by way of a further written response or a meeting with the complainant.
- The Patient Support & Complaints Team monitors draft response letters to ensure that all aspects of the complaint have been fully addressed.
- Trust-level complaints metrics are replicated at Divisional level to enable Divisions to identify the specific areas for improving performance and implement appropriate actions. Divisional complaints dashboards will also be used for quarterly performance reviews.
- Training has taken place with staff in Divisions who carry out investigations and/or write response letters, so that staff are supported to improve the quality of their investigations and letters. This training has been enhanced by the involvement of the Patients Association in rolling out this training to senior staff across the Trust.
- A new form is attached to each response letter sent for Executive sign-off. This includes details of who investigated the complaint, who drafted the response letter and who was the senior manager responsible for signing off the letter at divisional level. This enables the Executive to discuss the response letter directly with those members of staff should they have any queries.

6.3 Backlog of enquiries to Patient Support and Complaints Team

In the final quarter of 2013/14, a backlog of work developed in the Patient Support and Complaints Team. The receipt of complaints continued to be acknowledged in a timely way (within a maximum of three working days), and the majority of investigations continued to be carried out in a timely manner (as per section 6.1 above), however at the peak of the backlog it was taking up to four weeks for a caseworker from the Patient Support and Complaints Team to follow up the initial enquiry to agree the terms of the investigation that would take place. The backlog resulted from a combination of an increase in enquiries following the team's relocation to the BRI Welcome Centre, a notable increase in the complexity of enquiries, and staff sickness. Agency staff were employed as a short term measure to provide additional support to the team, resulting in a steady reduction in the backlog. Benchmarking data identified that the Trust's Patient Support and Complaints Team was notably smaller than complaints and 'PALS' teams in peer teaching trusts and the Trust Executive agreed to create three new permanent posts to enable the team to provide a robust and reliable service in the future (also see sections 1 and 2 of this report). A monthly quality metric will be developed in 2014/15 to enable to Board to monitor progress alongside existing complaints performance indicators.

7. Parliamentary & Health Service Ombudsman (PHSO)

The Trust had 17 complaints referred to the Parliamentary & Health Service Ombudsman in 2013/14. Eight complaints were not upheld, one was upheld and one was partially upheld. The remaining seven cases are still being considered by the Ombudsman (as at 31/5/14).

In the upheld case, the PHSO recommended that a letter of apology be sent to the patient together with a compensation payment of £750 and a copy of the action plan implemented by the Division. All of these actions have been completed. The partially upheld case involved problems experienced by a patient receiving injections into the eyes at Bristol Eye Hospital. The PHSO recommended that a letter of apology be sent to the patient, which has now been done. The complaint has been shared with the appropriate staff in order that they understand the implications of their actions when injecting patients. Staff have also been advised that they are able to use the counselling room for patients who may take a little longer to recover from the procedure and the senior nurse in charge will be available to help non-nursing staff to care for these patients.

Compared with 2012/13, there was a substantial increase in the number of complaints investigated by the PHSO. This was as a direct result of a change in the PHSO's practice, which has seen an increase in the total number of complaints cases they investigate across the NHS.

8. Being customer focused

The Patient Support & Complaints Team moved to its new office in the redeveloped Welcome Centre at the front of the Bristol Royal Infirmary Queen's Building on 6th December 2013. This has meant that a regular drop-in service has been reinstated following the provision of a limited service whilst the team were located in Trust Headquarters and the Bristol Dental Hospital's Chapter House. Since reopening, the team has received an average of around 25 drop-in enquiries per week. Throughout the year, the team has also continued to provide support to anyone wishing to make a complaint by telephone, email and in writing.

The team ensures that people are made aware of the independent complaints advocacy service offered by SEAP (Support Empower Advocate Promote) by providing a copy of SEAP's leaflet with every complaint acknowledgement letter and on an ad hoc basis as appropriate. SEAP can provide help and support to people who wish to make a complaint about NHS services. This service was formerly known as ICAS (Independent Complaints Advocacy Service).

A new patient information leaflet has been produced for the Patient Support & Complaints Team, advising people of the services offered by the team and the various ways in which the service can be accessed. In response to requests from staff and patients, the leaflet now also includes a simple complaints form, which people can complete and either drop into the office or put in the post. In addition, new posters are being designed by the Communications Team, to be displayed around the Trust, advising people of how they can make a complaint or raise a concern.

8.1 Information, advice & support

In addition to managing complaints, the Patient Support & Complaints Team also deals with information, advice and support requests. The total number of enquiries received during

2013/2014 is shown below, together with the numbers from 2012/2013 for comparative purposes:

Type of enquiry	Total Number 2012/2013	Total Number 2013/2014
Request for advice / information	405	323
Request for support	98	64
Compliments	154	336
Total	**657**	**723**

Many service users will contact he team for reasons other than complaints. This may be about:

- Their treatment and care
- Services which the Trust provides
- Signposting to other local or voluntary services
- Outpatient clinic appointments (patients may occasionally ask a member of the team to attend with them)
- Liaison for carers and patients who have additional support needs and complex health problems
- Communication with patients' healthcare teams to facilitate both parties being able to work together in the future.
- Assisting families who arrive in Bristol with a patient but do not live locally and require local orientation and signposting to further help about finding somewhere to stay.

8.1.1 Request for Advice/Information

Examples of typical enquiries about advice and information include:

- What is the waiting time for xxx procedure?
- Who do I contact to discuss xxx?
- Can I have my treatment at a different hospital/location?
- Is it true that my operation has been cancelled due to cost cuts?
- I'm having an operation soon, who do I speak to about some concerns/questions that I have?
- I need a letter from my consultant in order that I can get my driving licence back.
- How do I make a complaint about my GP?
- My transport hasn't arrived and I'm going to miss my appointment. Who do I contact?
- I'm on the ward and I need to know the password for the wi-fi.
- I was an inpatient last week and lost my glasses. What do I need to do?

8.1.2 Request for Support

Examples of typical enquiries about support include:

- I would like someone to come to my outpatient appointment with me for support.
- I've arranged to meet with my consultant, would you be able to come with me?
- I need to arrange for a translator/interpreter to be available at my mother's appointment, can you help?

- Are you able to help me get hold of my consultant's secretary?
- Who do I need to contact to arrange hospital transport?

8.2 Training

The Patient Support & Complaints Team undertook training for staff at all levels across the organisation in 2013/2014 to increase their confidence in dealing with complaints directly and to help resolve problems quickly for patients. Examples of training included:

- Responding to complaints for front line staff – Bristol Eye Hospital outpatient staff, Emergency Department staff, Dental Consultants.
- Complaints update training for Consultant Medical staff – delivered via Consultant Away Days and using learning from complaints and PHSO investigation outcomes.
- Investigating and responding to written complaints – for senior management and senior nursing staff involved with formal complaint investigation. This training has been further enhanced with input from the Patients Association and these sessions were well attended and well received by staff.

During 2013/14, the Patient Support & Complaints Team also continued to support the Communications Team by contributing relevant materials for *Living the Values* training. Examples of patient stories and complaints were used in this training to enable staff to understand the impact their behaviours and communications have on patient experience.

9. Learning from complaints and other sources of patient feedback

In line with recent reports from the Parliamentary & Health Service Ombudsman[3], the much publicised Francis Report, and the Clwyd/Hart Report, it is clear that a number of things need to happen to ensure effective complaint handling: leaders need to take responsibility for embedding effective complaint handling and learning; and organisations need effective mechanisms to manage and learn from all complaints.

Patients' first-hand experiences tell us most about the quality of care they receive and identify those areas where we need to make improvements. Compliments as well as complaints continue to be used to highlight areas of good practice that can be shared with others, as well as leading to changes in the way we work.

One way in which the Trust learns from complaints is by way of sharing patient stories, i.e. anonymised versions of real complaints and compliments which evidence how learning has been shared across a department/ward, a Division and/or the Trust. These stories are shared each month at the Patient Experience Group, with contributions alternating between the Divisions on a rotational basis. After a story has been received by PEG and reviewed for wider learning, it is usually reported to the Board the following month as a preface to the monthly Quality & Performance report. These stories are an invaluable way of helping us to understand how the services we deliver impact on our patients. They are recognised as an effective way of making sure the patient's voice is heard and that improvement of services is centred on the needs of the patient.

The Trust also learns a great deal about patient experience from patient surveys that are carried out throughout the year. We regularly collect, monitor and analyse feedback that

[3] The NHS hospital complaints system – *A case for urgent treatment?* (April 2013)

people give us about our services in order to understand and improve their experience of hospital care. The main methods that we use to collect feedback are:

- A monthly inpatient survey, which is sent to approximately 1200 recently-discharged inpatients;
- Participation in the annual National Inpatient Survey to ensure our care compares favourably with other Trusts across the country.
- Comment cards available on every ward for people to provide feedback about the service they received.
- A programme of *Face to Face* interviews with inpatients about their experience whilst in our care.
- Focus groups and patient events around specific topics.
- Surveys, interviews and focus groups carried out by clinical staff.
- Comments posted on the NHS Choice and our own website.
- The NHS Friends and Family Test

Where appropriate, Divisions now produce action plans as part of responding to the findings of their investigations of individual complaints. Where persistent themes emerge from complaints and other forms of feedback, this learning may also be fed into divisional quality objectives as part of operating plans.

10. Looking ahead

University Hospitals Bristol NHS Foundation Trust continues to be proactive in its management of complaints and enquiries, acknowledging that all concerns are a valuable source of information. The way patients experience our services is vitally important to them, and the Trust actively encourages patients and service users to comment through the mechanisms described in this report. The improvements made this year in complaints data collection, together with collaborative and streamlined working practices, will enhance the quality of data we gather in 2014/15, enabling the Trust to react to this information.

The Trust recognises that important lessons can be learned from all complaints and the trust-wide value in sharing these.

A complaints work plan for 2014 has been developed following an internal review of recently-published national guidance from the Parliamentary and Health Service Ombudsman and the Patients Association, plus relevant recommendations from Francis and Clwyd/Hart. A copy of this plan is available upon request.

Appendix 1

2013/2014 KO41A return

Department of Health category: hospital service		**Total Number of Formal Complaints Received**
1	Hospital acute services: Inpatient	275
2	Hospital acute services: Outpatient	339
3	Hospital acute services: A&E	81
4	Elderly (geriatric) services	8
6	Maternity services	17
13	Other	55
Total		**775**

Department of Health category: clinical care group*	**Total Number of Formal Complaints Received**
Medical (including surgical)	579
Dental (including surgical)	45
Professions supplementary to medicine	35
Nursing, midwifery and health visiting	70
Scientific, technical and professional	3
Maintenance and ancillary staff	29
Trust administrative staff/members	14
Other	0
Total	**775**

* i.e. the clinical care category most closely associated with each complaint (a complaint may of course involve more than one clinical care category)

Department of Health category: complaint theme**		**Total Number of Formal Complaints Received**
1	Admissions, discharge and transfer arrangements	38
2	Aids and appliances, equipment, premises (including access)	2
3	Appointments delay/cancellation: Outpatients	43
4	Appointments delay/cancellation: Inpatients	94
7	Attitude of staff	128
8	All aspects of clinical treatment	227
9	Communication/information to patients (written and oral)	81
10	Consent to treatment	2
11	Complaints handling	1
12	Patients' privacy and dignity	1
13	Patients' property and expenses	8
17	Personal records (including medical and/or complaints)	2
18	Failure to follow agreed procedures	0
19	Patients' status discrimination (e.g. racial, gender, age)	2

20	Mortuary and post mortem arrangements	1
21	Transport (ambulances and other)	12
22	Policy and commercial decisions of Trusts	0
23	Code of openness - complaints	0
24	Hotel services (including food)	4
25	Other	129
Total		**775**

** i.e. the key theme associated with the complaint (a complaint may of course be about more than one theme)

Appendix 2

Equalities data

Information about the protected characteristics of people who complained about our services (or on behalf of whom a complaint was made) in 2013/14

Information about patients' ethnicity, age and gender which has been recorded on the Trust's patient administration system Medway can be extracted into the Ulysses Safeguard database used by the Patient Support and Complaints Team. However this information is not always available. Therefore, during 2014/15, the Patient Support and Complaints Team will commence the practice of routinely asking for the patient's ethnic group, age and gender if this data has not been pre-populated from Medway. Data for 2013/14 is provided below.

Ethnic group of patient	Number
White British	930
Any Other White Background	6
White Irish	4
African or British African	3
Caribbean or British Caribbean	2
White and Black Caribbean	2
Pakistani or British Pakistani	1
Indian or British Indian	1
White and Black African	1
Any Other Asian Background	1
Any Other Ethnic Group	3
Unknown	488
Total	1442

Age Group of Patient	Number
0-15	127
16-24	66
25-29	68
30-34	65
35-39	69
40-44	66
45-49	79
50-54	90
55-59	93
60-64	105
65+	455
Prefer not to say or Unknown	159
Total	1442

Gender of Patient	Number
Male	657
Female	764
Prefer not to say or Unknown	21
Total	1442

University Hospitals Bristol NHS
NHS Foundation Trust

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

14. Transforming Care Report – Quarter 1 2014/15
Purpose
The purpose of this report is to update Trust Board on the progress of the Transforming Care programme over the last quarter.
Abstract
The report describes the development of the Trust wide transformation projects which are being delivered, highlights of progress to date and the next steps.
Recommendations
The Board is recommended to receive the report for assurance
Report Sponsor
Chief Executive
Appendices
1. Transformation programme summary 2. Programme milestone status update to Transformation Board July 7th

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

Transforming Care Update to Trust Board

July 2014

The purpose of this report is to update Trust Board on progress with the Transforming Care programme. The report sets out the Trust wide programmes of work, the monitoring provided through Transformation Board, highlights of progress to date and the next steps.

1. The previous update to the Trust Board reported on the review of progress against the aims of each pillar, and set out the areas of focus and the planned interventions required.

Since April, as we have developed and refined scope and plans, the list of projects has been refined and as a result we have mobilised the following ten projects:

1. Compassion in Clinical Staff
2. 7 day early senior medical review
3. Transformation through Electronic Data Management
4. Operating Model - Unscheduled Care & Discharge
5. Operating Model - Planned Care
6. Operating Model - Children's
7. Breaking the Cycle Together - follow up
8. Cost benchmarking
9. Staff engagement programme
10. Leadership programme

The purpose and aims of each of these is captured in appendix 1 along with the identified project leads.

2. A detailed milestone plan has been developed for each project to support tracking of progress. The Executive Lead for each provides an update to Transformation Board monthly. At appendix 2 is shown the milestone status update provided to the July Transformation Board.

This report allows a review of completed milestones and a forward view of milestones due over the coming three months. This is to ensure we remain focussed on delivering the key short term activities which will deliver demonstrable progress and achieve the project aims.

3. Recent progress reported by some of the projects includes:

- We have implemented values based recruitment for Nursing Assistants and the roll out to other staff groups has been planned (Compassion in Clinical Staff)
- We have mobilised the process mapping and opportunity identification in preparation for the St Michaels initial implementation of the Evolve Electronic Data Management system (Transformation from Electronic Data Management)
- We have completed the training for ward based Discharge Champions, and have appointed Placement Navigators to accelerate the discharge of patients to residential care. We have also held integrated process review workshops with partner organisations from across the community to design changes to be implemented over the next 3 months (Operating Model – Unscheduled care and Integrated Discharge)
- We have completed the detailed design and commenced implementation of the managed pathways operating model. This will go live in the first ward (700) in early September (Operating Model – Planned Care)
- The communication of the renewed mission and vision is underway. A number of listening events have already taken place and more are planned to hear first-hand to how staff feel about working in our hospitals. (Staff engagement/Staff experience)
- We have identified the target cohorts for the priority leadership development work. (Leadership development)

We maintain a very strong focus on delivery of actions over quarter 2 which are designed to ensure that capability issues are addressed as we go into the winter period.

4. Risks, benefits and stakeholders have been identified during project development and are being managed by each project. These are tracked within a workbook for each project which is reviewed monthly by the Transformation Programme Management Office.

5. As these projects have been scoped and mobilised the Transformation Board has reviewed the deployment of our Transformation resource and ensured this capacity is aligned to the priority projects.

6. Alongside the mobilisation of this programme, we continue to track through routine KPI monitoring the sustainability of 2013/14 programmes, in order to ensure that progress made is not lost. Progress is monitored through both business as usual and project scorecards.

Highlights include:

Patient Flow: The percentage of patients discharged before 12 noon averaged 29.2% between April and June 2014 versus 19.2% for the same period in 2013, (equivalent to an additional 200 patients per month) reflecting the sustained impact of the Discharge Lounge and the changes to ward processes

Productive Outpatients: The average outpatients DNA (Did Not Attend) rate averaged 6.8% between April and June 2014 versus 9.4% in 2013, (equivalent to over 3,200 appointments across the quarter) reflecting the sustained impact of the Outpatients process changes and the automated reminder systems.

Fractured neck of femur pathway: The Trust rate of achievement of best practice tariff in quarter 1 this year was at 75% versus 35% last year. This reflects sustained improvement due to changes put in place across this pathway.

We establish a set of KPIs and a baseline performance measurement for each of our projects to allow this assessment of impact.

6. Next steps:

While we continue to track and monitor progress, the emphasis of Transformation Board is to maintain focus on delivery of tangible change in the next quarter, given the importance of establishing substantive changes ahead of the winter period.

Simon Chamberlain

Director of Transformation

21st July 2014

Transforming Care

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 1: Transformation Programme Summary

Pillar	Project	Purpose:	What will we do:	Exec Lead	Project lead
Delivering Best Care	**1. Compassion in Clinical Staff**	To ensure that the majority of patients/carers would report that they receive person centred care - kind, sympathetic and sensitive.	Assess our current position, learning from what others do; scope the areas where we need to do better, and the right type of interventions; mobilise a programme, including training (both general and targeted), and feedback mechanisms.	Carolyn/ Sue	Helen Morgan, Alex Nestor
	2. 7 day early senior medical review	To deliver consistent quality of care for patients admitted at weekends, consistent with a minimum standard of 14 hours to consultant review for emergency admissions	Define the weekend medical staffing levels consistent with our standards of care. Scope and cost a feasible solution, agree, and implement.	Sean	Peter Collins
	3. Transformation through Electronic Data Management	To ensure the transformational improvement opportunities made possible by the Evolve Electronic Data Management are realised	Roll out a structured approach to identify and prioritise the opportunities created by the Evolve system. Implement agreed change projects so that staff are fully engaged and benefits are delivered, consistent with the Evolve implementation.	Paul	Sarah Wright, Mel Jeffries
Improve Patient Flow	**4. Operating Model - Unscheduled Care & Discharge**	To establish an unscheduled care pathway, supported by a fully integrated Health and Social care team which reduces occupied bed days whilst improving patient outcomes and experience	Jointly design and implement new processes, performance management, reporting, roles & responsibilities and communications across organisations for complex discharge. Co-locate staff from the three organisations into one space. Ensure Out of Hospital bed capacity is consistent with our requirements. Extend the use of Early Supported Discharge principles within the integrated pathway	James	Rowena Green
	5. Operating Model - Planned Care	To ensure that elective and urgent tertiary activity proceeds unhindered through periods of high demand for acute medical care through our hospitals	Implement a Managed Pathways model across planned care services including a protected beds strategy, supporting scheduling tool and processes, updated Trust Escalation Policy, and performance monitoring. Implement a transformation programme across all theatre areas Establish short and long term changes as required to our critical care capacity	James	Andy Hollowood, Alan Bryan
	6. Operating Model Children's	To ensure our operating model in our Children's Hospital is resilient, especially to winter pressures	Deliver a programme of change to improve flow. Our vision is to deliver nine projects prior to winter 14/15 to facilitate flow, focusing on: Nursing, Communication, CED Refurbishment, Ward Processes, Elective Pathways, Winter Planning & Escalation, Paediatric OPAT, Complex Discharge, and a Breaking the Cycle Together week	James	Anne Frampton
	7. BTCT follow up	To deliver a step change in our compliance with the SAFER bundles, and in operational performance, as measured by the BTCT scorecard and avoidance of escalation. To sustain the cultural shift observed during the BTCT week	Establish the day to day routines and reporting which replicate the key features of the BTCT week. Establish the minimum standards expected and audit our progress against these. Scope further work required from the feedback and learning from the week	James	Andy Hollowood, Anne Frampton
Deliver Best Value	**8. Cost benchmarking**	To identify new and additional areas of savings, specifically in Medicine through review of reference cost and service line performance	Carry out further analysis to understand our high reference cost services. Identify and agree areas for further actions. Take forward a programme of work, monitored through the Division savings programme.	Paul	Paul Mapson
Building Capability	**9. Staff engagement programme**	To deliver a step change in staff experience, satisfaction and engagement, supporting a step change in patient experience and performance.	Design and roll out of a programme of staff engagement /staff experience activities. Engage our staff with the vision for the Trust, identify how teams should work locally to bring this vision to life, and roll out appraisal/ team working methods which support continuous improvement. This is a cultural change programme with a full three year action/implementation plan	Sue	Trish Ferguson-Jay
	10. Leadership programme	To deliver a leadership programme to build capability and drive organisational development, so that Transforming Care is at the core of the organisations practice and culture	Develop a tailored leadership development programme for priority groups. Agree the competencies and standards required. Provide support through a coaching and mentoring framework, aligned to personal development plans, and supported by a programme of quarterly leadership forums	Sue	Alex Nestor, Sam Chapman

Appendix 2: Transformation Milestone Status report

		Milstone review last month June 2014	Milestone plan next three months July 2014	 August 2014	 September 2014
Delivering Best Care	**Project:** Compassion in clinical staff **Exec Lead:** Carolyn Mills/Sue Donaldson **Project lead:** Helen Morgan	•Implement values based recruitment for RN's Midwives, NA's , domestic assistants, medical staff			
		✓ Implemented values based recruitment for Nursing Assistants	•Medical representative recruited to the group •Patient experience and complaints data	•Values based recruitment Nursing Assistant Assessment centre approach embedded	•Values based recruitment approach evaluated •focus group/workshops on concept of
	Project: 7 day early senior medical review **Exec Lead:** Sean O'Kelly **Project lead:** Peter Collins	✓ Standards and definitions for the CQUIN confirmed ✓ Baseline data collection carried out	• Data validation completed	•Data analysis compared with existing gap analysis •Data analysis shared with Divisions •Feedback received from Divisions •Baseline performance agreed & shared with CCG	•Gaps in consultant coverage which need to be addressed are agreed •Plans to address gaps drafted (to be signed off in October)
	Project: Transformation support to EDM **Exec Lead:** Paul Mapson **Project Lead:** Melanie Jeffries	✓ 'Potential opportunities log' on EDM workspace set up and ongoing management embedded ✓ Optimum level of process mapping defined ✓ Transformation opportunities Strategy agreed ✓ Set up workspace process for uploading photographs of complete process maps ✓ Roles and Responsibilities for the management/ delivery of the opportunities agreed	•Review of process maps to identify opportunities embedded •Reporting structure on opportunity management embedded •Weekly opportunities Triage meeting in place •Optimum level of process mapping in use •Transformation opportunities Strategy made operational for the duration of the pilot/project •Coaching of EDM Project Team on required process mapping technique •Workspace operational •Roles and Responsibilities made operational for the duration of the pilot/project	• Opportunities identified during reviews planned and implemented	
Improve Patient Flow	**Project:** Operating Model - Unscheduled care & discharge **ID:** Integrated Discharge **ESD:** Early supported Discharge **DWDO:** Diagnosing Weekend Discharge Opportunities **Exec Lead:** James Rimmer **Project Lead:** Caroline Daley	✓ ID: Discharge Champions trained ✓ ID: Baseline data for integrated discharge workshop ✓ ID: Align with other projects(ie Better Care) ✓ ID: Scorecard developed ✓ ID: Contract signed for Placement Navigators ✓ ESD: Explore opportunities with key stakeholders ✓ ESD: Agree approach with key stakeholders DWDO: Implement IT solution to improve Medical staff communication to all Divisions	•ID: Integrated working workshop to identity solutions •ID:Placement Navigators operational •ESD: Scope project •ESD: Review opportunities with existing services •DWDO: Feedback opportunities to SLT with recommendations	•ID: Review process map to agree and prioritise opportunities •ID: Develop Project Plan for 1st wave of projects from w/shop • ESD: Agree pilot pathway	•ID: Start 1st wave of projects from workshop •ID: Establish 2 wave of projects PTeam from workshop •ESD: Develop project plan for pathway •ESD: Go-Live pilot patient pathway
	Project: Operating Model - Planned Care **Exec Lead:** James Rimmer **Project Lead:** Sarah Nadin / Andrew Hollowood	**Update:** •Established planned care programme board - Cross Divisional •Project delivery team established	•Updated milstone plan validated and approved by SHN & Specialised Services •Revised scheduling process - workshops held and process re-designed	•Revised scheduling process and SOP approved •Scheduling tool designed and approved •Pre-launch training completed •Trust wide escalation policy updated	•Managed beds process llive in first ward (700)
	Project: Operating Model - Children's **C:** Communication Project **EP:** Elective Pathways **N:** Nursing **WP:** Ward Processes **HIAS:** Home Intravenous Antibiotic Service **WPE:** Winter planning and escalation **RCED:** Re-design Children's ED **Exec Lead:** James Rimmer **Project Lead:** Anne Frampton	**Update:** Project groups for each of the seven projects set up, project on a page and 6 out of 7 action plans completed.	• C: Scoping complete for new communication system •HIAS: Business Case agreed with commissioners regarding home IV antibiotics • RCED refurbishment begins •WP: Discharge criteria and standard template for discharge information agreed for key clinical pathways •WPE: Data analysis complete to ensure clear understanding of demand on beds over winter	•RCED: new ways of working implemented •EP: Cancellation Protocol implemented when required •N: Bespoke recruitment campaign for Bank nursing staff completed •N: Explore use of Trust appointment reminder system to send message to staff re shift fill •WP: Standard equipment trollies on each ward	•N: Fully recruited nursing workforce in place prior to winter •WPE: 2014/15 winter plan comple, implemented and reviewed escalation policy published •WP: New ward processes embedded as business as usual •C: Technology solution implemented •Programme wide: Carry out BTCT at BRCH
	Project: BTCT follow up **Exec Lead:** James Rimmer **Project Lead:** Caroline Daley	✓ Senior review gap analysis ✓ Audit medicine ✓ Sign off of SAFER bundles ● Distribution of SAFER	•Divisions embedding processes •Divisional audits •Deployment of plan SHN complete •Proposals on Estates response to BTCT •IM&T communications on response to BTCT •Lessons learned shared for BRCH BTCT •BRCH week delivery team mobilised	•BRCH preparation actions on track	•Children's BTCT week takes place
Deliver Best Value	**Project:** Cost benchmarking **Exec Lead:** Paul Mapson **Project Lead:**	✓ Medicine Reference cost and benchmark analysis completed	•Findings documented and next steps agreed	•Next steps captured in savings programme	
Building Capability	**Project:** Staff engagement programme **Exec Lead:** Sue Donaldson **Project Lead:** Trish Ferguson-Jay	● Work with leaders - share the Trust's vision and mission ● Plan /deliver communications to wider organisation on renewed mission and vision. ✓ Support for staff – wellbeing/stress (EAP) listening and action – following up Breaking the Cycle and addressing concerns about work pressures/staffing levels.			
			•Identify those with formal leadership/ management/ supervisory roles to agree target groups for project work •Draft outline appraisal practice developed	•Proposal for 360 degree appraisals completed and shared •Plans agreed for further listening events	•Guidance for managers on team meetings shared •Full census based staff survey rolled out •Pilot of new appraisal mwthod launched •Further listening events launched
	Project: Leadership programme **Exec Lead:** Sue Donaldson **Project Lead:** Alex Nestor	● Introduce programme of quarterly leadership forums, and access to learning sets	✓ Identify and agree who is in the leadership/managerial community to identify target cohorts for development programmes	•Micro-teach sessions for difficult conversations developed	•Establish a line managers forum •Scope diagnostic for effective team working •Clearly articulate and agree what it means to be a leader – competencies and standards of behaviours •Develop and agree 1 – 3 year OD plan for the Trust

✓ Milestone complete / Activities on plan to achieve milestone
● Milestone behind plan, with action to remedy
✘ Milestone behind plan, project/programme risk

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

16. Finance Report

Purpose

To report to the Board on the Trust's financial position and related financial matters which require the Board's **review.**

Abstract

The summary income and expenditure statement shows a surplus of £1.039m (before technical items) for the first three months of 2014/15. This represents an adverse variance of £0.412m against plan.

The net overspending for Clinical Divisions is currently being offset by:

- Corporate share of income plan increases less the share of under-performance on SLA to date;
- Estimated slippage on reserves due to increments, scheme slippage and provisions; and
- An expected favourable variance on financing costs (depreciation and PDC Dividend).

It is anticipated that the year-end value for the above 3 lines will be sufficient to cover the expected overspend on Divisions. The main risks to this are as follows:-

- Performance fines exceed the £1m budget. This is currently the case due to RTT and 6 week diagnostic failures;
- Commissioner challenges resulting in non-payment of SLA charges; and
- Activity delivery under plan or using premium rates.

The month 3 deficit stands at £2.6m which as a straight-line projection would result in a £10.4m year-end deficit. The level of actions to generate the net adjusted Operating Plan is valued at £7.5m. Hence there is a significant level of risk – particularly in the Medicine, Surgery, Head and Neck and Women's and Children's Divisions.

Recommendations

The Board is recommended to receive the report for assurance.

Report Sponsor

Director of Finance and Information

Appendices

- Appendix 1 – Summary Income and Expenditure Statement
- Appendix 2 – Divisional Income and Expenditure Statement
- Appendix 3 – Analysis of pay expenditure
- Appendix 4 – Executive Summary
- Appendix 5 – Summary of Divisional Variances and RAG Ratings
- Appendix 6 – Financial Risk Ratings
- Appendix 7 – Release of Reserves

Previous Meetings

This report was presented to the Finance Committee meeting held on 28 July 2014.

Finance Committee
28th July 2014
Agenda Item 5.1

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £1.039m (before technical items) for the first three months of 2014/15. This represents an adverse variance of £0.412m against plan.

The position needs to be seen in the context of Divisions' Operating Plans which have been submitted as their final version. The following table sets out the submitted Operating Plan position and compares the forecast out-turns assessed by Divisions after taking into account their Month 3 actual results.

	Operating Plans 2014/15			Position to 30 June	Forecast Outturn 2014/15
	Position 1 July	Non Recurring	Net		
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic and Therapies	5	200	205	46	202
Medicine	(483)	278	(205)	(537)	(206)
Specialised Services	(103)	336	233	(97)	1
Surgery, Head and Neck	(3,449)	400	(3,049)	(1,154)	(2,439)
Women's and Children's	(723)	452	(271)	(938)	(1,077)
Estates and Facilities	-	143	143	43	143
Trust HQ	21	-	21	(9)	40
Trust Services	-	-	-	38	-
Totals	**(4,732)**	**1,809**	**(2,923)**	**(2,608)**	**(3,336)**

The Operating Plans have been adjusted in respect of additional non-recurring support issued to Divisions (phased by equal months). This support is generated by the level of actual Month 12 SLA income being higher than the estimate made in the 2013/14 Accounts. The value of this was £1.8m, in other years it has been much lower and can even be negative. The support is therefore a bonus for Divisions and is to be used to improve their ability to deliver their financial plan.

Each Division has been tasked with ensuring that they can reconcile the month 3 position to the submitted Operating Plan. The factors that generate an improvement in the financial position from the month 3 straight line projection to the year-end forecast will be clearly set out and then these factors will represent a plan that will be performance managed during the year.

Hence the net adjusted Operating Plans of a £2.9m deficit are forecast to deliver a £3.3m year end deficit. The month 3 deficit stands at £2.6m which as a straight-line projection would result in a £10.4m year-end deficit. The level of actions to generate the net adjusted Operating Plan is valued at £7.5m. Hence there is a significant level of risk – particularly in the Medicine, Surgery, Head and Neck and Women's and Children's Divisions.

The adverse position in Clinical Divisions is currently being offset by the following factors:

- Corporate share of income plan increases less the share of under-performance on SLA to date – a net favourable variance of £0.64m;
- Some estimated slippage on reserves of £0.62m due to increments, scheme slippage and provisions;
- An expected favourable variance on financing costs (depreciation and PDC Dividend) of £0.74m due to phasing of capital schemes and the District Valuer 5 year revaluation impact.

It is anticipated that the year-end value for the above 3 lines will be sufficient to cover the expected overspend on Divisions.

The main risks to this are as follows:-

- Performance fines exceed the £1m budget. This is currently the case due to RTT and 6 week diagnostic failures.
- Commissioner challenges resulting in non-payment of SLA charges.
- Activity delivery under plan or using premium rates.

The table below shows the Trust's income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £2.608m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 31 May	June Variance	Variance to 30 June
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(963)	(112)	(1,075)
Non Pay	1,463	530	1,993
Operating Income	47	34	81
Income from Activities	(919)	(473)	(1,392)
Sub Totals	(372)	(21)	(393)
Savings Programme	(1,514)	(701)	(2,215)
Totals	**(1,886)**	**(722)**	**(2,608)**

Pay budgets have an overspending of £0.112m in the month and a cumulative overspending of £1.075m. For the Trust as a whole, bank, agency, overtime, waiting list initiative and other payments totalled £1.9m in June (cumulative £5.7m).

N**on-pay budgets** show a favourable variance of £0.530m in the month and £1.993m to date. The underspending relates in the main to clinical supplies and the proportion of contract transfer funding which has yet to be used – in effect offsetting the income from activities under performance.

Operating Income budgets show a favourable variance of £34k for the month, and a cumulative underspending of £81k.

Income from Activities shows an adverse variance of £0.473m in the month and £1.392m year to date. For June an in-month under performance is recorded for the Medicine (£0.152m) and Women's and Children's (£0.426m) Divisions. This is offset by the over performance recorded against Specialised Services (£84k), Diagnostics and Therapies (£36k) and Surgery, Head and Neck (£8k). Divisions continue to work on actions to deliver the contract volumes for the year.

The table below summarises the financial performance in June for each of the Trust's management divisions.

	Variance to 31 May	June Variance	Variance to 30 June
	Fav / (Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Diagnostic and Therapies	9	37	46
Medicine	(298)	(239)	(537)
Specialised Services	(128)	31	(97)
Surgery, Head and Neck	(841)	(313)	(1,154)
Women's and Children's	(620)	(318)	(938)
Estates and Facilities	7	36	43
Trust HQ	(19)	10	(9)
Trust Services	4	34	38
Totals	**(1,886)**	**(722)**	**(2,608)**

The results to 30 June are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0, May 4.0). Further information on the financial risk rating is given in section 6 below and appendix 6.

2. A summary of the main divisional budget changes in June is given at Appendix 7.

3. Savings Programme

The Trust's Savings Programme for 2014/15 is £20.771m. Savings of £2.977m have been realised for the three months to 30 June (66% of Plan), a shortfall of £1.5m against divisional plans. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme Performance to 30 June			1/12ths Phasing Adj Fav / (Adv)	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	357	383	26	(82)	(56)
Medicine	595	277	(318)	(164)	(482)
Specialised Services	454	345	(109)	(206)	(315)
Surgery, Head and Neck	1,092	334	(758)	(139)	(897)
Women's and Children's	833	440	(393)	(62)	(455)
Estates and Facilities	251	257	6	(24)	(18)
Trust HQ	261	266	5	1	6
Other Services	634	675	41	(39)	2
Totals	**4,477**	**2,977**	**(1,500)**	**(715)**	**(2,215)**

4. Income

Contract income is £2.23m lower than plan for the 3 month period to 30 June. Activity based contract performance at £98.51m is £1.36m less than plan. Contract rewards / penalties at a net income of £1.84m is marginally less than plan. Income of £13.91m for 'Pass through' payments is £0.70m lower than Plan.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Activity Based			
Accident & Emergency	3.37	3.37	-
Emergency Inpatients	17.75	17.87	0.12
Day Cases	8.90	8.36	(0.54)
Elective Inpatients	12.32	11.84	(0.48)
Non-Elective Inpatients	4.23	4.16	(0.07)
Excess Bed days	1.77	2.15	0.38
Outpatients	17.71	17.43	(0.28)
Bone Marrow Transplants	2.06	2.74	0.68
Critical Care Bed days	10.50	9.57	(0.93)
Other	21.26	21.02	(0.24)
Sub Totals	**99.87**	**98.51**	**(1.36)**
Contract Rewards / Penalties	2.01	1.84	(0.17)
Pass through payments	14.61	13.91	(0.70)
Totals	**116.49**	**114.26**	**(2.23)**

5. Expenditure

In total, Divisions have overspent by £0.722m in June. The table given in section 1 (page 3) summarises the financial performance for each of the Trust's management divisions. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

Three divisions are red rated[1] for their financial performance for the year to date.

The **Division of Medicine** has an adverse variance of £0.537m for the three month period to 30 June.

The Division has an overspending of £0.430m to date on pay budgets, an overspending of £36k in the month. Nursing staff expenditure is the most significant variance with an overspending of £0.283m. This is as a result of staff in post being higher than budgeted due to extra capacity wards, a need for a high level of 1:1 observations and excess agency costs.

Non-pay budgets have a favourable variance of £22k in the month and £0.240m to date. The clinical supplies heading records a favourable variance of £225k to date. A contributory factor is the lower than anticipated expenditure on respiratory equipment (within the Sleep Unit). Drugs and blood and blood products are £75k favourable to plan.

The Division reports a favourable variance of £59k in the month, cumulative £87k favourable variance on its Operating Income budgets.

[1] Division has an annualised cumulative overspending greater than 1% of approved budget.

Income from Activities shows an under achievement of £0.152m in the month and a cumulative favourable variance of £48k. There has been a notable reduction in activity based income due primarily to fewer (74) emergency admissions a reduction of 10% in the context of 1.5% fewer attendances to the Accident and Emergency department.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £1.154m for the three month period to 30 June.

Pay budgets are overspent by £0.696m to date - this is represents the pay proportion of the Division's underlying deficit (£0.976m) offset by a net underspending on other pay headings (£0.280m).

Non pay budgets are underspent by £0.190m in the month, cumulative £0.780m. This is mainly due to the release of $3/12^{th}$ of the non-recurring funding allocated at the start of the year, the further non recurring funding allocated in June and the release of reserves to offset contract underperformance. Clinical supplies are underspent by £102k as a result of activity being less than plan to date.

Income from Activities shows a small favourable variance in June (£8k) to reduce the cumulative deficit to £0.367m. SLA over performance by colorectal surgery, Upper GI, oral and maxillo facial and ophthalmology services have all made a positive financial contribution to the Division's performance. The Division continues to refine its specialty capacity plans to improve SLA performance from July onwards. Operating Income budgets show a favourable variance of £26k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £0.938m for the three months to 30 June, an increase of £0.318m in the month.

The overspending on pay budgets has reduced by £37k in June to give a cumulative adverse variance of £78k to date. Nurse staffing in paediatric medicine, cardiac and BMT are above ward funded levels. This is partially offset by vacancies in PIC, ED and theatres. Junior doctor agency costs to cover gaps in out of hours rotas have led to an overspending on medical staff budgets.

Non-pay budgets show an underspending of £0.201m in the month and £0.558m to date. This includes an underspending against the funding linked to the contract transfer where the higher levels of activity have yet to be delivered and non recurrent Trust support moneys.

Income from Activities shows an adverse variance of £0.922m to date, an increase of £0.426m in the month. Income targets have been set at significantly higher levels than 2013/14 outturn. Over £2m of activity-related growth to clear waiting list backlogs and planned services transfers has been built into the plan, most of which will deliver from Quarter 2 onwards hence £0.415m of underperformance year to date. In addition there are other significant variances such as CSP related services (£0.521m adverse) and Bone Marrow Transplants (£0.177m favourable).

Income from Operations budgets show an adverse variance of £41k to date mainly as a result of peripheral clinic income being less than plan and an adverse adjustment relating to March 2014 drug charges.

One Division is amber green rated.

Trust Headquarters Services report an underspending in June of £10k thereby reducing the cumulative overspending to £9k for the three month period to 30 June.

Three divisions are green rated.

The **Diagnostic and Therapies Division** reports an underspending for the month of £37k and a cumulative favourable variance of £46k to date. The cumulative overspending on non-pay and income from activities is fully covered by underspendings on pay and income from operations headings.

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £97k for the three month period to 30 June, an improvement of £31k in the month.

Pay budgets show an overspending of £157k for the month. This includes an overspending on nursing staff of £147k for which maternity leave payments are £40k greater than planned and an extra £61k has been spent on agency nursing staff to care for the high volume of BMT cases being treated in the BHOC post transfer of the adult service.

Non pay budgets show a favourable variance of £0.391m to date. The principal reason for this is the allocation of contract transfer funds and Trust support funding.

Income from activities shows an adverse variance of £30k, an improvement of £84k in the month. Whilst there was an underperformance on Cardiac Surgery by 31 cases in April and May the Division delivered the contracted level of activity for June. Cardiology activity has also underperformed due to temporary capacity reductions due to construction works to mid-July. The Division is planning to recover the 'lost' activity later in 2014/15.

The Facilities and Estates Division reports an underspending for the three month period to 30 June of £43k, an improvement in the month of £36k.

6. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the 3 months ending 30 June is 4. The actual financial risk rating is 4.0 (May 4.0). The actual value for each of the metrics is given in the table below together with the bandings for each metric.

The principal reason for the reduction in the liquidity metric performance is the recognition that the first tranche of the £70m loan repayment is to be made in June 2015 and this results in a movement in the balance sheet from long-term liabilities to short-term liabilities (i.e. less than 12 months). Further information showing performance to date is given at Appendix 6.

	March	April	May	June	Annual Plan 2014/15
Liquidity					
Metric Performance	2.71	0.26	12.23	7.35	2.53
Rating	4	4	4	4	4
Capital Service Capacity					
Metric Performance	3.04	2.36	2.78	2.88	2.51
Rating	4	3	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**

7. Capital Programme

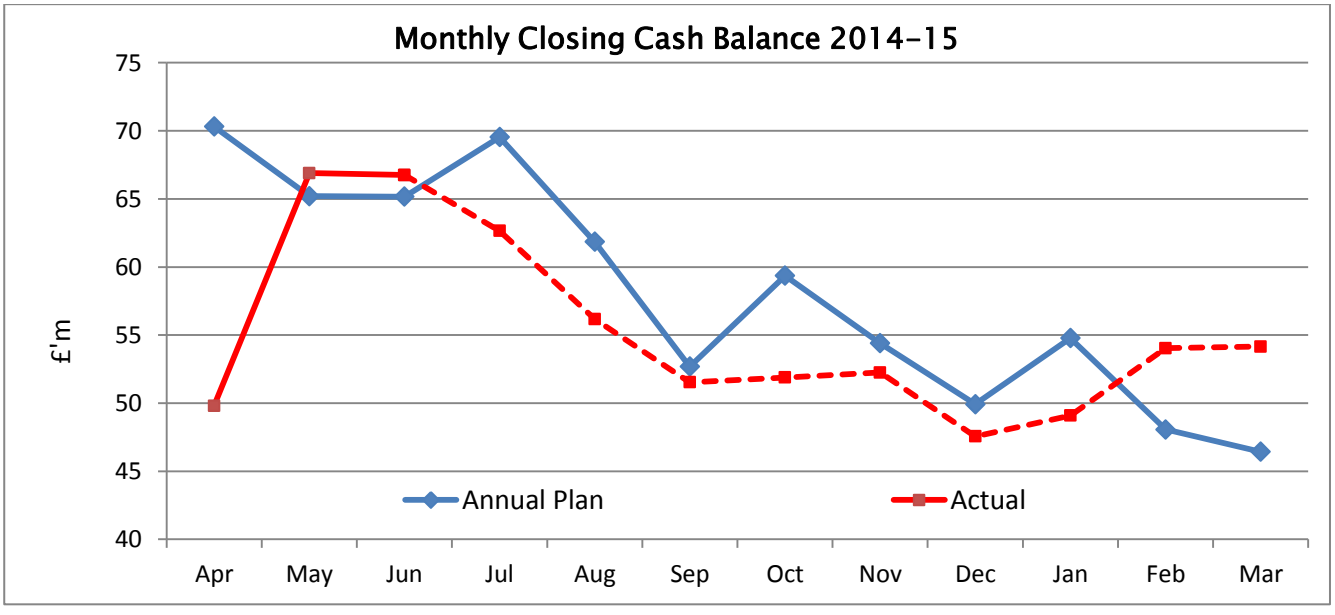
A summary of income and expenditure for the three months ending 30 June is given in the table below. Expenditure for the period of £17.195m equates to 97.5% of the current capital expenditure plan.

	Annual Plan	Three Months Ending 30 June		
		Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000	£'000
Sources of Funding				
Public Dividend Capital	2,625	-	-	-
Donations	8,625	1,520	1,520	-
Retained Depreciation	19,211	4,624	4,498	(126)
Prudential Borrowing	20,000	20,000	20,000	-
Sale of Property	700	-	70	70
Recovery of VAT	954	-	-	-
Cash balances	5,461	(8,507)	(8,893)	(386)
Total Funding	**57,576**	**17,637**	**17,195**	**(442)**
Expenditure				
Strategic Schemes	(32,740)	(13,867)	(13,488)	379
Medical Equipment	(7,973)	(960)	(848)	112
Information Technology	(9,024)	(1,358)	(1,439)	(81)
Roll Over Schemes	(2,932)	(230)	(165)	65
Operational / Other	(12,374)	(1,222)	(1,225)	(33)
Anticipated Slippage	7,467	-	-	-
Total Expenditure	**(57,576)**	**(17,637)**	**(17,195)**	**442**

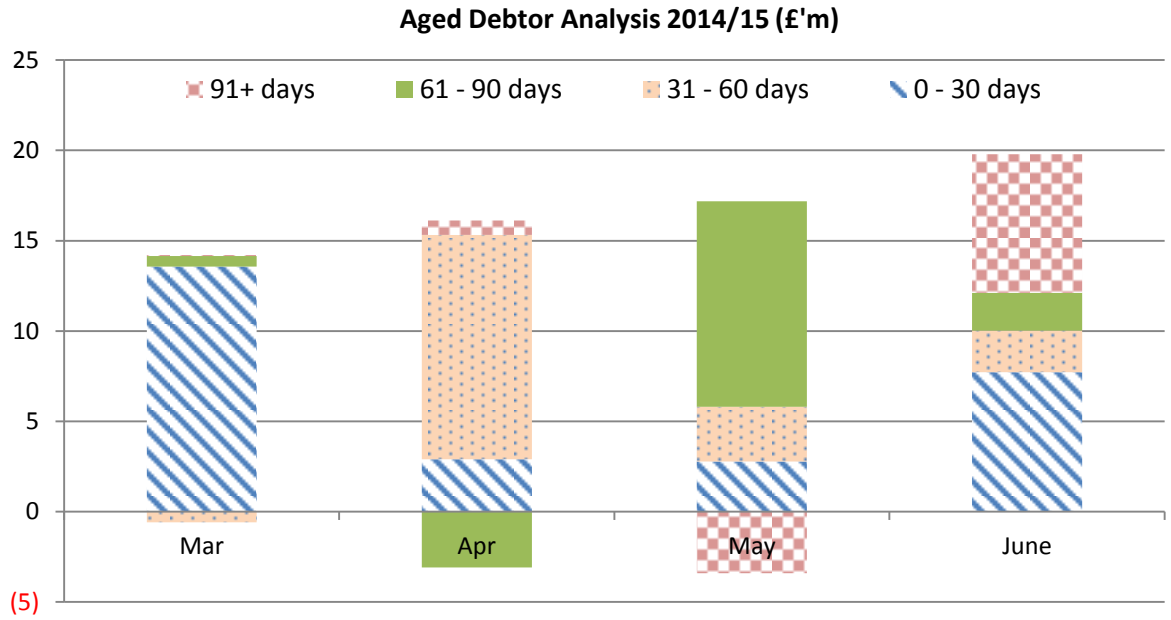
The Finance Committee is provided with further information on this under agenda item 6.

8. Statement of Financial Position (Balance Sheet) and Cashflow

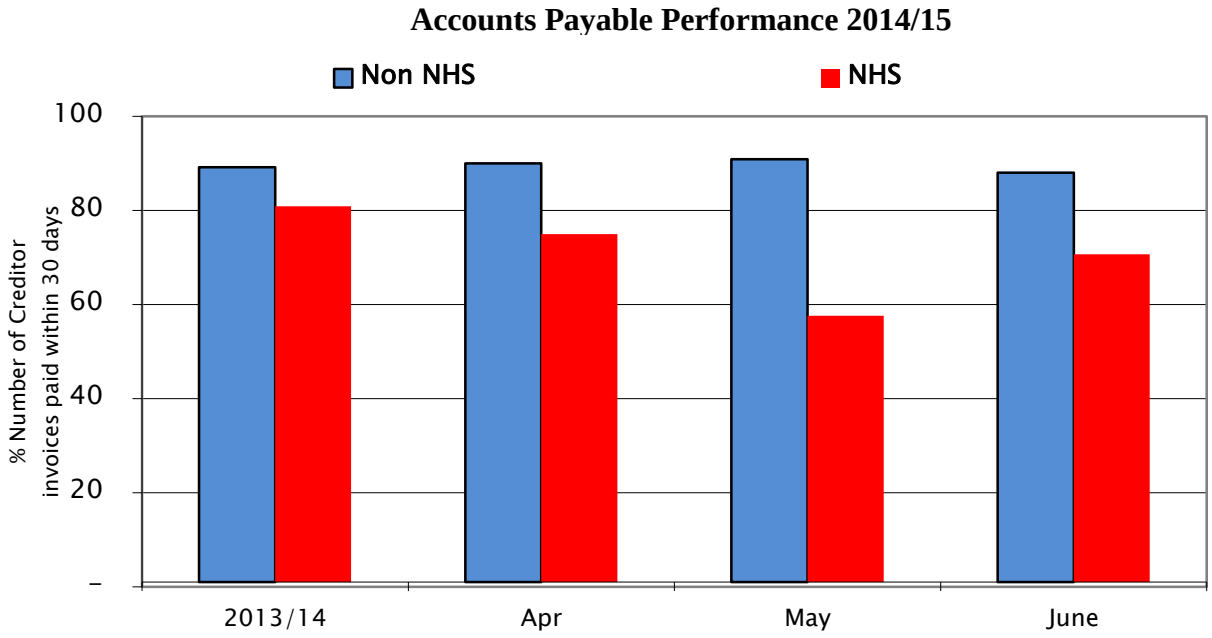
Cash - The Trust held a cash balance of £66.755m as at 30 June.



Debtors - The total value of invoiced debtors has increased by £6.004m during June to a closing balance of £19.791m. The total amount owing is equivalent to 12.9 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In June the Trust achieved 71% and 88% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Monthly Analysis of Pay Expenditure 2014/15
Appendix 4 – Executive Summary
Appendix 5 – Financial Risk Matrix
Appendix 6 – Continuity of Service Risk Rating
Appendix 7 – Release of Reserves June 2014

Appendix 1

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2014 – Summary Income & Expenditure Statement

Approved Budget / Plan 2014/15	Heading	Position as at 30th June			Actual to 31st May	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
481,580	From Activities	117,403	116,489	(914)	78,038	487,669
90,830	Other Operating Income	22,491	22,483	(8)	15,065	89,323
572,410	**Sub totals income**	**139,894**	**138,972**	**(922)**	**93,103**	**576,992**
	Expenditure					
(323,364)	Staffing	(80,876)	(82,157)	(1,281)	(54,687)	(325,924)
(193,839)	Supplies and Services	(48,253)	(48,033)	220	(33,083)	(214,084)
(517,203)	**Sub totals expenditure**	**(129,129)**	**(130,190)**	**(1,061)**	**(87,770)**	**(540,008)**
(17,480)	Reserves	(621)	–	621	–	–
37,727	**EBITDA**	**10,144**	**8,782**	**(1,362)**	**5,333**	**36,984**
	Financing					
2,220	Reserves	(198)	–	198	–	–
(21,808)	Depreciation & Amortisation – Owned	(5,452)	(4,795)	657	(2,822)	(19,181)
150	Interest Receivable	38	57	19	35	202
(338)	Interest Payable on Leases	(85)	(86)	(1)	(58)	(345)
(3,117)	Interest Payable on Loans	(738)	(739)	(1)	(475)	(3,142)
(9,031)	PDC Dividend	(2,258)	(2,180)	78	(1,358)	(8,718)
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**1,451**	**1,039**	**(412)**	**655**	**5,800**
	Technical Items					
8,588	Donations & Grants (PPE/Intangible Assets)	1,500	1,537	37	1,500	8,638
(24,204)	Impairments	–	–	–	–	(24,204)
1,232	Reversal of Impairments	–	–	–	–	1,232
(1,219)	Depreciation & Amortisation – Donated	(305)	(300)	5	(317)	(1,200)
(9,800)	**SURPLUS / (DEFICIT) after Technical Items**	**2,646**	**2,276**	**(370)**	**1,838**	**(9,734)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2014– Divisional Income & Expenditure Statement

Approved Budget / Plan 2014/15	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st May	Forecast Outturn variance
			Pay	Non Pay	Operating Income	Income from Activities	CRES			
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements									
478,152	Service Agreements	116,491	–	–	–	–	–	–	(3)	
(4,719)	Overheads	(536)	–	–	–	644	–	644	567	
39,431	NHSE Income	10,061	–	–	–	–	–	–	–	
512,864	**Sub Total Service Agreements**	**126,016**	**–**	**–**	**–**	**644**	**–**	**644**	**564**	**–**
	Clinical Divisions									
(47,806)	Diagnostic & Therapies	(12,014)	119	(147)	190	(60)	(56)	46	9	202
(66,101)	Medicine	(16,837)	(430)	240	87	48	(482)	(537)	(298)	(206)
(80,054)	Specialised Services	(19,221)	(157)	391	14	(30)	(315)	(97)	(128)	–
(95,230)	Surgery Head & Neck	(25,418)	(696)	780	26	(367)	(897)	(1,154)	(841)	(2,439)
(107,766)	Women's & Children's	(27,297)	(78)	558	(41)	(922)	(455)	(938)	(620)	(1,077)
(396,957)	**Sub Total – Clinical Divisions**	**(100,787)**	**(1,242)**	**1,822**	**276**	**(1,331)**	**(2,205)**	**(2,680)**	**(1,878)**	**(3,520)**
	Corporate Services									
(33,980)	Facilities And Estates	(8,340)	2	92	(32)	(2)	(17)	43	7	143
(23,295)	Trust Services	(5,807)	241	(169)	(105)	–	5	(28)	(29)	40
(3,426)	Other	(2,300)	(76)	229	(58)	(59)	2	38	4	(135)
(60,701)	**Sub Totals – Corporate Services**	**(16,447)**	**167**	**152**	**(195)**	**(61)**	**(10)**	**53**	**(18)**	**48**
(457,658)	**Sub Total (Clinical Divisions & Corporate Services)**	**(117,234)**	**(1,075)**	**1,974**	**81**	**(1,392)**	**(2,215)**	**(2,627)**	**(1,896)**	**(3,472)**
(17,480)	Reserves	–	–	621	–	–	–	621	414	3,984
(17,480)	**Sub Total Reserves**	**–**	**–**	**621**	**–**	**–**	**–**	**621**	**414**	**3,984**
37,727	**Trust Totals Unprofiled**	**8,782**	**(1,075)**	**2,595**	**81**	**(748)**	**(2,215)**	**(1,362)**	**(918)**	**(2,960)**
	Financing									
2,220	Reserves/Profiling	–	–	198	–	–	–	198	–	–
–	(Profit)/Loss on Sale of Asset	–	–	–	–	–	–	–	–	–
(21,808)	Depreciation & Amortisation – Owned	(4,795)	–	657	–	–	–	657	432	2,627
150	Interest Receivable	57	–	19	–	–	–	19	10	52
(338)	Interest Payable on Leases	(86)	–	(1)	–	–	–	(1)	(1)	(7)
(3,117)	Interest Payable on Loans	(739)	–	(1)	–	–	–	(1)	–	(25)
(9,031)	PDC Dividend	(2,180)	–	78	–	–	–	78	147	313
(34,144)	**Sub Total Financing**	**(7,743)**	**–**	**950**	**–**	**–**	**–**	**950**	**588**	**2,960**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**1,039**	**(1,075)**	**3,545**	**81**	**(748)**	**(2,215)**	**(412)**	**(330)**	**–**
	Technical Items									
8,588	Donations & Grants (PPE/Intangible Assets)	1,537	–	–	37	–	–	37	–	50
(24,204)	Impairments	–	–	–	–	–	–	–	–	–
1,232	Reversal of Impairments	–	–	–	–	–	–	–	–	–
(1,219)	Depreciation & Amortisation – Donated	(300)	–	5	–	–	–	5	–	19
–	Profiling Adjustment	–	–	–	–	–	–	–	–	–
(15,603)	**Sub Total Technical Items**	**1,237**	**–**	**42**	**37**	**–**	**–**	**79**	**–**	**69**
(9,800)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**2,276**	**(1,075)**	**3,550**	**118**	**(748)**	**(2,215)**	**(370)**	**(330)**	**69**

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14					2014/15						2012/13	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000
Women's and Children's	Pay budget	18,004	18,254	18,456	18,764	73,478	6,188	7,195	7,051	20,433	20,433	6,811	5,896	6,123
	Bank	446	514	448	406	1,813	172	195	163	530	530	177	170	151
	Agency	323	534	254	287	1,398	88	178	118	384	384	128	123	117
	Waiting List initiative	53	109	122	81	365	18	51	19	88	88	29	14	30
	Overtime	18	47	73	88	226	27	25	30	82	82	27	5	19
	Other pay	17,093	17,209	17,690	18,119	70,112	6,021	6,750	6,683	19,455	19,455	6,485	5,635	5,843
	Total Pay expenditure	17,933	18,413	18,587	18,981	73,913	6,326	7,199	7,014	20,539	20,539	6,846	5,947	6,159
	Variance Fav / (Adverse)	71	(159)	(131)	(216)	(435)	(139)	(4)	37	(106)	(106)	(35)	(50)	(36)
Medicine	Pay budget	11,063	11,044	11,066	10,978	44,151	3,747	3,932	3,930	11,609	11,609	3,870	3,689	3,679
	Bank	938	817	771	779	3,305	253	319	233	805	805	268	286	275
	Agency	758	681	424	491	2,354	116	133	202	451	451	150	115	196
	Waiting List initiative	68	45	21	17	151	21	3	2	26	26	9	12	13
	Overtime	22	57	57	61	197	11	6	7	24	24	8	6	16
	Other pay	10,195	10,301	10,616	10,631	41,743	3,638	3,615	3,514	10,767	10,767	3,589	3,424	3,479
	Total Pay expenditure	11,982	11,901	11,889	11,979	47,751	4,040	4,075	3,958	12,073	12,073	4,024	3,842	3,979
	Variance Fav / (Adverse)	(919)	(856)	(823)	(1,002)	(3,600)	(292)	(144)	(28)	(464)	(464)	(155)	(154)	(300)
Surgery Head and Neck	Pay budget	17,682	17,750	17,767	17,728	70,927	5,902	6,011	6,038	17,951	17,951	5,984	5,774	5,911
	Bank	562	520	447	330	1,859	140	190	133	463	463	154	187	155
	Agency	186	369	156	97	808	60	91	75	226	226	75	82	67
	Waiting List initiative	223	550	372	249	1,394	121	112	133	366	366	122	91	116
	Overtime	29	108	186	162	485	37	47	35	118	118	39	12	40
	Other pay	17,068	17,276	17,399	17,451	69,195	5,798	5,806	5,927	17,531	17,531	5,844	5,623	5,766
	Total Pay expenditure	18,068	18,823	18,560	18,290	73,741	6,156	6,245	6,302	18,704	18,704	6,235	5,996	6,145
	Variance Fav / (Adverse)	(386)	(1,074)	(793)	(562)	(2,814)	(254)	(234)	(264)	(753)	(753)	(251)	(222)	(235)
Specialised Services	Pay budget	9,091	9,206	9,186	9,234	36,718	3,138	3,184	3,255	9,577	9,577	3,192	2,991	3,060
	Bank	263	314	311	296	1,184	89	122	98	309	309	103	89	99
	Agency	342	479	542	518	1,882	116	170	223	509	509	170	99	157
	Waiting List initiative	98	53	133	95	379	21	47	23	91	91	30	24	32
	Overtime	25	38	60	59	182	10	13	19	43	43	14	6	15
	Other pay	8,440	8,510	8,492	8,638	34,079	2,947	2,931	2,945	8,823	8,823	2,941	2,870	2,840
	Total Pay expenditure	9,167	9,394	9,538	9,606	37,705	3,184	3,284	3,309	9,776	9,776	3,259	3,089	3,142
	Variance Fav / (Adverse)	(76)	(189)	(352)	(371)	(988)	(45)	(100)	(54)	(199)	(199)	(66)	(98)	(82)

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14					2014/15						2012/13	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average £'000	Mthly Average £'000
Diagnostic & Therapies	Pay budget	9,894	9,992	9,881	9,759	39,526	3,300	3,438	3,424	10,162	10,162	3,387	3,186	3,294
	Bank	96	91	65	54	306	16	27	22	64	64	21	33	26
	Agency	5	101	102	132	340	22	40	17	79	79	26	30	28
	Waiting List initiative	41	52	52	80	225	7	21	17	45	45	15	15	19
	Overtime	86	77	83	69	314	34	29	38	102	102	34	23	26
	Other pay	9,564	9,582	9,659	9,347	38,153	3,247	3,297	3,228	9,772	9,772	3,257	3,124	3,179
	Total Pay expenditure	9,792	9,904	9,961	9,682	39,339	3,326	3,414	3,322	10,062	10,062	3,354	3,225	3,278
	Variance Fav / (Adverse)	102	89	(80)	77	187	(26)	24	102	100	100	33	(40)	16
Facilities & Estates	Pay budget	4,706	4,531	4,611	4,586	18,435	1,535	1,594	1,509	4,638	4,638	1,546	1,553	1,536
	Bank	105	140	144	165	555	60	93	74	228	228	76	24	46
	Agency	109	75	74	88	346	21	18	41	80	80	27	98	29
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overtime	253	254	205	183	895	93	70	81	245	245	82	94	75
	Other pay	4,161	4,136	4,079	4,021	16,397	1,393	1,407	1,308	4,109	4,109	1,370	1,329	1,366
	Total Pay expenditure	4,628	4,606	4,503	4,457	18,193	1,568	1,589	1,505	4,662	4,662	1,554	1,545	1,516
	Variance Fav / (Adverse)	78	(75)	108	129	242	(32)	5	4	(24)	(24)	(8)	8	20
Trust Services (Including R&I and Support Services)	Pay budget	6,480	6,717	8,160	8,135	29,492	2,118	2,261	2,128	6,507	6,507	2,169	2,204	2,458
	Bank	170	179	156	176	680	52	65	47	165	165	55	44	57
	Agency	80	86	108	102	375	64	30	41	135	135	45	11	31
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0
	Overtime	30	19	20	45	114	11	9	11	31	31	10	15	9
	Other pay	6,029	6,221	7,472	7,703	27,425	2,083	1,967	1,960	6,011	6,011	2,004	2,030	2,285
	Total Pay expenditure	6,309	6,504	7,756	8,026	28,595	2,211	2,070	2,060	6,342	6,342	2,114	2,101	2,383
	Variance Fav / (Adverse)	171	213	404	109	897	(94)	190	68	165	165	55	103	75
Trust Total	Pay budget	76,920	77,494	79,127	79,184	312,726	25,928	27,613	27,335	80,876	80,876	26,959	25,292	26,060
	Bank	2,579	2,575	2,343	2,206	9,702	783	1,010	771	2,564	2,564	855	833	809
	Agency	1,805	2,325	1,660	1,715	7,506	488	659	718	1,865	1,865	622	558	625
	Waiting List initiative	483	809	700	522	2,514	188	234	194	616	616	205	156	210
	Overtime	463	599	684	667	2,413	224	200	221	645	645	215	162	201
	Other pay	72,549	73,235	75,409	75,911	297,103	25,127	25,774	25,566	76,465	76,465	25,488	24,035	24,759
	Total Pay expenditure	77,879	79,545	80,796	81,020	319,238	26,810	27,876	27,469	82,157	82,157	27,386	25,745	26,603
	Variance Fav / (Adverse)	(959)	(2,051)	(1,668)	(1,836)	(6,514)	(883)	(263)	(135)	(1,281)	(1,281)	(427)	(452)	(543)

NOTE: Other Pay includes all employer's oncosts.

Appendix 4

<table>
<tr><th>Key Issue</th><th>RAG</th><th>Executive Summary</th><th>Table</th></tr>
<tr><td>Financial Risk Rating</td><td>G</td><td>The Trust's overall Continuity of Services financial risk rating for the three months ending 30 June is 4 (actual score 4.0, May 4.0).</td><td>Agenda Item 5.1 App 6</td></tr>
<tr><td>Service Level Agreement Income and Activity</td><td>A</td><td>Contract income is £2.23m lower than plan for the 3 month period to 30 June. Activity based contract performance at £98.51m is £1.36m less than plan. Contract rewards / penalties at a net income of £1.84m is marginally less than plan. Income of £13.91m for ‘Pass through’ payments is £0.70m lower than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 30 June</th><th colspan="2">Higher than Plan</th><th colspan="2">Lower than Plan</th></tr>
<tr><th>Number</th><th>%</th><th>Number</th><th>%</th></tr>
<tr><td>A&E Attendances</td><td>30,131</td><td>319</td><td>1.1</td><td></td><td></td></tr>
<tr><td>Emergency
Non Elective</td><td>9,379
640</td><td>107</td><td>1.2</td><td>
50</td><td>
7.2</td></tr>
<tr><td>Elective
Day Cases</td><td>3,524
13,203</td><td>
235</td><td>
1.8</td><td>70</td><td>1.9</td></tr>
<tr><td>Outpatient Procedures
New Outpatients
Follow up Outpatients</td><td>12,469
36,669
75,464</td><td></td><td></td><td>811
2,909
4,549</td><td>6.1
7.4
5.7</td></tr>
</table>
An income analysis by commissioner is shown at Table INC 2.
Information on clinical activity by Division, specialty and patient type is provided in table INC 3.</td><td>Agenda Item 5.2 INC 1</td></tr>
<tr><td>Savings Programme</td><td>R</td><td>The 2014/15 Savings Programme totals £20.771m. Actual savings achieved for the first quarter total £2.977m (66% of Plan before the 1/12ths phasing adjustment), a shortfall of £1.5m against divisional plans.</td><td>Agenda Item 5.4</td></tr>
</table>

Key Issue	RAG	Executive Summary	Table
Income and Expenditure	A	The surplus before technical items for the first three months of 2014/15 is £1.039m. This represents an under performance of £0.412m when compared with the planned surplus to date of £1.451m. Total income of £138.972m is £0.922m lower than Plan. Expenditure at £130.190m is greater than Plan by £0.440m. Financing costs are £0.950m lower than Plan.	Agenda Item 5.3
D&T	G	£46k underspending to date. Division remains broadly in financial balance before receipt this month of non-recurring support.	
Med	R	Overspending in June brings cumulative position to £0.537m adverse. Under performance on income from activities and shortfall on savings programme are principal drivers towards June in month overspend of £0.237m.	
Spec Serv	G	Underspending of £31k reduces cumulative overspending to £97k. Position reflects non achieved savings (£315k) and underperformance on cardiac surgery and cardiology. Division plans for greater capacity to secure improvement.	
SH&N	R	Overspending to date of £1.154m is £39k lower than proportion of Operating Plan shortfall. Causal factors are historical non achievement of savings programme and under performance on income from activities. Significant progress made on savings programme and capacity planning to increase volume of services provided.	
W&C	R	Overspending to date at £0.938m, an increase of £0.318m in June. Principal factors are underperformance on income from activities (particularly CSP related specialities @ £0.521m) and non achievement of savings programme (£0.455m).	
F&E	G	Underspending of £43k reported for 3 months to 30 June.	
THQ	AG	Underspending of £10k in June has reduced cumulative overspending to £9k.	
Capital	G	The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. Expenditure for the first quarter totals £17.195m – this equates to 102.3% of the Annual Plan forecast for quarter 1.	Agenda Item 6
Statement of Financial Position and Treasury Management	G	The cash balance on 30th June was £66.755m. The balance on Invoiced Debtors has increased by £6.004m in the month to £19.791m. The invoiced debtor balance equates to 12.9 debtor days. Creditors and accrual account balances total £79.6m with £2.693m relating to deferred income. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 88% and 71% respectively. Payment performance by invoice value is 82% for Non NHS and 88% for NHS invoices.	Agenda Item 7 SFP 1 SFP 2 SFP 3

Appendix 5

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2014 - Risk Matrix

Corporate Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk		Progress / Completion
		Risk Score	Financial Value			Risk Score	Financial Value	
			£'m				£'m	
741	Savings Programme	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	JR	High	4.0	
962	Delivery of Trust's Financial Strategy in changing national economic climate.	High	-	Long term financial model and in year monitoring of financial performance by Finance Committee and Trust Board.	PM	High	-	
2116	Non delivery of contracted activity	High	10.0		JR	Medium	6.0	
1240	SLA Performance Fines	High	3.0	Regular review of performance.	DL	Medium	2.0	
	Commissioner Income challenges	Medium	3.0	Maintain reviews of data, minmise risk of bad debts	PM	Medium	2.0	
1858	Non receipt of pledges of charitable moneys to partly finance capital expenditure	Medium	2.0	Monitoring of capital expenditure. Maintain dialogue with respective trustees.	PM	Medium	1.0	
1623	Risk to UH Bristol of fraudulent activity.	Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	Low	-	

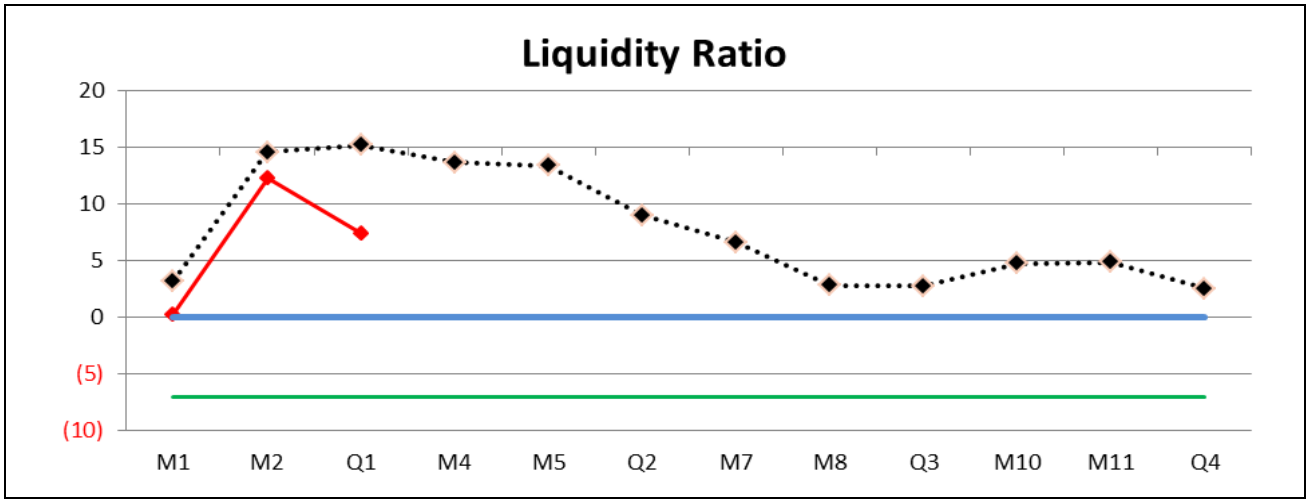
University Hospitals Bristol NHS
NHS Foundation Trust

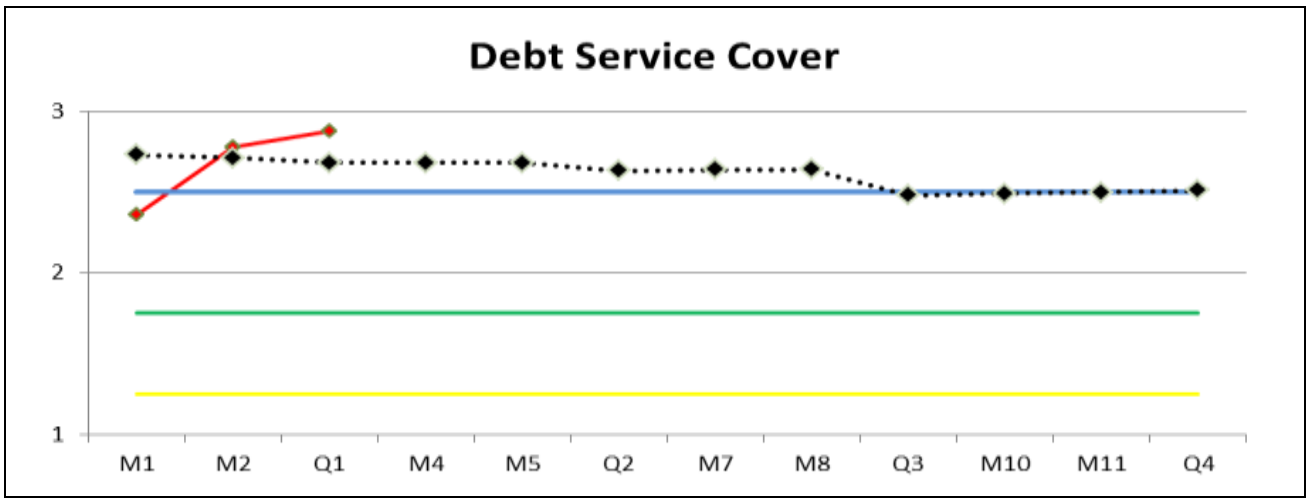
Appendix 6

Continuity of Service Risk Rating – June 2014 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics. The 2014/15 Annual Plan is shown as the black line against which actual performance will be plotted in red. The metric ratings are shown for **FRR 4 (blue line)**; **FRR 3 (green line)** and **FRR 2 (yellow line)**.

	March 2014	Annual Plan 2014/15	April 2014	May 2014	June 2014
Liquidity					
Metric Performance	2.71	2.53	0.26	12.23	7.35
Rating	4	4	4	4	4
Debt Service Cover					
Metric Performance	3.04	2.51	2.36	2.78	2.88
Rating	4	4	3	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**





Release of Reserves 2014/15 **Appendix 7**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve £'000	Inflation Reserve £'000	Operating Plan £'000	Savings Programme £'000	Other Reserves £'000	Non Recurring £'000	Totals £'000	Diagnostic & Therapies £'000	Medicine £'000	Specialised Services £'000	Surgery, Head & Neck £'000	Women's & Children's £'000	Estates & Facilities £'000	Trust Services £'000	Other £'000	Totals £'000
Provision as per Resources Book	2,000	4,468	59,894	(108)	12,885	3,750	82,889									
Fund technical items			(8,588)				(8,588)									
Adjustments to V7		(98)	5,339				5,241									
Revised provision	2,000	4,370	56,645	(108)	12,885	3,750	79,542									
April Movements	(199)	161	(29,944)	595	(7,954)	(1,052)	(38,393)	1,342	5,986	9,901	9,368	7,467	752	6,158	(2,581)	38,393
Month 1 balance	1,801	4,531	26,701	487	4,931	2,698	41,149	1,342	5,986	9,901	9,368	7,467	752	6,158	(2,581)	38,393
May Movements	(36)	(962)	(19,133)	-	(533)	(8)	(20,672)	1,622	154	205	1,326	12,583	989	345	3,448	20,672
Month 2 balance	1,765	3,569	7,568	487	4,398	2,690	20,477	2,964	6,140	10,106	10,694	20,050	1,741	6,503	867	59,065
June Movements																
MADEL funding					492		492								(492)	(492)
CQUINs assessment			(3,032)				(3,032)								3,032	3,032
2013/14 out-turn			1,809				1,809								(1,809)	(1,809)
Divisional support			(452)				(452)	50	69	84	100	113	36			452
Revised contracts			(234)				(234)								234	234
CQUIN projects			(145)				(145)		22	123						145
Fines and penalties						(1,000)	(1,000)								1,000	1,000
Drugs inflation returned		131					131	(131)								(131)
Other	(65)	(14)	(92)		(106)	(28)	(305)	9	22	75	24	38	15	90	32	305
Month 3 balance	1,700	3,686	5,422	487	4,784	1,662	17,741	2,892	6,253	10,388	10,818	20,201	1,792	6,593	2,864	61,801

University Hospitals Bristol NHS
NHS Foundation Trust

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

18 Quarterly Capital Projects Status Report

Purpose

The purpose of this report is to update the Board on the current status of the Trust's major capital development schemes.

Abstract

The attached summary updates the Board on progress, issues and risks arising from the Trust's major capital developments which are delivered and governed through the Strategic Development Department and associated programme infrastructure.

The Bristol Haematology and Oncology Centre programme is now complete. The Centralisation of Specialist Paediatrics scheme is now complete and a successful service transfer date was achieved on the 6th and 7th May.

Levels 5&6 of the ward block have completed and levels7&8 are imminent. The remainder of the ward block programme is experiencing some minor slippage against the revised programme reported previously, with work on-going with the contractor to mitigate any changes to the planned operational dates for each floor. However, the current intention is to mitigate this risk through a condensed commissioning programme.

The report notes a number of programme risks that are being actively managed and mitigated where possible.

Recommendations

The Trust Board is recommended to receive this report for **assurance**

Executive Report Sponsor or Other Author

- Sponsor – Director of Strategic Development and Deputy Chief Executive
- Other Author – Strategic Development Programme Director

Appendices

- Appendix A – Quarterly Status Report.

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Item ?? – 30th July 2014 Trust Board

1. Introduction

This status report provides a summary update for Quarter 1 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

CENTRALISATION OF SPECIALIST PAEDIATRICS		
1	**Decisions required**	None.
2	**Progress**	The construction works are now fully complete with all area operational following the successful service transfer of Burns and Neuroscience services from North Bristol Trust. A small amount of post contract snagging is being completed and the final account being agreed with the contractor.
3	**Budget**	A capital allocation of £31.531m is in the capital programme, including a level of assumed charitable funding support and the project remains within budget.
4	**Programme**	Completed

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS, GENERATORS AND QUEEN'S FAÇADE		
1	**Decisions required**	None
2	**Progress**	**BRI Phase 3** –The progress is as set out below Level 5 (Children's day case and CIU)complete and operational Level 6 (Adult ITU) complete due to be operational 2nd Sept 2014 Level 7&8 , contractor one week behind programme but expect to achieve planned operational date of 13th Aug 2014 Level 3&4 currently behind programme, contractor requested to deliver recovery plan to achieve planned operational date of 24th Sept 2014 Level 9 on programme to achieve planned operational date of 21st Jan 2015 Bed lifts completed and operational Passenger lifts completed and operation as is the level 2 lobby. **BRI Phase 4** – The space allocation for all departments remains robust, however further work is required to fully utilise Central Health Clinic. This is being supported through the recent decision to relocate Pain Management Services to the CHC from St Michaels. Two major Schemes have commenced on site • Surgical Assessment Suite- due to complete Nov 14 • Conversion of Queens Lecture Theatre to office accommodation - due to complete Dec 14 The second phase of the discharge lounge has been brought forward in the programme and will be complete by Oct 14. The next phase of works within the phase 4 programme will be the commencement of the existing ward accommodation refurbishment. **Queens Façade** – D&B Facades have been appointed as the preferred contractor for the scheme. All planning issues have been resolved and a Notice of Decision is imminent. Design work is on-going and during the next month sample panelling will be installed to resolve final design and planning condition details. An enabling scheme to rationalise all air conditioning units within the level 1 courtyard has been tendered and due to commence shortly.
	Budget	A total capital allocation of £115.7m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m. The scheme remains within its capital budget.
4	**Programme**	The ward block contract has incurred some slippage in the last reporting period and steps are being taken with the contractor to ensure planned

		operational dates can still be met.

5	**Risks**	**Risk**	**Mitigation Actions**
		Operational pressures prevent the planned reduction in beds in Q3 and subsequent closure of the Old Building. Impact on staff and resources through multiple layers of change in a short time period at the start of winter.	Detailed management of commissioning team sand plans. Early escalation of capacity shortfall. Strong version control of ward moves programme to ensure all teams working to the same programme.
		Medical model moves from acute physician to specialty take model. Risk of new model not operational in time to meet service redesign. MAU and OPAU would be restricted in ability to deliver model of care and thus planned reductions in LOS.	Funding for Acute Model of Care now agreed and being mobilised.
		Late handover of the ward block will result in delays for the final release dates of the Old Building, refurbishment of Queens building and programme & redesign in King Edward Building	Implement recommendations form Gateway review regarding improve communication from construction to operational team through ODG.
		Clinical Information System in ITU. Project plan from supplier may not align with the ward moves planned, risk of condensing clinical training and orientation which may cause operational safety, risk of delaying service go live and impact on overall ward moves programme.	Joint membership of CIS project group and key links represented at ITU Commissioning Group
		Delay in transfer out of Vascular Surgery beyond October 2014. Slippage has operational impact on SHN ability to implement new models of care and specialty working arrangements	Operational plan for further slippage being developed. Implications for Old Building Closure and impacts on other elective theatres due to delay of increased theatre capacity. Close working with NBT to maintain planned October transfer date.

BRISTOL HAEMATOLOGY & ONCOLOGY CENTRE (BHOC)		
1	**Decisions required**	None.
2	**Progress**	The project is now complete
3	**Budget**	The scheme final account is being assessed.

3. Conclusion

The Trust Board is requested to receive this report for assurance, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 22.07.2014

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

19. Constitution Review – Proposed Changes REPORT TO FOLLOW
Purpose
Abstract
Recommendations
The Board is recommended to receive the report for approval
Report Sponsor
Trust Secretary
Appendices
•

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

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

20. Risk Assessment Framework Monitoring and Declaration – Quarter 1 2014/15

Purpose

The Trust is required to make its Quarter 1 declaration of compliance with the 2014/15 Monitor Risk Assessment Framework by 31st July 2014. The purpose of this report is to set out the Senior Leadership Team's recommendations to the Board in support of this declaration.

Abstract

Since 1 April 2013, all NHS Foundation Trusts (FTs) require a licence from Monitor stipulating specific conditions that they must meet to operate. Key among these are financial sustainability and governance requirements. The 'Ris*k Assessment Framework'* constitutes Monitor's approach to overseeing the sector under the new rules. It explains how Monitor will use the framework to assess individual FTs compliance with two specific aspects of their work: the continuity of services and governance conditions in their provider licences.

The aim of a Monitor assessment under the Risk Assessment Framework is to show when there is:

- a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or
- poor governance at a NHS Foundation Trust.

These will be assessed separately using new types of risk categories set out in the Framework; each FT will be assigned two ratings. The role of ratings is to indicate when there is a cause for concern at a provider. It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

This report sets out the Trust's risk rating for governance and finance, as calculated using the criteria set out in the Risk Assessment Framework.

The Director of Strategic Development and Deputy Chief Executive have provided an analysis of governance risk (Appendix A).

The Director of Finance and Information has provided commentary on financial risk to the Finance Committee (Appendix B).

Following making the necessary enquires, the Senior Leadership Team confirms that it is not aware of any matters arising during the quarter requiring an exception report to Monitor which have not previously been reported.

Recommendation

The Trust Board of Directors is recommended to approve the following Quarter 1 declaration for submission to Monitor by 31 July 2014:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 1 to be, the RTT Non-Admitted standard, the A&E 4-hour standard and the 62-day GP cancer standard;
- Confirmation that the Board anticipates that the Trust will continue to maintain a 'Continuity of Service' risk rating of at least 3 over the next 12 months; and
- Confirmation that as far as the Board is aware, there are no matters arising in the quarter requiring an exception report (as per Diagram 6, page 22 of the Risk Assessment Framework).

Report Sponsor

Chief Executive

Appendices

Appendix A – Monitor Quarter 1 declaration against the 2014/15 Risk Assessment Framework for Governance; and

Appendix B – Monitor Quarter 1 declaration against the 2014/15 Financial Summary for the quarter-ended 30 June 2014.

Monitor Quarter 1 Declaration against the 2014/15 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 1 declaration of compliance with the 2014/15 Monitor Risk Assessment Framework by 31st July 2014.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 1, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

In the future Monitor intends to include in its list of Governance Concerns patient and staff metrics including changes in satisfaction rates, turn-over rates, levels of temporary staffing and cost reduction plans in excess of 5%.

The resultant Governance Rating that Monitor publishes will depend on further investigations it conducts following Governance Concerns being triggered. The following shows the rationale for the application or either a GREEN or a RED rating:

Table 1 Monitor's process for determining the Governance 'status' of a Foundation Trust

Governance 'status' of the Foundation Trust		Governance rating: What Monitor will publish
No evident concerns	→	Green
Issue identification **Prioritisation** **Consideration of breach**	Emerging concerns (e.g. persistently failing access targets; major third party concerns, financial issues) Further information requested Concerns serious enough to trigger formal investigation Breach or likely breach identified; formal/informal action pending	**Current status and a description of:** • Factors driving concerns • Actions Monitor is taking/considering • Next steps
Action Formal regulatory action under sections 105 (Enforcement undertakings), 106 (Discretionary requirements), and/or 111 (Licence condition and Powers of removal, suspension and disqualification of directors and governors)	→	Red

Each quarterly declaration to Monitor must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to Monitor as part of the narrative that accompanies the submission.

Monitor compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at

risk in the annual plan risk assessment, the trust may be required to commission an independent review of its self-certification and associated processes. In the 2014/15 Monitor Annual Plan the Trust declared three standards to be at risk of failure in the year:

- A&E 4-hour maximum wait
- 62-day GP cancer standard
- 18-week Referral to Treatment Time (RTT) non-admitted standard

2. Performance in the period

Table 2 shows the performance in quarter 1 against each of the standards in Monitor's Risk Assessment Framework. The following standards were not achieved in the quarter, consistent with the risks declared in the Annual Plan:

- A&E 4-hour standard (1.0)
- 62-day GP Cancer standard (1.0)
- RTT Non-admitted pathways standard (1.0)

This gives a Service Performance Score of 3.0, which equates to a GREEN rating. Under the rules set-out within the Risk Assessment Framework, the failure of the RTT Non-admitted and the A&E 4-hour standards in quarter 1 would trigger Governance Concerns for repeated failures of the same standard. However, Monitor has already reviewed performance against both these standards, along with the 62-day GP cancer standard, and has confirmed that the Trust will be restored to a GREEN rating (for quarter 4, which these repeated failures also relate to), and will only being taken into escalation if the agreed recovery trajectories are not achieved.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of August and therefore the position shown in Table 2 remains draft. Performance against the 62-day screening standard is currently 0.3% below the 90% standard, due to breaches at treating providers. For this reason the Trust is pursuing breach reallocation to secure achievement of this standard if final validation by other providers does not take overall performance above the 90% standard.

Quarter 2 2014/15 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in Monitor's 2014/15 Risk Assessment Framework in quarter 1, along with the key risks to target achievement for quarter 2 2014/15. The mitigating actions that are being taken are also provided, along with the residual risk.

The A&E 4-hour standard was failed in quarters 1, 3 and 4 of 2013/14, prior to being failed in the most recent quarter. Performance in June was, however, above the 95% standard. The Trust is continuing to implement its Operating Model for 2014/15, which will include in quarter 2 a repeat of the Breaking the Cycle Together initiative which led to significant, although relatively short-lived, improvements in patient flow and performance. Performance in quarter 2 of 2012/13 and 2013/14 was above the 95% standard. Whilst patterns of emergency flows associated with the closure of Frenchay Hospital's Emergency Department are still emerging, experience from June suggests the level of attendances and emergency admissions, whilst challenging, are currently manageable. Along with the anticipated boost in performance that the Breaking the Cycle Together initiative is likely to bring, it is forecast that the 95% standard will be achieved in the quarter, consistent with our commitment to Monitor.

Performance against the 62-day GP standard was variable in 2013/14, and heavily influenced by the volumes of late referrals, medical deferrals and patient choice, in the context of a generally strong performance against the 85% standard for internally managed pathways. The lack of breast and urology in the Trust's portfolio of cancer services continues to make achievement of the

national standard significantly more challenging as breast is one of only two services nationally (the other being skin) which routinely achieves the 85% standard each quarter. The Trust has agreed a recovery trajectory for improving performance against the 62-day GP standard, with an action plan underpinning this. Performance in quarter 1 was above the trajectory for the quarter as a whole, but below the 85% standard. The forecast remains that recovery will take a further quarter, with the 85% standard being achieved again in quarter 3.

It was originally agreed with the commissioners that the transfer of Head & Neck services from North Bristol Trust (NBT) at the end of March 2013 would result in a potential failure of the RTT non-admitted standard for the first two quarters of 2013/14, due to the longer than expected waiting times at the point of transfer and partial validation of pathways. However, the RTT Non-admitted standard has now been failed for the last four quarters. Although good progress has been made in addressing the Head & Neck backlogs, there continue to be bulges in demand that have lengthened waits for first outpatient appointments especially in dental specialties. Detailed activity plans were developed at the end of 2013/14, which are being refreshed on a continuous basis in order to reduce backlogs and keep pace with demand. In line with the recovery trajectory, it is forecast that it will take a further quarter to minimise residual backlogs and reach a position for sustainable achievement going into quarter 3 2014/15.

There is a national focus on the need to reduce the size of elective waiting lists, and in particular the numbers of patients waiting over 18 weeks for admitted treatments. Following discussion with commissioners and Monitor, the Trust is now planning for a breach of the Admitted RTT Standard for the months of July and August and thus quarter 2; for this reason, the RTT Admitted standard is recorded as having a default high residual risk of failure in quarter 2.

The Trust reported 13 cases of C. diff for the quarter against the nationally set limit of 40 for the year (i.e. 10 for the quarter based upon the flat profiling by Monitor). A review meeting with commissioners has confirmed that 1 of the 13 reported cases was considered to be avoidable (i.e. a lapse of quality of care), which is what will be reported to Monitor.

Five standards have a moderate residual risk of being failed in 2014/15. These are: the 62-day screening cancer standard, the 31-day first definitive cancer standard, the 31-day subsequent surgery cancer standard, the RTT ongoing pathways standard, and the A&E 4-hour standard. Further details of the risks to achievement of these standards are detailed in Table 2. These standards will remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

3. Recommendation

The recommendation from the Senior Leadership Team (SLT) is to declare the standards failed in quarter 1 to be, the RTT Non-Admitted standard, the A&E 4-hour standard and the 62-day GP cancer standard. It is recommended that the forecast failure of the RTT non-admitted and 62-day GP cancer standards, in line with the agreed recovery trajectory, are flagged to Monitor as part of the narrative that accompanies the declaration (see Appendix 2). The declaration will note further work is in hand to assess the regulatory implications of the national initiative to further reduce admitted RTT backlogs throughout Quarter 2 and at this stage a planned failure is predicted for July and August (only).

Table 2 Summary of performance in quarter 1 2014/15, and the risks to quarter 2 compliance

Indicator	Score	Achieved in Q1 2014/15?	New risks to Q2 2014/15?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for admitted pathways (aggregate)	1.0	Yes – achieved each month	Yes – significant increase in backlog	- Long waits for first outpatient appointments in Adult ENT, Dermatology, Dental and some paediatric specialties. - Increasing admitted backlogs in some specialties, such as Ophthalmology, Upper GI and some paediatric specialties. - Performance impact of the request from NHS England for reduction in elective waiting lists being assessed, but a planned failure in July and August is expected and as such the risk to admitted RTT noted as high*	- In accordance with NHS England request, additional activity planned during quarters 2 and 3, to reduce the size of the backlog - Waiting list transfers to other providers (e.g. Independent Sector Treatment Centre) - Robust monitoring and escalation to optimise the number of long waiters booked each month.	High*	High*
18-weeks Referral to Treatment for non-admitted pathways (aggregate)	1.0	No	No – continued risks from Q1 2014/15	- Dental non-admitted backlogs reducing, but still being addressed - Waits for first outpatient appointments in Adult	- Additional activity planned in quarter 2 as part of the ongoing recovery plan, with continued weekly monitored and re-profiling of required capacity; this includes	High	High

[1] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

				ENT, Dental, Dermatology and some paediatric specialties reducing, but still above target - Non admitted RTT performance cannot be planned/managed in the same way as admitted pathways, because attendance at an outpatient appointment may, or may not, stop a patient's RTT clock	1600 additional dental appointments to meet bulge in demand - RTT steering group overseeing the implementation of the plans to reduce outpatient and other stage of treatment waits, with a weekly RTT working group reporting into this		
18-weeks Referral to Treatment for incomplete pathways (aggregate)	1.0	Yes – achieved each month	Yes – increasing admitted and non-admitted backlogs	- Same as for RTT admitted	- See RTT admitted and non-admitted plans - Plans to reduce first outpatient waiting times in dental specialties should reduce the non-admitted backlog and help off-set the high admitted backlog - Admitted backlogs to be addressed across quarters 2 and 3, which should enable the Ongoing standard to be achieved if the rate of reduction is sufficiently high - Small team of temporary staff appointed to validate 'On hold' patients on Medway, which is likely to drive improvements in RTT Ongoing performance	High	Moderate
A&E Maximum waiting time 4 hours	1.0	No – performance in Q1 = 94.7%	No – ongoing risks from Q1 (although performance in Q2	- Closure of Frenchay Emergency Department, and resulting pattern of emergency flows still emerging	- Implementation of Breaking the Cycle planned for the end of August, as part of the wider Operating Model for 2014/15 - Learning and actions taken	High	Moderate

			consistently good each year)	- Ambulance arrivals in Q1 11% higher than the same period last year (circa 3% attributable to Frenchay closure) - Length of stay is below that of the same period last year, but the reductions have been insufficient to absorb the increases in the number of over 75 year old patients being admitted to the Trust	forward to support performance at the Bristol Children's Hospital in future years if there is another spike in respiratory cases (expected impact quarter 3)		
Cancer: 62-day wait for first treatment – GP Referred	1.0	No – but achieved the recovery trajectory	No	- High levels of late tertiary referrals - Surgical capacity which can only be addressed fully in Q3 once vascular service transfers - High levels of medical deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are very difficult to mitigate) - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) bed related cancellations	- Cancer Performance Improvement Group focusing on pathway redesign for high volume, lower performing, tumour sites and improving steps in the pathway for high volume causes of breaches - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work - Patients on the cancer patient tracking list continue to be actively managed and any delays escalated to Divisional Directors and Chief Operating Officer - Twentieth ITU bed in operation - Breach reallocations to be agreed with late referring providers as necessary and where possible - See also A&E 4-hour plans	High	High

				- Recovery trajectory in place for Q2, but with forecast failure for the quarter as a whole			
Cancer: 62-day wait for first treatment – Screening Referred		Yes – 90% standard expected to be achieved with breach reallocation (7 out of 7.5 breaches incurred at other providers)	Yes – transfer of Avon Breast Screening	- Following the transfer of the Avon Breast Screening Service in 2014/15 the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, although more recently performance at other providers has deteriorated - Patient choice in bowel screening pathway - Age extension to the bowel screening programme - Colorectal elective capacity not always sufficient to meet demand - High volumes of bowel screening patients needing CT colonography, for which there is a capacity constraint - Numbers of cases reported under this standard will in the future be low, due to the loss of the breast pathways, so small	- Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored - Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers - Need for additional elective capacity for colorectal surgery continuously reviewed - All CT colon scanning and reporting delays escalated	High	Moderate

				numbers of breaches may have a large impact			
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	Yes	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds) - Having enough surgical capacity to meet peaks in demand, especially for the hepatobiliary service - Unpredictably high volume of delays due to medical deferrals in some quarters	- Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons - Review of Critical Care capacity as part of the 2014/15 Operating Model - Twentieth ITU bed operational, which has helped to reduce cancellations for this reason	High	Moderate
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for subsequent treatment - subsequent radiotherapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for first definitive treatment	1.0	Yes	No – continuing from Q1	- Thoracic surgery capacity shortfall - Unpredictably higher volumes of breaches, in previous quarters, due to medical deferrals and cancellations of surgery (mainly as a result of ITU/HDU bed availability)	- Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons - Twentieth ITU bed operational, which has helped to reduce cancellations for this reason - Review of Critical Care capacity as part of the 2014/15 Operating	High	Moderate

					Model - Head & Neck pathway review action plan continues to be implemented, including work to reduce delays to dental extractions prior to radiotherapy - Continue to pro-actively manage patients on the Cancer patient tracking list		
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	1.0	Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	Yes – 1 case agreed to be avoidable (i.e. lapse in quality of care) against a limit of 10 for the quarter; this is out of a total 13 cases reported	No	- Target for 2014/15 as a whole is confirmed at 40 cases (5 more than in 2013/14), - Flat profiling of annual target continues to be imposed by Monitor - Bristol community is an outlier for antibiotic prescribing	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application has been implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a lapse in quality of care to be demonstrated to the commissioners.	Moderate	Low
Certification against compliance	1.0	Yes	No	- No significant risks	See the standard set-out in Appendix 1, which the Trust is declaring	Low	Low

with requirements regarding access to healthcare for patients with a learning disability					compliance with.		

Appendix 1 – Learning Disability Access Criteria

Criteria	Trust evidence
1. Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• The Trust has a clinical alert system which has approximately 3,000 patients registered and is managed by the learning disabilities Nurse/team. This system has proven to be an effective way of identifying known patients with learning disabilities when accessing both inpatient and outpatient services • The Trust has an informative learning disabilities internal web page which includes referral pathways and documentation tools to support assessments, implementation and reasonable adjustments. The learning disabilities risk assessment gives opportunity for staff teams to record all reasonable adjustments made against the identified needs • When individuals with learning disabilities are referred to the learning disabilities team from carers or external providers (local authority), the team is able to support pre-planned admissions and make reasonable adjustments according to identified needs. As a Trust we are able to provide multiple procedures under one general anaesthetic, bringing diverse teams together as required for treatment and/or investigations
2. Does the NHS foundation trust provide readily available and comprehensive information to patients with learning disabilities about the following criteria: - Treatment options - Complaints and procedures and - Appointments?	• The Trust has a series of `Easy Read' leaflets. Easy Read uses pictures to support the meaning of text. It can be used by a carer/staff teams in support of the decision making process regarding treatment and care • The Trust 'Easy Read' range includes: ➢ Healthcare and treatment options ➢ Consent ➢ How to contact patient support and complaints team ➢ Going into hospital and what happens ➢ Learning disabilities liaison nurse ➢ Being discharged from hospital • The Trust has various appointment letters to support individuals individual needs
3. Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• The trust has a `Welcome pack' which profiles the Trust providing a range of information around admission and orientation when visiting • The learning disabilities risk assessment has a section to identify the needs of family and carers to ensure reasonable adjustments are made for them as well

	as the individual receiving direct care • The learning disabilities team provide support to all carers identified for individuals accessing both inpatient and outpatient services and continues from preadmission through to discharge planning. • The Trust has a Carers' Strategy and Carer support worker to support the needs of carers
4. Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff?	• The Trust `essential training' programme including at Trust induction learning disabilities awareness training for non-clinical and clinical staff and includes medical staff • The LD nurse delivers custom made training to meet the needs of existing staff groups as required • Annual training events are hosted for link nurses to support their knowledge and skills in caring for patients with learning disabilities
5. Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• The Trust consults with Learning Disability user groups when strategies and Easy Read materials are in draft format for comments • The Trust provides annual training events whereby users groups attend and receive training around health needs, procedures and support systems available when accessing acute services
6. Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	• The Trust has a Learning Disabilities Strategy that informs the work plan for the Steering Group and sets the standards • Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives • The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care • The Learning Disability Steering Group reports to the Patient Experience Group

Appendix 2 – Draft declaration to Monitor for Quarter 1

Declaration of risks against healthcare targets and indicators for 2014-15 by University Hospitals Bristol

These targets and indicators are set out in the Risk Assessment Framework

Definitions can be found in Appendix A of the Risk Assessment Framework

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring under Risk Assessment Framework	Risk declared at Annual Plan	Scoring under Risk Assessment Framework	Quarter 1 Actual: Performance	Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No		91.2%	Achieved	*Achieved in each month of Q1*
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	Yes		92.8%	Not met	*Average for the quarter 93.4%; lowest month 92.8%, which reflects backlog clearance.*
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	1	92.4%	Achieved	*Achieved in each month of Q1*
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	Yes	1	94.7%	Not met	*95% standard achieved in June (95.2%).*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	Yes		81.3%	Not met	*Late referral sufficient to reach 85%, but reallocations highly unlikely to be agreed.*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	1	90.3%	Achieved	*7 of 7.5 breaches incurred at other providers. Expecting to confirm reallocation of 0.5.*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					81.3%		*Figures subject to final national reporting*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					89.7%		*7 of 7.5 breaches outside of the control of the Trust.*
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		94.9%	Achieved	*Figures subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		99.4%	Achieved	*Figures subject to final national reporting*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	97.0%	Achieved	*Figures subject to final national reporting*
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	96.7%	Achieved	*Figures subject to final national reporting*
Cancer 2 week (all cancers)	93%	1.0	No		96.6%	Achieved	*Figures subject to final national reporting*
Cancer 2 week (breast symptoms)	93%	1.0	No	0	0.0%	Not relevant	
C.Diff due to lapses in care	10	1.0	No	0	1	Achieved	*Total 13 cases reported in Q1, 12 agreed not to be lapses in care.*
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No			No	
CQC compliance action outstanding (as at time of submission)	N/A		No			No	
CQC enforcement action within last 12 months (as at time of submission)	N/A		No			No	
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No			No	
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No	
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No	
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No			No	

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A There are three targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 1. These are: the A&E 4-hour standard, the RTT Non-admitted pathways standard, the 62-day GP cancer standard.

The Trust performed at 94.7% against the A&E 4-hour standard in the period, with the 95% standard being achieved in June. During the quarter the Trust continued to experience system pressures, including an 11% increase in ambulance arrivals above the same period last year. In contrast to quarter 3 and quarter 4 of 2013/14, when overall levels of emergency admissions stayed similar to the previous year, in quarter 1 this year the rise in ambulance arrivals was associated with a 9% increase in emergency admissions. An estimated two thirds of the increase in emeregency admissions is due to the change in emergency flows following the relocation of Frenchay Emergency Department and is broadly in line with our planning assumptions. However, the remaining rise is above that forecast from the Trust and community planning assumptions, and does not appear to reflect a change in admissions practices internally. Following the success of the Breaking the Cycle Together initiative at the end of March, levels of delayed discharges have stayed low, as have the number of over 14 day stay patients. However, at any point in time there still continues to be around 50 delayed discharge patients un-necessarily occupying acute beds.

B The changing age-profile of emergency admissions, with a further 8% rise in emergency admissions for patients aged 75 years and over experienced in quarter 3 and 4 2013/14, over and above that seen in the previous winter, poses risks to achievement of the 95% standard in quarters 3 and 4, as does the still emerging pattern and scale of emergency admissions following the relocation of Frenchay Emergency Department. The Trust is planning to mitigate these system risks through the work-streams of its Operating Model, which include the greater provision of out of hospital beds, Early Supported Discharge, weekend discharging, and further iterations of the Breaking the Cycle Together initiative, the next of which is planned for August.

Due to the transfer of Head & Neck services from North Bristol NHS Trust and the associated transfer of a large number of patients with extended waits, the Trust declared in its 2013/14 Annual Plan significant risks to the Trust's achievement of the non-admitted RTT standard, with the potential risk of failure in two quarters. The 95% standard was failed in quarter 2 and 3 2013/14, but then again in quarter 4 despite backlog levels reaching a sustainable level (i.e. greater than 95% of patients on ongoing non-admitted pathways were waiting less than 18 weeks). Over the latter half of 2013/14 the Trust has seen a significant increase in GP referrals, especially in capacity constrained specialties such as dental specialties and dermatology, the latter reflecting lack of adequate service provision in other parts of the community. The Trust has therefore implemented a plan of reduce waiting times for first outpatient appointments

C which has required significant additional capacity, especially in Dental specialties. The recovery plan runs over quarters 1 and 2 of 2014/15, during which the 95% standard will not be achieved as a result of backlog clearance. Further work is being undertaken to support the national initiative to reduce admitted RTT backlogs throughout Quarter 2, and at this stage a planned failure is predicted for July and August (only).

The 62-day GP cancer standard was failed in quarter 4, due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice). A programme of work on improving cancer pathways has continued into 2014/15, focusing on both further minimising internal causes of breaches, but also on working with other providers to reduce late referrals. The Board therefore declared a risk against this standard in quarter 1 and 2. Although the 85% standard was not achieved in quarter 1, performance was well above the recovery trajectory. During quarter 2 the Avon Breast Screening service transfers to North Bristol Trust. As a result the majority of 62-day breast screening pathways will no longer be shared with other providers; a small number of radiotherapy and chemotherapy treatments will still be undertaken in the Trust's Haematology & Oncology Centre. The remaining number of pathways reported by the Trust will be small, and therefore a small variation in the number of breaches will result in large fluctuations in performance. The Trust is continuing to take actions to mitigate pathway delays for remaining 62-day pathways (bowel and cervical cancers)

University Hospitals Bristol NHS
NHS Foundation Trust

For consideration and approval by

Finance Committee	28th July 2014 – Agenda Item 8
Trust Board	30th July 2014 – Agenda Item 21

QUARTER 1 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
July 2014

1. EXECUTIVE SUMMARY

This commentary covers the results for the quarter ending 30th June 2014. The Trust reports an EBITDA[1] surplus of £8.781m. This is £0.561m lower than the Annual Plan projection to date of £9.342m. The summary income and expenditure statement shows a surplus for the period of £2.276m (EBITDA and financing costs). The Continuity of Service Risk rating is 4 (actual 4.0).

	2013/14	June 2014	Plan 2014/15
Liquidity			
Metric Performance	2.71	7.35	2.53
Rating	4	4	4
Capital Service Capacity			
Metric Performance	3.04	2.88	2.51
Rating	4	4	4
Overall Rating	**4**	**4**	**4**

4	3	2	1
0	**(7)**	**(14)**	**<(14)**
2.5	**1.75**	**1.25**	**<1.25**

The financial plan for the year is a £5.800m income and expenditure surplus before technical items.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. NHS CLINICAL INCOME

NHS Clinical income is £2.248m lower than the Monitor Annual Plan, standing at £114.727m for the quarter. NHS Clinical income includes income from NHS commissioners and territorial bodies.

The variance for the quarter is explained in table 1 below:

Table 1 – Clinical Income – Quarter 1 - Variance from Plan

	£m
Monitor Plan	116.975
Under Performance (See Table 2 Below)	(2.248)
Quarter To Date Income	114.727

Activity and Income by Worktype

Performance against the current plan for the quarter is summarised below by worktype.

i. Elective Inpatients

Overall Elective Inpatients are £0.447m behind plan. Current temporary capacity restrictions as a result of construction work are impacting Cardiology activity volumes, offset by some over performing areas including Paediatric Surgery and Upper Gastrointestinal Surgery.

ii. Non-Elective / Emergency Inpatients

Non-Elective Inpatients are £2.432m behind plan for the quarter. The key driver of this is the transfer of Maternity Delivery activity into the Pathway work type which appears as part of Other NHS Income. There is also an underperformance in General Medicine / Geriatrics / Hepatology.

iii. Day Cases

Day Cases are £0.164m behind plan for the quarter. Cardiology performance is restricted due to temporary capacity restrictions as a result of construction work.

iv. Outpatients

Outpatient activity has under-performed by £1.193m; this is most largely driven by Genito-urinary Medicine activity transferring from NHS commissioners to local authorities, which appears under other Non-mandatory/Non Protected Clinical Revenue. There is also a general short term under performance against paediatric specialties following the transfer of specialised paediatric services from North Bristol Trust on 6/7th May.

v. Accident and Emergency

A&E has over-performed by £0.007m against plan.

vi. Other NHS

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, PbR Excluded Drugs & Devices, Contract Penalties, CQUINs and specialised services such as Bone Marrow Transplants. This category is £1.980m ahead of plan for the quarter, the most significant element of this is the transfer of Maternity delivery Pathway activity from other work types, although there is also an anticipated under performance against CQUIN plan and for contract penalties. CQUIN targets are more challenging this year.

Table 2 – NHS Clinical Income by Worktype

Worktype	Plan £m	Actual £m	Variance £m
Elective Inpatient	12.297	11.850	(0.447)
Day Case	8.680	8.516	(0.164)
Non-Elective Inpatient	24.257	21.825	(2.432)
Outpatient	17.883	16.690	(1.193)
Accident & Emergency	3.390	3.397	0.007
Other NHS	50.468	52.448	1.980
Totals	116.975	114.727	(2.248)

Over Performance by Commissioner

During the Local Delivery Plan process the Trust agreed to reduce Service Level Agreement values for demand management schemes put forward by Clinical Commissioning Groups that the Trust believed were over optimistic. Because the Trust did not expect these activity reductions to materialise the clinical income budgets were not reduced, and an income budget was created for a dummy commissioner - Variable Estimates. Table 3 below shows the cumulative income variances by commissioner and how the Variable Estimates income target then adjusts this for the overall position.

Table 3 Performance by Commissioner

Commissioner	Variance £'m	Variance %
NHS Bristol	(3.434)	(8.59)
NHS North Somerset	(1.470)	(13.58)
NHS South Gloucestershire	(1.041)	(14.07)
NHS Bath & NE Somerset	(0.523)	(20.21)
NHS Somerset	(0.173)	(8.67)
NHS Gloucestershire	(0.137)	(10.95)
NHS England	1.780	3.64
Other	1.443	22.87
Variable Estimates	1.302	57.37
Totals	(2.252)	(1.93)

Non Mandatory/Non Protected Revenue

Private Patient Revenue

Private Patient Revenue has under-performed by £0.291m for the quarter.

Other Clinical Revenue

Other Clinical Revenue is over-performing by £1.036m mainly due to over performance of non patient care services, distinction awards and sales of goods and services.

3. OTHER OPERATING INCOME

Overall other income is £1.085m higher than planned for the quarter. The main reasons are:

- Higher than planned income from the Trust's Research and Development CLRN contract £0.076m; and
- Higher than planned other income £0.975m. This includes higher than planned income for distinction awards, sales of goods and services, and charges for non patient care services.

4. EXPENDITURE

Overall operating costs of £130.190m for the quarter are £0.105m higher than plan. Trust pay costs are £0.132 m higher than plan and non pay costs are £0.027m lower than plan.

4.1 Pay Costs

Pay costs at £82.15m for the quarter were £0.132m, higher than plan due to lower than planned CIP delivery and higher than planned spend on agency staff offset by lower than planned spend on permanent staff and vacancies.

4.2 Drugs

Drug costs of £14.878m are £0.407m lower than plan for the quarter.

4.3 Clinical supplies and services

Clinical supplies and services costs at £14.084m for the quarter were £0.317m lower than plan mainly due to volume.

4.4 Other Operating Expenses including non clinical supplies

Other costs were £0.697m higher than plan. This is due mainly to lower than expected savings delivery and higher than planned spend on premises and fixed plant.

4.5 Depreciation

Depreciation charges at £4.397m were marginally lower than the Annual Plan projection of £4.412m for the quarter.

4.6 Impairment Losses

The Annual Plan provides for an impairment loss of £2m in the first quarter in respect of the Helipad incorporated within the BRI Phase III Redevelopment. An assessment, after consultation with the Trust's External Auditor, of the impairment charge will be made later in the year together with a number of other significant BRI Redevelopment schemes.

4.7 Non Operating Expenses

There are no significant variances within this section.

5. CAPITAL

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in April. At that stage expenditure for the year was projected to be £57.621m with expenditure for the first quarter of £16.811m. Actual expenditure at £17.195m equates to 102.3% of the Annual Plan projection.

The table provided below shows a comparison of the Trust's current plan with actual expenditure to date.

	Quarter ending 30th June 2014		
	Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000
Sources of Funding			
Donations	1,500	1,520	20
Retained Depreciation	4,624	4,498	(126)
Prudential Borrowing	20,000	20,000	-
Sale of Assets	-	70	70
Cash balances	(9,313)	(8,893)	420
Total Funding	**16,811**	**17,195**	**384**
Expenditure			
Strategic Schemes	(13,084)	(13,488)	(404)
Medical Equipment	(1,349)	(848)	501
Information Technology	(681)	(1,439)	(758)
Roll Over Schemes	(257)	(165)	92
Operational / Other	(1,440)	(1,255)	185
Total Expenditure	**(16,811)**	**(17,195)**	**(384)**

6. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £400.960m at the end of June is £2.603m higher than plan. This mainly reflects higher opening figures at 1 April than planned.

6.2 Inventories (formerly referred to as Stock)

At the end of June the value of inventories held totalled £10.829m. This is £1.771m higher than planned due to stock increases for services transferred from North Bristol NHS Trust and short-term increases for cardiac catheterisation and Pharmacy.

6.3 Current Tax Receivables

The balance of £1.851m at the end of June represents moneys owed to from Trust by the HMRC for additional VAT that is recoverable under legislation. These moneys will be received in July or in the case of those recoverable under the BRI redevelopment scheme at the end of the build project.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance of trade and other receivables at the end of June at £17.186m is £10.164m higher than plan due to quarterly invoices recently having been issued. Moneys owed to the Trust but not yet invoiced, are shown as Accrued Income and this is currently £0.722m which is £7.063m lower than the plan figure. The Trust continues seeking to reduce the amount of money owed to the Trust. The invoiced debtor balance at 30th June equates to 12.9 debtor days.

6.5 Prepayments

The prepayment balance at the end of June is £3.494m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is higher than the plan of £ 2.882m.

6.6 Non Current Assets held for Sale

This item relates to the sale proceeds for the disposal of the Kingsdown Garage site. The Trust completed the disposal of this asset in July 2014.

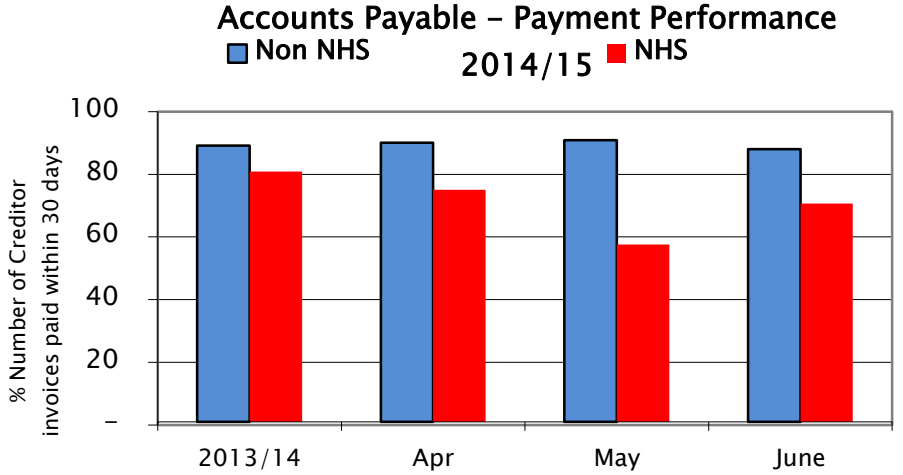
6.7 Deferred Income

Deferred income of £2.693m is £0.146m lower than the plan of £2.547m. This relates mainly to research money.

6.8 Trade Creditors / Other Creditors / Capital Creditors

Trade, Other and Capital Creditors total £26.755 m at the end of June. This is £6.538m above the plan projection of £20.217m.

The Trust aims to pay at least 90% of undisputed invoices within 30 days. For Quarter 1 of 2014/15 the Trust achieved 66% (83% by value) and 90% (83% by value) compliance against the Better Payment Practice Code for NHS and Non NHS creditors respectively.



6.9 Other Financial Liabilities

The closing balance for accruals at £34.430m is £12.037m higher than the plan of £22.403m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the quarter end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th June together with comparative information taken from the Trust's Annual Plan.

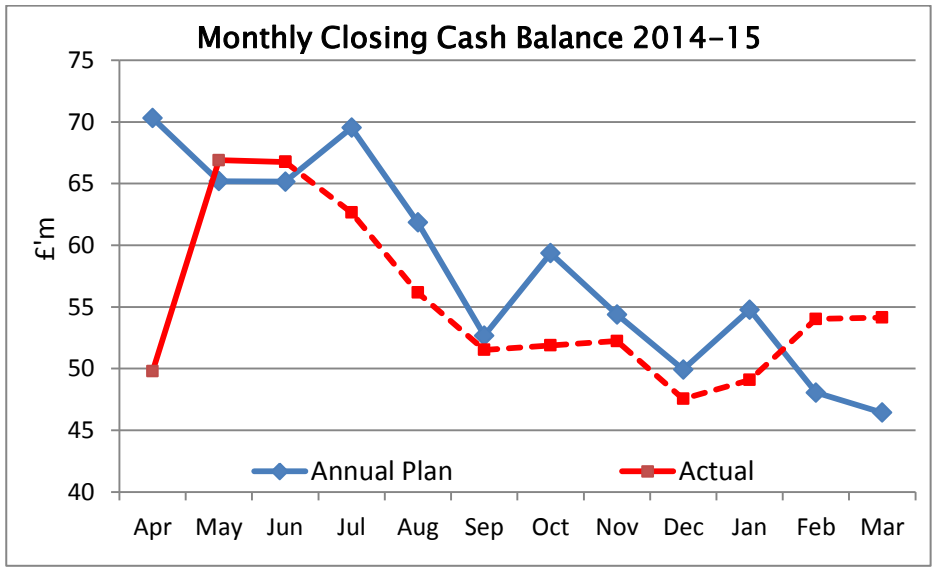
Summary Statement of Financial Position

	Position as at 30th June 2014		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current assets			
Intangible	8,107	6,800	(1,307)
Property, Plant and Equipment	390,250	394,160	3,910
Non current assets total	**398,357**	**400,960**	**2,603**
Current assets			
Inventories	9,058	10,829	1,771
Current Tax Receivables	680	1,851	1,171
Trade and Other Receivables	7,022	17,186	10,164
Other Financial Assets	7,995	826	(7,169)
Prepayments	2,882	3,494	612
Cash & Cash Equivalents	63,923	66,874	2,951
Non Current Assets held for sale	0	700	700
Current assets total	**91,560**	**101,760**	**10,200**
ASSETS TOTALS	**489,917**	**502,720**	**12,803**
Current Liabilities			
Loans	(3,115)	(3,713)	(598)
Deferred Income	(2,547)	(2,693)	(146)
Provisions	(250)	(139)	111
Current Tax Payables	(6,500)	(6,479)	21
Trade and Other Payables	(20,217)	(26,755)	(6,538)
Other Financial Liabilities	(22,403)	(34,440)	(12,037)
Other Liabilities	(5,500)	(5,385)	115
Current liabilities total	**(60,532)**	**(79,604)**	**(19,072)**
NET CURRENT ASSETS/(LIABILITIES)	**31,028**	**22,156**	**(8,872)**

	Position as at 30th June 2014		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current liabilities			
Loans	(91,575)	(90,976)	599
Provisions	(182)	(177)	5
Finance Leases	(5,519)	(5,493)	26
Non current liabilities total	**(97,276)**	**(96,646)**	**630**
TOTAL ASSETS EMPLOYED	**332,109**	**326,470**	**(5,639)**
Taxpayers' and Others' Equity			
Public Dividend Capital	193,480	191,501	(1,979)
Retained Earnings	81,735	81,944	209
Revaluation Reserve	56,809	52,940	(3,869)
Other Reserves	85	85	-
TAXPAYERS' EQUITY TOTALS	**332,109**	**326,470**	**(5,639)**

7. Cash and Cash Flow

The Trust held cash balances at the end of June of £66.874m. This is £2.951m more than the Annual Plan projection of £63.923m. The graph shown below provides a comparison of actual and projected month-end cash balances for 2014/15.



University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

21. Board Assurance Framework – Quarter 1 Update

Purpose

To provide the Board with the quarterly update of progress against the Trust's objectives at the end of Quarter 1 and to provide assurance of the control of any associated risks to delivery.

Abstract

The purpose of the Board Assurance Framework is to track progress against the Trust's stated medium term objectives and specifically to track progress against the annual milestones which were derived as part of the 2014/15 annual planning cycle. It is a major source of assurance to the Board, that the Trust is on track to meet its strategic objectives.

Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

Following a re-fresh of the Trust's Strategy, the Strategic Objectives have been revised to reflect the agreed vision for the Trust and the objectives that underpin its delivery. The annual milestones reflect the progress required in the current year to ensure delivery of the strategic objective.

Risks to delivery arising from known risks are referenced through the BAF to their entry on the Corporate Risk Register (CRR). Predicted failure to achieve one or more objectives within the BAF is also recorded as a risk in its own right, on the CRR.

Quarter 1 Position

There is one objective where the inherent risk to delivery is considered high and is therefore RED rated. These are:

- To deliver the annual Cash Releasing Efficiency Savings programme in line with the LTFP requirements.

There are 37 objectives where delivery is forecast therefore with a residual rating of GREEN and 7 AMBER rated objectives.

Finally, following discussion at Risk Management Group (RMG) it has been agreed that the Board Assurance Framework should note the date that the objective was last reviewed by the named monitoring group, to provide evidence and further assurance that the objective is being actively managed. This will be instigated from Quarter 2 report.

Recommendations

The Board is asked to receive the report **for assurance**

Report Sponsor
Chief Executive
Appendices
• Board Assurance Framework Quarter 1 Update

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
	16th July 2014				Risk Management Group – 9th July 2014

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		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 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	25%-50%	First steps towards the delivery of these actions have been delivered but not at the pace required in many cases. These will now be pulled together in overarching themes - protected pathways, discharge processes, Out of Hospital Care and Breaking the Cycle Follow up.	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
		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 Develop action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners.	50% - 75%	Final agreement with commissioners reached with exception of two areas (endocrinology services and e-prescribing of chemotherapy). Action plan in hand to address.	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
		Deliver a programme designed to enhance compassion in clinical staff	Review values training to incl. evaluation of impact on behaviours 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	25% - 50%	Scoping of process/content/outcomes of what compassionate care programme would look like complete/action plan to deliver complete Work on training material commenced. Values based recruitment commenced for NA's - feedback positive from participants and assessors. RN/medical values based recruitment in planning stages	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
		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. Deliver the complaints annual work plan, which includes learning from Francis/Clywd Hart	25% - 50%	Case for increased resources approved May 2013. Three new posts are currently being recruited to. Progress with delivery of some actions in complaints work plan has been affected by backlog of enquiries to Patient Support and Complaints Team, however all actions will be delivered and progress is regularly reviewed by the Head of Quality (Patient Experience and Clinical Effectiveness) and the Patient Experience Group.	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
		To address existing shortcomings in the quality of care and exceed national standards in areas where	Deliver the stretch and quality improvements as per 14/15 CQUIN schedule	0% - 25%	CQUIN. Specialist CQUINs have been agreed and baselines set in the majority of cases. Local CQUINs have not	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	delivery against annual quality objectives reviewed monthly via Flow Group			CN	Clinical Quality Group

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 consistently deliver high quality individual care, delivered with compassion.	national standards in areas where the Trust is performing well.	Deliver all annual quality objectives described in the Trust's quality report		set in the majority of cases. Local CQUINs have not yet been finalised. Corporate quality objectives. Four objectives have been agreed which will be delivered through the Trust's Transformation Programme: reducing cancelled operations, ensuring no discharges out of hours, reducing inpatient moves and ensuring patients are treated on the right ward for their condition. During Q1, metrics for these objectives have been agreed and baseline data is being gathered. Last minute cancelled operations in YTD is above national standard (0.8%). 1,610 ward outlier bed days YTD. Out of hours discharges in YTD 9.2% (YTD = end of May). The fifth objective is to review and refresh the Trust's approach to patient and public partnership. Q1 progress – 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.	ownership of delivery?.	delivery of CQUIN monitored via SLT, robust monitoring of annual quality objectives, delivery of flow projects.	monthly via Flow Group, CQC and Trust Board.				
		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 Explore options for increasing monthly response rate to meet increased national targets	25% - 50%	OPD / day case methodology has yet to be released by NHS England (had been due in June). Monthly response rates for inpatient and ED FFT using paper-based solutions are already exceeding national targets. Action plan in place to improve response rates for maternity FFT. Ongoing exploration of potential for targeted use of new technologies to further improve uptake. Plans to provide monthly A3 posters for each ward displaying its FFT performance.	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
		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	0% - 25%	Standards remain in draft form	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 Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities	0% - 25%	Initial engagement with Eleanor Grey QC in hand. Stock take of compliance with standards and prior recommendations underway and held through Risk Oversight Group. Programme Manager appointed to start early July to lead work. Proactive media continues.	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
		To achieve upper quartile performance standards for all nationally benchmarked patient safety measures	Monitor performance and take corrective action when appropriate. Review Patient Safety Group function within Trust governance apparatus.	25% - 50%	Patient safety group function review planned.	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 Patient Safety Group				MD	Senior Leadership Team
2		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	25%-50%	Helideck operational May 2014. Level 5 handed over June 2014. Progress is monitored by the BRI Redevelopment Board; progress remains on track for delivery.	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

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 ensure a safe, friendly and modern environment for our patients and our staff	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	50%-75%	Key elements of Major Incident and Business Continuity issues identified in the internal and external audits have been addressed. Remaining outstanding issue is Board paper to be presented June 2014. Ongoing updates of plan remain on track for Q2 and Q4 delivery.	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	0% - 25%	Estates Strategy approved by Board and work to develop Outlines Business Case now underway and on track for consideration by Board in Autumn. Process to evaluate priorities for residual estate yet to commence but planning in hand.	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	75% - 100%	On target to deliver expectations 1,3,7,8 by end of June Board report re staffing scheduled for June Board Boards in place outside ward displaying staffing information as per national guidance Trust website gone live displaying staffing information/linked to NHS choices Detailed report of planned and actual staffing levels to be reviewed by workforce steering group monthly from July	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	0% - 25%	A detailed programme of work is underway. Delivery is supported by a cross-Trust working group.	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	25% - 50%	Action plan developed - to be considered at the next Health and Safety Committee.	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 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.	0% - 25%	Broader definition of who is a leader - to pick up front-line supervisors under discussion. New style leaders forum to be developed. Workforce and Organisational Development Strategy to be considered by Senior Leadership Team and Trust Board over the next few months.	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
		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 Revise the priorities in line with the draft strategic vision for UH Bristol To provide a revised Teaching & Learning Strategy in March 2015	25% - 50%	Review of UH Bristol's approach to Education, Teaching and Learning underway, including governance arrangements.	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

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
4	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	Phase 2 Implementation Phase 3 Design	50%-75%	Programme in hand and will be implemented by the year end. Phase 3 ongoing progress.	IT implementations are inherently high but with adequate mitigation.	Proper programme monitoring and management processes will manage the risks through the IM&T Committee and CSIP Committee.	IM&T Committee and CSIP Committee			DoF	Information Management and Technology Committee
		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 (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.	25% - 50%	a) Progress is being maintained and performance in quarter 4 was good. 75-100% on this element of the objective. b) Progress on track to deliver by 31/3/15 - 0-25%. c) on track - 0-25% d) Well on track; information provided via TRG; 50-75% e) Discussions ongoing with clinical divisions; 0-25%.	(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
		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. (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.	0% - 25%	a) and b) - new post banded and approved.	(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
		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 (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)	0% to 25%	a) rolling programme of review just initiated Work ongoing.	(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
		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	50%-75%	Scope and aims of each project have been approved by Transformation Board, and teams have been mobilised against each	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	25% - 50%	Detailed project plans in place for some, to be completed by early July, enable tracking reporting and intervention by exception	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	25% - 50%	Each project to have clear near term milestones to get actions underway and to build momentum	Do not act with pace	Transformation Board to hold to account for delivery	Progress updates to Trust Board			COO	Transformation Board
5	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	UH Bristol to be represented at BFC meetings and provide steer on changes to the services we provide Model any impact on UH Bristol services from proposed changes to models of care developed through the BCF Programme	25%-50%	Initial outline plan has been delivered by Bristol CCG and Bristol City Council with minimal involvement from stakeholders. COO or nominated deputy will sit on the steering group to ensure UH Bristol is involved/informed of the plans as they develop.	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
		We will effectively host the Operational Delivery Networks that we are responsible for.	Establish governance arrangements for both Critical Care Networks.	25% - 50%	Clinical Directors appointed for both 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.	25% - 50%	Trust input to BHP at Board level active.	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

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 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	0% - 25%	CRN Host governance meetings established.	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	50%-75%	SLA signed in line with Heads of Terms	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	50%-75%	Q2 13/14 published	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	75%-100%	Trust remains on target to meet objective this year.	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	75%-100%	As at 15th April 2014 77% of the 2014/15 target has been identified on a risk assessed basis The Trust has a savings target for 2014/15 of £20.760m the current identified plans amount to £15.97m. It is imperative that new savings schemes are implemented urgently in order to improve this percentage. At the present time there is little assurance that the Trust will achieve the target set for this financial year. hence the red RAG rating. Within the forecast outturn of £15.797m there remains non recurring savings identified of £2,680m. The Trust also operates a pipeline system under which schemes that have not reached sufficient maturity to be included in the official plan are held until the schemes have robust plans and are deemed to be deliverable. As at 15th April 2014 the value associated with these schemes was £6.693m	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	75% - 100%	Plan approved by Board in June.	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.	0% - 25%	Clinical Strategy Group leading work and reporting to SLT. Board Seminar on Weston and appraisal of risks and benefits commenced. Board discussion planned for July meeting.	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	25% - 50%	PP Steering Group supported proposal to develop PP visual identity Scheme for front door is all agreed with the exception of confirmation of the visual identity but is ready to progress once this has been approved	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. Interim Deputy Chief Operating Officer to be recruited whilst substantive position recruited.	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	50%-75%	Financial Risk Rating of 4 to Month 12 2013/14	Delivery of CRES plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.			DoF	Finance Committee
		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.	0%-25%	Work underway to consult on options for future team structure. Aim to commence recruitment following appointment	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

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 ensure we are soundly governed and are compliant with the requirements of our regulators		To review effectiveness of Board sub-committees including approach to workforce governance	0%-25%	Incorporated in Trust Secretary work programme but work yet to commence in earnest.	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.	0%-25%	Incorporated in Trust Secretary work programme but work yet to commence in earnest.	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	0%-25%	Incorporated in Trust Secretary work programme, QGAF assessment prioritised and in hand.	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.	25% - 50%	Draft action plan completed and reviewed by SLT. To be finalised with Board. Draft communications plan completed. To be reviewed by CQC inspection working group. CQC project manager appointed as internal secondment, commencing mid-July. 'Breaking the Cycle' week agreed for w/c 4th August. Work ongoing as per agreed preparation and coms action plans Fortnightly steering group established	No risks at the moment.	not applicable	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
		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	75%-100%	Completed	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.	75%-100%	Completed	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	25% - 50%	Draft report received from IST and draft action plan in development Weekly monitoring in place and variance from plan being reviewed via the RTT Operational Group. Further work on data quality of the first outpatient waiting list has been completed with ability to flag RTT / non-RTT pathways introduced to support PTL Management.	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	25% - 50%	Cancer Performance Improvement Group TOR has been approved and group is meeting fortnightly to track progress against plan. SNH are assessing options for extended days to support increased capacity for Thoracic ahead of the current target date of October. Performance for 62 day cancer is on track against trajectory.	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									

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

22. Corporate Risk Register

Purpose

The Corporate Risk Register contains risks identified as having a potential impact on corporate objectives, including any risks escalated by the divisions.

Escalated risks from divisions may be reassessed against corporate objectives.

The Corporate Risk Register was considered by the Senior Leadership Team on 16 July 2014 and any risks recommended by a division for either inclusion or removal from the register were formally approved at that meeting.

This report provides details of all amendments to the Corporate Risk Register since the previous report submitted to the Trust Board in April 2014.

Abstract

New Corporate Risks:

- 1704 - Corridor Queue Outside The Emergency Department
- 2126 - Reputational Damage Arising From Adverse Media Coverage of Trust Activities
- 2579 - Risk of cancelled operations and failure to achieve cancer pathway standards
- 2647 - Risk of untimely resolution of complaints (May 2014)
- 2664 - Risk of reputational damage to paediatric cardiac services

Risks De-escalated to Divisions

- 1977 – Lack of Capacity on NICU (Women's and Children's)
- 2647 – Risk of untimely resolution of complaints (July 2014) (Trust Services)

Risks Closed

- 2476 - Operational Readiness of Helideck

NOTE: This abstract has been completed using the format of submissions to previous Quality & Outcomes Committee meetings. It is intended that the nature and content of this report will be reviewed prior to the next Risk Management Group meeting in October 2014.

Recommendations

The Board is recommended to receive the report for assurance

Report Sponsor

Chief Executive

Appendices

- Corporate Risk Register

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
	16/07/2014	25/05/2014			Risk Management Group 09/07/2014

Corporate Risk Register 22/07/2014

Number	Risk Title	Executive Lead	Risk Rating
741	Cash Releasing Efficiency Savings (CRES) Schemes	Chief Operating Officer - James Rimmer	Very High (Red)
1704	Corridor Queue Outside The Emergency Department	Chief Operating Officer - James Rimmer	Very High (Red)
2126	Reputational Damage Arising From Adverse Media Coverage of Trust Activities	Director Of Strategic Development - Deborah Lee	Very High (Red)
2344	Risk To Achievement of Strategic Objectives	Director Of Strategic Development - Deborah Lee	High (Amber)
2479	Performance Risk to Monitor Green Rating	Chief Operating Officer - James Rimmer	Very High (Red)
2579	Risk of cancelled operations and failure to achieve cancer pathway standards	Medical Director - Sean O'Kelly	High (Amber)
2664	Risk of reputational damage to paediatric cardiac services arising from the independent review of the service	Medical Director - Sean O'Kelly	Very High (Red)

Corporate Risk Register Report

Risk Number: 741 ***Status:*** Action Required ***Date:*** 01/09/2006 ***Risk Title:*** Cash Releasing Efficiency Savings (CRES) Schemes

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Financial	Programme Steering Group	Dean Bodill	James Rimmer	Chief Operating Officer - James Rimmer	25/06/2012	10/01/2015	16 Very High (Red)	1 Low (Green)

BAF Reference and details of strategic objective:

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

Risk Description	Details of Control or Assurance	Effectiveness
Risk of Plans under achieving and impacting on trust annual and planned outturn. Savings are not identified, are duplicated or double counted, slippage in delivery, activity growth consumes benefit, in year costs pressure or competing priorities eliminate gains.	Monthly Divisional CRES reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CRES Programme Steering Group, monthly updated at a glance reports	High
	Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed	High
This risk is also reflected in divisional risks 1912, 1420 and 1021 .	Divisional control of vacancies and procurement monitored at monthly performance meetings. Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery.	Medium
	Regular Reporting to the Finance Committee and Trust Board	High

Action Plan for Risk: 741 ***Action Number:*** 8 ***Responsibility Of:*** ***Target date:*** / /

No Actions

Corporate Risk Register Report

Risk Number: 1704 ***Status:*** Action Required ***Date:*** 05/11/2010 ***Risk Title:*** Corridor Queue Outside The Emergency Department

Domain	*Monitoring Group*	*Risk Assessor*	*Risk Owner*	*Executive Lead*	*Assessment Date*	*Next Review Due:*	*Current Risk Rating*	*Target Risk Rating*
Patient Safety	Senior Leadership Team	Janice Sutton	Peter Collins	Chief Operating Officer - James Rimmer	22/07/2014	20/10/2014	16 Very High (Red)	9 High (Amber)

BAF Reference and details of strategic objective:

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

Risk Description	*Details of Control or Assurance*	*Effectiveness*
At regular intervals patients on ambulance trolleys are queuing in the corridor outside of the E.D due to department at full capacity. Condition of these patients is not known and there is a risk of patient deterioration and/or collapse.	Allocation of emergency department (ED) nurse to corridor patients to triage and prioritise admission to ED as space becomes available. Assistant nurse who completes vital signs and a pain score within 15 minutes of all ambulance arrivals	Medium
Patients can wait up to two hours without assessment, treatment or care. The frequency of ambulance conveyances is variable and not always within the receiving Trusts control. There is a lack of availability of oxygen, suction, of privacy and dignity	Formal escalation policy for ED when pressure rises. Try to restrict number of patients queuing to 3 by triggering internal escalation plans.	Medium
	Supplementary oxygen from portable cylinders and Portable suction from ambulances or from ED resuscitation room.	Medium
Patient experience is also compromised from being unwell in public area, and having to discuss confidential information in a public thoroughfare.	If possible keep cubicle space free in Ed to use as rolling cubicle for toileting, undressing of patients etc.	Medium
Patient may not have basic needs met and may be at an increased risk of developing pressure damage.	Ambulance crews to monitor patients vital sign and pain control as per own protocol or if needed on a more regular basis as guided by the ED shift coordinator. All vital signs need to be reported to the ED shift coordinator Prioritise patients and off load when ED capacity available	Medium
Breeches, late bed requests, inadequate prioritising, Longer treatment period required, Additional treatment required, Patient suffers for longer than is necessary.	Pressure area care by ambulance crews, if this is part of their remit. Can advise patients to change position in some instances	Low
Delay to ambulance crew.	ED notes of these patients kept with the ED shift coordinator. Patients in corridor identified in this way on the tracking system. Put queuing patient id no on shift coordinators sheet. Ensure the CSMs are aware of patients queuing	Medium
	When capacity becomes available it will be used for the patient of highest priority	Medium
	RATTing protocol in place	Medium
	Night Duty Pool Nurse allocated each night to attend ED within 15 minutes to nurse the first 3 patients in the queue.	Medium

Action Plan for Risk: 1704 ***Action Number:*** 13 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

SH&N BTCT action plan - Escalation - define clear expectations of the issues to be escalated (based on the safer bundle and checklist) and clear routes for escalation between patient flow, ward

sisters, matrons and silver.

Action Plan for Risk: 1704 ***Action Number:*** 14 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

SH&N BTCT action plan - Checklist, Confirm daily checklist, Allocation it's completion as part of the patient flow role, as part of daily tasks.

Action Plan for Risk: 1704 ***Action Number:*** 15 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

SH&N BTCT action plan - Reporting, monitoring and measurement - Divisional scorecard requirements to be agreed with IM&T; Senior review, Senior nurse on ward round, EDD and reverse triage completed, Discharges before 12, TTAs commenced the day before discharge, TTAs completed before 12, Theatre start times, Number of patients in recovery overnight, Number of over 14 day LOS patients, Social worker allocated within 2 working days of a section 2.

Action Plan for Risk: 1704 ***Action Number:*** 18 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

SH&N BTCT action plan - Bronze team and escalation - Ward sister / nurse in charge role to be clearly defined and rolled out. Matron - duty matron role for surgery to be clearly defined - including interaction with patient flow, CSM & discharge team.

Action Plan for Risk: 1704 ***Action Number:*** 19 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

Redefine patient flow Patient flow role and those on the rota. Rota to be increased.

Action Plan for Risk: 1704 ***Action Number:*** 20 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

SH&N BTCT action plan- Silver command - ADH, LG, JP, Sn & RG on rota to be agreed. Role to be defined.

Action Plan for Risk: 1704 ***Action Number:*** 21 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/05/2014

SH&N BTCT action plan - Divisional workshop/briefing to be set up to roll out new escalation process. Divisional meeting to be arranged with all WLO, Matrons, sisters and consultants.

Action Plan for Risk: 1704 ***Action Number:*** 12 ***Responsibility Of:*** Janice Sutton ***Target date:*** 31/07/2014

To support management of ambulance delays, divisions to ensure a nurse is identified from each division to provide support for the ambulance queue if the SWASFT SOP in enacted. This list is managed via the CSM team.

Action Plan for Risk: 1704 ***Action Number:*** 24 ***Responsibility Of:*** Bernadette Greenan ***Target date:*** 25/08/2014

Matrons and CSMs to in still operational discipline to ensure beds are vacated earlier in the day and 5 beds are vacant on MAU at 5pm each day

Action Plan for Risk: 1704 ***Action Number:*** 22 ***Responsibility Of:*** Emma Redfern ***Target date:*** 30/09/2014

SHINE project In ED - Patient Safety Check list to ensure all patients receive the same level of observation and assessment.

Action Plan for Risk: 1704 ***Action Number:*** 10 ***Responsibility Of:*** James Rimmer ***Target date:*** 30/09/2014

New Operating Model for 2014/15 been developed to improve patient flow and reduce likelihood of ambulance delays. Progress being monitored via Senior Leadership Team.

Action Plan for Risk: 1704 ***Action Number:*** 23 ***Responsibility Of:*** Richard Jeavons ***Target date:*** 30/09/2014

Additional ED Consultants business case to provide extended cover in ED awaiting approval.

Action Plan for Risk: 1704 ***Action Number:*** 17 ***Responsibility Of:*** Rowena Green ***Target date:*** 31/10/2014

Senior review - Gap analysis undertaken per all spec. identified areas to address are;
ENT, T&O, Vascular. Vascular has senior review with registrar. Transfer out will address issue with consultant cover. T&O options to increase consultant led presence being addressed through job planning
Escalation of Failure in other areas to be undertaken through agreed routes.

Risk Number: 2126 ***Status:*** Accepted ***Date:*** 03/06/2013 ***Risk Title:*** Reputational Damage Arising From Adverse Media Coverage of Trust Activities

Domain	*Monitoring Group*	*Risk Assessor*	*Risk Owner*	*Executive Lead*	*Assessment Date*	*Next Review Due:*	*Current Risk Rating*	*Target Risk Rating*
Reputational	Senior Leadership Team	Fiona Reid	Deborah Lee	Director Of Strategic Development - Deborah Lee	22/04/2014	27/04/2014	15 Very High (Red)	2 Low (Green)

BAF Reference and details of strategic objective:

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

Risk Description	*Details of Control or Assurance*	*Effectiveness*
Risk of reputational damage arising from adverse media coverage of Trust actiivties	Pro-active monitoring of forthcoming inquests, robust inquest preparation including pro-active & reactive communication and media management as considered appropriate.	Medium

Action Plan for Risk: 2126 ***Action Number:*** 1 ***Responsibility Of:*** Deborah Lee ***Target date:*** 30/04/2014

Identify Trust actiivties at risk of attracting adverse media and ensure proactive management and mitigation of these risks and associated supporting communications

Corporate Risk Register Report

Risk Number: 2344 **Status:** Accepted **Date:** 08/01/2014 **Risk Title:** Risk To Achievement of Strategic Objectives

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Business	Senior Leadership Team	Deborah Lee	Deborah Lee	Director Of Strategic Development - Deborah Lee	08/01/2014	18/07/2014	9 High (Amber)	2 Low (Green)

BAF Reference and details of strategic objective:

Achieve Full Compliance with Health & Safety Requirements / Achievement of CRES / Compliance with EUWTD / Compliance with CQC Standards / Maintain GREEN Monitor Risk Rating

Risk Description

Risk of failure to achieve one or more strategic objectives within the Board Assurance Framework.
1. We will consistently deliver high quality individual care, delivered with compassion.
2. We will ensure a safe, friendly and modern environment for our patients and our staff
3. We will strive to employ the best and help all our staff fulfil their individual potential.
4. We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
5. We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.
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
7. We will ensure we are soundly governed and are compliant with the requirements of our regulators

Details of Control or Assurance ***Effectiveness***

Executive Director ownership and accountability for each stratgeic objective with responsibility for ensuring delivery and devloping remedial action plans where necessary — Medium

Action Plan for Risk: 2344 ***Action Number:*** 1 ***Responsibility Of:*** Exec Team ***Target date:*** 30/04/2014

Recovery plans for each high risk objectve to be developed alongside risk assessment of impact of non-achievement with approriate risk management and mitigation plans developed.

Corporate Risk Register Report

Risk Number: 2479 ***Status:*** Action Required ***Date:*** 05/03/2014 ***Risk Title:*** Performance Risk to Monitor Green Rating

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Statutory	Senior Leadership Team	Rhiannon Hills	James Rimmer	Chief Operating Officer - James Rimmer	05/03/2014	09/07/2014	16 Very High (Red)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

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

Risk Description	Details of Control or Assurance	Effectiveness
Prolonged failure of one of the following performance indicators, or concurrent failure of 4 or more indicators leading to loss of green status in Monitor risk rating:	RTT Steering Group (monthly and weekly)	Medium
	Cancer Steering Group	Medium
Referral to Treatment Time Standards Cancer Standards ED Standards Healthcare Acquired Infections	Project plans for new Operating Model 2014/15 being overseen via the Senior Leadership Team (SLT)	Medium
	Weekly reporing of against performance indicators and escalation to Steering Groups, Service Delivery Group and Senior Leadership Team as appropriate.	High

Action Plan for Risk: 2479 ***Action Number:*** 3 ***Responsibility Of:*** Rhiannon Hills ***Target date:*** 30/06/2014

Breaking the Cycle Together initiative being run w/c 31st March 2014 to help rebalance adult bed base and reaffirm standards for both UHB and partner organisations

Action Plan for Risk: 2479 ***Action Number:*** 2 ***Responsibility Of:*** Rhiannon Hills ***Target date:*** 30/09/2014

Monitoring of trajectories (activity and waiting list) to ensure first outpatient waiting times are reduced in line with target for end of quarter 2

Action Plan for Risk: 2479 ***Action Number:*** 4 ***Responsibility Of:*** Rhiannon Hills ***Target date:*** 30/09/2014

New Operating Model for 2014/15 has identified 7 projects to be taken forward to improve flow and support delivery of the 4 hour standard, RTT and Cancer Standards, Each project has a executive and divisional lead.

Action Plan for Risk: 2479 ***Action Number:*** 5 ***Responsibility Of:*** Rhiannon Hills ***Target date:*** 31/12/2014

See also Risk Numbers 1383 - Health Acquired Infections, 1412 Cancer Standards, 1422 4 hour performance, 1967 RTT Standards

Corporate Risk Register Report

Risk Number: 2579 **Status:** Action Required **Date:** 15/04/2014 **Risk Title:** Risk of cancelled operations and failure to achieve cancer pathway standards

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Patient Safety	Divisional Governance Group SHN	Deborah Lee	Fiona Jones	Medical Director - Sean O'Kelly	04/06/2014	31/08/2014	9 High (Amber)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

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

Risk Description

There is a risk of cancelled operations and failure to achieve cancer pathway standards arising from lack of availability of cellular pathology cover for all theatres lists operating due to one of the pathologist resigning it will be impossible to ensure cover for frozen section on Wednesday morning. The impact of this risk is not just restrcited to the thoracic specialty, other specialities like OG cancer services are also affected. This means that patients need to be scheduled according to the availability of pathologists and this may build in delays to their cancer pathway.

Details of Control or Assurance	Effectiveness
Other consultant colleagues will assist in providing service for frozen section but there are competing demands from other speciality and due to the arrangement of the workload there might be no pathologist available in the lab on Wednesday morning	Medium
Avoid to operate on cancer patients on Wednesday morning	Medium

Action Plan for Risk: 2579 ***Action Number:*** 1 ***Responsibility Of:*** Elizabeth Worsam ***Target date:*** 13/05/2014

Locum consultant to be recruited

Corporate Risk Register Report

Risk Number: 2664 ***Status:*** Action Required ***Date:*** 05/06/2014 ***Risk Title:*** Risk of reputational damage to paediatric cardiac services arising from the independent review of the

Domain	Monitoring Group	Risk Assessor	Risk Owner	Executive Lead	Assessment Date	Next Review Due:	Current Risk Rating	Target Risk Rating
Reputational	Divisional Risk Management Group W&C	Rebecca Dunn	Bryony Strachan	Medical Director - Sean O'Kelly	16/07/2014	05/09/2014	16 Very High (Red)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

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

Risk Description

Risk of reputational damage to paediatric cardiac services arising from the independent review of the service, resulting in loss of patient trust and confidence and negative impact on staff morale, retention and recruitment. NHS England has published the terms of reference for the independent review into children's cardiac services in Bristol. The review will be led by Eleanor Grey QC, an independent barrister and former Counsel to the Bristol Royal Infirmary public inquiry, and Sir Ian Kennedy, the former chairman of the Bristol public inquiry, who will act as consultant advisor.

The Review will be independent and its terms of reference have been drawn up following conversations with the families affected. The review will establish an office in Bristol and seek to ensure all interested parties have an opportunity to make a contribution. The review team will issue a public call for evidence and make further announcements about how to get in touch as soon as possible.

There are a number of risks to the Trust and the Children's Hospital as a result of this investigation. These are
1. Patient and Family trust in the service
2. Staff wellbeing and morale
3. Possible impact on service delivery because of the time and resource required to assist the investigation

Details of Control or Assurance	***Effectiveness***
Risk Oversight Group chaired by Chief Executive reporting to the Trust Risk management Group Program Manager in progress of appointment Care First external company appointed to support staff Weekly briefing meetings for staff	High
Regular Cardiac briefing meetings open to all staff	Medium
Project manager appointed to support the review, staff members involved in the review, and collation and management of evidence.	High
Care first company introduced to the Trust to support staff with pressure in, or outside of, the workplace.	Medium
Frequent monitoring of progress against relevant action plans	Medium
Cardiac transformation project to optimise performance in elective pathways	Medium
Quality in Cardiac services projects on patient involvement, consent and information, and palliative care	Low

Action Plan for Risk: 2664 ***Action Number:*** 1 ***Responsibility Of:*** ***Target date:*** / /

No actions Added.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a meeting of the Trust Board of Directors to be held in Public on 30 July 2014 at 10.30 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

23. Governors Log of Communications

Purpose

The purpose of this report is to provide the Trust Board of Directors with an update on all open questions on the Governors' Log of Communications, and those questions that have been added or modified since the previous meeting of the Trust Board of Directors.

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 Board is recommended to receive the report to note.

Report Sponsor

Chairman

Appendices

- Appendix A: Governor Log – Items since the previous meeting.

Governors' Log of Communications

23 July 2014

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.

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