University Hospitals Bristol NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC

Date: Thursday 30 April 2015
Time: 11.00 am – 13.00 pm
Venue: Conference Room, Trust Headquarters

Distribution:

Chair:	John Savage	Trust Chairman
Board Members:	David Armstrong	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
	Robert Woolley	Chief Executive
	Alex Nestor	Deputy 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:	Debbie Henderson	Trust Secretary
	Isobel Vanstone	Corporate Governance Administrator (Minutes)
Apologies:	Sue Donaldson	Director of Workforce and Organisational Development
	Jill Youds	Non-executive Director
Observers:		
	Aiden Fowler	NHS Fast-Track Executive
	Members of the Council of Governors	
Copy for Information:	Members of Council of Governors	
	Heather Ancient*	PwC – External Auditor
	Jenny McCall*	Audit South West – Internal Auditor

*Agenda and Minutes only

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

Isobel Vanstone, Corporate Governance Administrator, Trust Headquarters. Telephone: 0117 34 23602
Email: isobel.vanstone@uhbristol.nhs.uk

University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for the Meeting of the Trust Board of Directors held in Public
To be held on 30 April 2015 at 11.00am – 1.00pm
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page No*
1. Chairman's Introduction and Apologies To note apologies for absence received	Chairman	
2. Declarations of Interest To declare any conflicts of interest arising from items on the meeting agenda	Chairman	
3. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 31 March 2015	Chairman	4
4. Matters Arising (Action log) To review the status of actions agreed	Chairman	14
5. Chief Executive's Report To receive the report from the Chief Executive to note	Chief Executive	15
Delivering Best Care and Improving Patient Flow		
6. Patient Experience Story To receive the Patient Experience Story for review	Chief Nurse	19
7. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Quality and Outcomes Committee Chair's report c) Board Review – Quality, Workforce, Access	Deputy CEO/ Director of Strategic Development	22
8. Terms of Reference for Quality and Outcomes Committee To receive the terms of reference for approval	Trust Secretary	104
9. Transforming Care Report To receive the report for assurance	Chief Executive	114
10. 2015/2016 Annual Plan To receive the plan for approval	Deputy CEO/ Director of Strategic Development/ Director of Finance & Information	119
Delivering Best Value		

11. Finance Report To receive the report for assurance	Director of Finance & Information	180
12. Finance Committee Chair's Report To receive the verbal report for assurance	Finance Committee Chair	
13. Quarterly Capital Projects Status Report To receive this report to note	Deputy CEO/ Director of Strategic Development	201
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14. Briefing on amendments to Monitors' Risk Assessment Framework To receive the briefing to note	Chief Executive	205
15. Q4 Risk Assessment Framework Monitoring and Declaration Report To receive the declaration for approval	Chief Executive	209
16. Board Assurance Framework 2015/16 To receive the report for assurance	Deputy CEO/ Director of Strategic Development	224
17. Corporate Risk Register To receive the report for assurance	Chief Executive	234
18. Board of Directors Code of Conduct Declaration (including Fit and Proper Person Test declaration) To receive the declarations for assurance	Chairman	242
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Information		
20. Governors' Log of Communications To receive the Governors' log to note	Chairman	265
21. Speaking Out Policy To receive this report for assurance.	Deputy Director of Workforce	269
22. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: 27 May 2015, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

University Hospitals Bristol NHS
NHS Foundation Trust

Unconfirmed Minutes of the Meeting of the Trust Board of Directors held in Public on 31 March 2015 at 11:00am, Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

Board members present:
John Savage – Chairman
Robert Woolley – Chief Executive
Deborah Lee – Deputy Chief Executive/Director of Strategic Development
Sue Donaldson – Director of Workforce and Organisational Development
Paul Mapson – Director of Finance & Information
James Rimmer – Chief Operating Officer
Carolyn Mills – Chief Nurse
Emma Woollett – Non-Executive Director
David Armstrong – Non-Executive Director
Julian Dennis – Non-Executive Director
John Moore – Non-Executive Director
Guy Orpen – Non-Executive Director
Jill Youds – Non-Executive Director
Alison Ryan – Non-Executive Director
Lisa Gardner – Non-Executive Director

Present or in attendance:
Mark Woodstock – Patient Experience Story
Debbie Henderson – Trust Secretary
Isobel Vanstone – Corporate Governance Administrator (Minutes)
Penny Hilton – Fast-Track Executive
Aidan Fowler – Fast-Track Executive
Fiona Reid – Head of Communications
Amanda Saunders – Head of Membership and Governance
Nathan Filer – Journalist, Guardian (Observer)
Lucy Bubb – Deloitte (Observer)
Tony Watkin – Patient Experience Lead
Sue Silvey – Public Governor/ Lead Governor
Clive Hamilton – Public Governor, North Somerset
Brenda Rowe – Public Governor
Graham Briscoe – Public Governor, North Somerset
Wendy Gregory – Public Governor
Angelo Micciche – Patient Governor
Pam Yabsley – Patient Governor
Ray Phipps – Patient Governor
John Steeds – Patient Governor
Marc Griffiths – Appointed Governor
Jeannette Jones – Appointed Governor
Florene Jordon – Staff Governor
Ian Davies – Staff Governor
Alex Middleditch – Staff Member
Phoebe Syme – Staff Member
Andrew Mallick – member of the public

97/03/15 Chairman's Introduction and Apologies
Apologies for absence were received from Sean O'Kelly, Medical Director. The Chairman welcomed Mr Mark Woodstock, in attendance for the Patient Experience Story, Lucy Bubb representative of Deloitte and Nathan Filer, Guardian journalist.

John Savage took an opportunity to thank Penny Hilton on behalf of the Board, who had been with the Trust as part of the Fast Track Executive Scheme. John expressed sincere gratitude for her hard work and contributions during her time with the Trust and wished her well for the future. John also noted that Aidan Fowler, Fast Track Executive, would remain at University Hospitals Bristol (UHB) for a further period of two months following extension of his contract.

98/03/15 Declarations of Interest
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. No new declarations of interests were received.

99/03/15 Minutes and Actions from Previous Meeting
The Board considered the minutes of the meeting of the Board of Directors held in public on 27 February 2015 and approved them as an accurate record, subject to the following:

Emma Woollett referred to minute number 83/02/15 and clarified that the action related to the development of a process to ensure compliance with a Code of Conduct. It was:

RESOLVED:
- **That the minutes of the meeting held 27 February 2015 be agreed as an accurate record of proceedings, subject to amendments outlined in the minutes**

100/03/15 Matters Arising
Matters arising and actions complete were noted by the Board.

101/03/15 Chief Executive Report
Robert Woolley took an opportunity to record the Board's sadness in memoriam for the unexpected death of Dr Paula Murphy, Consultant Radiologist, who died suddenly in March. Dr Murphy had been with the Trust for 20 years and had made a huge contribution to the organisation as Clinical Director and in her previous role as Chair of the Hospital Medical Committee. A memorial service would be held at Clifton Cathedral in memory of Dr Murphy.

Robert reported that the Trust had undertaken a great deal of work to produce a viable business plan for 2015/16 via negotiations with commissioners regarding the contract and reminded Board members that he had been given delegated authority by the Board to make a decision on behalf of the Board with regard to the Enhanced Tariff Offer from NHS England.

Robert confirmed that Trust opted for the enhanced tariff offer, under protest, and referred to a number of risks currently outstanding and the timeline to conclude contract negotiations and planning. A draft Annual Plan would be submitted to Monitor by 7 April 2015 which would include a number of assumptions and conditions prior to submission of the final plan to the April Board of Directors meeting for approval.

Robert referred to continuing pressures in terms of performance and the recovery trajectories with regard to referral to treatment times and 4 hour A&E waiting times and provided assurance regarding the Easter planning period and the implementation of structures to support resilience during this time. Robert stated that the Trust would repeat the Breaking the Cycle exercise with a review to operating a 'perfect week'. This would require significant support, escalation plans, management and administrative resource to help sustain high quality care and patient flow. The Board noted that the Trust's approach to Breaking the Cycle had been recommended nationally for adoption by all Trusts.

Robert referred to the new Care Quality Commission (CQC) standards implemented on 1st April 2015 relating to Duty of Candour and the Fit and Proper Person Test for Directors and confirmed that Trust had been demonstrating compliance for some time and would continue to do so. The standards also required Trusts to display their CQC ratings at each designated site and plans had been developed to implement this. Robert briefed the Board on the outcome of the recent meeting with CQC to discuss the Trust's progress against the action plans following the recent formal inspection. The CQC expressed satisfaction with the Trust's progress and gratitude for the level of assurance provided in response to the recommendations.

Following a query from Emma Woollett regarding progress in relation to the cellular pathology transfer, Robert Woolley stated that a high level meeting had taken place with colleagues at North Bristol Trust (NBT) and there had been an acceptance regarding the Trust's requirements for the development of a formal Service Level Agreement for the centralisation of the service. It was acknowledged that the Trust required further assurance regarding the mechanisms by which NBT will achieve the required standards for all services. Robert also stated that there remained a level of uncertainty in relation to the time table as a result of the procurement of a new NBT laboratory information management system and delays to implementation. It was also noted that although this may not affect the transfer, the transfer would not proceed until a robust Service Level Agreement had been developed. It was agreed that the current position would be communicated to staff affected by the transfer. It was:

RESOLVED:

- **That the Board receive the Chief Executive's Report to note**

102/03/15 Patient Experience Story

Carolyn Mills stated that the purpose of the patient story was to provide a patient focus context for Board discussions and an opportunity to reflect on patient and staff experience, organisational culture and quality of care. Carolyn introduced Mr Mark Woodcock.

Mr Woodcock spoke about his experience as a patient in the Bristol Heart Institute and noted his positive experience of the clinical care provided. Mr Woodcock felt that the open access clinic was excellent in terms of providing a more effective and efficient method of accessing treatment and alleviating pressures in the system. Clinical staff had been very professional and clear in the treatments provided to him as a patient. Mr Woodcock felt that the discharge lounge had been a very good innovation, and freed up beds quickly but felt it was in the wrong place on the 5th floor in the centre of the BRI. He felt that patients would benefit from it being situated in the front entrance of the BRI.

Mr Woodcock referred to the impact of the cancellation of tests and stated that as the admission and surgery had been timetabled, as a single person household, the patient needed

to plan in accordance and ahead of time with regard to support post-discharge. Mr Woodcock noted that 34% of the population in Bristol were classified as single person households and felt that this needed to be taken into consideration with regard to managing the discharge process whilst acknowledging the links with community services.

Mr Woodcock noted that whilst x-rays were undertaken, there had been a lack of communication regarding the procedure, which could often be intimidating for patients.

James Rimmer thanked Mr Woodcock for sharing his story and noted the reference to the impact of cancellations. James confirmed that this represented part of the Trust's quality objectives for 2015/16 and noted that the reference to single person households would be reported back through the planning process relating to the Better Care Fund regarding how the acute, community and social care services could better support the discharge process in the future. James also referred to mobile phone access within the discharge lounge and acknowledged that this also required improvement.

Alison Ryan noted the importance of communicating effectively with patients as well as the provision of high clinical standards and asked Mr Woodcock to reflect on his experience in terms of being treated as an individual. Mr Woodcock felt that this varied and stated that qualified staff exhibited more confidence in terms of treating him as an individual and made particular reference to the excellent communication and delivery of care provided by anaesthetists.

Jill Youds asked Mr Woodcock for his views with regard to empathy and compassion. Mr Woodcock referred to his observations whilst a patient and stated that staff were indeed caring and compassionate, but sometimes, patients who had been deemed to be 'stable' may not have received as much attention.

Robert Woolley thanked Mr Woodcock for his time and his clear, honest and generous appraisal of his experience, including the feedback in terms of areas for improvement. Robert took an opportunity to reassure Mr Woodcock that a patient would not be discharged without appropriate support in place at their destination.

Robert also referred to empathy and compassion and stated this remained a priority for the Trust, not only how it could address the issue related to work place stress for members of staff, but also on how the Trust could influence the Business Planning to provide sufficient capacity to mitigate demand, reduce occupancy pressures and provide staff with capacity to manage patients with more empathy and compassion. Robert also noted that the Trust had embraced the issues of communication, and confirmed the Trust's commitment to improving communication in 2015/16 and beyond.

Sue Silvey referred to a recent personal experience as a relative of a patient in the Emergency Department and reiterated the importance of communication and the impact this can have on patient experience. It was:

RESOLVED:

- **That the Board receive the Patient Experience Story for review and thank Mr Woodcock for sharing his story**

103/03/15 Quality and Performance Report

Overall Performance

Deborah Lee presented the report and noted an improvement in performance in relation to the Referral to Treatment (RTT) recovery trajectory, which continued to be monitored regularly. The Trust had exceeded the trajectories for admitted and non-admitted RTT care and in relation to A&E 4 hour waiting time performance, the Trust reported 94.9% for the month against a 95% target. The Trust had exceeded the recovery trajectory for the quarter, however had been previously agreed by Monitor as 91.8%. Deborah referred to the improvement in performance during the period, indicating a number of improved conditions related to occupancy and patient flow.

Quality and Outcomes Committee Chair's Report

Alison Ryan reported on the business of the Quality and Outcomes Committee held on 26 March 2015 and noted that the committee had requested further intelligence in terms of numbers as well as percentages for monitoring performance. The Committee had been encouraged by this and the ability to receive assurance on the impact of interventions and initiatives.

The Committee had been presented with an update on the CQC action plans which confirmed the Trust remained on target against individual actions with the exception of essential training. The Trust had reported 85% compliance against a target of 90% across core essential training topics at the end of February and the CQC had acknowledged that represented a significant achievement. The Committee also received assurance with regard to the system wide action plan to address patient flow. Alison referred to actions included subsequent to the development of the initial action plan, demonstrating commitment from all organisations to improve patient flow for the whole system.

The Committee agreed the draft Annual Quality Objectives for 2015/16 including the choice of mandated indicators for audit by the External Auditors. These were confirmed as; percentage of incomplete pathways within 18 weeks; emergency waiting time of 62 days from urgent GP referral to first treatment for all cancers; and the indicator selected by the Council of Governors as Dementia.

Alison made particular reference to a request by the Committee to review Dental Hospital Never Events in-depth in relation to wrong tooth extractions. Considerable investigation had been carried out and the report provided high level assurance that actions and recommendations from the review had been implemented. The Committee agreed to continue to review the implementation of the actions.

Alison noted that levels of patient satisfaction in Maternity Services had been identified as lower than elsewhere in the Trust, although higher than the national average. The Committee requested further assurance that all actions had been taken to address any issues and the Committee agreed to further monitor this area until full assurance could be obtained.

The Committee proposed that additional breakdown of complaint reporting be undertaken to identify complainants by their designation as patient, carer, relative or children to further understand the number of complaints which had been generated by a third party. It was felt that this would add value in terms of gaining further understanding of how the Trust had responded to the needs of other service users, particularly carers.

Jill Youds referred to the deterioration of performance in February with regard to dementia screening. Carolyn Mills shared this concern and the expectation that the Trust should have seen a step change, but confirmed that analysis of divisions and hotspots had been undertaken

to enable areas to be targeted. Carolyn reassured members of the Board that there had been no areas of concern.

Access

James Rimmer took an opportunity to thank members of staff for their hard work and dedication with regard to delivery of access performance, continuing high quality care to patients and the Monitor recovery trajectory. James noted that the Trust had treated more children within four hours and noted an increase in initiating treatment of children within the first hour. Referral to Treatment times in children's theatres had also improved.

In response to a query from David Armstrong regarding ownership of action plans relating to never events and serious incidents, Robert Woolley confirmed that the Quality and Outcomes Committee had delegated responsibility for ownership, oversight and assurance of these areas including learning and outcomes. Robert also noted that a level of reactive investigation, action planning and response was in place at operational level as part of routine business. Robert confirmed that the purpose of the Corporate Action Plan document had been to identify those Executive level plans which had not been captured in the routine management of operations and risk. Robert also confirmed that the Trust had in place mechanisms to allow escalation of issues to the Board as and when appropriate via the Trust's governance and reporting structures.

John Moore referred to hospital acquired pressure sores and noted an increase in numbers from October 2014 and queried if practices had been appropriately embedded. Robert Woolley noted that there had been no increase in the rate per 1000 bed days for the quarter. Guy Orpen noted that patient falls had also increased along the same timeline and Robert Woolley stated that the winter period had represented seasonal deterioration particularly during December. Deborah Lee referred to the current review of the quality and performance report which would include a more proactive approach to reporting and the means by which the Board could forecast potential areas of deterioration in performance.

Wendy Gregory referred to incident number 2015 811 and queried the timescales for incident reporting and responses and the criteria used to define an incident as 'serious' or a 'never event'. John Savage acknowledged that the question would be included on the Governors log and a response would be provided.

In response to a query from Clive Hamilton regarding the management of change in relation to the transfer of Specialist Paediatric Services in May 2014, James Rimmer noted that the external review found that the outcomes and benefits for children treated had significantly improved as a result of combining the services from NBT and UHB to develop the standalone Paediatric Trauma Centre. Robert Woolley also confirmed that the external review stated that the level of integration had been remarkable.

Clive Hamilton referred to the Eye Hospital and Referral to Treatment times for non-admitted patients and the trajectory that the Trust would not be compliant until January 2016. James Rimmer provided assurance that although challenging, the recovery plans remained robust to deliver against the trajectory. Deborah Lee confirmed that with regard to adults, the Trust had met the trajectory and had been green rated. Deborah also emphasised that there had been no issues with regard to first attendance and the recovery trajectory related to follow-up backlogs.

Workforce

Sue Donaldson stated that the workforce agenda had been considered in detail at the Quality and Outcomes Committee. Sue referred to essential training in the context of Care Quality Commission review and action plans and noted 85% compliance at the end of February against a target of 90% for core topics. Sue noted that although the Trust would be unlikely to achieve the target at the end of March, it represented significant progress when compared to previous quarters. It was:

RESOLVED:

- **That the Board receive the Quality and Performance Report for assurance**
- **That the query with regard to the criteria for defining a 'serious incident' and 'never event' be included on the Governors log**

104/03/15 Preparation for Annual Quality Report (Quality Account) including Draft Corporate Quality Objectives for 2015/16.

Carolyn Mills referred to the report and confirmed that the content had been discussed at length at the Quality and Outcomes Committee. Carolyn explained that the Trust's Quality Report (Quality Account) including confirmation of the Trust's Quality Objectives for 2015/16 would be presented to the April Board meeting. It was:

RESOLVED:

- **That the Board receive the Draft Quality Report (Quality Account) for assurance**

105/03/15 Quarterly Complaints and Patient Experience Reports

Carolyn Mills presented the report and noted two additional assurance reports for: Bristol Eye Hospital to provide assurance regarding the number and content of complaints; and Maternity Services to provide assurance about the actions taken to bring performance against the Trust metric "kindness and understanding" in line with the Trust norm.

Carolyn drew the Board's attention to the two Ombudsman complaints, one upheld and one partially upheld. Julian Dennis suggested that deeper analysis of reporting be undertaken to identify complainants by their designation. Julian felt this would add value to help the Board understand how the Trust responds to the needs of other service users, particularly carers.

Jill Youds stated that the Maternity Services report did not provide an adequate level of assurance and a request had been made for a further report to the Quality and Outcomes Committee identifying the impact of actions taken recently and what further actions would be required to improve patient experience scores and complaints in comparison to other areas in the Trust. Jill stated that the ambition should be to perform substantially better than the national benchmark. A visit for Non-Executive Director members of the Quality and Outcomes Committee had been arranged to take place in April.

Wendy Gregory referred to the quality of complaint responses and the decrease in rates of satisfaction of responses. Carolyn Mills confirmed that a review of the quality of complaint responses had been included in the Trust's quality objectives for 2015/16. Wendy also referred to the frustration experienced by patients and service users with regard to a failure to answer calls via the main switchboard and the number of complaints relating to the Children's Emergency Department and Ward 39, relating to attitudes of staff. Robert Woolley confirmed that the need for a Trust wide transformation programme focusing on patient communication had been identified and scoping would commence in May. It was:

RESOLVED:

- **That the Board receive the Quarterly Complaints and Patient Experience Reports for assurance**

106/03/15 National Staff Survey Results

Sue Donaldson referred to the National Staff Survey results which had been previously distributed to members of the Board and the Council of Governors. Sue noted key issues for the Trust which impact on overall staff experience and staff engagement. A review would be undertaken of the significant work currently on-going with regard to staff experience including a review of the pace and impact of current initiatives.

With regard to benchmarking Sue noted that the Trust had been examining learning from the King's Fund and the work by Professor Michael West with other NHS Trusts. Initial discussions will be undertaken at the Trust's Senior Leadership Team with a clear focus on organisational leadership and the importance of equipping frontline leaders to influence staff experience across the Trust. Sue emphasised the importance of a full census survey to enable teams to identify the most appropriate actions relevant to their teams.

Guy Orpen also suggested using the Trust's appraisal process to examine staff motivation and engagement. Sue Donaldson agreed and noted the use of appraisals to outlined expectations and receive regular feedback, not only from an individual perspective but also as a team.

Robert Woolley reported that the deterioration in the staff engagement domain score had been reflected nationally and he felt that the Trust had a strong desire and opportunity to improve two way communications. Sue made particular reference to the need to focus on staff motivation and morale and noted that some Trusts had made a positive impact in these areas notwithstanding national pressures related to pensions and pay.

Jill Youds referred to the question relating to recommending UHB as a place to work and noted that responses had been in line with the national average. Robert Woolley also noted that the Trust had achieved 5% above the national average with regard to staff recommending UHB as a place to receive treatment. Jill Youds noted that a meeting had been arranged with Jill and Deborah Lee to discuss two-way communications with staff supported by local leadership. It was:

RESOLVED:

- **That the Board receive the National Staff Survey Results for assurance**

107/03/15 Finance Report

Paul Mapson reported that year to date remained satisfactory and noted the forecasted benefit of £750,000 at the year-end relating to the waiver of Referral to Treatment penalties. The summary income and expenditure statement showed a surplus of £6.904m, representing a favourable variance of £1.587m against plan year to date. The divisional overspend had increased in February, resulting in a year to date overspend of £9.966m. The report included Operational Resilience income of £0.851m that had been recognised to meet additional costs incurred in February.

Julian Dennis referred to contract income £1.96m lower than plan and Paul Mapson confirmed that this related to underachievement of planned activity. It was:

RESOLVED:

- **That the Board receive the Finance Report for assurance**

108/03/15 Finance Committee Chair's Report

Lisa Gardner reported on the business of the Finance Committee and noted that the Trust had forecast the year-end in line with the financial plan. Lisa commented on the extremely tight timeframes for annual reporting deadlines with accounts to be submitted by 23rd April 2015. Lisa reported that the Committee had raised concern regarding the financial position of Medicine and Women and Children's divisions but the Committee would continue to monitor their position going forward into 2015/16.

The Committee received an update with regard to planning for 2015/16 and beyond following the Board development session during March. A report had been received from the Surgery, Head and Neck division and Lisa felt that the divisions had acknowledged the Trust's financial position in real terms and the impact of this on capital programmes. The capital scheme, although complex, had been examined in the context of divisional spend which had been under constant review. It was:

RESOLVED:

- **That the Board receive the Finance Committee Chair's Verbal Report for assurance**

109/03/15 Monitor feedback on Quarter 3 Submission against the Risk Assessment Framework

Robert Woolley referred to the Monitor feedback following the Trust's Quarter 3 submission, submitted to the Board for information. The report confirmed that the Trust had failed six of the access targets under Monitors' Risk Assessment Framework. The Governance Risk rating had been placed under review. Robert reported that the Trust continued to provide Monitor with information on a monthly or more frequent basis regarding progress against the recovery trajectory. It was:

RESOLVED:

- **That the Board receive the Monitor feedback on Quarter 3 Submission against the Risk Assessment Framework for assurance**

110/02/15 Audit Committee Chair's Report

John Moore provided a verbal update following the meeting of the Audit Committee held 10 March 2015. Reports were received on: Internal Audit; Local Counter Fraud Service; Losses and Compensation; Single Tender Actions; Risk Management Group; and financial year-end issues.

The internal audit plan and Local Counter Fraud Service Plan for 2015/16 had been approved. Additionally it had been agreed to extend the contract of the Trust's External Auditor, PriceWaterhouseCoopers, for a further period of 12 months. PWC had served as the Trust Auditors for three years, and John noted that the contract permits two, one-year extensions. A report recommending the extension for formal approval by the Council of Governors would be submitted to the April meeting.

Internal Audit issued an Amber report on Procurement Controls which highlighted an issue regarding the duties and responsibilities of budget holders. In addition, John noted that there remained insufficient assurance with regard to separation of duties. It was agreed that despite the significant focus on procurement during 2014/15, ongoing work would be included in the Internal Audit plan for the coming year, specifically for non-clinical procurement issues.

The interim report from the External Auditor reported positively and the Committee noted the Quality Accounts mandated indicators would focus on 62 day RTT in addition to the mandatory 18 week pathway RTT metric. Dementia had also been selected by the Governors as the locally selected indicator.

It was agreed that the choice of indicator be subject to the appropriate approval process and would be submitted to the Quality and Outcomes Committee for approval in March.

The Committee received a report outlining key issues relating to the 2014/15 Annual Report and Accounts planning in advance of the May meeting at which the audited accounts would be considered for approval. The report outlined the significant judgements expected to be used by the Trust in the preparation of the Annual Accounts for the valuation of assets, impairments and calculation of depreciation charges. Kate Parraman informed the Committee of the policy and controls in place with regard to the statement on the Trust's policy on the use of off-payroll arrangements. John also referred to the requirement for the Chief Executive, as Accounting Officer, to sign the Annual Report and Accounts following their approval at Trust Board in May. The Committee had been advised of the cover arrangements that would be in place during this period.

The Committee received the Board Assurance Framework (BAF) and raised concern that the BAF had appeared inconsistent with current organisational performance. A discussion took place with regard to clarifying the purpose of the BAF. It was agreed that Deloitte would be asked to feedback on the strengths and weaknesses of the Trust's current systems and processes to put in place improvements in line with best practice. It was:-

RESOLVED:

- **That the Board receive the Audit Committee Chair's Report for assurance**

95/02/15 Governor's Log of Communications

The Chairman reported that the Governor's Log had been acted upon. It was:-

RESOLVED:

- **That the Board receive the Governor's Log of Communications to note**

96/02/15 Any Other Business

There no further issues to report

Meeting close and Date and Time of Next Meeting

There being no other business, the Chair declared the meeting closed
The next meeting of the Trust Board of Directors will take place on Thursday 30 April 2015, 11.00am, the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

……. ……2015
Chair Date

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 31st March 2015
Action tracker

Outstanding actions following meeting held 31st March 2015					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**87/02/15**	Outcome of the review of new exit arrangements to be included in the May Quarterly Workforce report	Director of Workforce & OD	May 2015	N/A
2	**87/02/15**	Response to the National Staff Survey to be submitted to the Board for assurance	Director of Workforce & OD	May 2015	Staff engagement update to May Board
3	**84/02/15**	Action plan and assurance report from the Saville Review to be submitted to the Board for assurance	Chief Nurse	June 2015	In line with Monitor submission
4	**33/11/14**	Review of structure and format of the Quality and Performance Report to ensure it remains fit for purpose	Director of Strategic Development/ Deputy CEO	May 2015	N/A
Completed actions following meeting held 31st March 2015					
5	**83/02/15**	Review of compliance of a Code of Conduct for the Board of Directors to be undertaken	Trust Secretary	April 2015	Complete – agenda item
6	**103/03/15**	Query relating to criteria for defining a 'serious incident' and 'never event' be included on the Governors' Log	Trust Secretary	April 2015	Complete

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
5. Chief Executive's Report									
Sponsor and Author(s)									
Robert Woolley, Chief Executive									
Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. Key issues to note 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 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.									
Impact Upon Board Assurance Framework									
The Senior Leadership Team is the executive management group responsible for delivery of the Board's strategic objectives and approves reports of progress against the Board Assurance Framework on a regular basis.									
Impact Upon Corporate Risk									
The Senior Leadership Team oversees the Corporate Risk Register and approves changes to the Register prior to submission to the Trust Board.									
Implications (Regulatory/Legal)									
There are no regulatory or legal implications which are not described in other formal reports to the Board.									
Equality & Patient Impact									
There are no equality or patient impacts which are not addressed in other formal reports to the Board.									
Resource Implications									
Finance	√	Information Management & Technology	√						
Human Resources	√	Buildings	√						

Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	√

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – APRIL 2015

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in April 2015.

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the current position in respect of performance against Monitor's Risk Assessment Framework.

The group **supported** the recommendation to declare the standards failed in Quarter 4 to be the Referral to Treatment Non-Admitted, Admitted and Ongoing pathways standards, the Accident and Emergency 4-hour standard, the 62-day GP and 62-day Screening cancer standards. The planned ongoing failure of the Referral to Treatment standards as part of the agreed trajectory should be flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-day GP standards and the Accident and Emergency 4-hour standard, as part of the narrative accompanying the declaration.

The group **approved** the Significant Incident Extreme Escalation Plan, with some minor amendments.

The group **received** an update on the financial position for the 12 months to 31 March 2015.

The group **received** a further update on the current status of the compliance actions following the Care Quality Commission inspection, for both internal Trust actions and the external pan-Bristol 'patient flow' actions.

3. STRATEGY AND BUSINESS PLANNING

The group **endorsed** actions to take forward an approach for staff engagement with further discussion taking place at a strategic meeting at the beginning of May.

The group **approved** a revised Speaking Out (Whistleblowing) Policy, a timeline for implementation, conversion of a one-page summary of the Speaking Out Policy into a Simple Guide and recommendations for implementation of the Francis Freedom to Speak Up review.

The group **approved** a Risk Management Strategy for 2015/2016 and Terms of Reference for the Risk Management Group.

The group **approved** the draft Monitor Operational Plan 2015/2016 and Assessment of Compliance with the targets in the 2015/2016 Risk Assessment Framework, with some further amendments, prior to submission to the Trust Board.

The group **noted** an update on the business planning round 2015-2016, including development of Operating Plans 2015/2016 and final position on capital prioritisation.

The group **received** an update following the Breaking the Cycle Together 'perfect week' and **agreed** next steps.

The group **received** the Board Assurance Framework 2014/2015 Quarter 4 update prior to onward submission to the Trust Board.

4. RISK, FINANCE AND GOVERNANCE

The group **noted** the current position in respect of the transfer of Cellular Pathology to North Bristol Trust and risks to the proposed timetable.

The group **noted** the Elective Care Intensive Support Team closure report detailing the progress made by the Trust and any issues which remained outstanding.

The group **approved** the Corporate Risk Register report prior to onward submission to the Trust Board and Divisions confirmed their **support** and engagement in a review of whether the Corporate Risk Register should contain corporate risks rated 12 or above.

The group **noted** the Quarter 4 Serious Incident Report.

The group **noted** the status of the Trust's Partnership arrangements.

The group **noted** a low impact Internal Audit Report in relation to Removing Health Inequalities – Children with Disabilities, progress on Internal Audit recommendations that remained outstanding and the Internal Audit Work Plan for 2015/2016.

Reports from subsidiary management groups were **noted**, including an update on the work of the Transforming Care programme and on the activities of the Communications Department.

The group **noted** risk exception reports from Divisions. No new high risks were reported.

The group **received** for information Divisional Management Board meeting minutes.

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
April 2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
6. Patient Experience Story									
Sponsor and Author(s)									
Carolyn Mills – Chief Nurse Tony Watkin –Patient Experience Lead (Engagement and Involvement)									
Intended Audience									
Board members	x	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

Patient and staff stories reveal a great deal about the quality of services, the culture of an organisation and the effectiveness of systems and processes to manage, improve and assure quality. This video, sourced from the Patient Voices Programme, introduces us to Matthew, a keen and enthusiastic medical student. Using reflective storytelling we see how Matthew successfully performs a 'by-the-book' catheterisation, but the realisation that there is more to his vocation than technical know-how leads him to reflect on the true nature of caring for patients.

The story will be presented at the Trust Board meeting by way of video:
http://www.patientvoices.org.uk/flv/0257pv384.htm

The purpose of presenting this patent story to Board members is to:

- Set a patient focussed context for the meeting.
- For Board members to reflect on how the story is relevant to UHBristol and the context in which clinicians are trained and work.

Key issues to note

The story highlights a number of key issues:

Positive:

- The clinical effectiveness of the clinical care received.
- The positive intent behind the student doctors actions.
- The ability of the student doctor to reflect on their practice.

Negative:

- The personal anxiety of the student doctor in his recognition of the need fo,r and his ability to provide, compassionate care when focussed on undertaking a technical procedure for the first time.
- The uncertainty the student doctor experienced by not having his role explained to the family.
- The challenge of providing the appropriate support necessary for student doctors to transition from simulated patient interventions to real-life.

Recommendations
To receive and reflect on the story.
Impact Upon Board Assurance Framework
No impact - links with Objective to deliver annual quality objectives-
Impact Upon Corporate Risk
No links to corporate risks.
Implications (Regulatory/Legal)
Learning from feedback supports compliance with CQC's fundamental standards – regulation 4, person centred care, regulation 5, dignity and respect, regulation 7, safe and appropriate treatment. Regulation 22 good governance.
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	x

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
7. Quality and Performance Report
Sponsor and Author(s)
Report sponsors: • '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) Report authors: • Xanthe Whittaker (Head of Performance Assurance & Business Intelligence / Deputy Director of Strategic Development) • Anne Reader (Head of Quality (Patient Safety)) • Heather Toyne (Head of Workforce Strategy & Planning)
Intended Audience

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
<u>Purpose</u> To review the Trust's performance on Quality, Workforce and Access standards. <u>Key issues to note</u> 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.**
Impact Upon Board Assurance Framework
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Impact Upon Corporate Risk
As detailed in the individual exception reports.
Implications (Regulatory/Legal)
Links to achievement of the standards in Monitor's Risk Assessment Framework.

Equality & Patient Impact							
As detailed in the individual exception reports.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
28/04/15					

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

April 2015

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SECTION A – Performance Overview

Summary

The key changes to Organisational Health Barometer indicators between the Previous and Current reported periods are as follows:

Improvements in the period:

Moving from RED to GREEN – 1 indicator

- A&E 4-hours – 95% standard achieved.

Moving from AMBER to GREEN – 2 indicators

- Summary Hospital-level Mortality Indicator (SHMI) – moving from a SHMI score of 68.9 to 60.8;

- Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment) – moving from 78.6% to 85.7% (please note that the thresholds have been re-based, to keep this in line with the latest peer group figures and reports generated by National Institute for Health Research).

Deteriorations in the period:

Moving from GREEN to AMBER – 1 indicator

- Savings Plan achievement – see separate Finance Report for further details

Moving from GREEN to RED – 1 indicator

- Same sex accommodation breaches – four breaches incurred for less than 8 hours, to enable a medical bed to be found for a frail elderly, acutely unwell patient in the Emergency Department;

Please note: The move from Amber to Red for the Number of Cancer Standards Failed was reported last month, but has not been highlighted again due to this being a quarterly measure.

The Organisational Health Barometer continues to highlight the challenges in meeting national waiting times standards in the face of rising demand and increasing patient complexity. The impact of the Trust's performance against the access standards is reflected in the Monitor Risk Rating, and also in the contract penalties forecast.

Performance against the 4-hour standard improved during March, with the 95% standard being achieved for the first month since June 2014. The recovery trajectory for the quarter was also achieved. There was a marked improvement in performance against the 4-hour standard within the BRI, which correlated with a decrease in bed occupancy. This appears to partly be due to a reduction in the number of patients staying over 14 days, but also fewer Emergency Department attendances converting to emergency admissions. Other measures of patient flow, including levels of delayed discharges, ambulance hand-over delays, the number of ward moves and the number of bed-days patient spent outlying from their specialty wards, all sustained the improvements seen in previous months, or showed further improvements in the period.

There was a further reduction in the number of patients waiting over 18 weeks from Referral to Treatment in the period, for both non-admitted and admitted patient pathways (see Exception Reports A5 to A7), and the Trust also achieved the target reduction in the number of patients waiting over 6 week for a diagnostic test at month-end (see Exception Report A8). The Trust remains on track to deliver further reductions in long waiters in April, in line with the agreed trajectories for recovery of performance against the RTT standards during 2015/16.

For quarter 4 as a whole, the Trust failed six of the standards in Monitor's Risk Assessment Framework. These are the A&E 4-hour standard, the Referral to Treatment Time (RTT) Admitted, Non-admitted and Ongoing standards, and the 62-day GP and Screening Cancer Standards. In Monitor's Risk Assessment Framework failure of all three RTT standards, as in the current quarter, is capped at a score of 2.0. The two 62-day cancer standards are grouped into a single combined indicator, scoring 1.0. Overall this gives the Trust a draft Service Performance Score for the quarter of 4.0 against Monitor's Risk Assessment Framework. Having restored the Trust to a GREEN rating for quarter 1, Monitor has requested and received further information following multiple breaches of the A&E, Referral to Treatment and cancer waiting time targets, before deciding next steps.

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	90	N/A	Green: >= 86 Red: < 85	↑	Current month is February 2015
A02	Patient Complaints as a Proportion of Activity	0.291%	0.273%	0.261%	Green: <0.21% Red: >0.25%	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	0	4	8	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	2	7	Green: 0 Red: >= 1	↑	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	4.91	4.53	4.80	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)	4	6	78		↑	
C02	Cumulative Number of Avoidable C.Diff cases	7	7	7	Below Trajectory	→	Latest data is up to end of February 2015

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	80.4%	80.5%	84.9%	Green: >=90% Red: <85%	↑	
D02	Number of Cancer Standards Failed	1	2	2	Green: 0 Red: >=2	↑	Previous is confirmed Q2. Current and YTD is confirmed Q3.
D03	A&E 4 Hour Standard	89.5%	95.01%	92.2%	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	68.9	60.8	64.1	Green: <65 Red: >=75	↓	Previous is January 2015 and Current is February 2015
E02	30 Day Emergency Readmissions	348	289	3437	Below 13/14 Readmission Rate	↓	Previous is January's discharges where there was an emergency Readmission within 30 days. Current is February's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.24	4.36	4.26	Green: <= Quarterly target 3.70 Red: >= Quartrely target 3.70	↑	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	85.1%	87.3%	87.1%	Green: >= 90% Red: < 90%	↑	
F04	Outpatient appointment hospital cancellation rate	9.1%	9.1%	8.9%	Green: <=6.0% Red: >=10.7%	→	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	13.8%	13.8%	13.8%	Green: < target Red: >=10% above target	→	
G02	Staff Sickness	4.6%	4.4%	4.1%	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	43,947	4,039	4,039	Green: Above 2012 Red: Below 2012		Current (and YTD) is rolling Calendar YTD position. Previous is Jan-Dec 2014 and Current is Jan 2015
H03	Percentage of Studies Meeting the 70 Day Standard (Submission to Recruitment)	78.6%	85.7%	85.7%	Green: >=81.4% (Upper Quartile) Red: <70.7% (Median)	↑	Annual rolling data, updated once every 3 months. Reported quarterly to match reporting to DH. Current is Q4 2013/14 – Q3 2014-15. Previous is Q3 2013/14 – Q2 2014/15.

PERFORMANCE OVERVIEW

Governing Well

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
J01	Monitor Governance Risk Rating	4	4	N/A	Green: < 4 Red: > = 4		Previous shows the Q3 declared poisition. Current shows the position in quarter 4 to date. Please note that Monitor is still to confirm the Trust's official rating for quarter 3.

Delivering Our Contracts

The Previous column represents Month 10. Current (and YTD) represents Month 11 2014/15.

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£7.98	£7.99	£7.99	> 50% Green < 50% Red		This is Potential year-end rewards and reflects assessment of performance as at January (81%).
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£0.56	£0.51	£0.51	Green: Below Plan Red: Above Plan		Data is variance above (+) or below (-) plan, with a higher negative value (and lower positive) value representing better performance.YTD and Current is variance reported for February which reflects assessments available so far for all penalties excluding EMTA, for which no baseline is agreed with commissioners. RTT waiver July 14 to March 15 is now confirmed.

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 savings Current and YTD is Current Year To Date. For Savings 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	97%	79%	79%	Green: >=90% Red: < 75%		

Notes

Unless otherwise stated, Previous is February 2014 and Current is March 2015

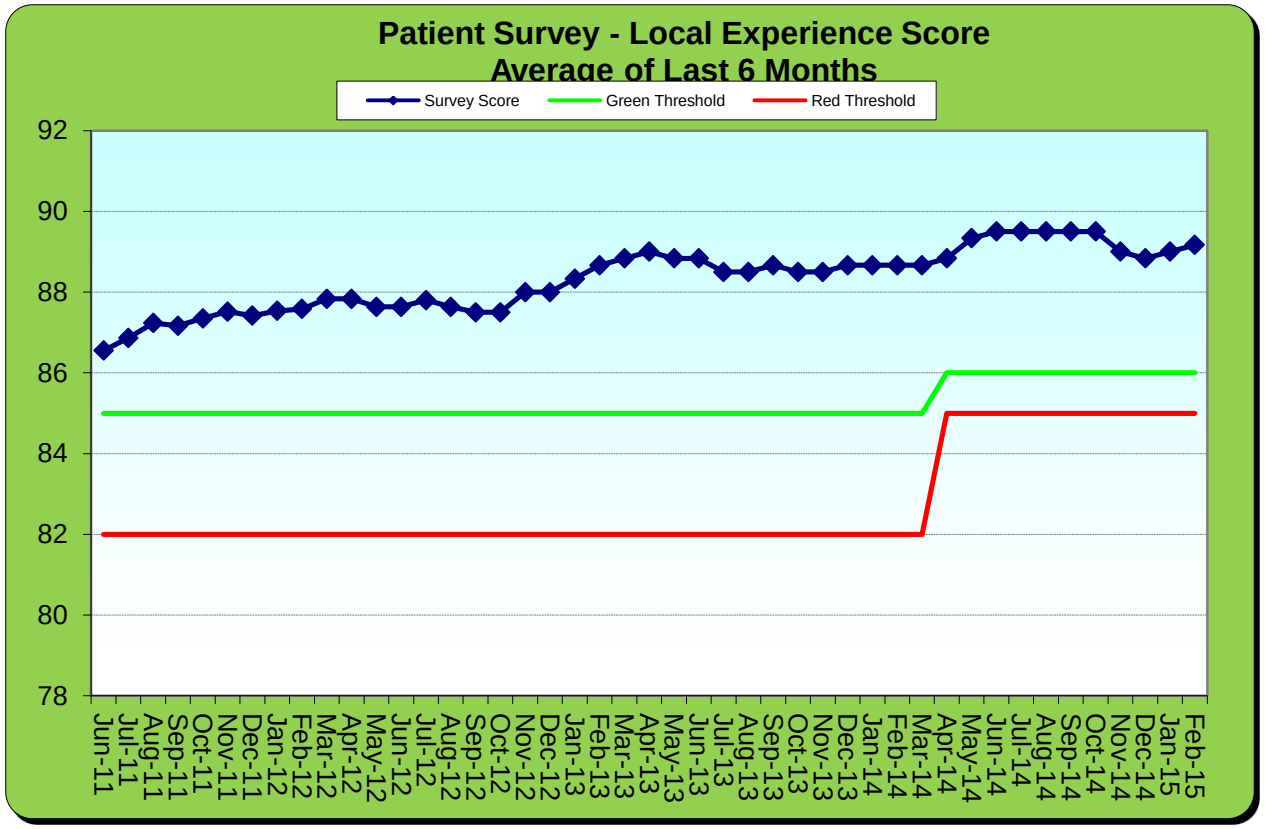
YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2014 up to and including the current month

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

PERFORMANCE OVERVIEW

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Patient complaints as a proportion of activity	In *Quality* section of this report	
Same sex accommodation breaches	In *Quality* section of this report	
Hospital acquired pressure ulcers (grade 3 or 4)	In *Quality* section of this report	
18-week Referral to Treatment Times (RTT) admitted pathways	In *Access* section of this report	
Number of cancer standards failed	See Additional Information	The 62-day GP and 62-day Screening waiting times standards were confirmed as failed at the end of quarter 3, as previously reported. Further details of performance against these standards can be found in the *Access* section of this report.
A&E 4-hour standard	In *Access* section of this report	
30 Day Emergency Readmission	In *Quality* section of this report	
Overall Length of Stay	See Additional Information	Length of stay remained above target. However, this was in part due to the number of long stay patients discharged in the period, which contributed to lower bed occupancy and a recovery in performance against the 4-hour standard.
Theatre productivity	See Additional Information	Overall theatre utilisation was lower than planned. This was mainly due to high levels of theatre staff sickness in the month, mainly at the Children's Hospital.
Staff sickness	In the *Workforce* section of this report	
Turn-over	In the *Workforce* section of this report	
Monitor Governance Risk rating	See Section C - *Monitor Risk Assessment Framework*	
Contract penalties above plan	See separate *Finance Report*	


Patient Survey - Local Experience Score
Average of Last 6 Months
Survey Score
Green Threshold
Red Threshold
92
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
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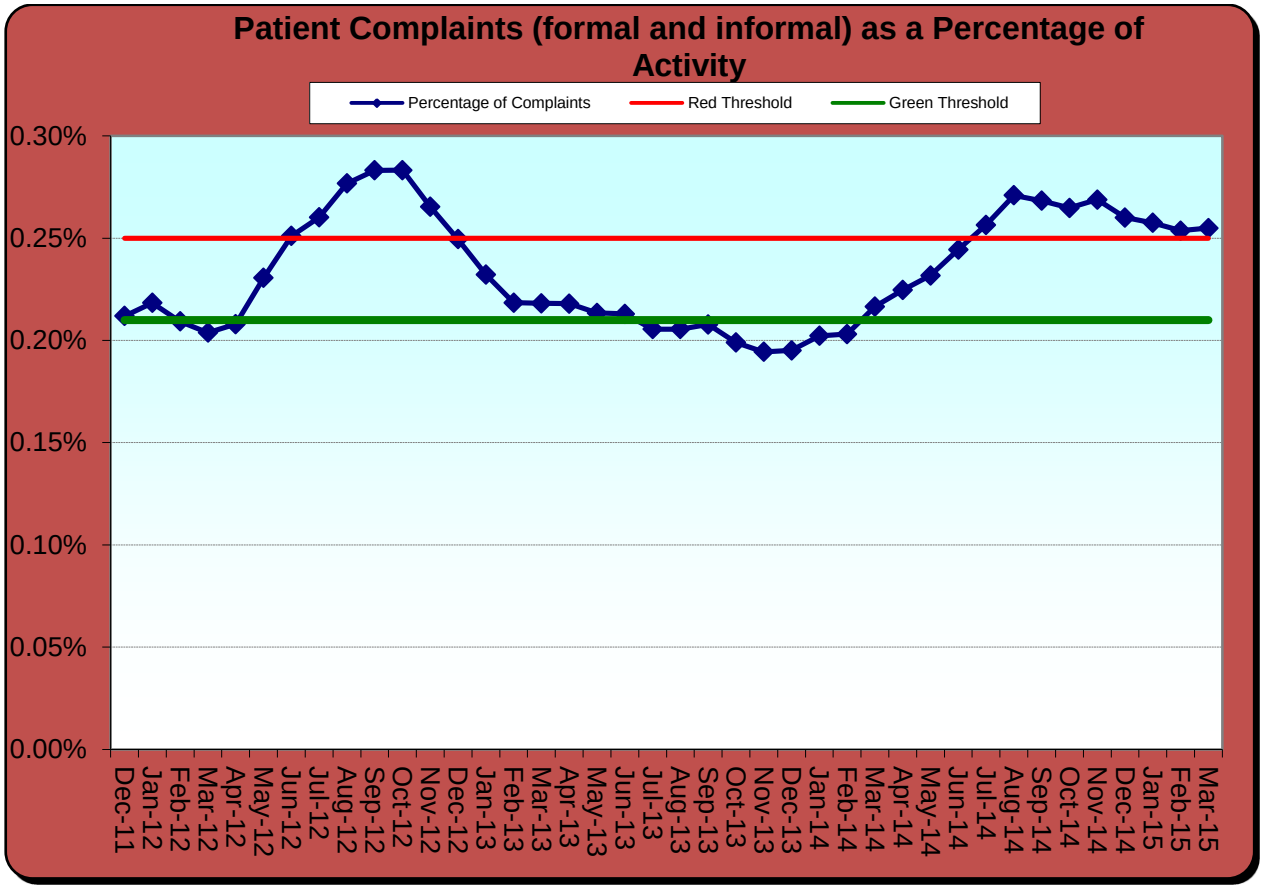
Patient Complaints (formal and informal) as a Percentage of Activity
Percentage of Complaints
Red Threshold
Green Threshold
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
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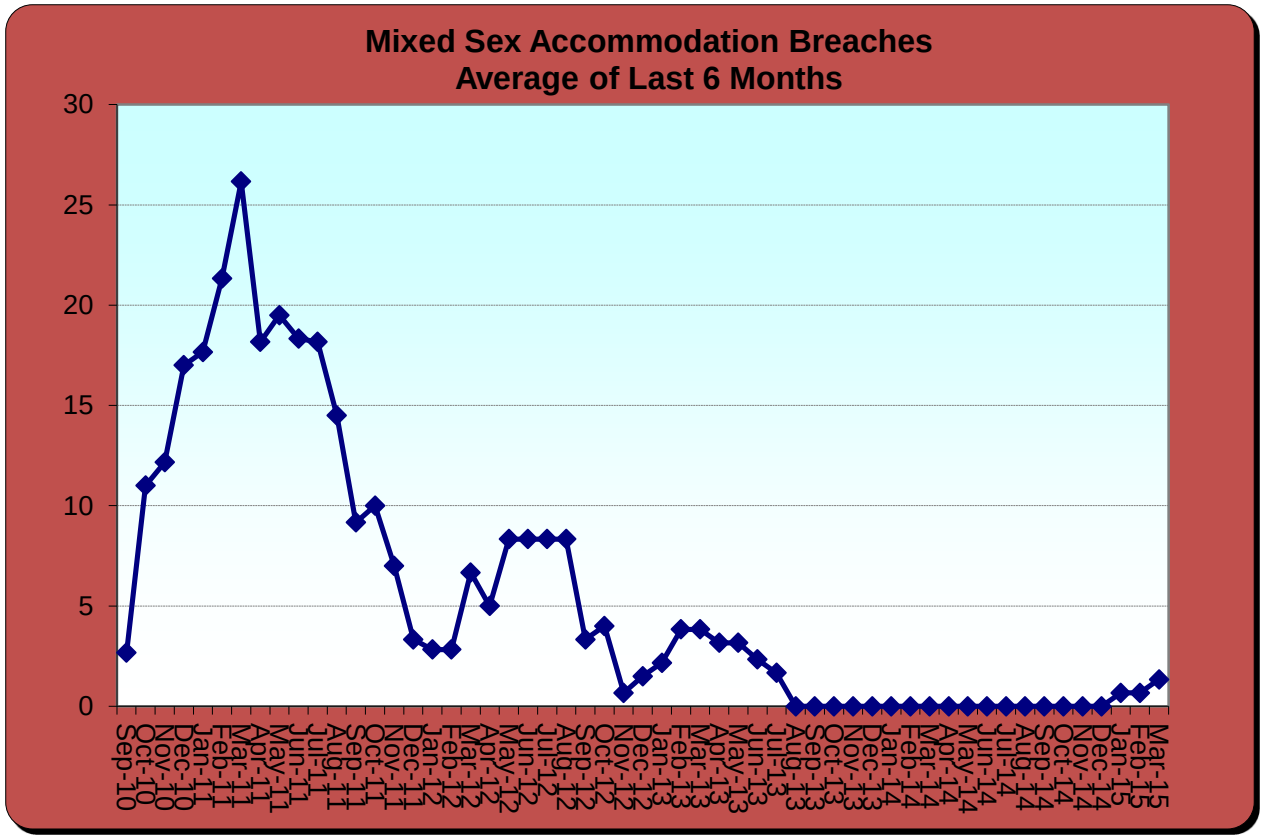
Mixed Sex Accommodation Breaches
Average of Last 6 Months
30
25
20
15
10
5
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
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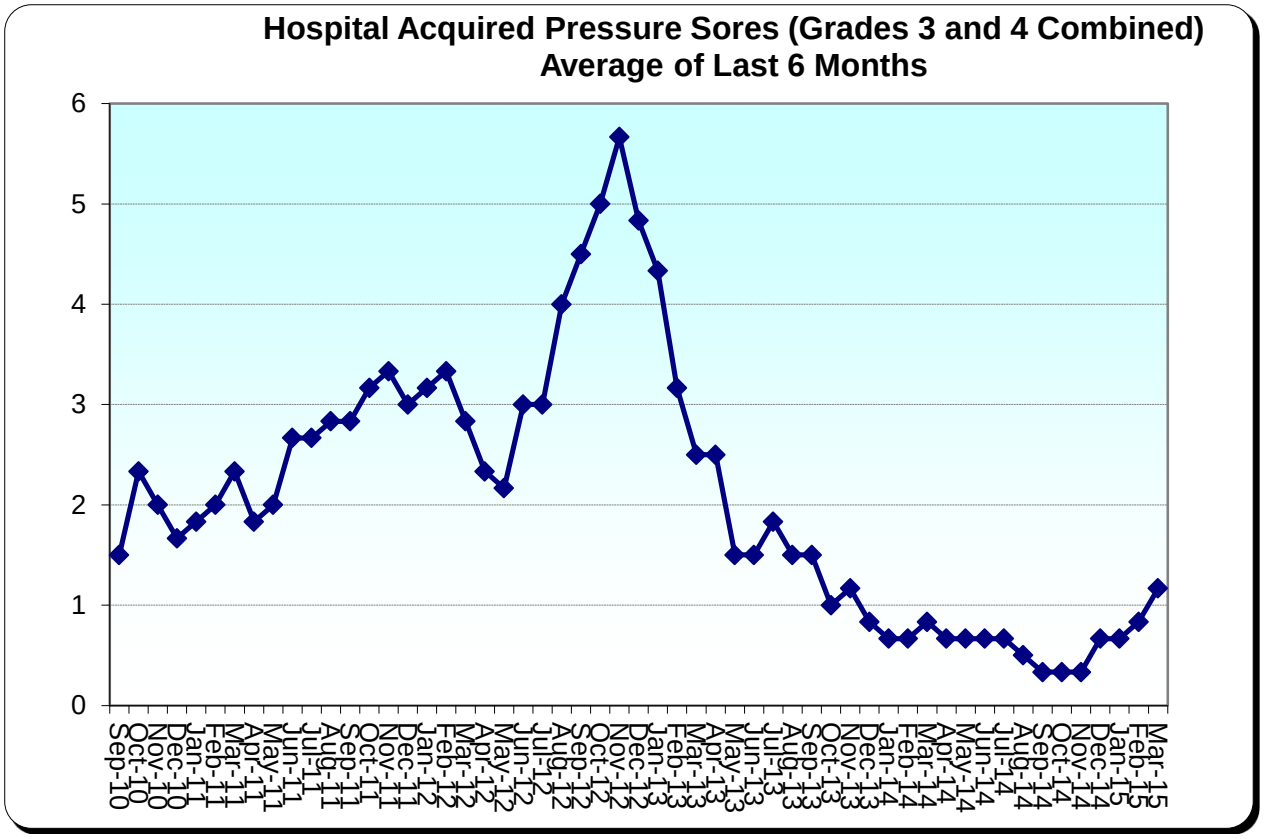
Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
6
5
4
3
2
1
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
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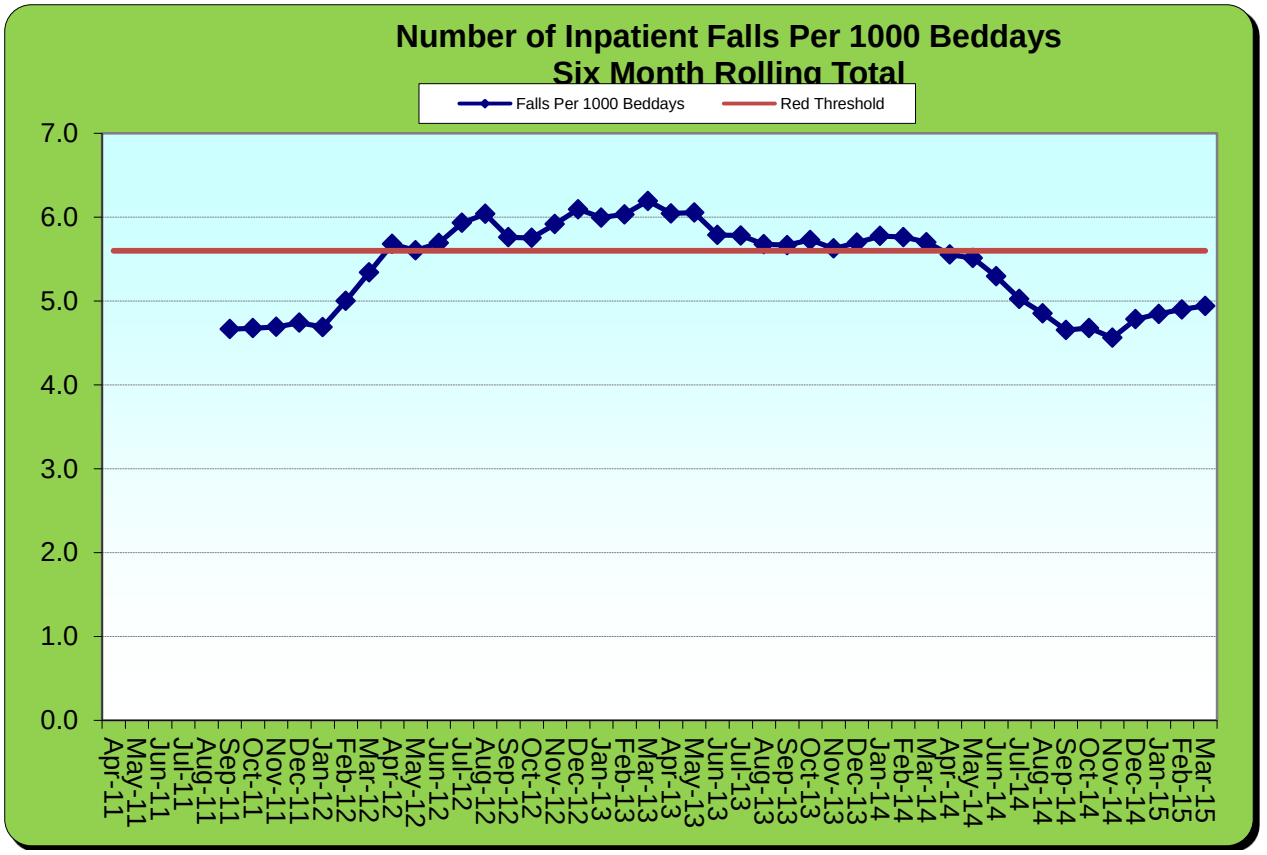
Mar-15


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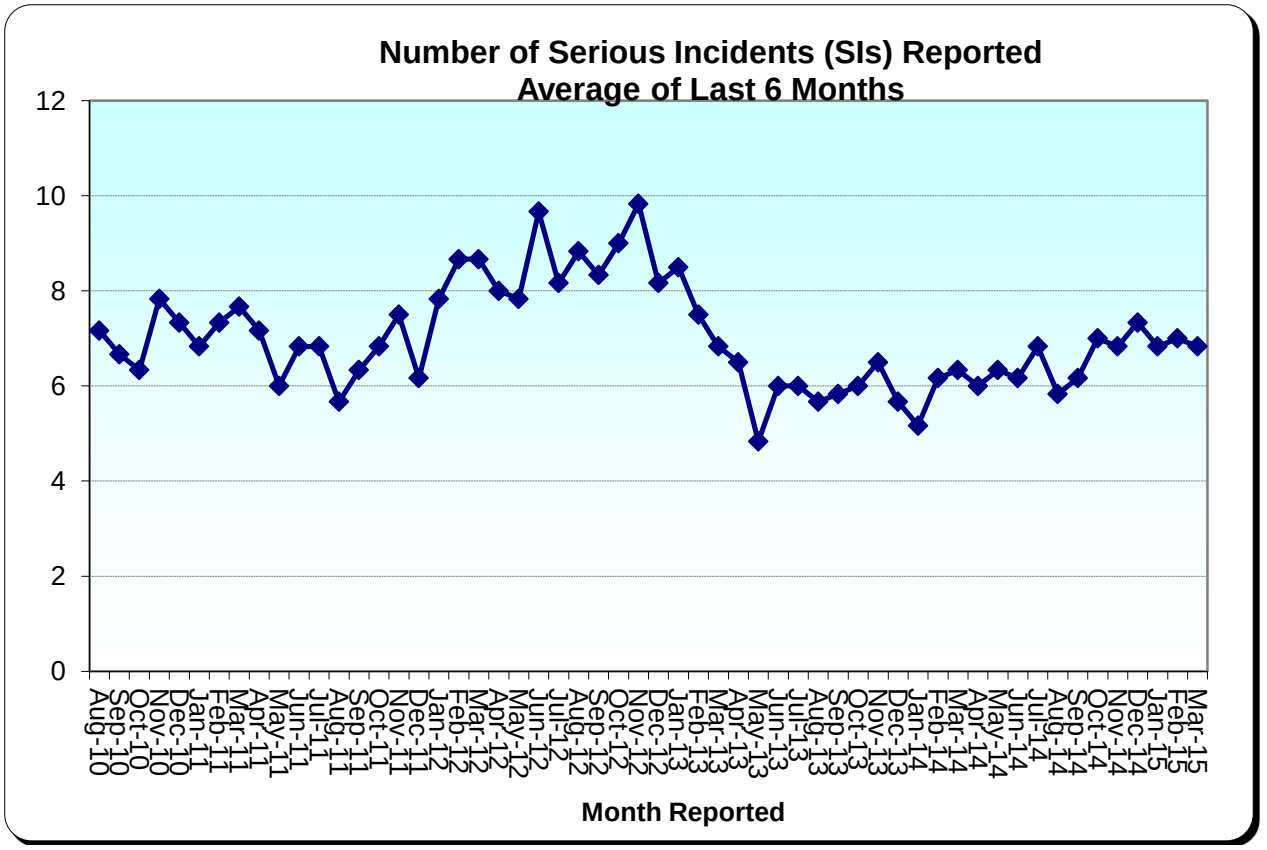
Number of Serious Incidents (SIs) Reported
Average of Last 6 Months
12
10
8
6
4
2
0
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
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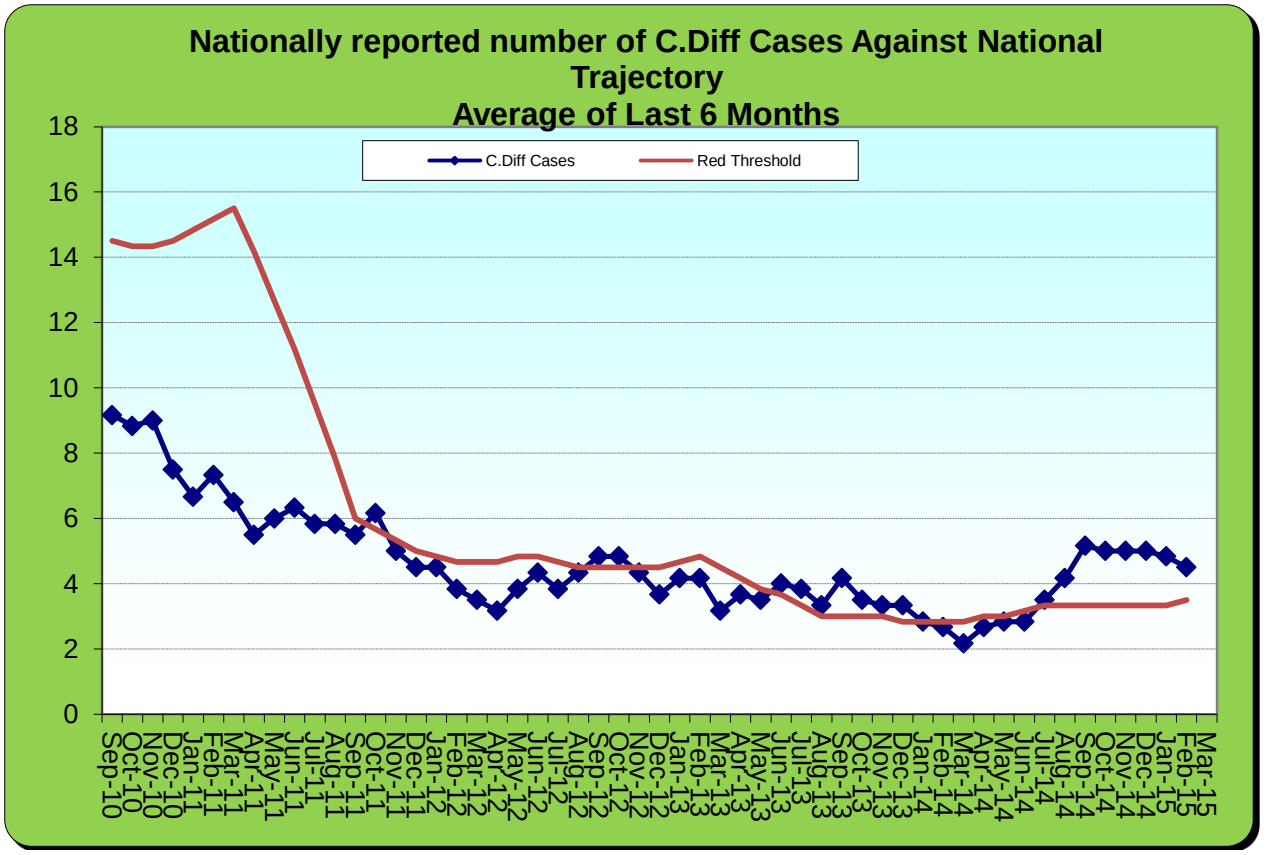
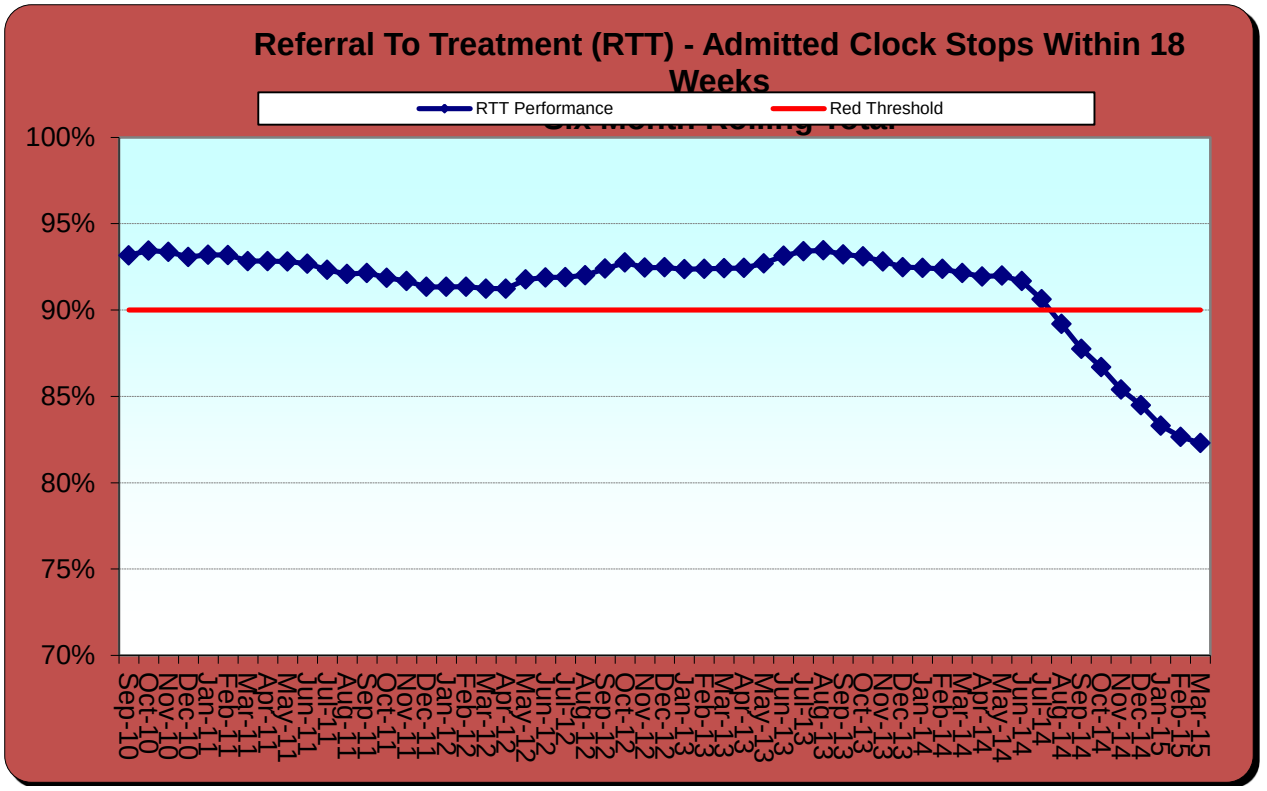
Month Reported



Please note: The RAG rating for this graph is based upon our performance taking account of the level of potentially avoidable cases, and not the total cases report.


Referral To Treatment (RTT) - Admitted Clock Stops Within 18 Weeks
RTT Performance
Red Threshold
100%
95%
90%
85%
80%
75%
70%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
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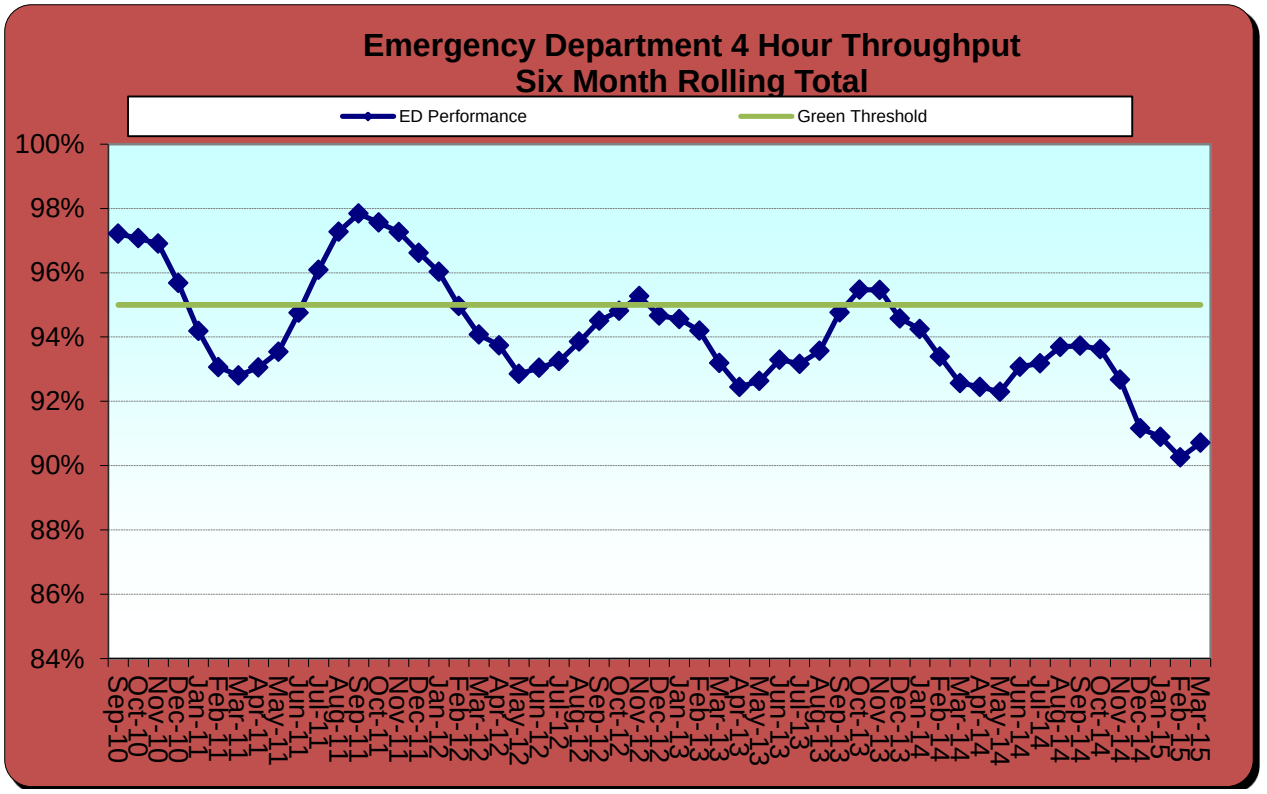
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15


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
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
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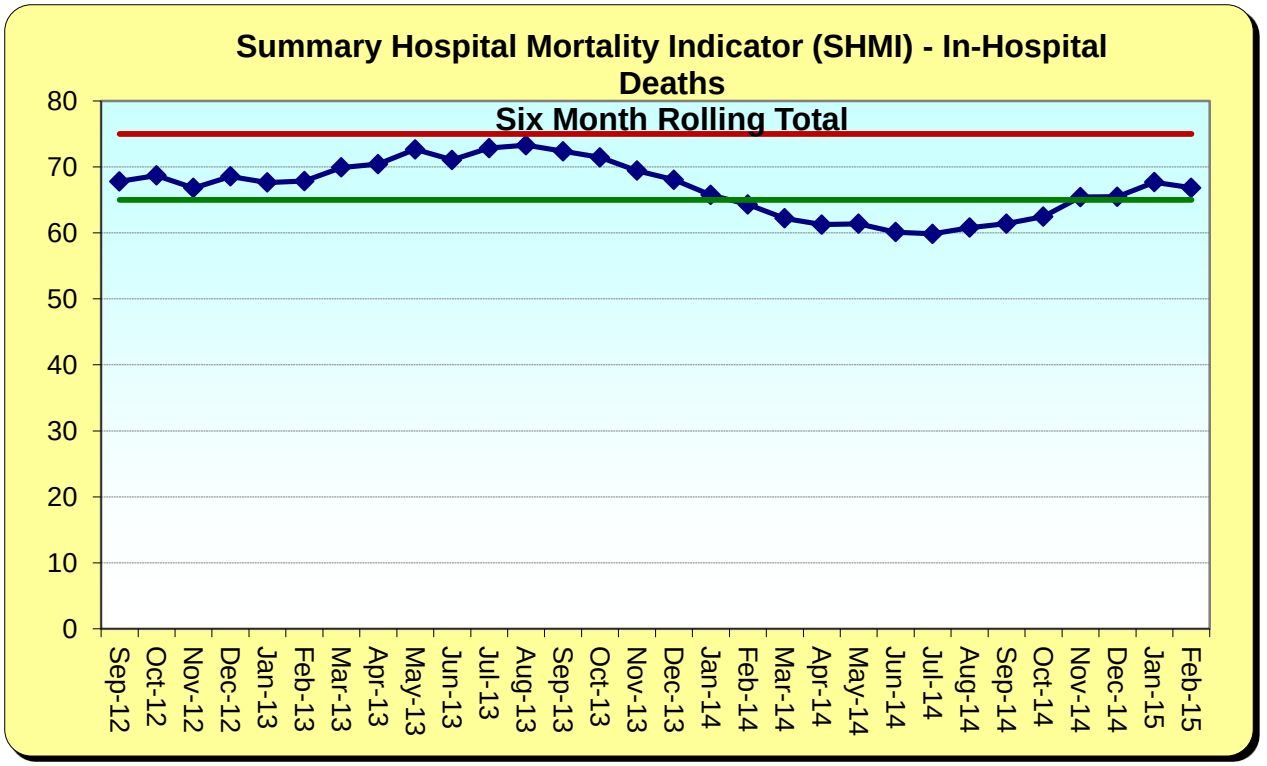
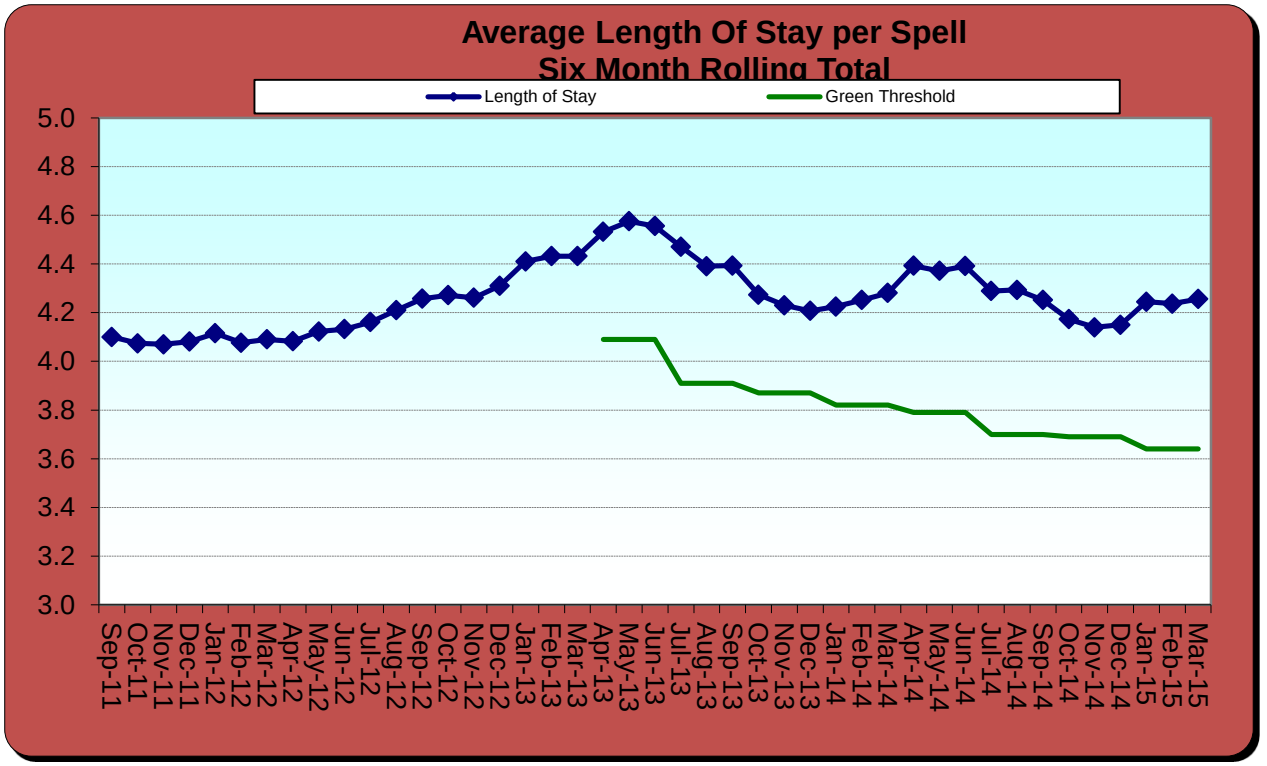
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15


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
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15


Average Length Of Stay per Spell
Six Month Rolling Total
Length of Stay
Green Threshold
5.0
4.8
4.6
4.4
4.2
4.0
3.8
3.6
3.4
3.2
3.0
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
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Feb-14
Mar-14
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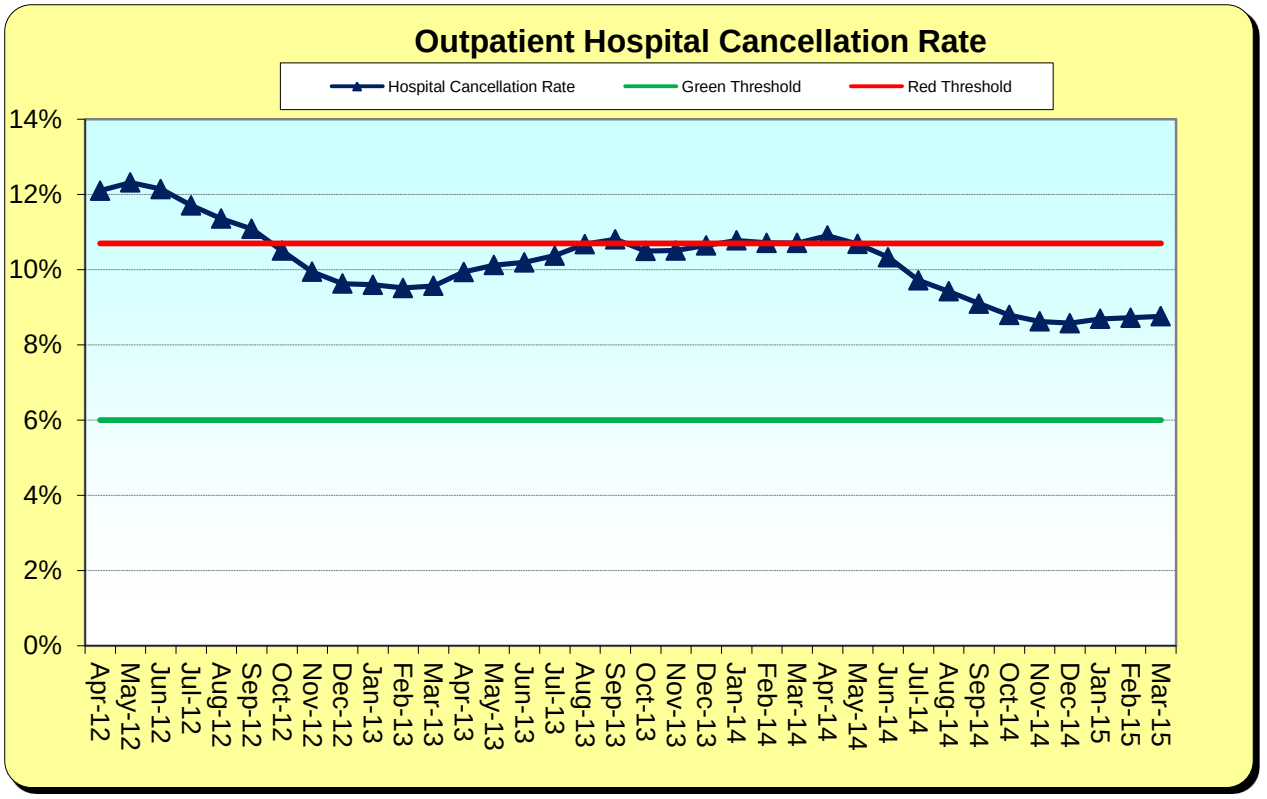
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15


Outpatient Hospital Cancellation Rate
Hospital Cancellation Rate
Green Threshold
Red Threshold
14%
12%
10%
8%
6%
4%
2%
0%
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15

SECTION C – Monitor Risk Assessment Framework

For quarter 4 as a whole the Trust failed to meet six of the standards in Monitor's 2014/15 Risk Assessment Framework. Exception reports are provided for these standards, as follows:

- RTT Non-admitted standard (1.0) – *Access section*
- RTT Admitted standard (1.0) — *Access section*
- RTT Ongoing standard (no additional score – see note below) – *Access section*
- 62-day Referral to Treatment GP and 62-day Screening Cancer standards (1.0 combined standard) – *Access section*
- A&E 4-hour maximum wait (1.0) – *95% standard achieved in March, and recovery trajectory target met for the quarter, therefore no exception report provided*

Please note: In Monitor's Risk Assessment Framework failure of all three RTT standards as in the current quarter, is capped at a score of 2.0.

Overall this gives the Trust a Service Performance Score of 4.0 against Monitor's Risk Assessment Framework. Having restored the Trust to a GREEN rating for quarter 1, Monitor has requested and received further information following multiple breaches of the A&E, Referral to Treatment and cancer waiting time targets, before deciding next steps.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 4 2014/15.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15*	Q4 Actual*	Notes	Q4 Draft Risk Assessment Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	8	✖	✓	✓	✓	8	✓	8 potentially avoidable cases year to date, against a limit of 40.	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.6%	✓	✓	✓	✓	99.0%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	94.6%	✓	✓	✓	✓	94.7%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.7%	✓	✓	✓	✓	97.1%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.2%	✖	✖	✖	✖	77.9%	✖		Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	88.4%	✓	✓	✓	✖	80.6%	✖		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	84.9%	Achieved each month	Achieved each month	Not achieved	Not achieved	80.5%	✖		Not achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	90.3%	Not achieved	Not achieved	Not achieved	Not achieved	89.4%	✖		Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.4%	Achieved each month	Achieved each month	Not achieved	Not achieved	89.3%	✖	Standard failed - but scores for RTT failure capped at 2.0	Not achieved (see notes)
	7	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.9%	✓	✓	✓	✓	97.5%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	95.8%	✓	✓	✓	✓	94.3%	✓		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%	92.2%	✖	✖	✖	✖	91.9%	✖		Not achieved
	10	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
		CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
					Risk Rating	GREEN	GREEN	Triggers further investigation	Triggers further investigation	Triggers further investigation	Triggers further investigation		

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

***Q4 Cancer figures based upon confirmed figures for January and February, and draft figures for March. The C diff figures are for April to March.**

4.0
Meets criteria for triggering further investigation (but see notes in Overview section)

1.1 QUALITY TRACKER

Topic	ID	Title	Green	Red	13/14	14/15 YTD	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Patient Safety																						
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	0	1	2	5	1	1	2	3	3	3	3	3	4	4	5	5	2	3	4	5
	DA03	C.Diff Cases - Monthly Totals	-	-	38	50	5	4	4	4	6	8	4	4	4	3	4	0	13	18	12	7
	DA03c	C.Diff Avoidable Cases - Cumulative Totals	40	40	-	8	0	1	1	2	3	5	6	6	6	7	8	8	1	5	6	8
	DA02	MSSA Cases - Monthly Totals	25	25	27	33	1	0	3	7	1	4	1	3	4	3	2	4	4	12	8	9
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	100%	100%	100%	99.9%	100%
	DD02	MRSA Emergency Screenings	95%	80%	94.8%	94.7%	96%	95.5%	94.9%	94.3%	95.3%	91.4%	95.8%	94.4%	93.4%	95.5%	94.4%	95.9%	95.4%	93.6%	94.5%	95.3%
Infection Checklists	DB01	Hand Hygiene Audit Compliance	95%	80%	96.8%	97.2%	97.6%	96.9%	97.8%	96.8%	96.9%	97.1%	96.3%	97.2%	97.6%	97.1%	97.4%	97.6%	97.4%	97%	97%	97.4%
	DB02	Antibiotic Compliance	90%	80%	88%	89.3%	91.8%	88.2%	87.9%	89.6%	86.2%	88.5%	90.3%	91.2%	89.1%	90.6%	88.8%	88.8%	89.4%	88.2%	90.3%	89.4%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	87%	79%	95%	95%	96%	95%	96%	93%	96%	96%	95%	95%	94%	95%	96%	96%	96%	95%	95%	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	98%	89%	96%	96%	95%	97%	95%	96%	97%	97%	97%	98%	98%	98%	98%	98%	96%	97%	97%	-
	DC03	Cleanliness Monitoring - High Risk Areas	95%	79%	95%	95%	96%	96%	96%	91%	96%	95%	95%	96%	95%	95%	96%	96%	96%	94%	95%	-
Serious Incidents	S02	Number of Serious Incidents Reported	-	-	73	78	5	7	5	10	3	7	10	6	8	7	4	6	17	20	24	17
	S02a	Number of Confirmed Serious Incidents	-	-	71	59	5	7	5	8	3	6	8	4	7	5	1	-	17	17	19	6
	S02b	Number of Serious Incidents Still Open	-	-	-	14	-	-	-	-	-	-	1	1	1	2	3	6	-	-	3	11
	S03	Serious Incidents Reported Within 48 Hours	80%	80%	83.6%	88.5%	80%	57.1%	80%	100%	100%	100%	80%	83.3%	100%	100%	100%	83.3%	70.6%	100%	87.5%	94.1%
	S04	Percentage of Serious Incident Investigations Completed Within Timesca	80%	80%	92.4%	73.3%	100%	50%	83.3%	70%	85.7%	100%	50%	66.7%	37.5%	80%	66.7%	100%	82.4%	81.8%	46.7%	76.2%
Never Events	S01	Total Never Events	0	1	2	6	1	1	0	0	0	0	0	1	0	1	1	1	2	0	1	3
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	-	-	12090	11588	933	954	1010	1104	1038	1258	1151	1028	1073	1017	1022	-	2897	3400	3252	2039
	S06a	Patient Safety Incidents Per 100 Admissions	-	-	9.24	9.38	8.71	8.56	9.07	9.14	9.52	10.48	9.84	9.45	9.7	8.92	9.72	-	8.78	9.72	9.67	9.3
	S07	Number of Patient Safety Incidents - Severe Harm	-	-	44	83	4	6	8	5	4	16	3	12	6	12	7	-	18	25	21	19
Patient Falls	AB01	Falls Per 1,000 Beddays	5.6	5.6	5.68	4.8	5.08	5.18	4.28	4.51	4.59	4.26	5.23	4.5	5.59	4.89	4.91	4.53	4.85	4.45	5.11	4.77
	AB06a	Total Number of Patient Falls Resulting in Harm	24	25	27	28	1	5	2	0	3	5	2	4	1	2	1	2	8	8	7	5
Falls (CQUIN Improvement)	AB07a	Number of Inpatient Falls (CQUIN)	429	429	0	1476	129	136	109	116	116	108	134	114	144	132	120	118	374	340	392	370
	AB07b	Inpatient Falls (CQUIN) - Improvement from Baseline	0	0	0	-311	-12	-8	-35	-44	-33	-43	-22	-26	-8	-23	-15	-42	-55	-120	-56	-80
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.651	0.651	0.656	0.387	0.433	0.343	0.314	0.427	0.396	0.394	0.312	0.553	0.388	0.37	0.45	0.269	0.363	0.406	0.417	0.361
	DE02	Pressure Ulcers - Grade 2	-	-	184	110	11	8	8	10	10	10	8	13	8	9	10	5	27	30	29	24
	DE03	Pressure Ulcers - Grade 3	0	1	13	9	0	1	0	1	0	0	0	1	2	1	1	2	1	1	3	4
	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%	98.8%	98.9%	98.7%	98.1%	98.4%	98.6%	98.9%	98.7%	99%	99%	99.1%	99.4%	99.2%	98.6%	98.7%	98.9%	99.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	90%	93.4%	94.4%	96.4%	94.3%	94%	95.3%	96.6%	93.2%	92.6%	92.3%	96.7%	92.4%	92.9%	96%	94.9%	95.1%	93.8%	93.8%
Nutrition	WB05	Nutrition: Screening Tool Completed	90%	90%	-	93.7%	-	-	-	92.8%	91.8%	94.2%	93.4%	95.1%	93.8%	91.3%	94.6%	96%	-	92.9%	94.1%	93.9%
	WB03	Nutrition: Food Chart Review	90%	85%	82.5%	88.9%	94.7%	87.4%	87.7%	89%	89.3%	93.1%	88.3%	87.2%	87.8%	87.4%	88.4%	87.9%	89.5%	90.4%	87.8%	87.9%
Safety	Y01	WHO Surgical Checklist Compliance	100%	99.5%	99.6%	99.7%	99.7%	99.6%	99.4%	99.5%	99.7%	99.6%	99.7%	99.6%	99.4%	100%	100%	100%	99.6%	99.6%	99.6%	100%

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Quarterly Totals 14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Patient Safety																						
Medicines	WA01	Medication Errors Resulting in Harm	1.61%	2%	0.68%	0.45%	1.3%	0%	0.78%	1.09%	0.52%	0.56%	0%	0.57%	0%	0%	0%	0.54%	0.66%	0.72%	0.2%	0.21%
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	95%	95%	98%	96.5%	98.8%	100%	96.5%	93.3%	97.4%	97.6%	98.6%	97.1%	95%	90%	95.3%	95.6%	98.4%	96%	97.7%	93.8%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	85%	75%	92%	95.5%	98.8%	99.1%	90.9%	86.4%	94.7%	98.8%	98.3%	98.2%	95%	98.4%	-	100%	96.1%	92.6%	97.8%	99%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.5%	2%	1.91%	1.01%	1.18%	0.55%	0.38%	1.41%	1.42%	0.69%	1.21%	0.86%	0.37%	1.55%	1.54%	0.52%	0.68%	1.19%	0.84%	1.23%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	95.6%	92.8%	94.1%	96.6%	95.7%	96.7%	96%	96.7%	96.9%	96.5%	96.1%	96.7%	97%	96.7%	97.9%	96.5%	96.1%	96.7%	96.6%	97%
	AK04	Safety Thermometer - No New Harms	98.2%	97%	97.2%	98.4%	98.2%	98.4%	98.5%	98.9%	98.7%	98%	97.9%	97.8%	98.5%	98.4%	99.3%	98.7%	98.3%	98.5%	98.1%	98.8%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	95%	90%	84%	89%	89%	83%	91%	91%	96%	88%	88%	86%	83%	92%	96%	88%	88%	92%	85%	91%
	CA01	Number of Verified Crash Calls from Adult General Wards	92	108	-	51	3	5	5	4	9	3	2	2	3	6	5	4	13	16	7	15
Discharges	TD04	Out of Hours Discharges			9%	8.1%	9.5%	9%	8.2%	8.6%	7.6%	8.1%	7.7%	7.3%	7.6%	8.2%	7.1%	8.8%	8.9%	8.1%	7.5%	8.1%
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	90%	80%	-	97.9%	-	-	-	-	90%	100%	85.7%	100%	100%	100%	100%	100%	-	96.4%	97%	100%
	CS03	Number of CAS Alerts Overdue At Month End	0	0	-	0	-	-	-	-	0	0	0	0	0	0	0	0	-	0	0	0
Clinical Effectiveness																						
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital D	65	75	67.2	64.1	59.7	64.5	57.3	56.1	66.5	64.1	65.9	85.4	58.5	68.9	60.8	-	60.6	62.2	68.7	65.4
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	100	100	95.2	95.8	-	-	95.8	-	-	-	-	-	-	-	-	-	95.8	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	80	90	75.8	68.4	67.1	66	63.1	58.1	74.7	73.9	70.4	89.7	63.3	71.3	57.6	-	65.4	69	73.1	65.5
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	80%	50%	83.9%	89%	100%	78.9%	100%	76.2%	82.4%	91.3%	90.5%	85%	100%	83.9%	95.5%	83.3%	93.8%	83.6%	92.3%	86.7%
Readmissions	C01	Emergency Readmissions Percentage	2.7%	2.7%	2.71%	2.8%	2.72%	2.97%	3.03%	2.51%	2.95%	2.96%	2.45%	2.39%	2.99%	3.06%	2.76%	-	2.91%	2.8%	2.61%	2.92%
Maternity	G04	Percentage of Normal Births	64%	61%	61.7%	61.5%	63.6%	58.9%	62.4%	64.7%	61.4%	63.8%	58.9%	65.5%	59.6%	60%	59.8%	57.9%	61.7%	63.4%	61.3%	59.3%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	90%	90%	77.4%	76%	88.9%	70%	82.6%	82.1%	71.4%	61.3%	77.8%	73.3%	70%	78.3%	89.7%	72.7%	78.9%	71.3%	73.6%	81.1%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	90%	90%	78.8%	93.4%	94.4%	93.3%	95.7%	100%	96.4%	93.5%	88.9%	86.7%	93.3%	95.7%	93.1%	86.4%	94.4%	96.6%	90.3%	91.9%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	90%	80%	61.7%	70.1%	83.3%	66.7%	78.3%	82.1%	67.9%	54.8%	70.4%	60%	66.7%	78.3%	82.8%	50%	74.6%	67.8%	66.7%	71.6%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	80%	80%	55.1%	56.2%	52.3%	53.6%	36.8%	48.6%	53.7%	61.1%	62.8%	59%	62.8%	55%	66.7%	-	47.3%	54.4%	61.6%	61.7%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	90%	80%	84.2%	85.8%	90.9%	96.4%	81.6%	97.3%	78%	86.1%	88.6%	87.2%	79.1%	75%	87%	-	89.1%	86.8%	84.9%	81.9%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	60%	60%	55.8%	58.2%	60%	30%	57.1%	25%	72.2%	66.7%	58.8%	73.3%	64.7%	50%	57.1%	50%	48.3%	61.4%	65.3%	52.8%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	90%	80%	67.7%	65%	57.1%	52.3%	49%	62.1%	67.5%	66.6%	61.4%	63.7%	62.9%	78.3%	77.3%	81.6%	52.6%	65.4%	62.6%	79.3%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	90%	80%	60.6%	84.1%	71.7%	78.3%	59.5%	84.7%	81.7%	87.3%	87.1%	92.2%	82.2%	90.7%	88.5%	94.2%	70.3%	84.7%	86.3%	91.7%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	90%	80%	65.4%	58.5%	47.6%	56.5%	22.7%	55.2%	50%	35.9%	78.3%	73.3%	68%	82.4%	81.3%	90.5%	42.4%	44.8%	74.3%	85.2%
	AC04	Percentage of Dementia Carers Feeling Supported			-	75.2%	60%	62.5%	90%	-	-	70%	80%	88.9%	64.3%	87.5%	81.8%	-	69.7%	57.1%	78.7%	85.2%
Outliers	J05	Ward Outliers - Beddays	9029	9029	10626	11216	697	951	769	659	749	908	1338	876	1169	1364	847	889	2417	2316	3383	3100

QUALITY

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 13/14	Annual 14/15 YTD	Monthly Totals Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Quarterly Totals 14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4
Patient Experience																						
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	-	-	89	92	90	88	89	89	89	89	89	89	90	-	90	89	89	90
	P01g	Patient Survey - Kindness and Understanding	-	-	-	-	94	94	93	92	93	94	93	93	94	93	93	-	94	93	93	93
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	30%	25%	29.6%	38.7%	45.9%	39.5%	39.5%	35.5%	32.9%	33.1%	36.1%	41.3%	29.5%	37.9%	33.9%	59.3%	41.6%	33.8%	35.5%	44%
	P03b	Friends and Family Test ED Coverage	20%	15%	13.3%	20.8%	15.7%	21.4%	19.2%	16.1%	22.7%	26.2%	20.2%	14.9%	16%	17.3%	22.5%	37.1%	18.9%	21.6%	17.1%	26.1%
	P04a	Friends and Family Test Score - Inpatients	70	64	75.9	75.8	78.4	73.3	73.5	72.4	75	76.8	73.6	73.4	81.8	79.9	73	77.1	75.2	74.8	75.8	76.9
	P04b	Friends and Family Test Score - ED	51	42	70.1	69.5	75.8	71.4	69.3	72.4	69.7	67.1	67	69.5	69.8	70.9	65.2	68.8	71.8	69.4	68.6	68.3
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.21%	0.25%	0.212%	0.261%	0.238%	0.226%	0.277%	0.282%	0.321%	0.266%	0.224%	0.251%	0.224%	0.267%	0.291%	0.273%	0.248%	0.288%	0.232%	0.277%
	T03a	Complaints Responded To Within Trust Timeframe	95%	85%	76.4%	85.9%	93.1%	82.5%	83.3%	91.5%	88.3%	88.1%	84.4%	82.9%	82.9%	84.8%	83.7%	85.3%	86.3%	89.5%	83.4%	84.7%
	T03b	Complaints Responded To Within Divisional Timeframe			71.1%	83.8%	82.8%	86%	91.7%	76.1%	83.3%	81.4%	77.9%	78.6%	87.1%	87.9%	81.4%	92.6%	86.9%	80%	81.1%	88.1%
	T04a	Complainants Disatisfied with Response			62	84	6	4	11	8	4	2	7	9	8	11	7	7	21	14	24	25
Ward Moves	J06	Average Number of Ward Moves			2.26	2.32	2.34	2.3	2.33	2.34	2.38	2.42	2.32	2.37	2.25	2.24	2.28	2.24	2.32	2.38	2.31	2.25
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	0.92%	0.92%	1.02%	1.08%	0.98%	0.96%	1.1%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.02%	1.16%	1.16%	0.97%
	F01a	Number of Last Minute Cancelled Operations	-	-	690	749	54	54	64	84	54	68	52	108	41	58	46	66	172	206	201	170

1.2 SUMMARY

This month, the Board's attention is drawn to some particularly positive changes, including outstanding improvements in Friends & Family Test coverage in both inpatients areas the emergency departments in the Bristol Royal Infirmary and the Bristol Eye Hospital, whilst sustaining a good score for those who would recommend our services to their friends and family. Also, there has been marked improvement in all three of the dementia metrics following the change to electronic recording of data and continued support by the Dementia Project Nurse.

As detailed in the exception reports provided, challenges remain in relation to performance for treating patients with fractured neck of femur and for high risk Transient Ischaemic Attack (TIA) patients and grade three pressure ulcers.

Unfortunately, one never event occurred in March, the details of which are provided in the exception report. However, following investigation, NHS England has downgraded a "wrong tooth extracted never event" which was reported in August 2014. The quality dashboard has been updated to reflect this change.

Achieving set threshold (39)	**Thresholds not met or no change on previous month (9)**
- Trust apportioned Clostridium difficile cases against national trajectory - MRSA screening – emergency - MRSA screening – elective - Hand Hygiene Audit - Cleanliness monitoring: overall Trust score - Cleanliness monitoring: very high risk areas - Cleanliness monitoring: high risk areas - Serious Incidents reported with 48 hours - Serious incident investigations completed within required timescale - 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 4 hospital acquired pressure ulcers - Percentage of adult in-patients who had a Venous Thrombo-Embolism (VTE) risk assessment - Nutritional screening completed - Medicines reconciliation performed within one day of admission (Assessment and cardiac wards)	- Antibiotic prescribing compliance - Percentage adult in-patients who received thrombo-prophylaxis - 72 hour Food Chart review - WHO surgical checklist compliance - Non-purposeful omitted doses of listed critical medication - Stroke care: percentage receiving brain imaging within 1 hour - Stroke care: percentage spending 90% + time on a stroke unit - Dementia admissions-case finding applied - Percentage of complaints resolved within agreed timescale

QUALITY

- Medicines reconciliation performed within one day of admission (Oncology and Gynaecology wards) - 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 - Central Alerting System (CAS) alerts completed within timescale - Percentage of CAS alerts overdue at month end - Summary Hospital Mortality Indicator (SHMI) in-hospital deaths - 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 - Dementia admissions-assessment completed - Dementia admissions-referred on to specialist services - 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 - Number of complainants dissatisfied with our response (not responded in full) - Last minute cancelled operations: percentage of admissions	
Quality metrics not achieved or requiring attention (12)	**Quality metrics not rated (11)**
- MRSA (Meticillin Resistant *Staphylococcus aureus*) bacteraemias against trajectory - MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - Never Events - Number of grade 3 hospital acquired pressure ulcers	**Thresholds to be agreed** - Dementia-carers feeling supported - Out of hours discharges **Metrics for information**

QUALITY	
- Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - 30 day emergency re-admissions - Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours - Fractured neck of femur patients treated with 36 hours - Percentage of normal births - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hour - Patient complaints as a proportion of all activity - Average number of ward moves	- Monthly number of *Clostridium difficile* cases - 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 March the percentage of documented appropriate responses for adult patients with a EWS of 2 or more was 88% against an improvement target of 95% for Q4. For quarter 4 as a whole this was 91% meaning we did not achieve this element of the CQUIN;
- 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 March the number of cardiac arrest calls was 4 against the GREEN threshold target of 8. For the year as a whole there were 51 arrests representing a 47% reduction from the baseline of 96 arrests.

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 March there were 42 fewer falls against a target of 5 fewer than baseline. For there year as a whole there were 311 fewer falls than the age adjusted baseline. We have therefore achieved this element of the CQUIN;
- 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 implemented these five actions.

1.3.3 Friends and Family Test

We 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 March was 59.3% against a target of 30% for inpatients, and 37.1% against a target of 20% 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 March was 81.6% against a target of 90%
    2. Percentage of patients positively identified in 1) who had a diagnostic assessment - performance in March was 94.2% against a target of 90%
    3. Percentage of patients positively identified in 2) who were referred for further diagnostic advice - performance in March was 90.5% against a target of 90%.

1.4 CHANGES IN THE PERIOD

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

- Early Warning Scores acted upon down ↓ from 96% in February to 88% in March;
- Fractured Neck of Femur overall best practice tariff standards ↓ from 82.8 % in February to 50% in March due to a combination of breaches in time to theatre and ortho-geriatrician review;
- Friends and Family Test coverage in the Emergency Department up ↑ again from 22.5% in February to 37.1% in March;
- Friends and Family Test coverage for in patient areas up ↑ from 33.9% in February to 59.3% in March;
- All three dementia metrics: "Find" up ↑ from 77.3% in February to 81.6% in March, "Assess" up ↑ from 88.5% in February to 94.2% in March, "Refer" up ↑ from 81.3% in February to 90.5% in March.

Exception reports are provided for eleven RED rated indicators*.

*Please note: an exception report is not provided for MRSA cases although it is red on the dashboard. This is because the measure continues to be a cumulative measure throughout 2014/15 rather than number of cases each month. The red threshold of one case was triggered in April 2014 therefore this measure will automatically remain red for the rest of 2014/15. There were no new cases in March 2015.

1. MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory
2. Never Events
3. Number of grade 3 hospital acquired pressure ulcers
4. Deteriorating patient- appropriate response to an Early Warning Score of 2 or more.
5. 30 day emergency re-admission
6. Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours
7. Fractured neck of femur patients treated with 36 hours
8. Percentage of normal births
9. High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hour
10. Patient complaints as a proportion of all activity
11. Average number of ward moves

QUALITY

Q1. 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 identified in patients in hospital for more than 2 days. The limit is to have no more than 25 cases in 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 four Trust apportioned cases of MSSA in March 2015. These were as follows:

- Two cases in the Division of Women's & Children's
- Two cases in the Division of Medicine.

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.

Recovery plan, including expected date performance will be restored.

All cases of MSSA in patients that have been in hospital at least two days are investigated by the clinical team, with learning shared at the Infection Control Group bi monthly meeting, chaired by the Chief Nurse. The actions to reduce the number of MSSA cases are as follows:

- MSSA screening continues in Cardiac and Renal services;
- Additional Aseptic Non Touch Technique (ANTT) sessions and workshops have been instigated.

QUALITY

Q2. EXCEPTION REPORT: Never Event	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Never Events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 25 different categories of Never Events listed by NHS England.

Performance in the period, including reasons for the exception:

One Never Event occurred in March in the category "Wrong site surgery". A biopsy of a lesion on the right lower eyelid was performed instead of the biopsy of a lesion on the right caruncle[1] of the eye.

A full Root Cause Analysis investigation is underway.

Recovery plan, including expected date performance will be restored:

- The full investigation of this incident is still underway, but the initial review showed that an administrative error led to the wrong operation being listed and the surgeon consented the patient (who also had a lesion right lower eyelid) for the listed operation rather than the operation planned in the patient's notes. The surgeon carried-out the operation the patient had consented for. The WHO Surgical Safety Checklist was correctly used, but it incorporates the check for the correct operation with what is written on the consent form so would not have prevented this incident.

[1] The lacrimal caruncle is at the inner corner of the eye

QUALITY

Q3. EXCEPTION REPORT: Number of hospital acquired grade 3 pressure ulcers	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

The rate of hospital acquired pressure ulcers grade 2 and above for March 2015 was 0.27 per 1,000 bed days against a trust target of 0.651.

Division	March 2015	Feb 2015	Jan 15	Dec 14	Nov 14	Oct 14
Medicine	0.20	0.64	0.09	0.30	0.54	0.21
Specialised Services	0.46	0.26	0.92	0.23	0.72	0.47
Surgery Head &Neck	0.49	0.72	1.21	1.28	1.20	0.89
Women & Children's	0.13	0.15	0.00	0.13	0.13	0.00
Trust	**0.27**	**0.45**	**0.37**	**0.39**	**0.55**	**0.31**

Of these reported incidents, the Trust had 2 validated category 3 hospital acquired pressure ulcer reported for the month of March 2015, one within Medicine, and one within Surgery Head & Neck.

Initial reviews indicate learning points for the wards. The reassessment of risk of pressure ulcer for the patients was not consistently documented, nor were there clear nursing actions for pressure area care following risk assessment.

Full Root Cause Analyses (RCAs) are underway to review these incidents. Meetings will follow with ward sisters, matrons, tissue viability lead and deputy chief nurse to discuss the RCAs together with lessons learned and an action plan.

Recovery plan, including expected date performance will be restored:

- The Trust has seen a number of grade 3 hospital acquired pressure ulcers over the last few months. Recent changes to documentation have been implemented, with roll-out of new paperwork in April 2015 to improve and capture nursing assessment and intervention to prevent/reduce pressure ulceration. The focus of "back to the floor" will be on the completion of documentation over the next month. A plan is in place to audit the new documentation in October

QUALITY

Q4. EXCEPTION REPORT: Deteriorating Adult Patient-response to an Early Warning Score of 2 or more	**RESPONSIBLE DIRECTOR: Chief Nurse**

Description of how the standard is measured:

The response to a deteriorating patient is set-out in a well-established protocol that was implemented alongside the Bristol Observation Chart which identifies the parameters which comprise the Early Warning Score. Compliance is assessed by monthly audits by front-line staff (usually the Ward Sister).

The audit consists of reviewing the observations carried-out in the previous 24 hours for all adult patients, identifying those occasions where an early warning score of two or more was triggered and checking the documented response on each occasion to see if it was consistent with protocol. We have set ourselves an improvement target to reach 95% by Quarter 4, and have agreed this with commissioners as part of a CQUIN.

Performance in the period, including reasons for the exception:

Performance in March was 88%. Sixty out of 68 patients with an Early Warning Score (EWS) of two or more had documented evidence of a response consistent with the escalation protocol.

The eight patients who did not have documented evidence of a response to an Early Warning Score of two or more occurred in the Divisions of Medicine and Surgery, Head & Neck, across four wards. Of note this month is that these four wards all had higher than usual numbers of deteriorating patients in the audit, 24 deteriorating patients between them (range 5 to 7).

Recovery plan, including expected date performance will be restored:

- Each case has been followed-up by the Ward Sister concerned, and learning shared with relevant staff;
- Following our pilots, we have recently implemented the visual cues in the form of magnets for "status at a glance" boards for EWS of 2+ and EWS 4+.
- Deteriorating patient remains a key part patient safety training on Induction and updates;
- Deteriorating patient project continues. This includes face-to-face training, with all nursing staff in conducting manual observations and a reminder about EWS escalation and SBAR. Progress has been difficult as times with pressure on clinical areas being unable to release staff for on the spot training but we aim to complete this by end of May;

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 February there were 289 emergency readmissions within 30 days of discharge, which equates to 2.76% of discharges. This is a significant reduction on January's level of readmissions (3.06%), and only 0.06% above the target level of readmissions of no more than 2.70%. The rate of readmissions is 0.09% above the 2.7% target for the year to date, and 0.03% above the rate reported for quarter 4 of 2013/14. The Trust continues to review any specialties which are identified through benchmarking reports as having a higher than expected readmission rate, relative to national and clinical peers.

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. EXCEPTION REPORT: Percentage of Normal Births	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

Performance against this indicator is calculated as the percentage of all births at St Michael's that are "normal". Normal is defined as women whose labour starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously.

Women who experience any one or more of the following are excluded: induction of labour (with prostaglandins, oxytocics or Artificial Rupture of Membranes), epidural or spinal, general anaesthetic, forceps or ventouse, caesarean section, or episiotomy."

This data is taken from Medway Maternity each month via an analyst using the above criteria it includes birth in all clinical settings both in the hospital and at home whether planned or by accident

Performance in the period, including reasons for the exception:

In March normal births were at 57.9%. There is concern that the reduced normal birth rate is related to the high induction of labour rate at 30%, due to the use of oxytocin and artificial rupture of membranes. Even if these women progress to a normal birth without drugs, or intervention they are excluded for these reasons.

There are many high risk women who have to give birth at St. Michael's due to maternal and fetal clinical reasons, and referrals from across the South West area as their babies require surgical input once born. Many of these women and babies require induction and assistance due to their complications, resulting in a slightly higher percentage than other units would expect.

Recovery plan, including expected date performance will be restored:

- We are always considering normal birth and encouraging women both during the ante-natal and intra-partum period to give birth normally. This will continue;
- We are reviewing our clinical guidelines in line with the NICE Intrapartum Care guideline which may alter the proportion of women encouraged to give birth in the Midwife Led Unit; there have been significant changes to the recommendations for fetal monitoring in labour which may reduce the number of cardiotocographs classified as pathological and thereby reduce the intervention rates;
- A high percentage of inductions is noted here at St. Michael's and there is an audit underway to review the induction of labour pathway, including the indication for induction of labour. Induction of labour will undoubtedly affect our normal birth rate as induction includes use of oxytocin and Artificial Rupture of Membranes, hence this 30% of women are excluded each month from our target group of women from the outset. Women undergoing induction of labour are also more likely to require epidural anaesthesia and as a result of this require an instrumental

QUALITY

delivery;

- The Normal Birth Working Group has been re-established to review the audit of the induction of labour pathway.

QUALITY

Q7-8. 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 (BPT) 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:

Performance for March for time to theatre was 72.7%; six of the twenty two patients did not receive surgery within 36 hours.

Performance for March for ortho-geriatrician review was 86.4%; three of the twenty two patients did not have an Ortho-geriatric review within 72 hours.

Further details regarding the reasons for non-achievement are given below:

- The three patients that were not reviewed by an ortho-geriatrician within 72 hours were both admitted during a week when two of the three ortho-geriatricans were absent (one due sickness) and despite significant attempts to secure a locum doctor, this was not achieved;
- Of the six patients that did not receive surgery within 36 hours: one patient was a missed fracture which was detected after the 36 hour window. The remaining five were not able to be admitted due to lack of theatre capacity, follow a peak in emergency activity (both for fractured neck of femur and general trauma). A contributing factor to reduced theatre capacity is an acute bottleneck in recovery which is being addressed as a matter of priority;
- A further two patients did not go to theatre for clinical reasons.

This means that best practice standards were not met for 11 out of 22 patients (50%).

QUALITY

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

The Division of Surgery, Head & Neck continues to focus on improving performance in the time to theatre for hip fracture patients:

- Operational focus is currently on embedding the new all-day weekend operating, and ensuring staffing can support this on an ongoing basis; this will include running these lists on Bank Holidays, which started at Easter. Funding for continuation of this model, from April onwards is included (as a cost pressure) in the SH&N Operating Plan given the expectation that Resilience Funding will not continue in 2015/16;
- A new Trust-wide transformation programme has commenced, with a project specifically focussed on orthopaedic theatre utilisation and efficiency; including a specific work stream on emergency pathways;
- Further job plan changes have been agreed which will improve the spread of trauma time across the week and enable an additional hip fracture case to the start of planned limb reconstruction theatre lists;
- Enhancement of theatre staffing in the evening to allow for two "planned over-runs" as opposed to the current one, in light of the frequency of this occurrence;
- Delivery of a range of actions to address the theatre recovery bottleneck to improve throughput.

The improvement trajectory below for time to theatre shows that the actual number of breaches in March against the recovery plan.

Month (of patient discharge)	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**
Total patients	31	27	15	30	23	29	22
Expected 36 hour breaches	**7**	**7**	**6**	**5**	**5**	**3**	**3**
Performance trajectory	**77%**	**77%**	**80%**	**83%**	**83%**	**90%**	**90%**
Actual 36 hour breaches	12	6	4	9	5	3	6
Actual performance	**61%**	**78%**	**73%**	**70%**	**78%**	**89.7%**	**72.7%**

QUALITY

Q9. EXCEPTION REPORT: High Risk Transient Ischaemic Attack (TIA) Patients Starting Treatment Within 24 Hours	RESPONSIBLE MANAGER: 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, ECG, Brain scan) completed within the 24 hour window. The 24 hour window starts at first contact with any health professional. Only counts patients who attend as Outpatients, not those who are admitted to hospital.

Performance during the period, including reasons for exception:

Performance in March was 50% against a target of 60%, which equates to eight out of sixteen TIA patients in March not starting treatment within 24 hours. The reasons for this are:

- One patient presented late to GP (after 10 days); however delay for MRI scan due to capacity meant this took place more than 24 hours from first contact;
- One patient received a late clinic appointment as first fax referral from GP did not arrive (North Somerset patient);
- One patient had a delayed MRI scan due to difficulties accessing a slot in time;
- One patient (travelling from North Somerset) was seen the day after referral, but investigations were completed at 28 hours;
- One patient was referred after 16:00 hours, but was seen at the following day but investigations were completed at 26 hours;
- There was no clinic slot for one patient;
- One patient was referred on a Saturday by the BRI Emergency Department, but not picked up by North Bristol Trust who provide the weekend service;
- One patient was seen in the BRI Emergency Department on the 20/3, but not seen in clinic until 23/3, and was not down-graded at triage (but should have been).

Recovery plan, including expected date performance will be restored:

- A commissioner meeting will take place in relation to the patient who was not picked up by North Bristol Trust;
- The issues with MRI capacity have been discussed with Diagnostics & Therapies Division;
- A discussion with the appropriate member of the medical team has taken place regarding the patient not downgraded at triage.

QUALITY

Q10. 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 against 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 March 2015, complaints received represented 0.27% of clinical activity (approximately one in every 365 patient episodes of care). This is a decrease percentage-wise on the 0.29% reported in February 2015; although the actual number of complaints received increased from 171 in February to 181 in March 2015. Of the complaints received in March, 88 are being progressed through formal resolution. There were no notable changes to the numbers of complaints received by each Division compared to February, and all Divisions saw an increase in the number of complaints received compared with the same period last year (March 2014).

The divisional breakdown is shown below:

Division	Total complaints received in March 2015	Percentage of patient activity	Areas with highest number of complaints in March 2015
Diagnostics & Therapies	11 (5 in February)	Not recorded for this Division	Radiology x 3
Surgery, Head & Neck	72 (66 in February)	0.25%	Bristol Eye Hospital x 26 Bristol Dental Hospital x 11 ENT Outpatients x 8 Upper GI x 5
Medicine	39 (29 in February)	0.28%	Emergency Department x 7 Ward A300 (MAU) x 6 Sleep Unit x 4
Women & Children	29 (32 in February) Bristol Children's Hospital – 17 St Michael's Hospital – 12	0.19%	Paediatric Orthopaedics x 2 Paediatric Cardiology x 2 Emergency Department & Ward 39 x 2 Ward 37 Renal Unit x 2 Gynaecology Outpatients x 2
Specialised Services	24 (32 in February)	0.30%	Bristol Heart Institute Outpatients x 14

	Bristol Heart Institute – 19 Bristol Haematology & Oncology Centre - 5		Chemo Day Unit (Outpatients) – BHOC x 5

In the Division of Surgery Head & Neck, the number of complaints received by Bristol Eye Hospital remained high, increasing to 26 complaints (compared with 20 in February 2015). Of these 20 complaints, 11 were in respect of cancelled or delayed appointments/operations, 4 were about failure to answer the telephone and 3 were in respect of attitude of medical and nursing staff.

There was a further small decrease in complaints received by the Bristol Dental Hospital, with 11 complaints, compared with 15 in February and 14 in January 2015. Of these 11 complaints, there were no discernible trends, with just two regarding cancelled/delayed appointments and two in respect of attitude of dentists.

In the Division of Medicine, there was a decrease in the number of complaints received by the Emergency Department, with 7 being received in March 2015 (9 in February). Six complaints were received by Ward A300 (MAU) and four by the Sleep Unit. There were no discernible patterns noted in respect of the complaints received by the Emergency Department. However, 3 of the 4 complaints received by the Sleep Unit were regarding failure to answer telephones. Of the 6 complaints received by Ward A300 (MAU), 2 were in respect of clinical care and 2 were about a failure to answer telephones.

In the Division of Specialised Services, the number of complaints received by the Bristol Heart Institute Outpatients Department remained high at 14, compared with 15 in February. Of these 14 complaints, 9 were about cancelled or delayed appointments and 6 were in respect of unanswered telephones. There were 5 complaints received for the Chemo Day Unit (Outpatients) at Bristol Haematology & Oncology Centre, with 3 of these being in respect of clinical care.

The Divisions of Women's & Children's Service and Diagnostics and Therapies there were no discernible trends other than shown in the table above.

Recovery plan, including expected date performance will be restored:

February and March 2015 complaints data will be discussed in detail by Heads of Nursing at the Trust's Patient Experience Group meeting on 16th April 2015.

QUALITY

Q11. EXCEPTION REPORT: Average Number of Ward Moves	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the standard is measured:

This is one of our quality objectives for 2014/15 and is defined as the average number of ward moves per patient spell. This measure includes only spells where patient has had at least 2 overnight stays and is calculated as total ward moves divided by total spells.

We are aiming to achieve a 15% reduction by quarter 4 2014/15, from a 2013/14 baseline of 2.26. We have calculated seasonally-adjusted quarterly targets of 2.32 (Quarter 1), 2.20 (Quarter 2), 2.09 (Quarter 3) and 1.97 (Quarter 4).

Performance in the period, including reasons for the exception:

In the month of March 2015 there was an average of 2.24 ward moves per patient against the quarterly target of 1.97. However, performance for the quarter as a whole, at 2.25 moves per patient, is lower than the same period last year at 2.35 moves.

Recovery plan, including expected date performance will be restored:

- The lay-out of the wards and increase in single rooms in the new build should decrease the necessity to move patients to address gender, specialty, acuity and isolation requirements;
- Increased bed numbers in the Medical Assessment Unit will decrease the need for transfers off to down-stream inpatient wards. The move took place on November 4th 2014;
- Actions taken to improve patient flow, as detailed in the Emergency Access Resilience Plan, should also help to ensure patients get to the right bed, following any assessment period they need, and do not necessitate a further move;
- A specification for a Ward Moves report has been agreed with the Performance Information Team. This report will include information on how many ward moves each patient has undergone on their current admission. This will support the dynamic risk assessments made by the Clinical Site Team on patient placement;
- The Ward Moves Tracking report is now being used by the Clinical Site Management Team.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the **Division of Diagnostics and Therapies:**

- As in 2013/14, we set ourselves the goal of reducing omitted doses of critical medicines. This is important to patient safety and quality of care to ensure that the patient receives the maximum benefit from their medicines and avoid harm. From the improved baseline at the end of 2013/14 (1.91% of patients having a non-purposeful omitted dose, measured by sampling methodology in approximately 1000 patients each month, monitoring the previous three days of treatment), we continued to focus on this measure as a priority. We were successful in reducing the percentage of omitted doses of critical medicines to 1.01%, a 47% reduction, following an ongoing detailed ward level focus. A poster entitled "Reduction of omitted critical medication in an acute Trust" demonstrating our safety improvements in this respect has been accepted for the British Medical Journal / Institute for Health Improvement International Forum on Quality and Safety in Healthcare in which takes place at the end of April;

- Weight Management Support In Maternity For Obese Ladies - This involves the weight management service and midwives working collaboratively to improve referral rates of obese (Body Mass Index – BMI - of 30 kg/m^2 or more) pregnant ladies to the specialist weight management service for personalised advice on how to maintain a healthy weight in pregnancy (obesity in pregnancy is one of the most commonly occurring risk factors in obstetric practice);

- The roll-out of the Boots pharmacy as our primary outpatient dispensing provider has been a success and has seen excellent service Key Performance Indicators delivery and financial results, for example, 99% of patients waited 30 minutes or less for their medications to be dispensed and accuracy of dispensing was 99.95% in March 2015 . This success has also contributed to the recruitment of a pharmacist to manage risk in the Neonatal Intensive Care Unit; funded by savings from outsourcing our outpatient dispensing;

- Successful sub-contracting of the clinical element of the Orthotics service which has made financial savings and enhanced the quality of the service. The new subcontracted model will allow for more timely review of patients and improve wait times. The company we have subcontracted the service to have a wealth of knowledge which is particularly good as experienced Orthotists are in short supply;

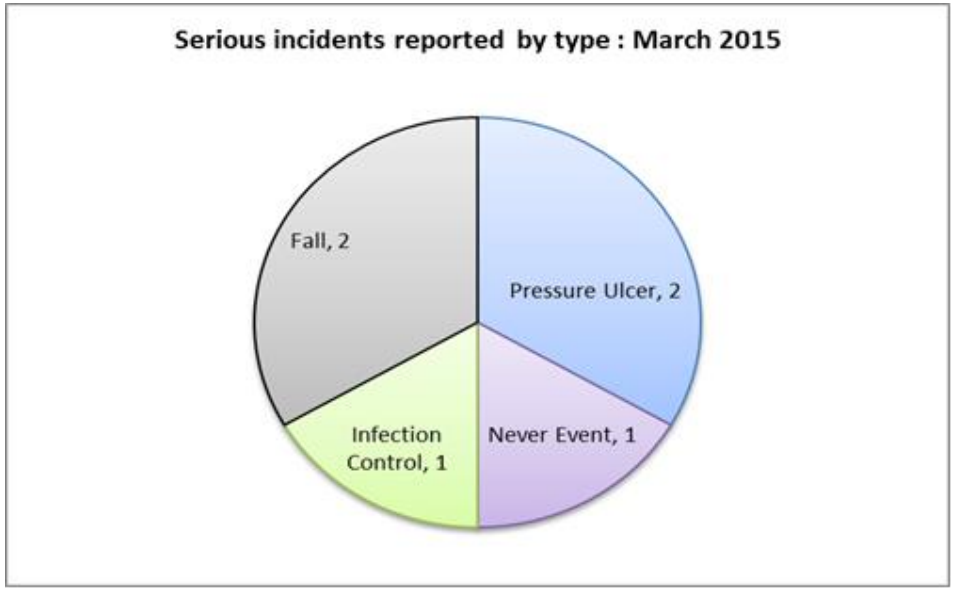
- The Outpatient Parenteral Antibiotic Treatment service at the Bristol Royal Hospital for Children is now running, with considerable input from pharmacy in supporting the launch of this new way of working. This service enables children and young people, who are medically stable but requiring prolonged courses of intravenous antibiotics, to have their treatment managed at home rather than in hospital. A community nurse visits the patient daily to administer the antibiotics and the patient is reviewed at weekly clinics by a consultant;

QUALITY

- Following successful transfer of the Paediatric Epilepsy Surgical Programme from North Bristol NHS Trust, we now provide highly specialist Neurophysiology investigations for pre-surgical evaluation and surgery as part of the Children's Epilepsy Surgery Service. We are one of four designated centres within England who have been commissioned by the national Paediatric Neurosciences Clinical Reference Group to undertake this specialty. We have recently expanded and opened a second bed.

1.6.2 SERIOUS INCIDENT THEMES

There were six serious incidents reported in March as shown below:



Further details are provided in the table below:

Date of Incident	SI Number	Division	Incident Details	Investigation
09/03/2015	2015 9201	Medicine	Grade 3 Pressure Ulcer	Investigation underway
11/03/2015	2015 9701	Medicine	Patient fall resulting in fracture.	Investigation underway
19/02/2015	2015 9896	Surgery, Head and Neck	Never Event : Wrong Site Surgery	Investigation underway
16/03/2015	2015 10550	Women and Children	Neo-natal Intensive Care Unit closed due to outbreak of para influenza	Investigation underway
17/03/2015	2015 10560	Surgery, Head and Neck	Grade 3 Pressure Ulcer	Investigation underway

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Date of Incident	SI Number	Division	Incident Details	Investigation
24/03/2015	2015 11352	Medicine	Patient fall resulting in fracture.	Investigation underway

WORKFORCE

2.1 SUMMARY & EXCEPTION REPORTS

Although it is recognised that many of the contributory factors are impacting on more than one workforce Key Performance Indicator (KPI), an exception report is provided for each of the RED-rated indicators, which in March 2015 were as follows:

- Workforce numbers - compared with budgeted establishment
- Bank and agency usage – compared with target
- Vacancies – compared with target
- Turnover - compared with target
- Sickness – compared with target

Key Performance Indicators (KPIs) in the quarterly workforce report, which is next due in May, 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 annual Operating Plan process. For those targets which are below plan, exception reports are provided which detail performance against target. Graphs in the Supporting Information section are continuous from the previous year to provide a rolling perspective on performance.

KPI thresholds were determined on the basis of previous years' performance and through benchmarking with other comparable Trusts. Some ambition was built into the thresholds to move UH Bristol to the upper quartile in respect of staff experience. During March 2015, Divisions have developed operating plans for 2015/16, which include workforce KPIs, which come into effect from April 2015, and will be reflected in the report produced in May.

WORKFORCE

W1. EXCEPTION REPORT: Workforce Numbers	RESPONSIBLE DIRECTOR: Director of Workforce and Organisational Development

Description of how the standard is measured:

Workforce numbers in Full Time Equivalent (FTE) including substantive, bank and agency staff, compared with targets set by Divisions for 2014/15.

Performance in the period, including reasons for the exception:

Total workforce numbers (substantive and bank and agency) variance was unchanged from February, 2.2% above budgeted FTE, largely due to the continued high usage of bank and agency staff. Expenditure was within 0.04% of the pay budget during March due to year end funding adjustments, and so there is no exception for pay. The annual overspend of 1.2% for the year 2014/15 will be explained in more detail in the quarterly workforce report in May. Performance by Division is provided in the table below.

Total workforce numbers including bank and agency	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc Estates and Facilities)	Facilities & Estates
March 2015	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Actual Employed	7544.1	930.0	1078.2	790.2	1643.9	1722.7	655.9	723.2
Bank and Agency	586.5	16.5	204.7	65.4	93.6	88.6	48.4	69.4
Total Workforce Numbers	8130.6	946.5	1282.9	855.6	1737.5	1811.3	704.3	792.6
Budgeted Numbers	7958.8	945.2	1213.3	825.9	1732.9	1755.6	700.7	785.3
variance target +/-	(171.8)	(1.3)	(69.6)	(29.7)	(4.6)	(55.6)	(3.6)	(7.3)
Percentage variance	2.2%	0.1%	5.7%	3.6%	0.3%	3.2%	0.5%	0.9%

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

Work to target excess bank and agency usage is described in W3 below.

WORKFORCE

W2. 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:

During March, temporary staffing comprised 7.2% of total staffing numbers (FTE) compared with 7.3 % last month, and an annual average of 6.6%. Agency staffing accounted for 2.1% of total staffing for March, compared to an annual average of 1.5%. Agency usage has increased by 13 FTE and bank usage has reduced by 15.9 FTE. The overview below by Division shows usage for bank and agency against the thresholds set by Divisions.

Bank (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Bank March 2014	303.5	8.2	97.3	31.4	64.8	43.3	31.7	26.9
Target set by division	242.9	12.1	76.0	19.0	50.8	43.8	28.2	13.0
Bank February 2015	416.2	9.8	144.3	46.4	67.9	65.1	36.1	46.7
Variance from target (FTE)	(173.3)	2.3	(68.3)	(27.4)	(17.0)	(21.2)	(7.9)	(33.7)

Agency (FTE)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Agency March 2014	79.7	2.7	23.8	19.4	6.5	10.8	8.0	11.1
Target set by division	37.3	2.0	8.3	3.2	6.9	8.7	4.9	3.3
Agency February 2015	170.3	6.6	60.4	19.0	25.7	23.5	12.3	22.7
Variance from target (FTE)	(133.0)	(4.7)	(52.1)	(15.8)	(18.8)	(14.8)	(7.4)	(19.4)

Trust-wide, bank and agency usage continues to be for the following reasons:

- Workload/clinical needs, increased acuity, extra capacity and administrative workload reduced slightly to 42.0% from 42.1% of overall usage;
- Cover for vacancies increased to 28.7% from 27.3 %;
- Cover for sickness absence reduced to 11.7% from 12.4%;
- Nursing assistant one-to-one care reduced to 8.0% from 8.6% of usage.

At the end of March, there were 11 additional capacity beds open in Medicine which is a reduction of 32 because of changes in the funded bed base.

WORKFORCE

14.4% of usage was due to increased acuity and dependency, and 5.4% of usage was due to additional bed capacity, reflecting operational pressures.

The table below shows usage when Operational Resilience funded FTE is excluded, estimated on the basis of average costs of bank and agency.

Bank & agency usage (excluding operational resilience funded) FTE	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services (exc Facilities & Estates)
October 2014	517.58	15.24	163.08	62.93	93.61	80.39	63.13	39.21
November 2014	522.65	21.50	161.64	63.94	96.02	80.47	62.52	36.56
December 2014	489.13	14.25	141.06	54.45	99.68	65.08	67.66	46.95
January 2015	414.97	9.98	107.68	51.66	80.67	60.85	61.78	42.35
February 2015	473.64	15.60	91.05	63.07	97.71	85.45	73.73	47.03
March 2015	469.35	8.56	115.21	57.17	88.70	81.89	69.39	48.43

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

The bank and agency action plan will be regularly reviewed by the Recruitment and Retention Group. Progress this month is summarised below:

Enhanced Rostering, Operational and Workforce Planning:

- Additional KPIs covering more areas are now in place and are being reported in the Safe Staffing paper submitted to Quality and Outcomes Committee. All adult ward areas now receive a monthly overview of budgeted, actual and indicative staffing based on acuity and dependency returns. From May 2015, ward performance information will be displayed to enable staffing levels to be assessed in the context of quality indicators, staffing used and the resource envelope.

Improved Bank fill rate to reduce the proportion of premium agency staffing

- The system to replace NHS texting has an added functionality that staff can text back to fill a shift, rather than needing to ring or email. This service is being rolled out and extended to other bank staff including admin and clerical, interpreters and Facilities & Estates;
- The Senior Leadership Team and Pay Assurance Group agreed that the intensity bonus for bank-only staff would be increased from April 1st;
- Shifts can now be paid at the end of the month they are worked, encouraging substantive staff to undertake additional hours;
- The re-appointment process was reviewed in March to create a more streamlined process tailored to the applicant, not repeating employment checks unnecessarily for current employees and provision of a single point of contact to undertake administration to register for the bank;
- Divisions continue to monitor long term bank assignments to ensure an appropriate use of temporary staff, releasing staff into other assignments where more appropriate. Long-term agency usage for administrative & clerical roles is now under review.

WORKFORCE

W3. EXCEPTION REPORT: Vacancy Levels	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.

Performance in the period, including reasons for the exception:

Vacancies have remained at 5.2%, with reductions in Women's & Children's, Facilities & Estates and Trust Services Divisions.

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
March 2014	4.4%	5.2%	1.0%	3.5%	3.6%	3.4%	10.5%	7.1%
Actual March 2015	5.2%	1.6%	11.1%	4.3%	5.1%	1.9%	6.4%	7.9%
FTE vacancy March 2015	414.7	15.2	135.1	35.7	88.9	32.9	44.8	62.1

There are 45 FTE more staff employed in March than in February, including 21.5 FTE registered nurses. However, this is not fully reflected in reported vacancy levels because the budgeted establishment in the Medicine Division has increased by about 35 FTE as funding has been assigned to previously unfunded beds. Registered nurse vacancies have reduced from 7.3% (171 FTE) to 6.7% (158.4FTE), and ancillary vacancies have reduced to 5.9% (46.1 FTE). There continue to be "hot spots" of high vacancies, including Paediatric and Neonatal Intensive Care Units, Medicine wards, and key medical posts in Diagnostics & Therapies and Specialised Services Divisions.

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

Progress on the agreed recruitment action plan is as follows:

<u>Increased speed of recruitment - Conversion to hire</u>

- Focused work continues with escalation where required to overcome blockages in workflow.

<u>IT infrastructure within the end-to-end recruitment process</u>

- A formal project plan has been compiled for the implementation of the new recruitment management system. An initial launch is planned for the end of May with full implementation by the end of June 2015. Contracts are currently being finalised with the supplier and the first stage training

will commence in April. Baseline measurements will be used to inform ongoing reviews and benefits realisation.

Additional resources in the recruitment team, to deliver the challenges of recruitment over the next year

- Given the ongoing high volumes of recruitment and further demands indicated through the Divisional operating plans, the team structure remains agile, within existing resources, to ensure challenges are met effectively.

Marketing campaign to target the national UK market

- A robust marketing campaign has commenced to attract registered nurses for the Bank, including local radio, social media and press advertising. Outcomes will be reported next month.

Overseas Recruitment

- It has been agreed that UH Bristol representatives will attend the careers fairs in Dublin and Belfast in April 2015. The newly established Recruitment and Retention sub-group will be overseeing the potential overseas recruitment campaign for registered nurses. Demand and timeframes are currently being assessed in conjunction with Heads of Nursing and HR Business Partners.

Progress in March with respect to staff groups where vacancies are particularly high is described below:

Ancillary (Cleaning, Catering and Portering) Recruitment

- At the end of March there were 48 vacancies for Domestic Assistants across the Trust, of which 35 posts have been offered. A further open day has been arranged for 12th May to target the remaining vacancies;
- 19 Domestic Assistants and 8 Bank Domestic Assistants joined the Trust in March. An open day was held for Domestic Assistants Trust-wide and 13 candidates were conditionally offered posts;
- As a result of the Bristol Royal Infirmary Redevelopment, there were 27 vacancies in March. These vacancies have now all been filled through recruitment, slotting in, reconfiguration of hours at the Bristol Heart Institute and some bank domestic staff taking up substantive posts.

Nurse Recruitment

- 53 final offers were made to external candidates in March 2015, of which 19 were Registered Nurses and 34 were Nursing Assistants;
- Three Nursing Assistant assessment centres were held in March resulting in 46 recruits. A campaign will take place in the summer to target those who will be taking a year out after A levels to be employed as potential “interns”.
- 14 Return to Practice applicants resulted in 1 offer for the Children’s Hospital, for the programme commencing in mid-May.

WORKFORCE

W4. EXCEPTION REPORT: Rolling Turnover	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Description of how the standard is measured:

Turnover is measured as the total (FTE) permanent employees who have left, as a percentage of the 12 month average total (FTE) permanent staff in post, presented as a cumulative, rolling 12 month figure compared with a Trust wide trajectory to achieve 10% by the end of 2014/15.

Performance in the period, including reasons for the exception:

Rolling turnover remains unchanged at 13.8% in March. Rates by Division are shown in the table below:

Turnover by Division	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Cumulative Rolling Turnover March 2014	11.0%	8.8%	13.3%	12.8%	10.9%	9.4%	11.3%	12.1%
Actual Cumulative Rolling Turnover March 2015	13.8%	11.4%	13.7%	16.6%	15.1%	12.0%	15.3%	14.0%
Approximate leavers (FTE) over previous 12 months	882	95	124	114	199	168	85	98

There were 132 permanent staff leavers compared with 135 a year ago. The biggest changes in turnover rates this month were a reduction in Facilities & Estates Division from 14.7% in February to 14% in March, and an increase in Diagnostic & Therapies Division from 10.8% to 11.4%. Changes in rates in other Divisions were less marked, fluctuating by 0.3 percentage points or less.

Retirements were unusually high at 22 compared with a monthly average (financial year to date) of 10.4. Nineteen staff left due to "work life balance" compared with an average of 22.6, and 19 left due to "relocation" (average 23.5). The highest turnover continues to be amongst unregistered nursing, which increased this month, from 23.5 to 24.3%.

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

Progress against the priorities agreed with Senior Leadership Team is as follows:

Nursing/Midwifery Assistants

- *Communication* – work to develop a Trust-wide Nursing/Midwifery Assistants Forum and a number of listening events is being taken forward

by Divisions, as an integrated approach as part of the wider engagement work;

- *Pre and post-induction support* – the Trust is currently reviewing both induction and appraisal processes and corporate nursing leads are now in the process of developing corporate induction to align with work in relation to competences;
- *Revised nursing assistant pathways* –A nursing pathways review meeting took place on 11 March which concluded that generally the pathways are working well, and that the assessment centre process is effective, with very positive feedback from candidates and recruiting managers;
- *Career Progression* – Corporate nursing leads are ensuring there are clear competence and training for each nursing role. A pro-forma to use for all job descriptions, which will clearly lay out competence and training expectations for the first 12 months of employment, is being developed. It is planned that by July, all core job descriptions will have been revised to ensure consistency, and will be presented to the Nursing and Midwifery Committee. After this, the priority will be to develop a nursing website to display all nursing-related information covering training, development and career progression at UH Bristol.

Incentives

As part of the Reward and Performance Management element of the Workforce and Organisational Development Strategy, the Trust is exploring the use of a range of incentives. Having secured funding from Above and Beyond, the Trust is taking the opportunity to promote the considerable range of benefits it provides for staff, including producing a staff benefits booklet for display in ward/department areas and a revised staff benefits page on the Trust Intranet. The Trust is currently reviewing its long service awards and the Division of Surgery, Head and Neck will be piloting the use of 'thank-you' cards next month.

Staff Engagement

The comprehensive programme of staff engagement work continues with key headlines this month including:

- Aston Organisational Development training for team coaches commenced in March 2015. This training will equip two cadres of trainee coaches to work with teams across the organisation using practical, research-based, diagnostic and development tools which will enable to the Trust to improve performance through the development of effective team based working and positive organisational cultures;
- A survey regarding inpatient nursing staff views on shift patterns was rolled out during December and early January. A report will be presented to the Executive Team in April 2015 for full consideration;
- The Speaking Out Policy and practice review process has taken place. Full consultation on the policy will now take place, with the re-launch of the full policy and procedures in June and July 2015;
- The 2014 Staff Survey results have been received and fully analysed. Findings have been presented to Executive Team, Board, Senior Leadership Team and Quality & Outcomes Committee and shared with staff side during March. The Senior Leadership Team are currently re-examining the overall approach to staff experience, with a particular emphasis on securing more direct involvement and greater collaboration between local managers and their teams in designing solutions and action plans to address the concerns raised.

WORKFORCE

W5. 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:

Sickness rates have reduced from 4.6% to 4.4%. There were reductions in all Divisions compared with last month, apart from Surgery Head & Neck and Facilities & Estates.

There was a 15% reduction in days lost to colds and flu, which was the top reason for absence in the previous three months (see section 2.2.1). In March, the top reason was Stress, Anxiety and Depression related absence, which increased by 15%. During March, there was also a 17% increase in days lost due to the combination of back and musculo-skeletal related absence.

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 March 2013	4.3%	2.6%	5.2%	3.5%	4.3%	4.1%	4.2%	6.9%
Target March 2014	3.6%	2.7%	4.3%	3.9%	3.2%	3.3%	2.7%	5.2%
Absence March 2015	**4.4%**	**3.1%**	**5.4%**	**2.7%**	**5.1%**	**4.0%**	**3.4%**	**6.7%**
Cumulative absence March 2014	4.1%	2.9%	5.0%	3.8%	3.9%	3.9%	3.3%	6.5%
	0.8%	0.4%	1.1%	-1.2%	1.9%	0.7%	0.7%	1.5%

Progress against recovery plan

- In the context of our overall health and well-being programme, key activity is highlighted below.

Influenza

- 4168 staff, including 3444 frontline staff, have been vaccinated to date, representing 60% of frontline staff and showing a 9% improvement compared with 2013/14.

Stress Management/ Health and well-being

WORKFORCE

- Smoke free secondary care practitioners will be recruited for a fixed term of a year from April 2015. Duties will include the implementation of a revised smoke free policy and providing cessation support for staff, patients and visitors (funded by public health, Bristol City Council);
- The Wellbeing Charter (Public Health England), has been applied for and is subject to self-assessment with an assigned person to guide the Trust through the process;
- 67 staff have attended the extended modules of 'Making Change' and 'Identifying and Managing Work Related Stress' as part of a resilience building initiative. This concludes at the end in April 2015 when a full evaluation will be completed;
- A Staff Health and Wellbeing framework was approved by the Workforce and Organisational Development Group at the end of March.

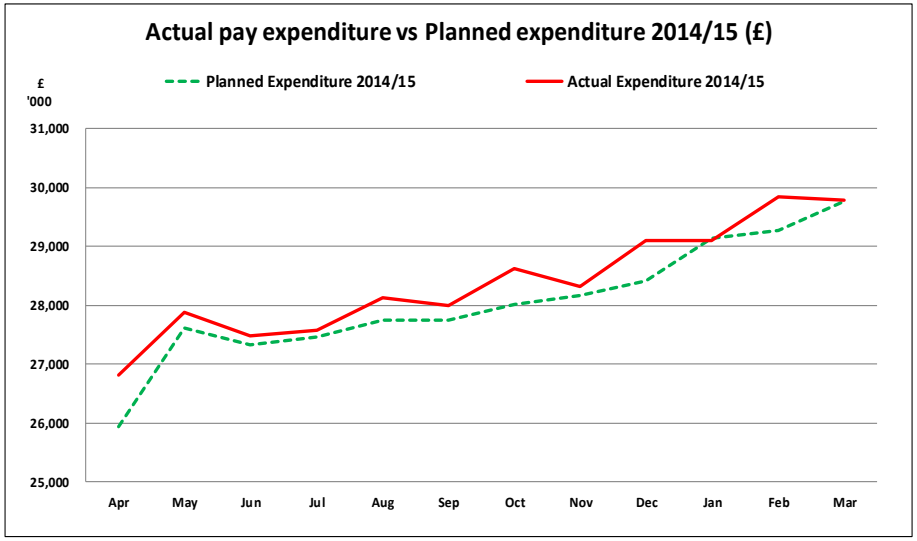
Musculo-skeletal

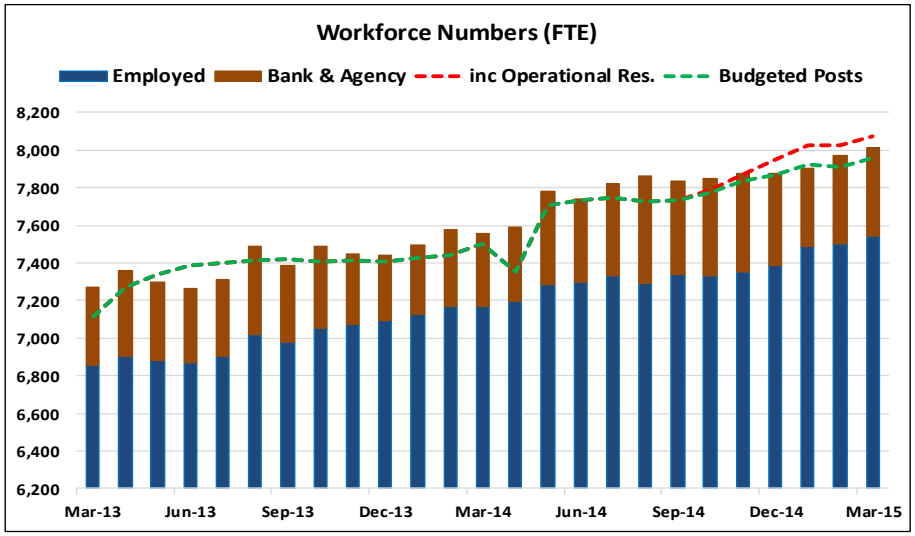
- Physio Direct consultations were at similar levels to the previous month - 76 in March, compared with 77 in February;
- Musculo skeletal clinics are at full capacity with additional clinics scheduled in April and May aiming to reduce waiting times for manager referrals;
- The Manual Handling Team provided more than 122 follow-up visits in March, providing advice and assessments in relation to best practice, musculoskeletal wellbeing, patient safety, equipment and workstation /office space advisory visits;
- Occupational Health and the Health and Safety teams have been working in partnership to target disorders associated with working practice and environment;
- A multi-professional Bariatric Focus Group has been convened which has a combined patient and staff wellbeing remit, with a staff support sub-group. Results from this intervention will be available by summer 2015.

2.2 SUPPORTING INFORMATION

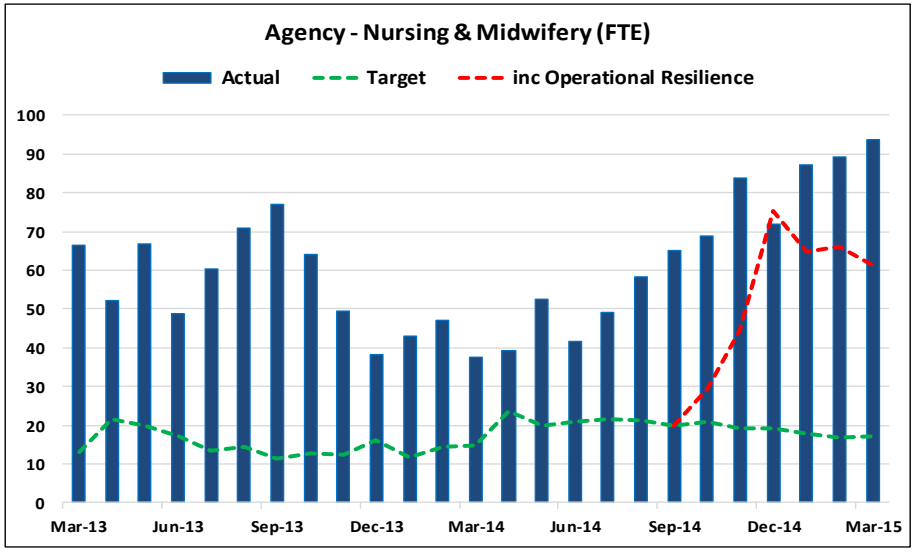
2.2.1 Performance against key workforce standards

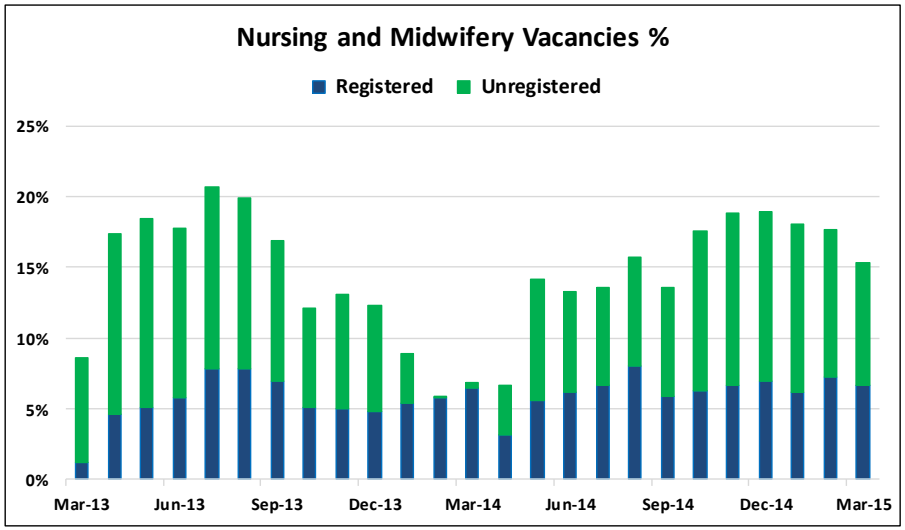
This section provides an outline of the Trust's performance against workforce indicators for workforce expenditure, workforce numbers, and bank and agency usage, with an additional chart to show how the variance against target for agency usage has reduced. There are also graphs to show nursing agency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

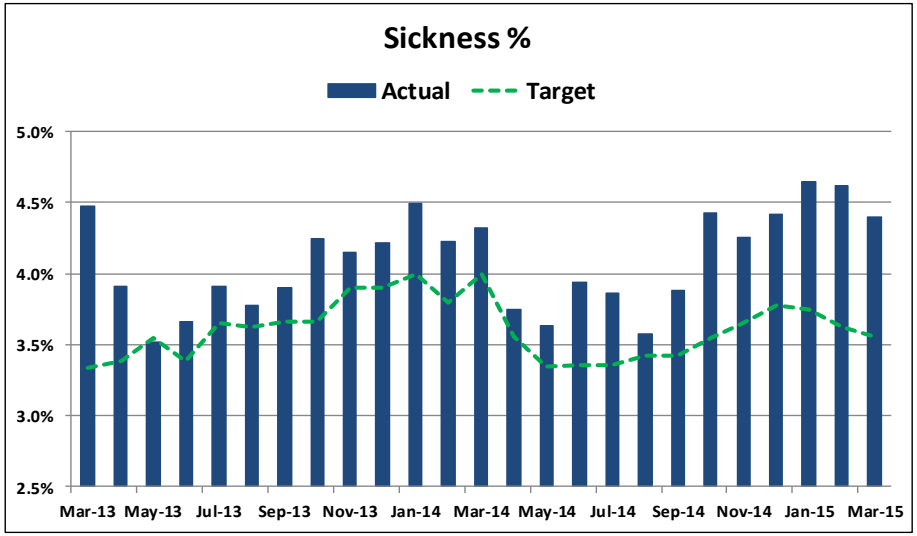


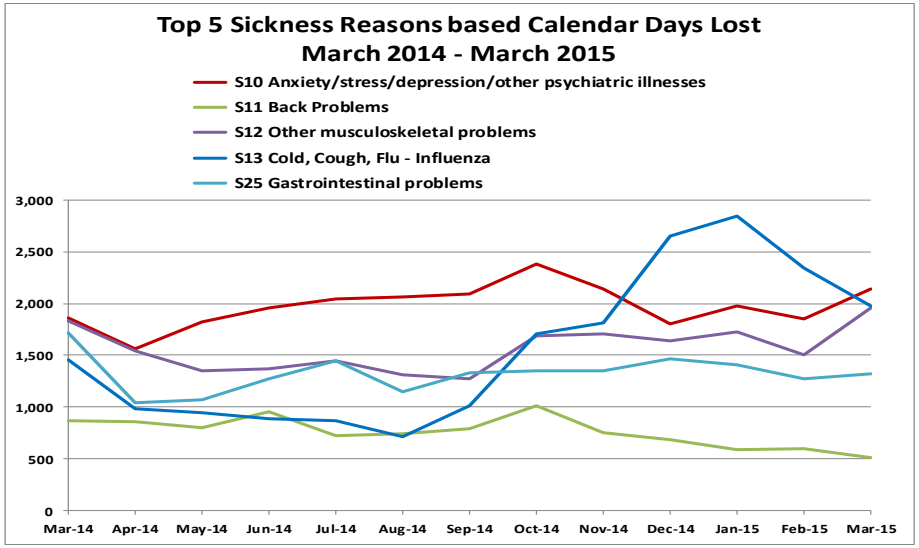


WORKFORCE

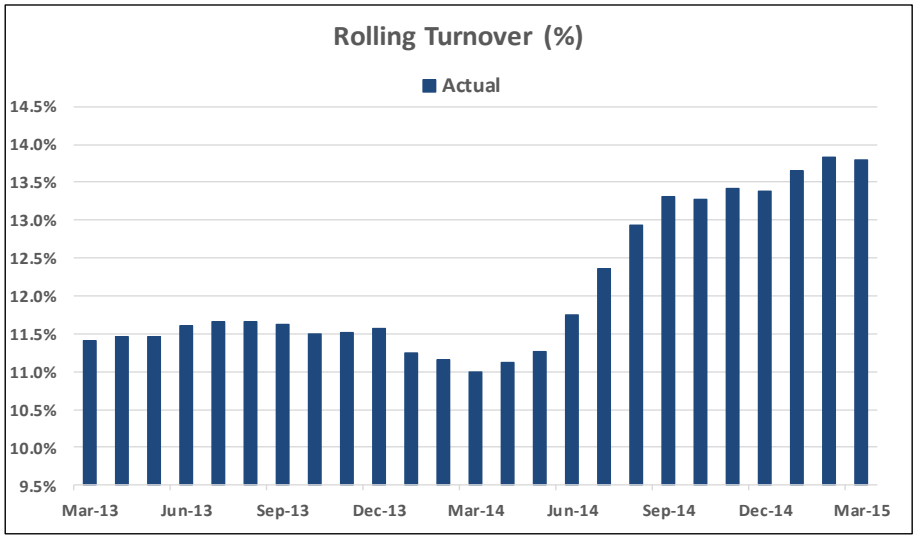

Agency - Nursing & Midwifery (FTE)
Actual
Target
inc Operational Resilience
100
90
80
70
60
50
40
30
20
10
0
Mar-13
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15


Nursing and Midwifery Vacancies %
Registered
Unregistered
25%
20%
15%
10%
5%
0%
Mar-13
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15


Sickness %
Actual
Target
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15

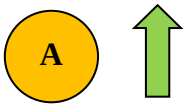
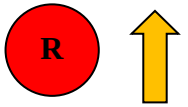
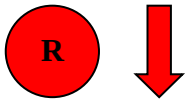
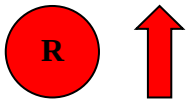
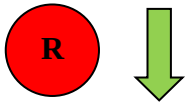
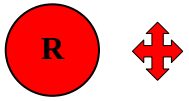
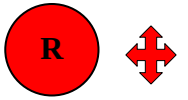

Top 5 Sickness Reasons based Calendar Days Lost
March 2014 - March 2015
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
3,000
2,500
2,000
1,500
1,000
500
0
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15

WORKFORCE


Rolling Turnover (%)
Actual
14.5%
14.0%
13.5%
13.0%
12.5%
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
Mar-13
Jun-13
Sep-13
Dec-13
Mar-14
Jun-14
Sep-14
Dec-14
Mar-15

2.2.3 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 January. Red rated indicators are outside tolerance limits and exception reports are provided for these.

Indicator	RAG Rating[2]	Commentary	Notes
Workforce Expenditure (£)		Workforce expenditure adverse variance from budget reduced from 2.0% above budget to 0.04% below budget in month compared with February 2015.	See summary, supporting information and exception report.
Workforce Numbers (FTE)		Total workforce numbers including bank and agency increased by 42.0 FTE compared with the previous month. Workforce numbers were 2.2% above budgeted FTE, which is no change from February 2015.	See summary, supporting information and exception report.
Bank (FTE)		Bank reduced by 15.9 FTE to 416.2 FTE (compared with a target of 242.9 FTE) in March 2015. Operational Resilience Pressures funding equated to 13.8% (57.3 FTE) of total bank FTE in February 2015.	See summary, supporting information and exception report.
Agency (FTE)		Agency increased by 13.0 FTE to 170.3 FTE (compared with a target of 37.3 FTE) in March 2015. Operational Resilience Pressures funding equated to 24.6% (59.8 FTE) of total agency FTE in February 2015.	See summary, supporting information and exception report.
Sickness absence (%)		Sickness absence reduced to 4.4% in March; compared to 4.6% in February. This is 0.7 percentage points above the monthly target of 3.7%.	See summary, supporting information and exception report.
Turnover (%)		Rolling turnover (excluding fixed term contracts, junior doctors, and bank) remained static at 13.8% compared a target this month of 10.0%.	See summary, supporting information and exception report.
Vacancy (%)		Vacancies remained static at 5.2% this month, compared with a target of 5%.	See summary, supporting information and exception report.

Note: RAG (Red, Amber, and 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.

2.2.4 Monthly forecast and overview

Measure	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	March 15 Target
Budgeted Posts (FTE)	7499.3	7355.2	7709.5	7732.9	7744.9	7729.1	7733.4	7775.8	7833.6	7872.4	7927.2	7912.4	7958.8	7782.3
Total Staffing (FTE)	7556.5	7588.1	7780.7	7739.6	7821.9	7864.8	7835.5	7859.9	7910.8	7954.2	8004.1	8088.6	8130.6	7544.1
Bank (FTE) Admin & Clerical	64.9	71.3	89.2	83.7	88.8	103.5	86.4	95.8	93.5	102.5	89.1	101.0	101.4	63.3
Bank (FTE) Ancillary Staff	34.6	38.0	54.6	51.8	51.9	73.3	59.0	55.6	47.5	57.4	51.5	62.7	51.7	17.6
Bank (FTE) Nursing & Midwifery	197.4	203.6	249.5	220.8	241.8	274.2	233.7	247.2	245.0	254.8	227.2	257.5	253.7	148.1
Agency (FTE) Admin & Clerical	25.7	23.4	22.4	21.1	19.3	27.7	26.4	29.9	49.0	52.9	25.2	39.2	44.5	11.6
Agency (FTE) Ancillary Staff	8.3	0.0	6.8	4.9	15.0	12.1	7.6	7.9	14.3	9.7	12.1	11.5	19.9	2.8
Agency (FTE) Nursing & Midwifery	10.9	13.0	12.2	12.1	13.3	10.4	8.1	13.0	17.9	9.0	13.4	16.3	12.1	5.8
Overtime	37.5	39.2	52.4	41.6	49.1	58.3	65.0	68.9	83.7	71.9	87.2	89.3	93.9	17.0
Sickness absence[1] Rate (%)	83.7	76.4	48.2	62.3	49.6	67.5	60.2	78.9	64.3	76.9	47.0	65.8	91.4	47.9
Appraisal (%)	4.3%	3.7%	3.6%	3.9%	3.9%	3.6%	3.9%	4.4%	4.3%	4.4%	4.6%	4.6%	4.4%	3.6%
Consultant Appraisal[5] (%)	85.9%	87.1%	86.3%	87.2%	86.3%	86.9%	85.3%	84.4%	83.5%	85.1%	83.7%	84.4%	85.6%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	0.0%	89.1%	89.2%	83.0%	85.5%	88.8%	89.1%	88.4%	90.3%	89.0%	89.7%	90.6%	89.3%	85.0%
Rolling Average Turnover[3] (with exclusions) (%)	17.8%	17.8%	18.0%	18.6%	19.0%	19.4%	19.7%	19.5%	19.6%	19.4%	19.7%	19.7%	19.6%	
Vacancy[4] Rate (%)	11.0%	11.1%	11.3%	11.7%	12.4%	12.9%	13.3%	13.3%	13.4%	13.4%	13.7%	13.8%	13.8%	10.0%

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.
   Consultant appraisal process allows 15 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 March 2015**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 4)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (9)	**Underachieving (3)**
- 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* - 31-day diagnosis to treatment cancer standard - *first treatment* - 2-week wait urgent GP referral cancer standard - A&E Time to Treatment - A&E Left without being seen rate - A&E Unplanned re-attendance - Reperfusion times (door to balloon time of 90 minutes)	- A&E Maximum waiting time (4-hours) - Reperfusion times (call to balloon time of 150 minutes) – *local target not achieved* - Ambulance hand-over delays over 30 minutes (year-on-year reduction)
Failing (10)	**Not reported/scored (0)**
- Referral to Treatment Time for non-admitted patients - Referral to Treatment Time for admitted patients - Referral to Treatment Time for incomplete pathways - 62-day referral to treatment cancer standard – *GP referred* - 62-day referral to treatment cancer standard - *Screening referred* - A&E Time to Initial Assessment - Delayed Discharges - Last-minute cancelled (LMC) operations + 28-day readmission - 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 reported figures for January and February, and draft figures for the quarter to date. 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

	Target	Thresholds Green	Thresholds Red	Previous YTD	Year to date (YTD)	Month Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Quarter Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	96.6%	95.8%	97.1%	97.0%	96.0%	97.0%	93.2%	94.8%	94.7%	96.3%	97.5%	94.3%	95.7%	Cancer standards report two months in arrears	97.4%	96.7%	95.0%	96.1%	95.1%
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.9%	96.9%	97.5%	97.9%	96.2%	96.8%	96.2%	96.2%	95.7%	94.0%	98.5%	97.8%	98.4%		96.0%	97.2%	96.4%	96.2%	98.1%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.8%	99.6%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	99.0%	98.1%		99.7%	99.7%	100.0%	99.6%	98.5%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	95.1%	94.6%	97.9%	93.2%	93.5%	94.0%	97.8%	91.7%	96.4%	92.3%	95.0%	95.5%	91.4%		94.1%	94.9%	94.6%	94.8%	93.7%
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.6%	97.7%	97.9%	98.9%	95.1%	97.6%	98.4%	97.4%	98.2%	99.5%	97.2%	96.4%	97.7%		95.7%	97.2%	97.8%	98.3%	97.0%
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.7%	79.2%	75.3%	81.1%	85.1%	79.4%	77.6%	74.3%	78.8%	81.4%	84.6%	80.0%	75.0%		75.1%	80.4%	76.8%	81.6%	77.5%
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	93.7%	88.4%	90.3%	90.2%	90.9%	90.2%	94.3%	83.3%	73.3%	100.0%	90.9%	66.7%	55.6%		94.4%	90.4%	90.8%	84.4%	60.0%
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	89.0%	90.5%	97.5%	86.1%	100.0%	86.7%	70.0%	89.3%	85.7%	100.0%	90.5%	84.4%	94.4%		85.3%	95.3%	83.1%	90.4%	89.7%
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	92.7%	84.9%	91.9%	91.8%	90.1%	87.2%	84.4%	82.4%	85.2%	83.1%	84.3%	80.5%	80.4%	80.5%	92.0%	91.2%	84.7%	84.3%	80.5%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	93.1%	90.3%	93.6%	94.0%	92.8%	89.7%	90.0%	89.0%	89.2%	88.8%	89.9%	88.9%	89.3%	90.0%	92.6%	93.4%	89.5%	89.3%	89.4%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.5%	90.4%	92.7%	92.5%	92.1%	92.0.%	91.1%	90.0%	89.4%	88.7%	87.5%	88.9%	89.4%	89.7%	92.7%	92.4%	91.0%	88.5%	89.3%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	93.7%	92.2%	94.5%	94.3%	95.2%	92.4%	93.7%	92.4%	93.8%	88.6%	86.3%	90.9%	89.5%	95.0%	91.3%	94.7%	92.8%	89.6%	91.9%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	15	14	14	12	11	13	12	11	12	12	36	14	14	29	14	12	12	15	15
	A&E Time to treatment decision (median) - in minutes	60	60	52	54	53	57	55	59	47	55	51	59	57	48	50	53	51	55	54	55	50
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	1.6%	2.3%	2.7%	2.2%	2.4%	0.2%	2.5%	2.6%	2.5%	2.6%	2.4%	2.7%	2.5%	2.5%	2.5%	2.4%	1.7%	2.5%	2.6%
	A&E Left without being seen	5%	5%	1.8%	1.8%	1.5%	1.9%	1.4%	2.2%	2.0%	2.0%	1.5%	2.3%	1.6%	1.6%	1.5%	1.6%	1.8%	1.6%	2.1%	1.8%	1.6%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	1.02%	1.08%	0.98%	0.96%	1.10%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1.00%	0.85%	1.03%	1.17%	1.02%	1.16%	1.16%	0.97%
	28 Day Readmissions	95%	85%	89.6%	89.8%	94.2%	85.2%	94.4%	95.3%	90.5%	85.2%	85.3%	90.4%	87.0%	82.9%	94.8%	93.5%	90.3%	91.3%	90.6%	87.3%	91.0%
	6-week wait for key diagnostics	99%	99%	98.6%	97.5%	98.3%	96.6%	97.3%	97.7%	97.0%	98.1%	99.1%	98.3%	95.8%	95.5%	97.9%	97.9%	98.8%	97.4%	97.6%	97.8%	97.1%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	82.4%	79.4%	78.6%	78.3%	82.1%	80.6%	76.9%	81.8%	79.4%	73.8%	80.0%	78.3%	87.1%		78.9%	79.4%	79.6%	77.2%	81.8%
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	92.9%	92.5%	96.4%	93.5%	96.4%	88.9%	94.9%	90.9%	94.1%	81.0%	92.0%	95.7%	96.8%		91.1%	95.1%	91.7%	88.1%	96.1%
	Delayed discharges (Green to Go List)	30	41	Not applicable	51.8	56	51	58	50	53	57	44	55	42	59	49	48	63.7	55.0	53.7	47.0	52.0
	Ambulance hand-over delays (over 30 minutes) - 10% reduction on 13/14	0	91.2	100.0	106.7	96	100	79	139	144	100	77	131	168	119	78	49	112.0	91.7	127.7	125.3	82.0

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 A&E Time to Initial Assessment figures exclude the Bristol Children's Hospital performance, due to problems with reporting accurate figures from Medway Patient Administration System (PAS). Work is ongoing to address the data issues.
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 relative to the last reported period:

- Cancer 31-day diagnosis to treatment (subsequent surgery) ↓ (down from 95.5% in January to 91.4% in February); *expected to be confirmed as achieved for quarter 4 as a whole;*
- A&E 4-hour maximum wait ↑ (up from 89.5% in February to 95.0% in March); *recovery trajectory also achieved for the quarter;*
- Time to Initial Assessment ↑ (up from 14 minutes in February to 29 minutes March); *this is a data quality issue only, which has arisen following the reporting of assessment times at the Bristol Children's Hospital; local intelligence confirms all hand-overs are carried-out within 15 minutes;*
- Ambulance hand-over delays over 30 minutes ↓ (down from 78 in February to 49 in March);

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

3.4 EXCEPTION REPORTS

Exception reports are provided for eight 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 key measures of patient flow, Delayed Discharges and Ambulance Hand-over delay performance 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 (LMC)
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) Admitted pathways standard
6) Referral to Treatment Time (RTT) Non-admitted pathways standard
7) Referral to Treatment Time (RTT) Incomplete pathways standard
8) Six-week diagnostic wait

ACCESS STANDARDS

A1-A2. EXCEPTION REPORT: Last-minute cancellation (LMC) + 28-day readmission following a LMC	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;
2) The number of patients cancelled at last-minute for non-clinical reasons who were not readmitted within 28 days of the date of the cancellation, as a percentage of all cancellations in the period.

This standard remains part of the NHS Constitution.

Monitor measurement period: Not applicable

Performance during the period, including reasons for exception:

There were 66 last-minute cancellations (LMCs) of surgery in March (1.03% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in March were as follows:

- 36% (25 cancellations) were due to no high dependency bed/intensive therapy unit bed being available to admit a patient to;
- 15% (10 cancellations) were due to a lack of theatre time due to clinically complicated patients needing more time in theatre than expected, and/or the morning theatre session running over;
- 9% (6 cancellations) were due equipment failure (5 of the 6 relating to the failure of a piece of endoscopy equipment for two day-case lists on consecutive days)
- 7% (5 cancellations) were due to an emergency patient being prioritised;
- 6% (4 cancellations) were due to no ward beds being available;
- 24% (16 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging.

Of the 66 cancellations, 21 were day-cases and 45 were inpatients (32% day-cases). On average, seventy percent of the Trust's admissions in a month are day-cases. The higher cancellation rate for inpatient procedures is likely to be a result of one of the main causes of cancellation being lack of a bed on high dependency bed/intensive therapy unit. Day-case procedures do not require high dependency bed/intensive therapy unit beds, and are also less likely to be cancelled due to cases running over because they were more complicated than expected.

In March 93.5% of patients cancelled in the previous month were readmitted within 28 days of the cancellation, against a national standard of 95%. Although still missing the target, like in February, this represents a significant improvement on recent months in 2014/15. There were three breaches of 28-day readmission standard in the month, of which two patients were due for readmission for procedures within the Bristol Eye Hospital, and one patient needed to be readmitted for a procedure within the Bristol Royal Infirmary. In all three cases, the patients could not be re-admitted within 28-days due to a combination of clinician availability and more clinically urgent patients requiring admission.

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:

- Ongoing implementation of 4-hour plans, the actions from which should reduce cancellations related to bed availability;
- 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);
- The opening of the new adult Intensive Therapy Unit (ITU) will provide greater flexibility to manage a higher proportion of patients needing higher levels of clinical input, thereby reducing the likelihood of a patient needing to be cancelled due to not ITU bed being available;
- Elective activity is routinely discussed at every 08:30 Site Team and the 16:45 Silver Command patient flow meetings. No patients are cancelled without a cross Divisional discussion to ensure other options have been explored.

Progress against the recovery plan:

The national standard of less than 0.8% of operations being cancelled at last-minute for non-clinical reasons was not achieved in March. However, overall performance for quarter 4 was significantly better than the same period last year, with the quality objective being met for the quarter.

Performance against the 28-day readmission standard also remained good in March, with the 95% standard being missed by 1.5% (less than 1 patient).

Maintaining a lower level of ward-bed related cancellations remains the minimum requirement for achievement of both the last-minute cancelled operations and the 28-day readmission standards. The actions in the emergency access resilience plan should reduce levels of last-minute cancelled operations and improve performance against the 28-day readmission standard.

ACCESS STANDARDS

A3 – A4. EXCEPTION REPORT: 62-day referral to treatment cancer standard 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 standard 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

Performance in February was 75.0% against the 85% standard. This was below the recovery trajectory for the month of 85.4%. There were 9.4 more breaches in the month than 'expected' in the plan. Late referrals remained the leading cause of breaches in the period. The main variances were in the number of breaches due to administrative issues/pathway management, delayed outpatient appointments and patient choice to delay.

Performance for internally managed pathways was 80.4% against the 85% standard. Performance for shared pathways was 62.5%. If the breaches for those referrals received late (i.e. on or after day 42 in the pathway) were re-allocated in full to the referring provider, performance would have been 80.5%, and above the 85% standard.

Breach reasons - February	Trajectory (expected number)	Actual number	Variance	Percentage of breaches (actual)
Late referral	4.7	5.5	0.9	28%
Medical deferral/Clinical complexity	2.7	4.0	1.3	20%
Patient choice to delay	0.9	2.5	1.6	13%
Histology delay	0.2	0.0	-0.2	0%
Delayed outpatient appointment	0.3	2.5	2.2	13%
Delayed admitted diagnostic	0.3	1.0	0.7	5%
Administrative delay/pathway management	0.3	3.0	2.8	15%
Delays at other provider	1.0	0.0	-1.0	0%
Elective cancellation	0.1	0.5	0.4	3%
Elective capacity	0.2	0.0	-0.2	0%
Other	0.0	1.0	1.0	5%
	10.6	**20.0**	**9.4**	**100%**

60% of breaches were due to primarily unavoidable reasons, including late referral, medical deferral, clinical complexity and patient choice.

There were 11 breaches (55%) relating to internally managed pathways and 9 breaches (18 pathways x 0.5 accountability) relating to shared pathways.

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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 February 2015, the 85% standard was only achieved for breast and skin cancers at a national level, with all other tumour sites performing at or below 80.1%. The national average performance across all tumour sites was 80.8% (a deterioration on the previous month). The Trust is now the only acute provider in the country that provides neither breast nor urology cancer outpatients or surgical services. It is calculated that the impact of our tumour site case-mix equates to a 3.5% reduction in expected performance. This figure is without any adjustment for the tertiary nature of our services.

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 GP Screening

Performance in February was 55.6% against the 90% standard, with only bowel screening reporting treatments in the month. There were 2 breaches in the period, one internally managed pathway breaching due to patient choice, a shared pathway (0.5) breaching due to patient choice, and a further shared pathway (0.5) breaching at another provider following timely referral from UH Bristol. The loss of the majority of Breast Screening treatments in quarter 2 2014/15, following the transfer of Avon Breast Screening (ABS) to North Bristol Trust, has, as expected, had a significant impact on performance. Bowel is now the highest volume tumour site for 62-day screening treatments (shared and internal pathways) reported by the Trust. Nationally, bowel screening pathways performed at 63.5% against the 90% standard in February.

Recovery plan, including expected date performance will be restored:

A fortnightly cancer performance improvement group is taking forward further improvement priorities. These are identified from reviews of breaches, good practice from other providers, and in response to potential risks e.g. awareness campaigns. An action plan for cancer performance is maintained by the group and is also monitored at the Cancer Board and Service Delivery Group. The action plan is updated with new actions on an ongoing basis as these are identified, and all actions have an expected impact assigned to them which link through to the trajectory for performance improvement. The impact of some actions may take two months (i.e. the length of a pathway) to show the full effect, depending on the stage of the pathway they relate to. The action plan covers all cancer access targets, but with the primary focus being on those actions that will support delivery of the 62 day GP standard. The current/recently completed key actions are as follows:

The current/recently completed key actions are as follows:

- Implement joint clinics between respiratory physicians and thoracic surgeons, both internally and at referring providers, effectively removing the need for a second outpatient appointment. This has been implemented at UH Bristol and North Bristol Trust. An innovative project trialling remote pre-operative assessment via Skype technology has also started to support this clinic. Taunton clinics are due to start,

followed by Yeovil and Weston. Discussions will also be held with Gloucester and Bath hospitals with a view to rolling-out there;

- Reduce maximum wait for 2-week wait step to 7 days for 90% patients in six specialities where this will likely make a material difference to pathways. Patient choice does affect achievement of this standard in some specialties. All areas have made and sustained significant progress on this, with several consistently hitting the target and others coming very close;
- A specific pathway improvement project for Head and Neck, most of which has now completed. The implementation of this project's actions has seen a three-fold reduction in breaches for this speciality and the learning from this project is being applied elsewhere;
- Additional capacity for thoracic surgery, hepato-pancreato biliary surgery and Ear, Nose & Throat minor procedures has been created, following the move of vascular services to North Bristol Trust. This has considerably improved capacity problems in these specialities, particularly thoracic surgery, and has also reduced the impact of cancellations;
- Revisions to the colorectal two-week wait pathway are in progress, to support improved pathways for patients (fewer appointments) and ongoing attainment of waiting times standards in a time of rising demand. This work is being coordinated by the Strategic Clinical Network and Commissioning Support Unit, and has external funding and support from the 'ACE' Earlier Diagnosis of Cancer initiative, and is being carried out in conjunction with North Bristol Trust;
- Competency based training and assessment for Multi Disciplinary Team (MDT) co-ordinators and all administrative staff involved in booking cancer patients (both at start of post and on an ongoing basis) has been devised and rolled-out to reduce risk of administrative errors. The first new coordinators have been trained according to this programme and all existing staff will be assessed against the competencies as part of appraisal;
- Pathways with optimum timescales for lung and oesophago-gastric (OG) cancer (complex, relatively high volume specialities) are being developed and good progress is being made. The OG pathway was discussed at the Network Site Specific Group and received strong clinical engagement and support. Audit of actual against ideal performance is now being undertaken at all trusts to identify how we can implement the pathway. The Lung pathway is now being supported by North Bristol Trust, and colleagues from UH Bristol and North Bristol are working together on its further development. Some changes have already been implemented as a result of the work on this pathway, for example introduction of protected PET scan slots for patients had highest risk of complex pathways. The ultimate aim is for these pathways to be adopted across the South West and this has been discussed at several regional meetings;
- Pathway work for patients with lymphomas of the neck, who commonly have lengthy pathways due to passing between specialities, to design a smooth timely pathway. The pathway is now designed in draft and subject to clinical discussions as several of the elements would require a change of practice. The pathway aims to get patients onto the most appropriate pathway at an earlier stage;
- Additional bronchoscopes have been purchased, reducing risks of delays due to equipment failure and enabling the Trust to carry out in-house certain types of bronchoscopy which previously had to be sent to other providers;
- Implementation of the plan to manage impact of the 2015 national awareness campaign for oesophago-gastric cancer, which started on January 26th. Work has been undertaken by the Trust based on information obtained from trusts who participated in the regional pilot of the campaign has enabled impact on services post two week wait referral to be estimated and planned for;

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- Subject to agreement from commissioners, introduce direct booking of two week wait referrals via choose and book, which should increase the likelihood of patients attending their first appointments and doing so in a timely way, as well as having safety and patient experience benefits. This is particularly important in light of forthcoming changes to NICE guidance for cancer referrals. Other trusts who successfully use this system have been identified, and it is hoped we can work with them to demonstrate how the system works and thus allay the concerns held by some GPs about this;
- Developing an improved system for providing theatre time in main theatres to the gynaecology team within shorter timescales, for high risk patients requiring intensive care/high dependency care. A protocol has been drafted for this and is under discussion;
- Improving proactive management systems for fast track patients in radiology and pathology. The radiology system is in place and has reduced the number of queries for radiology, and the pathology system developments have been incorporated into the work surrounding the service transfer.

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 for October to December are confirmed following the completion of quarter 3 reporting. The reported performance for January and February is as shown, but may be subject to change when the whole quarter's data is submitted at the beginning of May.

	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	75.5%	81.6%	85.1%	80.4%	79.4%	77.6%	74.3%	76.8%	79.0%	81.2%	84.6%	81.6%	80.0%	75.0%		

62-day screening

The 90% standard was failed in February, with 2 breaches of the standard due to patient choice and delays at other providers.

ACCESS STANDARDS

A5-A7. EXCEPTION REPORT: Referral to Treatment Time (RTT) admitted, non-admitted and ongoing pathways standards	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

Waiting times for these standards are measured from the date of a referral made with an expectation of treatment, through to the commencement of first definitive treatment. A referral can be made by a GP or any other healthcare professional. A referral onto an 18-week pathway can also be made when a patient's condition has been monitored and a decision has been made that treatment is now required.

There are three different standards relating to Referral to Treatment Times (RTT). The first two measure the percentage of patients treated within 18 weeks for patients not needing an admission for their treatment (Non-admitted pathways), and those patients needing an admission (Admitted pathways). The targets for these are 95% and 90% respectively. The final standard measures the percentage of patients waiting under 18 weeks at month-end. This is referred to as the ongoing or incomplete pathways standard. The target is for at least 92% of patients to be waiting less than 18 weeks from referral. Failure of this standard is an indication that the number of non-admitted and/or admitted patients waiting over 18 weeks is higher than the sustainable level for achievement of the admitted and non-admitted standards. Failure of the ongoing/incompletes standard usually therefore results in failure of one or both of the non-admitted and admitted standards, until the number of over 18-week waiters is reduced.

Monitor measurement period: Monthly achievement required but quarterly monitoring. Performance is assessed by Monitor at an aggregated Trust level, rather than an RTT specialty level.

Performance during the period, including reasons for exceptions:

The Trust continued to under-perform against the three RTT pathways standards in March as expected, due to the volumes of long waiting patients treated in the period. The number of patients waiting over 18 weeks on admitted and non-admitted pathways remains higher than the sustainable level to support achievement of the admitted and non-admitted standards. But importantly, the backlog reduction trajectory targets were again met in the period (see final section of the exception report).

The ongoing RTT over 18-week waiting list had not been validated in full for several months. The lack of a 'clean' operational RTT waiting list had also limited the impact of improvements being made to 'picking' patterns and booking practices. These issues have been addressed through recent validation efforts.

The impact of the validation work of the recently appointed team of validators, along with the work of the national team, continued to be felt in March. In combination with the additional capacity put in place to treat more long waiters, this resulted in a further reduction, for both the admitted and non-admitted pathways, in the number of patients waiting over 18-weeks at month-end. As a result, performance against the RTT Ongoing pathways standard in March improved by a further 0.3%, from 89.4% to 89.7%.

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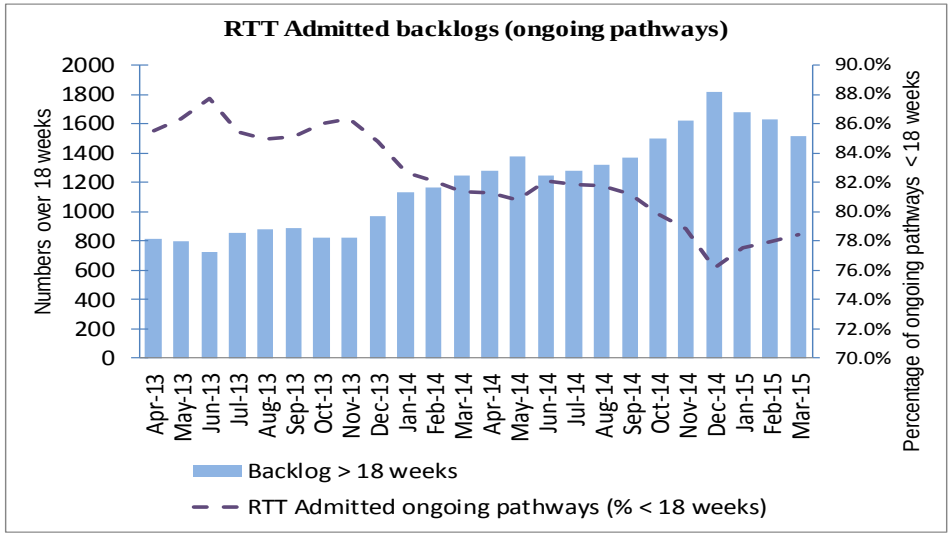
Graph 1 – RTT Admitted backlogs versus the percentage of patients on ongoing pathways waiting under 18 weeks.



Graph 2 – RTT Non-admitted backlogs versus the percentage of patients on ongoing pathways waiting under 18 weeks.

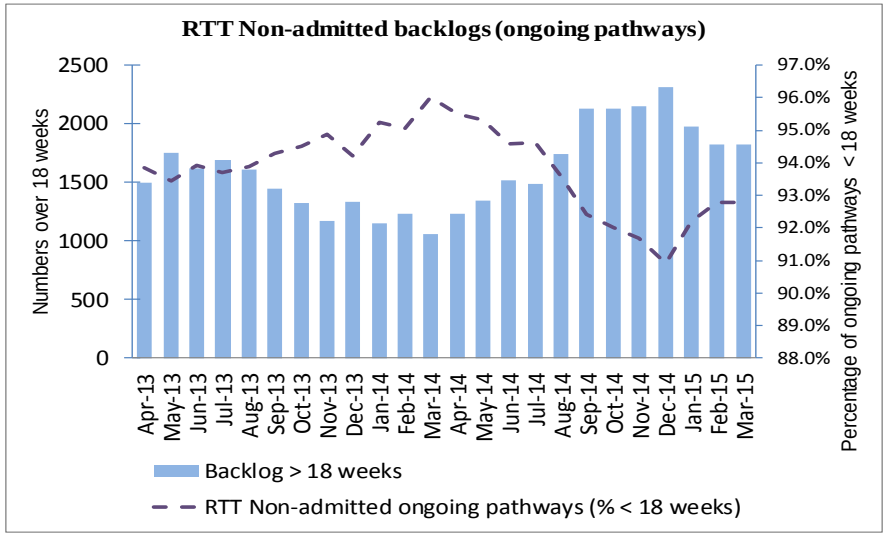


Table 1: Performance against the RTT Admitted standard at a national RTT specialty level in March.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	190	118	308	61.7%
Cardiothoracic Surgery	28	12	40	70.0%
Dermatology	165	50	215	76.7%
E.N.T.	183	5	188	97.3%
Gastroenterology	66	2	68	97.1%
General Medicine	13	7	20	65.0%
Gynaecology	180	25	205	87.8%
Ophthalmology	779	141	921	84.7%
Oral Surgery	266	48	314	84.7%
OTHER	837	281	1119	74.9%
Plastic Surgery	1	0	1	100.0%
Rheumatology	96	0	96	100.0%
Thoracic Medicine	14	0	14	100.0%
Trauma & Orthopaedics	63	7	70	90.0%
TOTAL	**2881**	**696**	**3579**	**80.5%**

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In March, six of the fourteen specialties achieved the 95% standard, compared with five in February. As in February, a high number of long waiting patients were treated in the month, reflecting the focus on picking patterns and treating as many long waiting patients as possible.

The performance of the top five highest volume specialties for admitted pathways within 'Other' was as follows, in order of volume of clock stops:

- Upper GI surgery – 58.9%
- Paediatric Ear Nose Throat – 37.7%
- Clinical Oncology - 100%
- Paediatric surgery – 75.7%
- Thoracic surgery 96.9%

Table 2: Performance against the RTT Non-admitted standard at a national RTT specialty level in March.

RTT Specialty	**Under 18 Weeks**	**18+ Weeks**	**Total Clock Stops**	**%age Under 18 Weeks**
Cardiology	144	36	180	80.0%
Cardiothoracic Surgery	23	6	29	79.3%
Dermatology	477	37	514	92.8%
E.N.T.	642	26	668	96.1%
Gastroenterology	35	40	75	46.7%
General Medicine	165	0	165	100.0%
Geriatric Medicine	46	0	46	100.0%
Gynaecology	324	5	329	98.5%
Neurology	76	7	83	91.6%
Ophthalmology	1020	70	1090	93.6%
Oral Surgery	224	42	266	84.2%
OTHER	3089	458	3547	87.1%
Rheumatology	110	1	111	99.1%
Thoracic Medicine	311	4	315	98.7%
Trauma & Orthopaedics	121	24	145	83.4%
TOTAL	**6807**	**756**	**7563**	**90.0%**

In March, six out of the fifteen specialties achieved the 95% non-admitted standard, compared with four in February. A low level of performance is planned during this period of recovery, reflecting the need for more long waiting patients to be treated in the month.

The performance of the top five highest volume specialties for admitted pathways within 'Other' was as follows, in order of volume of clock stops:

- Restorative dentistry – 46.7%

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- Radiotherapy treatments – 100%
- Paediatric ophthalmology – 76.5%
- Maxillo facial surgery – 94.9%
- Colorectal Surgery – 94.7%

Table 3: Performance against the RTT Ongoing pathways standard at a national RTT specialty level in March.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Ongoing	Percentage Under 18 Weeks
Cardiology	1891	343	2234	84.6%
Dermatology	1768	147	1915	92.3%
E.N.T.	2465	50	2515	98.0%
Gastroenterology	451	43	494	91.3%
General Medicine	91	3	94	96.8%
Gynaecology	1195	83	1278	93.5%
Neurology	270	89	359	75.2%
Ophthalmology	4105	242	4347	94.4%
Oral Surgery	2122	105	2227	95.3%
OTHER	12364	2173	14531	85.1%
Rheumatology	349	1	350	99.7%
Thoracic Medicine	559	4	563	99.3%
Trauma & Orthopaedics	1032	28	1060	97.4%
Cardiothoracic Surgery	236	33	269	87.7%
Geriatric Medicine	166	1	167	99.4%
TOTAL	**29064**	**3345**	**32403**	**89.7%**

In March, ten of the fifteen specialties achieved the 92% ongoing standard, which is the same as in February.

The performance of the top five highest volume specialties for admitted pathways within 'Other' was as follows, in order of total pathway volumes:

- Restorative dentistry – 77.7%
- Paediatric ENT –70.7%
- Clinical Genetic – 74.7%
- Paediatric T&O – 78.4%
- Paediatric dentistry – 90.0%

The number of patients waiting over 40-weeks from referral to treatment decreased from 161 at the end of February to 119 at the end of March, and

was significantly below the trajectory limit of 179. There were 4 over 52-week RTT waiters were reported at March month-end, compared with 11 at the end of February. This was below the forecast number of 11. All 4 52-week waiters were within paediatric specialties due to demand being significantly higher than capacity within these services (i.e. 1 for Paediatric Urology, 2 for Paediatric Trauma & Orthopaedics and 1 Paediatric Ear, Nose & Throat). All expected over 52-week waiters for the end of April have had dates for treatment booked in the month, with the exception of two, one of which is receiving a second opinion at a London trust.

Recovery plan, including expected date performance will be restored:

- Continued weekly focus from the weekly RTT Operational Group on treating longest waiting patients and improving 'picking' patterns to make best use of available capacity to reduce waiting times;
- Full demand and capacity modelling has been completed for all under-performing specialties, with the help of the Interim Management and Support (IMAS) team; these models take into account the level of capacity needed to meet the additional recurrent demand we are seeing, in addition to the capacity needed to clear the backlog; the modelling has been shared with the commissioners and Monitor, and has informed contract discussions for 2015/16; the outputs of this work have also resulted in the recovery trajectories shown in the next section of this Exception Report;
- Divisions are continuing to refer patients to external providers where possible, with Diagnostics & Therapies having already outsourced 550 patients' scans and treatment (see Exception Report A8);
- A monthly RTT Steering Group is overseeing the progress of the Operational Group as well providing 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 Interim Management and Support (IMAS) 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, a final report was agreed and the recommendations form the basis of a detailed recovery plan. The actions are now in the process of being implemented.
- The Trust now has in place a team of external validators, to facilitate validation of all patients in the RTT backlogs. This has been supplemented by support from a national team; a significant number of ongoing pathways are being closed down as a result of this validation;
- A local (community-wide) Patient Access Policy has recently been reviewed and has been implemented; the new Policy will enable the Trust to take appropriate action when patients delay their outpatient appointments or elective admissions, and where funding decisions are not made within an acceptable time period.

ACCESS STANDARDS

Progress against the recovery plan:

The trajectories below have been informed by the IMAS capacity and demand modelling. Progress against these will be reported on a monthly basis. The Trust is currently on trajectory with all elements of the recovery plan.

Please note, the trajectories shown below are the final versions, as now shared with Monitor and our commissioners, reflecting the Divisions' 2015/16 delivery plans.

Please note: A green RAG (Red, Amber, Green) rating indicates where the recovery trajectory is being met.

Over 18-week waiters	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Non-admitted (plan)	2455	2044	2068	1920	1754	1616	1548	1465	1391	1273	1193	1125	1056	1022	985
Non-admitted (actual)	1972	1819	1826												
Admitted (plan)	1857	1819	1772	1711	1533	1348	1179	1070	941	820	768	661	590	521	465
Admitted (actual)	1677	1627	1519												
Ongoing performance (plan)	87.0%	88.1%	88.0%	88.6%	89.6%	90.5%	91.2%	91.8%	92.5%	93.2%	93.7%	94.2%	94.7%	95.0%	95.3%
Ongoing performance (actual)	88.9%	89.4%	89.7%												
Admitted performance (plan)		80.0%	80.0%	80.2%	80.8%	80.8%	80.8%	82.1%	84.3%	86.5%	87.2%	88.6%	89.5%	89.8%	90.3%
Admitted performance (actual)		80.4%	80.5%												
Non-admitted performance (plan)		89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	90.2%	91.8%	92.4%	93.6%	95.0%	95.1%	95.2%	95.2%
Non-admitted performance (actual)		89.3%	90.0%												

ACCESS STANDARDS

A8. 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 March was 97.9% against the 99% national standard for 6-week diagnostic wait. This is above the recovery trajectory of 97.7%. There were 142 breaches of the 6-week standard at month-end, of which 89 were waiting for echocardiography scans (up from 66 in February), 20 were for MRI scans (down from 37), 30 were for paediatric gastrointestinal endoscopies (down from 37), and 3 other patients waiting for a range of different tests.

Demand in many diagnostic services has been out-stripping capacity. This is partly due to underlying demand rising, but also additional demand arising from work being undertaken to reduce the number of long waiting RTT patients. The ability to continue to meet the 6-week maximum wait has also been impacted by short and long-term staff absences, some of which were unforeseen.

A recovery trajectory has now been developed based upon detailed capacity and demand modelling for each diagnostic test, using a model provided by the Interim Management and Support (IMAS) team. The modelling takes account of the most recent level of demand for the service as well as the normal variation in capacity month on month. Capacity plans have now been developed to fill the gaps, with forecast achievement of the 6-week standard, on a sustainable basis from the end of June 2015.

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 previous months have been removed from the following list*:

- Month on month capacity plans have been developed for each test, to fill the identified gap in capacity;
- Short-term in-house capacity solutions being put in place to manage the peaks in demand through locums and additional sessions – especially cardiac stress echo and MRI;

ACCESS STANDARDS

- Additional cardiac stress echo sessions are being sourced from clinicians in other trusts where possible;
- Clinical validation of the appropriateness of referrals where demand is higher than expected is being undertaken;
- Routine MRI scans and musculo-skeletal ultrasound guided injections are now being provided by the Chesterfield Hospital, with a plan in place to outsource a total of 500 cases before the end of March (**Action complete**: as at the 31st March, 550 patients had been scanned by external providers);
- A consultant paediatric gastroenterologist post has been recruited; the successful applicant will now be in post towards the end of quarter 4; additional sessions will be run during the quarter, with the aim of clearing the majority of the backlog by the end of Quarter 1 2015/16.

Progress against the recovery plan:

Performance against the revised trajectory below will be reported on a monthly basis.

Month	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Total > 6 weeks	161	152	130	106	63	55	63	60
Performance trajectory	**97.6%**	**97.7%**	**98.0%**	**98.4%**	**99.1%**	**99.2%**	**99.1%**	**99.1%**
Actual total > 6 weeks	145	142						
Actual performance	**97.9%**	**97.9%**						
Trajectory achieved	**Yes**	**Yes**						

Risks remain for achievement of the end of April trajectory target, due to long term sickness and bereavement of a core member of the team that providers stress echo capacity. Additional sessions have been planned to reduce the backlog of patients waiting over 6 weeks and stay on track with the recovery trajectory.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting to be held in public on Thursday, 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
08. Quality and Outcomes Committee Terms of Reference Review
Sponsor and Author(s)
Sponsor: Alison Ryan, Non-Executive Director Chair of Quality and Outcomes Committee Author: Debbie Henderson, Trust Secretary

Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	**X**

Executive Summary
Purpose: This paper contains the proposed revised Terms of Reference for the Quality and Outcomes Committee, in line with the delegated authority from the Trust Board of Directors. Key Issues: Significant amendments to the Terms of Reference have been made with regard to the duties of the Committee, in particular, further clarity with regard to reporting and responsibilities relating to; complaints and patient experience; infection control; annual reporting and oversight; and serious incidents and never events and trust-wide learning.
Recommendations
The Board are asked to approve the revised terms of reference for the Quality and Outcomes Committee.
Impact Upon Board Assurance Framework
The terms of reference of the Quality and Outcomes Committee support the achievement of objective to deliver all quality objectives and exceed national standards.
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
In line with the Trust's Constitution, Standing Orders and Scheme of Delegation
Equality & Patient Impact
Nil specific

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other**
28/4/15					

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Quality and Outcomes Committee

Document Data	
Corporate Entity	Quality and Outcomes Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Carolyn Mills, Chief Nurse & Sean O'Kelly, Medical Director
Document Owner	Trust Secretary
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	01/05/2016

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/03/2011	1	Trust Secretary	Major	Initial draft for comment
26/04/2011	2	Trust Secretary	Major	Incorporated committee Chair's comments
27/04/2011	3	Trust Secretary	Minor	Revisions following initial meeting of committee members
25/05/2011	4	Trust Secretary	Minor	Final consideration by the Quality and Outcomes Committee
26/05/2011	5	Trust Secretary	Minor	For approval by the Trust Board of Directors
27/03/2012	6	Trust Secretary	Minor	Revisions recommended by Quality and Outcomes Committee for approval by the Trust Board of Directors
27/09/2012	7	Trust Secretary	Minor	Revision to meeting regularity from bi-monthly to monthly (in months where there is a meeting of the Board of Directors) in accordance with the purpose of scrutinising the Quality and Performance report prior to each meeting of the Board of Directors
21/04/2015	8	Trust Secretary	Minor	

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1. Constitution of the Committee

1.1 The Quality and Outcomes Committee is a non-statutory Committee established by the Trust Board of Directors to support the discharge of the Board's responsibilities ensuring the quality of care provided by the Trust.

2. Purpose and function

2.1 The purpose of the Quality and Outcomes Committee is to ensure:

2.1.1 That the Board establishes and maintains compliance with health care standards including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions (including Monitor);;

2.1.2 That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

2.1.3 That the Trust actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;

2.1.4 That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate;

2.1.5 That the Trust is striving for continuous quality improvement and outcomes in every services; and

2.1.5 Ensure that every member of staff that has contact with patients, or whose actions directly affect patient care, is motivated and enabled to deliver effective, safe, and person centred care in line with the NHS Constitution

2.2 To achieve this, the Committee shall:

2.2.1 Extend the Board's monitoring and scrutiny of the standards of quality, compliance, and performance of Trust services;

2.2.2 Make recommendations to the Board on opportunities for improvement in the quality of services;

2.2.3 Support and encourage quality improvement where opportunities are identified

2.3 The Committee shall discharge this function on behalf of the Board of Directors by:

2.3.1 Considering the Board's Quality Strategy and associated objectives, and scrutinising the quality, performance and compliance reports;

2.3.2 Seeking and considering such additional sources of evidence upon which to base its opinion on the robustness of Board Assurance with regards to 'quality governance'; and

2.3.3 Working in consultation with the Audit Committee and the Finance Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each Committee.

3. Authority

3.1 The Quality and Outcomes Committee

3.1.1 Monitor, scrutinise and where appropriate, investigate any quality or outcome activity considered to be within its terms of reference;

3.1.2 Seek such information as it requires to facilitate this monitoring and scrutiny; and

3.1.3 Obtain whatever advice it requires, including external profession advice if deemed necessary (as advised by the Trust Secretary) and may require Directors or other officers to attend meetings to provide such advice

3.2 The Quality and Outcomes Committee is a Non-Executive Committee and has no executive powers.

3.4 Unless expressly provided for in Trust Standing Orders, Trust Scheme of Delegation or Standing Financial Instructions the Quality and Outcomes Committee shall have no further powers or authority to exercise on behalf of the Trust Board of Directors.

4. Membership and attendance

4.1 The Quality and Outcomes Committee is appointed by the Trust Board of Directors from amongst the Non-Executive Directors of the Board and shall consist of not less than four members.

4.2 The following officers shall be required to attend meetings of the Quality and Outcomes Committee on a standing invitation by the Chair:

4.2.1 Chief Nurse

4.2.2 Medical Director

4.2.3 Chief Operating Officer

4.2.4 Director of Workforce and OD

4.3 Duly nominated deputies may attend in their Director's stead.

4.4 The Trust Secretary shall attend from time-to-time to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance

5. Quorum

5.1 The quorum necessary for the transaction of business shall be three members, all of whom must be independent Non-Executive Directors.

5.2 Committee members may be represented at meetings of the Committee by a duly

nominated delegate on no more than two successive occasions. Nominated delegates must be independent Non-Executive Directors.

5.2 A duly convened meeting of the Quality and Outcomes Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable as set out in these Terms of Reference.

6. Duties

The Quality and Outcomes Committee shall discharge the following duties on behalf of the Trust Board of Directors:

6.1 Quality Strategy

6.1.1 Receive and assess the Board's Quality Strategy and provide an informed opinion to the Board on the suitability of the associated objectives; and

6.1.2 Monitor progress and achievement of the Board's Quality Strategy

6.2 Annual Plan and Quality Report

6.2.1 Monitor the status of the Care Quality Commission Outcomes and Quality Objectives as set out in the Annual Plan; and

6.2.2 Review the Annual Quality Report prior to submission by the Executive to the Trust Board of Directors for approval.

6.3 Clinical and Service Quality, Compliance and Performance

6.3.1 Seek sources of evidence from existing Management Groups and Board Committees on which to base informed opinions regarding the standards of:

6.3.1.1 Clinical and service quality;

6.3.1.2 Organisational compliance with the fundamental standards of quality (as determined by the Care Quality Commission's registration requirements), and national targets and indicators (as determined by the Monitor Risk Assessment Framework); and

6.3.1.3 Organisational performance measured against specified standards and targets.

6.3.2 Review the quarterly Trust declaration against Monitor's Risk Assessment Framework (excluding financial information) prior to submission to the Board of Directors for approval;

6.3.3 Review the Board Quality and Performance Report

6.3.4 Review the Quarterly Workforce and Organisational Development report

6.4 Action Plan Monitoring

6.4.1 Monitor progress of the quality-related action plans (i.e., Francis recommendations)

6.5 Benchmarking, Learning and Quality Improvement

6.5.1 Consider relevant regional and national benchmarking statistics when assessment the performance of the Trust;

6.5.2 Review the Annual Clinical Audit report;

6.5.3 Receive quarterly reports on complaints and patient experience;

6.5.4 Receive reports to monitor against action plans arising from Serious Untoward Incidents, complaints and never events to ensure organisational-wide learning and ensure that actions have been completed;

6.5.5 To receive reports about patient experience and review the results and outcomes of local and national patient and staff surveys;

6.5.6 Receive and review quarterly reports on Infection Control and Safeguarding;

6.5.7 Receive and review the Equality and Diversity Annual Report;

6.5.8 Receive the monthly Nurse Staffing report on the information contained in the NHS national staffing return to ensure Trust-wide staffing levels remain safe.

6.6 Risk

6.6.1 Receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.

6.7 Quality Governance

6.7.1 Assess evidence of compliance with the Monitor Well Led Governance Framework; and

6.7.2 Identify any gaps in evidence or measures of quality utilised by the Board of Directors

6.8 Procedural Documents and Corporate Record Keeping

6.8.1 Assess the suitability of Trust-wide relevant Procedural Documents in accordance with the Trust Procedural Document Framework (i.e., Board Quality Strategy);

6.8.2 Maintain and monitor a schedule of matters arising of agreed actions (for the Committee only) and performance-manage each action to completion; and

6.8.3 Maintain the corporate records and evidence required to support the Board Assurance Framework document.

7. Reporting and Accountability

7.1 The Chair of the Quality and Outcomes Committee shall report to the Board of Directors on the activities of the Committee.

7.2 The Chair of the Quality and Outcomes Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement is needed).

7.3 Outside of the written reporting mechanism, the Committee Chair should attend the Council of Governors General meeting including the Annual Members Meeting, and be prepared to respond to any questions on the Committee's area of responsibility to provide an additional level of accountability to members.

8. Administration

8.1 The Trust Secretariat shall provide administrative support to the Committee.

8.2 Meetings of the Quality and Outcomes Committee shall be called by the secretary (as specified in 8.1) at the request of the Committee Chair.

8.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

8.4 Supporting papers shall be made available to Committee members no later than five working days before the date of the meeting.

8.5 The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and those in attendance.

8.6 Draft Minutes of meetings shall be made available promptly to all members of the Committee.

9. Frequency of Meetings

9.1 The Committee shall meet on a monthly basis, in advance of each meeting of the Board of Directors at which the Quality and Performance Report is to be considered, and at such other times as the Chair of the Committee shall require.

10. Review of Terms of Reference

10.1 The Committee shall, at least once a year, review its own performance and Terms of Reference to ensure it is operating at maximum effectiveness.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on
30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
9. Transforming Care Report

Sponsor and Author(s)
Sponsor: Robert Wooley, Chief Executive Author: Simon Chamberlain, Director of Transformation

Intended Audience									
Board members	X	Regulators		Governors		Staff		Public	

Executive Summary
Purpose The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. Key issues to note The report sets out the highlights of progress over the last quarter and the next steps.

Recommendations
The Board is recommended to receive the report for **approval**

Impact Upon Board Assurance Framework
To support the strategic objective to 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.

Impact Upon Corporate Risk
N/A

Implications (Regulatory/Legal)
N/A

Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Transforming Care Update to Trust Board
April 2015

The purpose of this report is to update Trust Board on progress with Trust wide programmes of work within the Transforming Care programme. The report sets out the highlights of progress over the last quarter and the next steps.

1. In the January update to Trust Board we shared the progress across a number of our programmes and described how our Operating Model work was evolving as delivery of some of the scope was completed and new scope was developed. Since the last update progress has continued to be made across all areas, and further changes to the scope of the programme of work continue to be made as we review our priorities for 2015/16. Transformation Board and the Senior Leadership Team continue to receive monthly updates on progress versus milestones, and meetings also receives detailed briefings on specific projects. The latest update on milestone progress is attached at appendix 1.

2. Operating Model – Planned Care: In January we described the renewed scope of work, focussed on 2 areas:

- Improvement to the day to day management of flow through provision of real-time accurate information supported by better use of existing IT, real time communications (applying learning from the Children's Flow programme), and real time reporting of barriers to flow

- A programme of transformation in the surgical administration services, which will address training, skills and ways of working and team working in the elective booking offices. This is aimed at ensuring elective planning is more robust and timely and is fully aligned with our RTT improvement plans.

3. Good progress has been made in both areas. The roll out of iPod Touch devices to enable real time communications across key role holders has taken place, and surveys have shown that staff believe this is having a real, positive impact on their ability to communicate within and across teams. The team is now developing an electronic ward whiteboard to improve the accuracy of data in real time on Medway, and a real time dashboard showing the ststus of patient flow and areas for escalation across the surgical pathway. Both these areas have strong IM&T support, helping us to exploit the data and capability of Medway to best effect.

The Admin Transformation programme is up-skilling staff, initially in inpatient booking areas. Training has covered Call Management, Delivering Bad News to patients and further technical training on managing patients on the 18 week pathway. Staff focus groups have shown that the training has been well received and valuable. A patient focus group takes place later in April to provide the teams with insights into how they can further improve the patient experience.

4. The value of the Planned Care programme is underlined by the Surgery Head & Neck Division's reconfiguration of its bed base. The reduction in surgical beds and transfer of ward A605 to Medicine was made possible largely by improvements in length of stay due to large part in patients being treated on the right wards, made possible in turn by the Managed Beds programme delivered in phase 1 of the programme. The current scope aims to build on this progress, targeting reduced theatre cancellations and further improvements in length of stay.

5. The Unscheduled Care and Integrated Discharge programme was re-scoped in January to align with both the CQC action plan and the 4 hour action plan agreed with Monitor.

A key step in the last quarter was the opening of the Integrated Discharge Hub where all teams and agencies supporting patient discharge are co-located and work closely on helping patients to be safely and promptly discharged to the most appropriate setting. The value of this change was seen vividly during the recent Breaking the Cycle Together event, where the progress made in integrating the work of the Hospital Discharge team with Bristol City Social Care, Bristol Community Health and other teams was stark. Versus the previous adult Breaking the Cycle event one year ago, the volume and nature of issues escalated was vastly reduced. The number of patients being referred into the hub is reduced due to the improved quality of referrals, and the number of patients on the Green to Go list has fallen by almost a half.

Beyond the Hub, the joint team has made good progress delivering other initiatives supporting the agreed CQC plan, including the phased introduction of the electronic CM7 form, the introduction of new pathways and the delivery of workshops with clinical teams in Medicine wards to develop ward processes and improve discharges. All of these are helping maintain progress on 4 hour performance as agreed in our improvement trajectory.

The scope of the Unscheduled Care will be further reviewed now in the light of the experience gathered during the Breaking the Cycle Together week, to make our ward processes more consistent to further improve discharge flow and length of stay

6. The transformational work in the Children's Hospital has been re-scoped to address surgical services. Alongside a programme to revise the theatre timetable to better align capacity and demand, work is taking place to reapply learning from the adult Planned Care programme, adopting the scheduling tools, addressing pathways and supporting the development of the booking teams. We are taking the appointment reminder system used in outpatients and adopting that to issue reminders for some surgical admissions to reduce the incidenceds of DNAs. And particular emphasis is being placed on the re-design of the emergency theatre pathway, to improve the patient experience and to improve the utilisation of non-elective teatre capacity.

7. The beenfits of the Children's Flow programme delivered last year continue to be visible. While activity levels through the children's hospital exceed the increases predicted by the CSP project, more children are being seen in ED within 4 hours. And the number of bed days avoided due to initiatives within the programme has now exceeded 600.

8. The Trust wide theatre transformation programme is now fully mobilised and addressing the themes which impact upon both theatre utilisation and patient and staff experience. Initial projects are addressing portering, staff capability, trauma list planning and provision of accurate information across theatres. Clinical teams from each theatre suite are actively engaged in the programme which has developed good momentum over the last quarter. A benefits realisation plan is being developed to specify the performance impact expected.

9. Both Transformation Board and the Senior Leadership Team have reviewed in detail the findings of the Staff Survey results published in March. We are committed to bring forward a transformational response to this to build on the work on staff engagement and staff experience already underway. The

Senior Leadership Team will devote further time to this in May to agree the scope of work to be taken forward.

10. In other changes to the scope of the programme: The Compassion in Clinical Care programme has made good progress in the last year in raising the profile of Compassion in our services. A programme to focus on developing our End of Life care services will be developed; The development of services across seven days is now to be driven by Division teams who will be implementing specific initiatives laid out in their Operating Plans. And Transformation Board will in future have greater visibility of the delivery of the Clinical Systems Implementation Programme, which features in the milestone plan.

Further details of the new programmes to be overseen under Transforming Care will be set out in the next update in July

11. During April a Breaking the Cycle Together event was held across the Trust. Teams from across the Trust have been focussed on identifying barriers to achieving our standards of quality and safety, reporting where we don't comply and fixing what they can. The event covered 38 in-patient areas across the Trust, and total of 101 volunteers have acted as Ward Liaison Officers (WLOs) over the period. Our health and social care community partners have strongly supported the event, participating in the daily activities and providing volunteers to act as WLOs

The event has been influential in getting our hospitals into a better position of occupancy and flow than they would otherwise have been. The escalation and reporting we operated have fixed issues more quickly than we otherwise might; Issues as diverse as leaking water heaters, patient transport, Wi-Fi access and access to care homes have been raised by WLOs and addressed.

At St Michael's Hospital, we tailored the event to test our preparations for the introduction of the Evolve electronic patient record system, and found that plans are well advanced and that awareness and readiness amongst staff was good.

In the coming days we will develop a full breakdown of findings from the checklists, from the issues raised and from the Fixit boxes. Plans will be developed in each Division to respond to the many issues raised, and we will develop "You said we did" reports to share progress with staff. Fixits and other issues which need a corporate response will be tracked by the Senior Leadership Team.

12. Next steps: During the next quarter our focus will be:

- To complete the planned revisions to the revised scope of the programme and develop detailed delivery plans as required, ensuring effective engagement with staff in the relevant areas
- To maintain the momentum of the projects through continued scrutiny via SLT and Transformation Board.

Simon Chamberlain,

Director of Transformation

22nd April 2015

Transforming Care

Appendix 1: Transformation Milestone Status report

University Hospitals Bristol NHS
NHS Foundation Trust

		Purpose		Milestone review last month March 2015	Milestone plan next three months April 2015	 May 2015	 June 2015
Delivering best care	**Project:** Transformation through Electronic Data Management **Exec Lead:** Paul Mapson **Project Lead:** Sarah Wright, Mel Jeffries	**To ensure the transformational improvement opportunities made possible by the Evolve Electronic Data Management are realised.**	✓ ● ✓ ✓	• Confirmation of the process changes to take place and timings • Electronic ED cause for concern process and form implemented • Learnings from User Acceptance Testing are incorporated into change plans supporting preparation for go-live • Pre implementation staff survey undertaken	• Final preparations for go-live • Breaking the Cycle Together assessment of readiness complete • Delivery of user training	• Go live in St Michaels hospital	• Follow up of change processes post go live completed • Preparations for the next phase of roll out underway
	Project: CSIP & Medway projects **Exec lead:** Paul Mapson **Project lead:** Steve Gray	**To make our administration and clinical recording processes safer, quicker and easier. Give our people information they need, right here, right now. Share appropriate information to support a joined-up service and help our patients to have confidence that we know what we're doing with them.**	✓ ✓ ✓ ✓ ✓	• Medicine & Surgery, Head & Neck patient flow iPods live • Clinical noting on Medway ready to deploy • Medway 2013.2 upgrade - new functions • Cardiology ICU electronic flowsheets live • Diagnostics & Therapies iPods configured	• First real-time dashboards live • First patient-check-in kiosks live • Non-radiology department PACS live • Specialised Services patient flow iPods live • New Medway functions (final 2013.2 release)	• Pilot of electronic discharge summary on Medway • First real-time whiteboards live • Casenotes electronified in St Michael's	• Non-radiology and pathology service orders live • New Bristol-wide laboratory system live
Improving patient flow	**Project:** Operating Model - Unscheduled Care & Discharge **Exec Lead:** James Rimmer **Project Lead:** Rowena Green	**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.**	✓ ✓ ●	• Enhance Recover Programme pilot implemented in OPAU • Single point of access for home from hospital service documented • Process for home from hospital service developed and communicated	• Single point of access for home from hospital service trialled	• Home from hospital service trial evaluated	
			● ● ●	• Go- Live with Non Weight Bearing patient pathway • Standardised Trusted Assessment Tool developed for Rehab Referral Pathway • 7 day CDCC model developed for Rehab Referral Pathway	• Evaluation and updating of Non Weight Bearing Pathway • Social care model for SBCH developed for Rehab Referral Pathway • Training a completed for Rehab Referral Pathway	• **P:** Project closure for Non Weight Bearing Pathway • **P:** Implementation of Rehab Referral Pathway	
			✓ ✓ ✓ ✓	• Pilot electronic CM7 fully evaluated • Roll out plan agreed for electronic CM7 • Communications undertaken • Final specification signed off	• CM7 live on Medical wards • CM7 Communication to remaining adult wards	• CM7 Roll out to adult wards completed • Evaluation of project and software completed • Actions from evaluation undertaken	• CM7 Project closure
			✓ ✓	• Working group established for modified pilot of GPSU/ACU at front door • Data on GP referrals and ambulance arrivals reviewed and opportunities identified	• Options for GPSU/ACU explored and business case developed (as appropriate) • Proposal for pilot developed for GPSU/ACU and approved by Divisional Board • Stakeholders engaged and feasibility and investment requirements assessed	• Implementation plan for GPSU/ACU changes agreed	
			✓ ✓ ✓	**15 before 10:** • Discharge audit results reviewed; Barries to timely discharge understood • Discharge Lounge criteria reviewed and updated • Matrons pilot with HCA support to prepare patients for early discharge started	• Patient information leaflet for the Discharge Lounge relaunched • Discharge Lounge staffing requirements reviewed • Ward Processes workshop for trial ward team held • Delivery plan for remaining Medical wards signed off	• Remaining Medical ward team workshops delivered • Staff and patient feedback on trial ward undertaken	• Evaluation undertaken • Actions required from evaluation understood
			✓ ✓ ●	• **Discharge to Assess** Patient pathways signed off • Options for improved patient transport developed • KPIs agreed	• **Discharge to Assess:** Documentation (choice) and leaflets aligned and agreed • Business case for community OTs developed • GP cover for out of hospital providers commissioned • Fully documented pathways developed • Communication to ward staff	• Pathway to care providers implemented • Discharge to Assess integrated with home from hospital service • valuation of out of hospital pathway undertaken	• Actions from evaluation undertaken
	Project: Children's Surgical Pathway Programme **Exec lead:** James Rimmer **Project lead:** Steve Sale & Charlotte Jones	**To have surgical pathways which support all specialties requiring theatre access deliver high quality care in the required clinical and national target timescales.**	● ✓ ● ● ●	• Prioritisation of theatre sessions required completed • Day case vs inpatients strategy agreed • Current theatre schedule reviewed and amendments required identified • Surgical and anaesthetic job plans amended where indicated • Emergency theatre planning demand and capacity analysis completed	• Emergency theatre capacity requirements agreed • Phased implementation of new theatre schedule commenced (9 month roll out) • Set up of training programme completed	• Additional equipment required for new theatre schedule identified • Additional equipment required for new theatre schedule procured	• New theatre schedule roll out continues
			✓ ✖ ✓	• Gap analysis of current pre admission service provided • Pre admissions services required agreed • Appropriate surgical pathway for enhanced recovery identified	• Configuration of Trust Envoy system for TCI reminders completed • Planning for Enhanced Recovery implementation underway	• Business case to expand pre admission services (if indicated) signed off • Next actions required to expand pre admissions services agreed and dates for delivery	• Go live with TCI reminders
			✓ ● ✖ ●	• Waiting list staff RTT training completed • Envoy system configuration for waiting list staff to send manual messages to patients completed • Waiting list staff trained to use Envoy system and go live • Emergency theatre planning demand and capacity analysis completed	• Configuration of theatre scheduling tool completed • New scheduling meeting agenda agreed and implemented • Partial booking letters set up in Medway • New BRHC scheduling standards written • Standardised use of emergency triage criteria implemented • Standardised communication process for planning of emergency patients and last minute changes implemented	• ICE booking forms implemented by specialty • Waiting list staff trained on ICE system • Further actions planned once demand and capacity analysis is understood	• Waiting list staff trained to use partial booking letters when required • BRHC scheduling standards implemented
	Project: Operating Model - Planned Care **Exec Lead:** James Rimmer **Project Lead:** Andy Hollowood & Alan Bryan **AT:** Admin Team Transformation Project **PF:** Patient Flow Project	**To ensure that elective and urgent tertiary activity proceeds unhindered through periods of high demand for acute medical care through our hospitals.**	✓ ✓ ● ✓ ✓ ✓ ● ● ●	• Delivering bad news training approved • SOP: Escalating calls to clinical teams first draft complete • SOP: ENT Surgeon approval of lists before weekly scheduling meeting first draft complete • First draft universal Waiting List Co-ordinator job description created • Staff satisfaction focus groups complete • Complaints and compliments audit initiated • WLO correspondence review complete • SOP: Communicating list changes to clinical teams approved	• Admin Standards Manager appointed • Patient Focus Groups complete • Universal Waiting List Co-ordinator job description HR review complete and next steps agreed • Results of staff satisfaction focus groups reported • Complaints and compliments audit complete • SOP: Escalating calls to clinical teams implemented • SOP: Communicating list changes to clinical teams implemented	• SOP: Other Specialities Surgeon approval of lists before weekly scheduling meeting implemented • Training business case approved and next steps agreed • Proposal for Waiting List Office Team Branding submitted to Divisional Board • Decision on sending correspondence by email received • Training business case approved and next steps agreed • Universal Waiting List Co-ordinator objectives approved • Quality Assurance work stream planning complete	• Delivering bad news training complete • Updated recruitment proposal rolled out to Line Managers • Universal Waiting List Co-ordinator objectives in operational use • Ongoing implementation of Quality Assurance work stream • Ongoing implementation of Local Induction Training work stream
			● ● ✓ ✓ ✓ ✓	• Real-time dashboard development complete • iPod proposal for Junior Doctors trial complete • Whiteboards Phase 1 plan approved • WiFi improvement testing pilot launched • Whiteboards Phase 1 working group established and kick-off meeting complete • Emergency pathways workstream initiated	• Real-time dashboard reviewed and approved, development complete • Discharge action plan approved • iPod for Junior Doctors trial complete • Roll-out plan for Dolphin House L3 / L4 WiFi approved • IM&T approach to sustainable scheduling tool approved • IM&T resource and timelines agreed for SOM meeting work stream	• iPod Patient Flow survey results complete • Real-time dashboard roll-out plan approved • Emergency Pathways workstream complete	• IT solutions development • STAU prototype whiteboard in operational use
	Project: Theatre Transformation Programme **Exec Lead:** Paul Mapson **Project Lead:** Jan Belcher	**To provide individualised safe quality patient care with maximum efficiency in responsive operating theatres Trust wide. Which in turn will support the capacity demands for surgical intervention.**	✓ ✓ ✓ ● ✓ ✓ ✓	• Data Quality Standard Agreed • Baseline Measures agreed • Pilot "New" Theatre dashboard available • BRI Recovery Transfer Nurse SOP implemented • Speciality Focus for each unit team engaged and actions identified • T&O Golden Case and Briefing Audit reviewed • Significant increase in semi elective patients admission via SAS following POA	• Data Quality Standard implemented • New Version Theatre Dashboard employed • Theatre Band 6 Role, Responsibilities and unit Co-ordinator role Trust wide reviewed and aligned • Speciality Focus actions commenced • BRI Porter Role Pilot commenced • Trauma World electronic Communication system trialed • Second Stage Recovery capacity review complete	• Data Quality Stanard delivered • Speciality Data shared with Leads and actions in response identified with lead • Speciality Focus actions progress review • Phase 1 BRI Porter Role Review complete • T&O Briefing standard agreed • Further Increase in semi elective patients admission via SAS following POA move opening of POD on level 6	• Consultant level data shared with individuals and actions in response identified with lead • Speciality Focus actions progress review • T&0 Briefing Standard implemented
Building capability	**Project:** Leadership Programme **Exec Lead:** Sue Donaldson **Project Lead:** Alex Nestor & Sam Chapman	**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.**	● ✓ ✓ ✓ ✓	• Pilot Action Learning Set approach commenced, using attendees from leadership development programmes • Business skills to launch in June 2015 finalised • Five year leadership strategy to underpin workforce and OD strategy developed • Working group to support the pilot of appraisal/succession planning/ talent management set up • Inaugural meeting of leadership development/staff engagement sub group • Planning of Leadership Spring conference June 3rd commenced	• Leadership Framework/ programme of work completed to underpin the Workforce and OD strategy • Leadership conference in June planning completed • First two learning and leading together lunchtime events evaluated • ALS approach following pilot in February evaluated • Leadership Healthcare programme for all managers and supervisors- ongoing 3 hour workshops (11 workshops in total), will run for several months	• Learning and Leading together events- review continued • Leadership framework signed off with workforce and OD group • Quarterly Leadership and Management Development report produced	• Monthly Learning and Leading together event- review continued following on from feedback • Leadership Conference to be held on June 3rd
	Project: Staff engagement Programme **Exec Lead:** Sue Donaldson **Project Lead:** Trish Ferguson-Jay	**To deliver a step change in staff experience, satisfaction and engagement, supporting a step change in patient experience and performance.**	● ✓ ● ✓ ✓ ✓ ✓	• Team coaches for Aston "high performing teams" journey recruited • Training for Aston coaches commenced and teams identified • Focus groups held to inform Nursing review of shift patterns • Simplified, more effective and clearer Speaking Out policy/process presented • Learning from Nursing Shift pattern survey/focus groups shared across organisation with recommendations regarding shift patterns • Full National Staff Survey findings analysed and presented to Executives, SLT and Staff Side. Approach agreed re development of divisional action plans.	• Work with first teams of pilot of Aston commenced • Revision of Speaking out Policy, process ahead of formal ratification in May and relaunch continued • Staff Survey findings used to fully inform final version of Divisional Engagement Plans • Working across the organisation to support focus groups, world café, listening events, team building to enhance both staff engagement and leadership development commenced and will run for several months	• Second training session for Cadre 1 of Aston coaches commenced • First training sessions for Cadre 2 of Aston commenced • Relaunch of Speaking Out Policy and Procedure	• Pilot of Aston training reviewed • Speaking Out processes communicated across the Organisation via Payslips.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
10. 2015/2016 Annual Operational Plan									
Sponsor and Author(s)									
Deborah Lee, Director of Strategic Development and Deputy Chief Executive.									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff		Public	

Executive Summary

Annual Operational Plan 2015/16

As a Foundation Trust we are required by our regulator, Monitor, to provide an operational plan covering the financial year 2015/16, which addresses the issues set out in Monitor's drafting guidance (Appendix 1)

The drafting requirement has changed from last year in a number of ways:

- We are only required to submit one plan, not two, as was the case in 2014 when we submitted both operational and strategic plans.
- Monitor have further cut down the requirement for that one (operational) plan – we are required to produce a c20 page plan covering 2015/16 in contrast to previous plans which covered two years and required significantly more detail to be included.
- We are required to produce a public version of the plan, for publication on the Monitor website, which will be produced following submission and by mid-May.

The plan has **three sections**.

Section 1 describes the context of our operational plan, and includes a review of our performance (financial, operational and quality) in 2014/15, a summary of local and national commissioning considerations, and a formal recommitment to the 5 year strategic plan that we submitted to Monitor in June 2014. This section requires the Trust to **recommit, refresh or recreate** the strategy developed last year – UH Bristol has **recommitted** to the existing strategy reflecting the fact that it remains broadly valid for the operating context we now find ourselves in.

Section 2 updates the strategic work we have done in the last 12 months, and describes how we, and others across the local heath economy, are responding to the NHS 5 year forward view. This section also sets out our Corporate Objectives, including a summary of our Workforce and Organisational Development Strategy and importantly a summary of our "Declaration of Compliance" with regulatory standards, which must accompany the submission – in contrast to previous years, the Trust is required not only to describe the standards at risk but to indicate the quarters in which failure may occur.

Section 3 contains the detail of our operational plans, setting out how we will achieve short term resilience in

what we have acknowledged will be a difficult year from an operational perspective. This section contains summaries of our capacity planning, IM&T, short term workforce, and financial plans.

Finally, the plan has been developed having had regard to the views of Governors who have shaped the priorities set out in the plan and have commented upon the draft plan. Governors will be asked to play a central role in confirming the content and readability of the public facing version of the plan.

Recommendations
The Board is asked to **approve** the Annual Operational Plan for submission to Monitor.
Impact Upon Board Assurance Framework
The priorities described in this plan are reflected in the corporate objectives set out in the 2015/16 Board Assurance Framework.
Impact Upon Corporate Risk
The Plan reflects the principle risks facing the organisations and the mitigations and controls in place.
Implications (Regulatory/Legal)
Submission of the Operational Plan is a regulatory requirement.
Equality & Patient Impact
The central aim of the Plan is to ensure equitable access to high quality services, for all patient groups.

Resource Implications			
Finance	**X**	Information Management & Technology	X
Human Resources	X	Buildings	**X**

Action/Decision Required							
For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	27/04/2015			22/04/2015	Governors Strategy Group 20/04/2015

Monitor Drafting Guidance 2015/16 Operational Plan

Section 1 – Strategic Context For The Plan – max. 3 pages

We expect foundation trusts to have a robust strategy to deliver high quality care for patients sustainably. Each trust's overarching strategy should have been set out in its strategic plan submission to Monitor in June 2014.

However, strategy development and planning should be an ongoing process and we therefore expect boards to have considered if, and how, the strategy needs to evolve as part of this operational plan.

The process of evolving the strategy will involve, primarily**, a review of the performance (financial, operational and quality) of the foundation trust in 2014/15 and consideration of the trust's external environment.**

Such analysis might include, but not necessarily be limited to:

- Significant variations in performance on strategic goals or in the progress of strategic initiatives: this involves effective performance tracking and open recognition of both good and poor performance.

- Changes in the overall performance of the foundation trust, such as a deterioration in financial or quality performance (in particular we would expect some brief commentary of performance against plan in 2014/15 and drivers of any major variance), or significant missed access targets.

- Significant changes in the external environment, such as an unexpected merger of other healthcare providers, deteriorating financial stability at the commissioning organisation, the collapse of a local provider or part of the primary care system, or the emergence of previously unavailable strategic options.

- Local commissioning assumptions and affordability restraints, so the foundation trust only puts in place initiatives that the LHE has the resources to support.

- Significant changes in government or regulatory policy: such as post-election shifts in policy on access targets, tariff levels and structure; organisational restructuring; or changes in regulatory standards.

Depending on the outcome of this analysis, this section of the operational plan should briefly explain how the board has, or intends to:

1) **Recommit** to the strategy: If the strategy's underpinning assumptions are still accurate, and implementation is on track, the foundation trust is likely to recommit to the strategy. This means briefly revisiting its delivery and ongoing development.

2) **Refresh** the strategy: If the foundation trust is happy with its strategy but the external environment has changed, it may want to refresh its strategy. This would involve checking whether it needs to change any assumptions or outputs.

Recreate the strategy: If the foundation trust does not have a strategy to meet its goals –

perhaps because the LHE has changed or the trust has identified new performance issues – it is likely to need to recreate its strategy.

Section 2 - Progress against delivery of the strategy – max. 5 pages

The operational plan needs to set out how the Trust will achieve sufficient progress on its strategic agenda, ie how the strategy will be delivered over the plan period. Monitor expect this section to include:

The operational plan needs to set out how the foundation trust will achieve sufficient progress on its strategic agenda, ie how the strategy will be delivered over the plan period. We would expect this section to include:

- A summary of how the foundation trust and its LHE partners intend to respond to the 'Five Year Forward View', particularly in the context of the joint planning guidance set out in 'The Forward View into action: partnership and planning for 2015/16'.

- Translation of the strategic initiatives into goals, targets and KPIs by year, so that they are reflected in the operating plan from year one onwards.

- Clear actions to address any poor performance identified, as part of effective performance management undertaken in the strategic context.

- A summary of productivity, efficiency and CIP programmes[18], including key themes and the extent to which these are tactical or transformational schemes. This should include plans to improve efficiency and productivity through the more effective use of information and technology (may also be addressed in the capital programme).

- A description of the capital programme, with particular reference to how it supports the strategic agenda.

- How resources have been reallocated over the period to reflect strategic priorities. This will mean agreeing responsibility for delivery and providing individuals with the support they need.

Section 3 - Plan for short-term resilience

Progress against the long-term sustainability agenda should also be balanced with the need to improve resilience in the immediate term. The latter should involve consideration of the Trusts quality priorities, its operational requirements for the period, and what this all means for the financial forecasts.

Quality priorities – max. 2 pages

The foundation trust should have a series of **quality priorities** for the next year, which connect to the needs of the local population and to the NHS mandate. It should do this by considering:

- national and local commissioning priorities
- the foundation trust's quality goals, as defined by its strategy and quality account
- an outline of existing quality concerns (from Care Quality Commission or other parties) and plans to address them
- the key quality risks inherent in the plan and how these will be managed.

Operational requirements – max. 3 pages

Foundation trusts should outline their assessment of **operational requirements** over the next year, based on robust activity and capacity modelling, and building on lessons from this year's winter and system resilience planning. This section should cover:

- an assessment of the inputs needed (such as physical capacity, workforce, workforce development, IT and beds), based on the foundation trust's understanding of its expected activity levels
- an analysis of the key risks, and how the foundation trust will be able to adjust its inputs to match different levels of demand.

Financial forecasts – max. 7 pages

This should all connect to the **financial forecasts** in the foundation trust's final operational plan. These will comprise one year of financial projections, and should be well-modelled and based on reasonable assumptions.[19] The forecasts should also be supported by a clear financial commentary narrative.

Collectively these should articulate the impact of:

1) **financial pressure,** being the local reflection of the planning assumptions set out in the joint planning guidance preceding this document

2) **activity,** relating to underlying demand movements and the impact of commissioning intentions

C

3) **other** key movements, such as investment in quality or non-recurrent income or expenditure

4) **Strategic initiatives,** such as, but not limited to, CIPs, service developments and transactions.

The financial template has been refreshed for 2015/16 to reflect these four key drivers, and it now has a number of summary tables and bridges which you may wish to include in the narrative document to support the commentary.

The first three items of the list above collectively represent the baseline or 'do nothing' scenario. The strategic initiatives (in item four) are the tactical and transformational responses by the foundation trust designed to close this gap.

The narrative financial commentary should address:

- assumptions underpinning these drivers.
- impact of these drivers on the overall financial forecasts, and in particular on forecast risk ratings and liquidity
- consideration of any sensitivity analysis[20]
- material variances between the financial projections for 2015/16 in last year's five year plan, and forecasts for the same one-year period in this year's operational plan (this should either be explained in silo or cross-referred to the strategic context).

Please note that material variances between the financial projections for 2014/15 in last year's plan and the actual 2014/15 outturn should have been covered in the strategic context.

Because of the required submission dates (27 February 2015 and 10 April 2015), each foundation trust's draft and final operational plans will be developed before a final 2014/15 year-end financial position is known. Therefore foundation trusts should use a projected year end outturn for 2014/15 based on the most up-to date and relevant information available.

We expect the 2014/15 outturn to be an accurate and carefully-considered indication of the foundation trust's year-end position. The outturn will be compared to the actual results reported in the quarter four submission. Unreasonable variances, which may constitute an indication of poor governance, may be subject to further investigation. The template to be completed by foundation trusts for the 2015/16 quarterly submissions will also be amended, so that it reflects the key changes we have made to the annual planning template.

University Hospitals Bristol NHS
NHS Foundation Trust

Operational Plan Document for 2015-16

University Hospitals Bristol NHS Foundation Trust

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Operational Plan for y/e 31 March 2016

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

Name	**Deborah Lee**
Job Title	**Chief Operating Officer and Deputy Chief Executive**
e-mail address	**deborah.lee@uhbristol.nhs.uk**
Tel. no. for contact	**0117 3423606**
Date	**14 May 15**

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

In signing below, the Trust is confirming that:

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

Approved on behalf of the Board of Directors by:

Name *(Chair)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	

Signature

Section 1 – The Strategic Context for our Plan

1.1 This year's challenge – and our focus

Welcome to the Operational Plan for University Hospitals Bristol, for the year 2015/16. It has been written in the context of the longer term direction which we set out last year in our 5 year strategic plan which, in broad terms, remains strategically valid. Our strategy - to develop our regional and tertiary services, whilst focusing upon the quality and efficiency of our local secondary care services - continues to serve us well but this plan also takes account of the way in which the environment in which we operate has changed and developed in the last year.

This change has a local component, driven by the developing work in which we are engaged across our local health economy, but it also has a national component; first in terms of the way in which national commissioning is developing, and secondly in terms of the direction that has been set – and the challenge issued – by the NHS Five Year Forward View[1].

The other key element that has shaped our plan this year is the combined forces of operational challenges – and that of flow in particular – alongside the tightening financial context. We signalled in last year's plans the difficulty we anticipated in 2015/16, and this year we are declaring a deficit plan (£5m before technical items) for the first time in 13 years despite planned delivery of 5.5% savings.

Finally, the deteriorating financial position of our nearest acute partner, North Bristol NHS Trust, and the ongoing operational and clinical challenges facing Weston Area Health NHS Trust (associated with their on-going acquisition) also provide an important operating context for the Trust.

Whilst our strategy remains sound, the aims we set out in last year's Operational Plan, to deliver significant performance improvements were not achieved. The issue which continues to most frustrate our efforts to deliver exceptional care, which meets all national standards, is the challenge of patient flow - this remains our key focus for the year ahead. However, the extent of progress should not be underestimated. Aided by the catalyst of the Care Quality Commission (CQC) inspection findings, which provided a further impetus to system working across the partner organisations, progress has been made on a number of fronts. As signalled in last year's plan, we have further integrated working between system partners and have recently set up a joint discharge hub comprising staff from all sectors across both health and social care, we have embedded weekly, multi-agency reviews of all inpatients, and in line with our transformation priorities, adopted new approaches to scheduling theatres and managing surgical beds. As a result of this, and other work, we have seen:

- Achievement of both RTT and A&E recovery plans, ahead of trajectory at the time of writing;
- Delivery of the A&E four hour standard in March 2015, the first month since June 2014
- Bed days lost to delayed discharge drop by 20% over the last winter compared to that of 2013/14 and fall from a high of 1523 in April 14 to 604 in April 15
- the number of patients delayed over 24 hours in in critical care, drop from 13.8 per month to 2.1
- Surgical length of stay reduce by 25% April 14 to April 15, from 6.8 to 5.1 days.
- Surgical productivity improvements lead to a 14%, average increase in monthly activity.
- 89% of orthopaedic patients are now typically admitted to the right ward, compared to 36% last year.

Further progress needs to be made, but results like this give us confidence that we are moving in the right direction in operational terms. There will be big challenges this year, but we are better placed than many to meet them. Our focus is explicitly on operational resilience in the next 12 months, and the content of this plan reflects that.

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

[1] http://www.england.nhs.uk/ourwork/futurenhs/

Our vision – as set out last year and to which we recommit - is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care. We want to be characterised by:

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

Finally, both the CQC inspection findings and the recent staff survey, serve to highlight the challenge that remains ahead in relation to our workforce. The Trust's national staff survey results left the Trust in the lower quartile of performers in many areas and notably in relation to staff engagement and morale. 2015 will reflect a renewed focus on the plans and strategies to re-engage our staff in the things that matter most to them and our patients.

1.2 Reviewing and evolving our Trust strategy

1.2.1 Review of Operational Performance

In the 2014/15 Annual Plan we identified risks to compliance with a number of standards - Accident and Emergency 4-hour standard, the Referral to Treatment Time (RTT) Non-admitted standard and the 62-day GP cancer standards. Our performance last year was consistent with this, with the exception of a wider scale of failure against the RTT standards and the additional failure of the 62-day referral to treatment cancer standard, for patients referred from the national screening programmes. A summary at a glance, of our current performance against national standards, is included at Annex A with further detail below.

Control of Infection

Although the Trust reported an increase in the total number of cases of Clostridium difficile infections in 2014/15 compared with 2013/14 (50 in 2014/15 compared with 38 in 2013/14), the commissioners' review of these cases confirmed that only eight of the fifty cases were considered avoidable by the Trust. The Trust was therefore confirmed as having far fewer cases than the centrally set annual limit that of 40 cases, and also achieved the limit set for each quarter of 2014/15. Disappointingly, the target of zero MRSA (Meticillin Resistant Staphylococcus Aureus) bacteraemias was not achieved in 2014/15, with five cases being reported in 2014/15. Of these five cases, two were confirmed to be contaminated samples, although were still attributed to the Trust for reporting purposes. The three confirmed cases is an increase in the two cases reported in 2013/14.

Access Standards

There was a decline in performance against the three Referral to Treatment Time (RTT) standards during 2014/15 which resulted in failure of all three standards in quarters two, three and four. The failure to sustain achievement of the RTT standards initially was due to a growth in the number of over 18-week waiters, with demand exceeding the level of capacity which could be put in place. However, the rise in the number of over 18 week waiters during the first quarter of the year led to a detailed review of the capacity required to both address the backlogs, and achieve sustainable 18-week waits going forward and the decision to embark upon a period of planned failure to address these backlogs. There were clear signs of recovery during quarter 4, with material reductions in the backlogs for both admitted and non-admitted patient pathways being realised, beyond that set-out in the recovery trajectories.

High levels of demand also brought challenges for achievement of the maximum 6 week wait for a diagnostic test. A recovery trajectory was put in place, underpinned by detailed capacity and demand modelling, with achievement of the 99% standard now expected by the end of quarter 1 2015/16.

Overall, performance against the cancer waiting times standards remained strong, with six of the eight national standards being achieved in every quarter. However, the 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer, was not achieved in 2014/15. The biggest single reason for the failure to achieve the 85% national standard was the late receipt of referrals from other providers, which alone accounted for approximately 40% of breaches in a month. Performance for solely internally managed pathways was above 85% in three quarters in 2014/15. The Trust continued to take action to reduce the length of wait for key steps in cancer pathways in 2014/15, including offering as many patients as possible the opportunity to be seen within 7 days of referral by the GP, instead of the national requirement of 14 days.

Disappointingly, the Trust failed to achieve maximum 4-hour wait in Accident & Emergency for at least 95% of patients in every quarter of the year. However, the Trust met the national Accident & Emergency clinical quality indicators in the period. The level of ambulance hand-over delays remained at a similar level to 2013/14, although significant improvements were seen in the latter half of quarter 4. A system-wide resilience plan was developed during the year, in association with partner organisations, in recognition of the increasing pressure on emergency services both locally and nationally. Encouragingly, the recovery trajectory which was developed from the expected impacts of the joint plan was achieved by the Trust in quarter 4, with year being rounded-off with achievement of the 95% standard in March.

Looking forward, the Trust is declaring a large number of indicators at risk of non-achievement. In part this reflects the planned failure of RTT standards but also reflects the inherent risk to cancer arising from our cancer portfolio (both case mix and tertiary status) and the on-going journey to sustainable A&E performance. The table below summarises the proposed declaration for 2015/16, based on the standards that we forecast are at risk of being achieved.

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Standards	RTT Non-admitted RTT Admitted RTT Incomplete/Ongoing 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted RTT Incomplete/Ongoing 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted 62-day GP cancer 62-day Screening cancer A&E 4-hours	RTT Admitted 62-day GP cancer 62-day Screening cancer A&E 4-hours
Score	**3.0**	**3.0**	**4.0**	**3.0**

1.2.2 Reviewing our financial performance

The results for 2014/15 confirm another year of strong performance and delivery for the seventh year of our financial strategy as a Foundation Trust, including:

- Delivery of an income and expenditure surplus of £6.3m, before technical items;
- A Continuity of Services financial risk rating of 4;
- An EBITDA (Earnings before interest, taxes, depreciation and amortization – ie operating surplus) of £35.8m (6.2%);
- Achievement of cash releasing efficiency savings of £16.5m;
- Expenditure on capital schemes of £44.3m;
- A healthy cash position (£63.4m) and a strong Balance Sheet.

We have already acknowledged the challenges ahead in general terms. In particular, they relate to the delivery of managing service level agreement activity, realisation of more than £24m of savings and continued service transformation to ensure the Trust's strategic objectives continue to be progressed.

1.2.3 Review of the Local and national commissioning landscape

The local commissioning landscape largely reflects the national landscape. The Trust's services are commissioned in the majority by the four local Clinical Commissioning Groups (Bristol, North Somerset, Somerset and South Gloucestershire – BNSSSG) and NHS England; all of whom continue to develop and mature. We are planning to have signed Heads of Terms by 27 April for major commissioners.

1.2.3.1 NHS England – Specialised Services

- Specialised Services now make up around 45% of our proposed contract income.
- NHS England has signalled its strong intent of aligned positions on risk share arrangements with the acute sector. University Hospitals Bristol opted for Enhance Tariff Option which values this risk share at 70% above stated baseline value (SBV).
- Our service development proposals are currently being reviewed by NHS England's regional prioritisation panel.
- With regard to meeting national service specifications, we are seeking clarity on the extent of compliance, as it had previously been against key requirements and full compliance against all requirements will require significant additional commissioner investment. This position is however, no different from the national position. And H Bristol is performing well against key requirements with some outstanding actions on derogated services
- NHS England has mandated QIPP (Quality, Innovation, Productivity and Prevention), CQUINs (Commissioning for Quality and Innovation), and the implementation of a new Clinical Utilisation Review nationally. The potential effect of these initiatives may be to have significant impact on current delivery of key IM&T projects and the latter is not supported by clinicians. We are seeking to ensure CQUINs are earnable, as per national guidance, at circa 80% of earnable income.
- The affordability of activity proposals – particularly RTT backlogs – is still under discussion.

1.2.3.2 Local Commissioning.

- BNSSSG CCGs[2] have seen some benefit of the pledged £1.5bn government funding following the publication of the 5 year forward view, discussion about how this will be allocated locally is ongoing; current agreements are reflected in our 2015/16 financial plan.
- A key consideration this year is the effect of programmes designed to divert services away from acute settings. Clinical Commissioning Groups aim to achieve this through levers such as the Better Care Fund (BCF), moving urgent care into the community, reviewing pathways (e.g. stroke, falls, diabetes, respiratory, obesity, Deep Vein Thrombosis), and integration. The Trust is actively engaged in these initiatives and the projected impact of the BCF is incorporated in contracts.
- Coding and Counting – Commissioners would like to implement a number of coding and counting changes, some of which are pricing changes, including the findings of an audit undertaken by an external party. We have agreed neutrality on coding and counting and pricing issues with all commissioners in line with 2015/16 commissioning intentions and planning guidance.
- Re-procurement of sexual health services has been put back to 2016/17 whilst Councils refresh their needs assessments and develop a joint BNSSG commissioning strategy. This is likely to include some integrated services commissioned by Bristol Clinic al Commissioning Group.
- Re-procurement of children's community services has also been delayed until 2017 pending clarity regarding the scope and specification of services.
- We have agreed activity levels and a resilience funding plan for 2015/16. Discussions continue regarding the impact of QIPP schemes.

[2] Bristol, North Somerset, Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs)

1.3 Recommitting to our 2020 Strategy

Our strategic intent was set out last year in our five year plan, and it remains to;

- *Provide excellent local, regional and tertiary services, exploiting the synergies that flow from this portfolio whilst addressing the resulting operational tensions that have the potential to impact upon the success of one or more areas. Our focus for growth (in the medium term) remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare.*
- *Deliver the benefits that flow from combining teaching, research and care delivery will remain our key advantage, along with recruiting, developing and retaining exceptionally talented and engaged staff.*
- *Do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or out sourcing services that others are better placed to provide and delivering new services where patients will be better served.*
- *Ensure that our patients – past, present and future - their families, and their representatives, will be central to the way we design, deliver and evaluate our services. The success of our vision to provide "High quality individual care, delivered with compassion" will be judged by them.*

In our judgement, the underpinning assumptions that we made last year are still valid. Accordingly, **we recommit to our strategic plan**, but acknowledge the work to be done to describe the medium term (3 to 5 year) path of implementation beyond the immediate operational challenge of this next financial year.

Using the Monitor Strategic Planning Toolkit[3], we judged that our work to produce the Monitor Strategic Plan last year took us, de facto, through the early elements of the of the toolkit (frame, diagnose, forecast, generate options and prioritise. We continue to focus on the 'deliver' and 'evolve' stages of the toolkit.

[3] https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

Section 2 – Delivering our 2020 Strategy

2.1 Delivering progress against our strategy

For the year ahead, delivering progress against our strategy will be achieved by working with a refreshed set of corporate objectives, derived from our Vision, as described in section 1.1 above and set out in our strategic plan in 2014. They are still the basis for our activity as a Trust and are summarised below and in more detail at Annex B.

Operational and financial issues make this an unprecedentedly challenging year ahead for the Trust. Accordingly, we are collectively focussed on the resilience of our services in the short term, which has to some extent partly crowded out our collective work to address some of the longer term issues of sustainability though all immediate threats and risks have been addressed. Accordingly, our Strategic Implementation Plan, designed to develop the outline plans for years 3 to 5 that we set out in our Strategic Plan, is still being developed. Where essential, we have linked developments in our operating plans to longer term aspirations, but we have had limited joint capacity – or resources – at our disposal to work toward, or invest in, the medium term. We will address this over the summer, and develop the detail of our 3-5 year plans by September, summarising strategic initiatives, goals, targets and Key Performance Indicators for years 3 to 5 of our 2014-19 plan.

2.2 Our Corporate Objectives

Our detailed corporate objectives are described in Annex B but flow from our 2014 Strategic Plan and in summary are:

- To consistently deliver high quality individual care, delivered with compassion.
- To ensure a safe, friendly and modern environment for our patients and our staff.
- To strive to employ the best and help all our staff fulfil their individual potential.
- To deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.
- To provide leadership to the networks we are part of, for the benefit of the region and people we serve
- To ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
- To ensure we are soundly governed and are compliant with the requirements of our regulators.

2.3 Responding to the 'Five Year Forward View'

We have considered the challenge set out in the NHS 5 year forward view and are working with others across the Local Health Economy to consider its implications for the Bristol health system of which we are an integral part. There are two key mechanisms by which this work is being taken forward.

The first is the **System Leadership Group**. This group, set up by local providers and commissioners, now includes the full range of organisations connected to and concerned with the local health economy (including the major local community providers and Bristol City Council). The agenda for this group is currently focussed on:

- Developing a joint vision for the Local Health System.
- Formally assessing the current 'readiness' of the local health economy to progress the Five Year Forward View agenda.
- Identifying – and committing, to a series of 3-5 year work streams as well as potential 'early wins' and a joint approach to resourcing this work.

The Trust has assessed and revised aspect of the executive portfolio to ensure that there is a clear, senior leadership focus on the way the Trust shapes the wider system within which it operates. The role of Director of Strategy and Transformation has been established to lead on this agenda.

The second key piece of work bringing organisations together across the local health economy is **Better Care Bristol** (the local Better Care Fund). As with other initiatives across England, the desired outcomes of Better Care Bristol are:

- Improved services, despite greater demand and less money.
- People cared for in their own homes, with reduced admissions to, and lengths of stay in, hospital.
- Help for people to better manage their own health conditions.
- Spending money on supporting people to live well in their communities, to prevent them needing costly health or social care services later.

We are a full partner in this work, and support the outline financial plan that underpins Better Care Bristol. However, the commissioning and provider sectors are not yet aligned on the impact of the initiatives. All parties have supported the aim of a 1.75% reduction in emergency admissions for each of the next two years (of those over 65) and an expectation that activity growth arising from demographic changes will be offset by further demand management initiatives. However, greater reductions in demand which commissioners have assumed, but which we have been assessed as high risk, have not been incorporated in the Trust's plan. To respond to these "tentative" initiatives, with capacity reductions would, in our view, jeopardise operational performance. However, we remain committed to working closely with our community partners to reduce reliance on hospital services.

2.4 Our Plans to Address Poor Performance

The Trust has been working closely with its commissioners and regulators to develop recovery plans to address those areas which the Care Quality Commission found not to be meeting fundamental standards and the three areas of poor performance in relation to national access standards – A&E, RTT and 62 day cancer standards. The key initiatives to address these access standards include

- A comprehensive capacity assessment of the demand for elective care, both outpatients and admitted, using external support (IMAS) resulting in the development of robust supply plans to eliminate backlogs and address shortfalls in recurrent capacity
- Instigation of demand management initiatives in some serves, to support timely access to care.
- Full validation of RTT pathways and migration of reporting to the Trust's Patient Administration System – Medway.
- A "resetting" and expansion of the Trust's bed base to support improved flow through a reduction in the occupancy level at which the Trust operates its bed stock.
- Further expansion of community initiatives, funded by the Better Care Fund, to avoid hospital admissions and promote early discharge.
- Implementation of a series of cancer improvement initiatives to address known bottlenecks in cancer services, including the introduction of incentives, through the CQUIN scheme, of partner Trusts to refer patients in a timely way.

An access recovery plan is included at Annex C and has been endorsed by the Board and our commissioners.

2.5 Our People – our workforce and organisational development strategy

We have made considerable progress with regard to our workforce strategy in the last 12 months. As described in section 6 of our Monitor Strategic Plan 2014-19, we have identified the workforce strengths, weaknesses, opportunities and threats for the University Hospitals Bristol, and from this, developed six key strategic themes. This analysis subsequently formed the basis of the Trust Workforce and Organisational Development Strategy, which was agreed by the Trust board in September 2014.

An action plan has been developed and approved, which is monitored by the Workforce and Organisational Development Group. Strategic themes provide the long term direction for workforce sustainability at University Hospitals Bristol. In addition, there are short term work programmes focussed on key operational resilience, which are described more fully in the section 3.2.3.

The key areas of progress over the past year and priorities for the coming year include the following.

Developing Leadership and Management Capability	• To date, we have put in place a comprehensive leadership programme for all front line supervisors and managers. • Our priority for 2015/16 is ensuring that all managers and leaders have the skills and competencies to support and develop staff creating a culture of high performance and continuous improvement.
Staff Engagement	• To date, we have focussed on improvement of two-way communication, including a programme of listening events, focusing on areas indicated by our staff, from the staff survey and other local feedback mechanisms. • Our focus in 2015/16 will be on implementation of the approach developed by Aston University to improve team working.
Recruiting and Retaining the Best	• To date, we have developed a marketing approach to attract suitable candidates, including social media for cleaning staff. • In 2015/16, we aim to improve the speed of recruitment from application to appointment by streamlining all processes, whilst continuing to ensure there are robust employment checks.
Reward and Performance Management	• To date, we have implemented a revised performance management policy which now links pay progression with performance management. • In 2015/16, we will improve the quality and application of staff appraisal.
Education and Research	• We have been focussed to date on the development of a forward looking Education and Development Strategy 2015 to 20, with a revised integrated governance process. • In 2015/16 we will focus on providing high quality training and development programmes to support a diverse, flexible workforce, underpinned by effective training needs analysis and planning.
Strategic Workforce Planning	• Over the last year, we have been working with Health Education South West to secure funding for robust Workforce Planning Training for Human Resources Business Partners • Our priorities for 2015/16 are to develop a framework to roll out training on workforce planning for key service managers.

2.6 Capital Investment

The Trust has invested significantly in the last three years to modernise its estate and 2014/15 saw the culmination of many of the strategic estates plans, including the opening of the new 10 storey ward block and the retirement of the Old Building to inpatient services. Whilst early days, there is significant evidence that this new estate, designed around the optimal adjacencies and co-location of services, is supporting the transformation of services in the way set out in the original business case. As discussed earlier, new models of surgical care, only possible because of the new estate have supported a 13% reduction in length of stay since the model was launched.

Plans for 2015/16 include the investment of an additional £34.2m of capital (net of slippage) – £15.8m in the conclusion of ongoing strategic schemes associated with the refurbishment of the BRI Queens and King Edward buildings (BRI Phase 4). £2.2m in backlog maintenance, £8.7m in operational capital and £7.5m in equipment and IM&T related investments. The vast majority of this latter investment is in support of mitigating immediate risks, enabling performance recovery through additional equipment or replacement / repair of obsolete equipment or estate. However, there remain challenges in supporting the liquidity position to maintain a CoSRR of 3 and as such £11.8m of slippage is presently assumed within the plan. The impact of this on quality has been assessed and the key impact is the continuation

of outpatient based services from the Old Building for a further three months and, whilst not ideal, is tolerable.

2.7 Productivity, Efficiency and Cost Improvement

The Trust's CIP programme for 2015/16 is £24.4m, with 37% of this sum still to be identified. The target is a combination of new efficiency requirements and undelivered cost efficiency from previous years. The nature of the initiatives to realise this saving are both transformational are transactional, as in previous years.

Transactional work streams for 2015/16 will see a renewed focus on controls, both pay and non-pay and the development of specific work streams to address those areas with a known high Reference Cost Index (RCI) - for 2015/16 the focus will be general medicine, cardiology and ENT , starting with diagnostic work to identify the "best in class" and then working with those organisations to understand how the Trust's services need to be reconfigured or transformed to achieve their levels of efficiency. Only those Trusts with services of demonstrably good quality have been included in the diagnostic.

Transformation initiatives are broad with the Trust starting the year with another Breaking The Cycle Together initiative and will include a significant revision to the acute model of care for emergency pathways, with the explicit goal of sustaining strong A&E performance and reducing length of stay sufficiently to restore the bed base back to planned levels – this is critical to future financial stability as these beds are partly funded non-recurrently from external resilience funds.

Our other transformation priorities for 2015/16 are:

- Further developing our Operating Model, driving improvements in patient flow and quality in our services. Our Operating Model work is managed through three strands: Unscheduled care, which with our health and social care economy partners is delivering improvement in emergency flow, ward processes and complex discharge pathways; Planned Care, which is transforming our elective care pathways to reduce cancellations and improve elective length of stay; and Children's Surgical flow, where improvements in capacity are being underpinned with changes to scheduling processes and team capability
- Under our Delivering Best Care programme we are taking forward specific agreed projects to develop 7 day working, and further developing our End of Life Care services
- We are delivering a programme of theatre transformation across all our theatre suites, to improve patient experience and improve utilisation of theatre capacity
- Improving staff engagement and communications – we will take forward a Trust wide programme to strengthen communications and engagement with our staff and respond to feedback from staff survey results
- We will further build our relationships with health economy partners, supporting system wide work in support of the Better Care Fund initiative.

We will start the year with a Breaking the Cycle Together initiative to reaffirm standards of quality and safety across our services and to gather further feedback to provide focus for our Operating Model work.

Section 3 – The Year ahead: Our Plan for short-term resilience

3.1 Our focus on Resilience

The focus of our plan this year is the resilience of our services and our finances – the challenge of maintaining quality (and thus performance) in the context of considerable operational and financial challenges. This section sets out our quality objectives, our operational requirements and what all of this means for deployment of our resources and our financial plan.

3.2 Our commitment to Quality

The Trust's quality strategy remains focused on patient safety, patient experience and effectiveness of care and our commitment to address the aspects of care that matter most to our patients. It outlines our plans to address these areas as well as to mitigate any quality risks that result from our challenging financial cost improvement plans. The quality of our clinical services will not be compromised. We view quality, safety and efficiency as mutually beneficial. Our commitment to this principle underpins both our quality priorities outlined in our 2014/15 Quality Account and the Trust's quality objectives for 2015/16, which are outlined below.

We continue to use the following four questions to examine our approach to quality:

- Do we understand quality and patient experience well enough in the Trust?
- How do we know that the services we provide are safe?
- What will it take to make all our services as good as they can be?
- How well do we involve our staff and patients in this agenda?

The Trust was inspected by the Care Quality Commission this year which has helped shape our quality priorities for the year ahead. Much of the Care Quality Commission report was positive, with urgent and emergency services, Intensive and critical care services, maternity and gynaecology services, services for children and young people and end of life care receiving a good rating. Medical, surgery and outpatient service were identified as requiring improvement. The Trust is working internally and with our partners in health and social care to make improvements in the areas identified as not meeting the required standards. An update on our CQC action plan – summarising our work in response to the report – is included at Annex D. Follow up of the responsive review by the Care Quality Commission of the operating department at the Bristol Royal Hospital for Children in November 2013 and the themed review of Dementia in 2014 were included in scope of our comprehensive review.

The Trust has received very positive patient feedback throughout the year with patients reporting their experience of kind and compassionate care and treatment. Friends and Family scores for our hospitals are better than the national average, with the vast majority of patients saying that they would recommend the hospital.

3.2.1 Our Quality Objectives

Looking forward, each year we consider national and local commissioning priorities related to provision of high quality services alongside available intelligence about the quality of all of our services (internal and external) and, with the involvement of our local stakeholders, patients and governors, agree a set of corporate quality objectives to reflect our agreed priorities. As a result of this approach, our quality objectives for 2015/16 the will focus on:

- Working with people to provide a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm;

- Achieving clinical outcomes for our patients that are consistently in the upper quartile of comparable Trust's performance.

The specific Trust Quality Objectives for the year ahead are shown below. As this report is submitted, these objectives are still draft, but will be confirmed as part of the ongoing development of the Trust Quality Report. Objectives 1, 2 and 3 are continued from last year's objectives. This is because, despite some improvements**,** the Trust has not delivered the level of quality improvement that it wanted to see in these areas. All three of these objectives relate to, and support, the Trust's strategic operational priority to improve the flow of patients though the Trust.

- Objective 1 - To reduce the number of cancelled operations
- Objective 2 - To minimise inappropriate patient moves between wards (time and place)
- Objective 3 - To ensure patients are treated on the right ward for their clinical condition
- Objective 4 - To improve the process/experience of patients discharge
- Objective 5 - To improve standards of written communication with patients
- Objective 6 - To improve the management of patients with a clinical diagnosis of sepsis
- Objective 7 - To improve the experience of cancer patients
- Objective 8 - To improve the quality of written complaints responses
- Objective 9 - To reduce appointment delays in outpatients; and to keep patients better informed about any delays

3.2.2. Quality assurance

Our Trust objectives, values, quality and efficiency strategies provide a clear message to all staff that high quality services and excellent patient experience are the first priority for the Trust Board. This message is reinforced through our five clinical divisions having specific, measurable quality goals as part of the process of producing their Annual Operating Plans. Progress against these plans is monitored monthly by Divisional Boards and by the Executive Team through the Divisional Performance Review process. The Board Quality and Outcomes Committee will also continue to review our progress against a range of quality performance indicators and our performance against Care Quality Commission's fundamental standards. Feedback and discussion is undertaken with governors via the Patient Experience Group, Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework which reports high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement.

Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

3.2.3 Risks to our Quality Objectives.

Despite our quality strategy and work to improve our patient flow, we have declared that the Trust is at risk of not achieving some healthcare targets and indicators in 2015/16. Firstly, we have declared that we may not achieve the threshold of 95% patients spending less than four hours in our A&E department in quarter 4. The issues that contribute to not meeting this target are complex. We have several pieces of work underway to address these issues. We are an active member of the Strategic Resilience group, one of the key aims of which is to provide a local whole system approach to addressing local emergency care and patient flow pressures.

The final, but significant risk to achieving our quality objectives is the risk that our staff are not engaged in our plans and motivated to support their delivery. All staff working in the NHS are facing huge challenges and our recent national staff survey demonstrates that for UH Bristol this issue is one that we must address if we are to succeed. Significant attention is being given to this agenda and emerging plans to address this are set out in the workforce section of this plan.

3.2.4 Managing the Risk of Cost Improvement Plans on Quality

The Trust has a robust approach to the assessment of the impact of cost reduction programmes on the quality of services. This includes a formal Quality Impact Assessment for all Cost Improvement Plans with a financial impact of greater than £50k and ANY scheme that eliminates a post involved in front line service delivery. These QIAs are required to be reviewed through Divisional quality governance mechanisms to ensure robust clinical oversight of plans, from those service areas affected.

In addition to this internal assurance of the impact of CIPs on quality, local commissioners also review plans, on a sample basis, to assure both the quality of approach and the impact of the most significant schemes (in financial terms).

Finally, the Medical Director and Chief Nurse are responsible for assuring themselves and the Board that cost improvement plans will not have an adverse impact on quality.

3.3 Our Operational requirements – the capability we need to achieve our objectives

3.3.1 Capacity Planning

During quarter 3 of 2014/15, the Trust undertook a detailed capacity and demand planning exercise, supported by the Interim Management and Support Team (IMAS). IMAS provided a modelling tool for planning the level of capacity required to reduce waiting times for first outpatient, diagnostic and elective admission, and achieve a sustainable waiting time for follow-up attendances. The Trust modelled the capacity required to reduce these stage of treatment waits in order to realise 18-week compliant Referral to Treatment Time (RTT) pathways. This exercise has informed the amount of recurrent activity that the Trust needs to provide to maintain 18-week waits once waiting times have been reduced and backlogs have been addressed. The level of non-recurrent work needed to reduce existing backlogs of long waiting patients has also been assessed and represents a significant increase in activity which brings with it operational challenges.

From these inputs the Trust has modelled the activity it requires commissioners to contract for in 2015/16. This level of planned activity for 2015/16 also takes account of the impact of in-year and planned service transfers, service developments, recurrent (demographic) growth and other known planned changes to activity levels. Below is a summary of the additional activity required in 2015/16 over last year, of which around 65% is recurrent growth.

- 1423 additional elective inpatients (10.1% increase)
- 3250 additional elective day cases (5.9% increase)
- 4113 additional outpatient procedures (7.4% increase)
- 15,471 additional outpatient new attendances (8.86% increase)
- 24,866 additional outpatient follow ups (7.06% increase).

Required activity, alongside our projections for the impact of demographic growth and system wide initiatives to reduce demand and improve flow, have led to a re-statement of the Trust's required bed base. Of significant note is the decision to invest in reductions in occupancy (to 90%) given the increasingly clear relationship between flow and occupancy levels – significant funding from commissioners, through the Strategic Resilience Group has enabled this to be achieved. Improvements in the surgical length of stay, on the back of the planned care transformation initiative, have also enabled a ward to swing from medicine to surgery which will further support optimal occupancy and ensure all patients are cared for in the right environment..

More detail on the activity and capacity requirements are set out in Annex C but in summary the following are the key physical inputs required.

- 18 fewer surgical beds, within the BRI bed base.
- 16.5 additional adult theatre sessions per week and 13.5 paediatric theatre sessions.

- 75 additional adult outpatient clinics and 14 paediatric clinics per week.
- Modelled requirement for 400 waiting list initiatives, 104 paediatric.

Key workforce impacts are assessed to be:

- 82.75 additional surgical and dental medical sessions per week to deliver RTT activity.
- 5 WTE consultants and 59 additional ward nursing staff to support expanded medical bed base.
- 41 WTE additional surgical nursing and therapy staff (excluding paediatric theatres).
- 14.5 WTE paediatric theatre staff.
- 17 WTE additional administrative staff.

3.3.2 Information management and technology (IM&T)

The IM&T Operational Plan for 2015-16 is focussed on the delivery of a Programme to support the long-term vision of the Trust's Clinical Systems Strategy (2012) whereby *every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again*. The Programme is overseen by the IT Management Group chaired by the Director of Finance and Information, and the planned benefits will include:

- Maximising value for money through competitive procurement and systems review.
- Improving efficiency e.g. records management; patient flow.
- Consolidating and integrating systems and information.
- Improving access to on-line patient information.
- Improving clinical communication and responsiveness.
- Providing Clinical Decision Support e.g. electronic prescribing.
- Supporting Patient Safety, including formal system assessments with clinical staff.
- Supporting good Information Governance including record keeping and audit.
- Supporting clinical research e.g. searchable clinical records.
- Improving workload planning e.g. new theatres scheduling system.
- Reducing the use and generation of paper-based documentation.

3.3.3 Workforce

There have been a number of workforce challenges in 2014/15. The buildings redevelopment, whilst welcomed by the majority, resulted in the loss of some staff who found the change to new ways of working was not for them; time from advert to recruitment has been lengthy and resulted in vacancies being long standing with high use of bank and agency to fill gaps and changes to the ways essential training is delivered have been significant and impacted on many staff. Positively, work streams to address these challenges are in train and the Trust achieved 88% for essential training at the end of March, which, whilst just shy of our 90% target, is significantly better than many Trusts – of note is the uptake of e-learning as a means of delivering core training requirements.

Changes in staff numbers planned for 2015/16 include reductions due to the transfer of cellular pathology to North Bristol Trust, and reductions due to savings programmes, and increases associated with Operational Resilience Cost Pressures and service transfers. These are summarised in the table below.

	Month 12 2014/15 Brought Forward	Changes 2015/16					March 2016
		Operational Resilience	Service Developments	Service Transfers	Additional Recruitment to fill Vacancies	Savings Programme 2015/16	
Staff Type	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Medical and Dental	1,100.25	13.81	7.54	(8.15)	8.76	2.60	1,124.81
AHP Scientific/Technical	1,300.12	1.00	8.95	(21.01)	1.84	(7.40)	1,283.50
Nursing and Midwifery Staff	2,869.97	39.67	10.86	6.81	5.01	(9.21)	2,923.11
Ancillary staff	737.55	2.00	1.00	-		(5.33)	735.22
Admin and Clerical and Senior Managers	1,536.21	4.14	11.60	(6.09)	19.49	(8.51)	1,556.84
Sub-total	**7,544.10**	**60.62**	**39.95**	**(28.44)**	**35.10**	**(27.85)**	**7,623.48**
Bank	416.23	No change on 14/15 Outturn					416.23
Agency	170.29	26% Reduction on 14/15 Outturn					126.01
Grand Totals	**8,130.62**						**8,165.72**

Recruitment

The monthly average vacancy level for University Hospitals Bristol was 5.3% and the target for 2015/16 is 5%. Registered nursing vacancies at University Hospitals Bristol at 7.1%, continue to be below the benchmark of 9% for similar Trusts in the Associated United Kingdom University Hospitals (AUKUH) cohort. An action plan to achieve the phased filling of vacancies was established in 2014/15, and this will continue into 2015/16, including procurement of a recruitment management system, and improved resources in the recruitment team. Given the demand for nursing staff in the tight labour market, with reduced numbers of newly qualified and experienced staff available, a trust-wide overseas recruitment initiative is being developed.

Workforce affordability

Regarding affordability, our main priorities in 2015/16 will be to reduce agency spend by recruiting to fill vacancies and reducing turnover, together with decreased sickness absence. Savings plans will result in a reduction of approximately 28 WTE in 2015/16. However, some savings will not have WTE reductions associated, but will reduce pay costs and increase productivity, including plans to change skill mix and reduce premium payments.

Bank and Agency Usage

The workforce plan assumes a 26% reduction on agency spend. The main reason for booking bank and agency is to provide cover for vacancies, and therefore the recruitment and retention programme will be essential to reducing temporary staffing spend. Agency spend will also be reduced through improved rostering, and better and earlier alignment of operational plans with workforce planning. This process ensures all agency requests are appropriately approved, with controls in place to monitor this. Options to improve the incentives for staff to undertake bank shifts are being developed and any changes will be implemented in 2015/16.

Retention

The target for turnover in 2015/16 is 11.5%. Turnover has increased in the previous year to 13.8%. In addition to work described in section 2.5, our focus is to retain staff (particularly nursing assistants, where turnover is particularly high) together with incentives and benefits for all new and existing staff.

Sickness Absence

The most recently available benchmark data shows that UH Bristol absence rates are broadly in line with comparable Trusts. The target for 2015/16 is 3.7%. Work to reduce absence over the next two years will build on existing programmes with a particular focus on addressing psychological causes of absence through a programme of stress management audits and support for staff.

Changes to junior doctor numbers

Work by the Director of Medical Education has helped to confirm that 10 posts will be lost from 2016 (5 Foundation Year 1 doctors and 5 Foundation Year 2 doctors) as a result of the national change to increase community placements. Work programmes to address the shortfall will be developed when the specialties have been identified, but are likely to include changes in workforce models and roles.

3.3.4 Key risks to the delivery of our Plan

The operational plan has been worked up in considerable detail in recent months and "stress tested" against a range of potential impacts. The key risks to delivery of the plan are set out below and mitigations to these risks have been largely identified and are described in summary below

- Commissioners do not contract for sufficient activity to enable RTT performance to be achieved – this risk is largely mitigated following agreement of contract activity levels, though the contract remains unsigned.
- Resilience funding is insufficient to support the enhanced bed base and investment in paediatric flow and winter pressures – this risk is expected to be mitigated through the reinvestment of RTT and other fines though not all commissioners have agreed to this approach.
- There are two primary risks to the workforce element of the plan; these are the supply of suitably qualified staff and the timeliness in which staff are recruited, and plans therefore able to be mobilised. In respect of the former, a range of recruitment and retention initiatives are being corporately led and supported, targeted to known 'problem' areas such as theatre staffing, where London-based recruitment fairs are planned. Where there are known staff shortages, alternative workforce models have been developed - for example, in restorative dentistry a new workforce model is being introduced, utilising dental nurses instead of dental consultants. Infrastructure to support this peak in recruitment activity is being strengthened to include additional recruitment staff and appointment panels. Finally, recruitment plans for all specialties have been developed and where recurrent posts will not be established from the outset, non-recurrent initiatives are in place to ensure backlogs do not grow.
- Demand for both elective and urgent care exceeds the levels assumed within the plan – this risk has been mitigated through comprehensive demand assessments and dialogue with commissioners. A range of initiatives to manage demand have been developed over recent months and historic gaps in supply have been addressed following the IMAS work which affords for limited excess demand to be managed without detriment to performance. Planning for occupancy at 90% also affords a degree of mitigation for unplanned peaks in demand, though consistent increases in occupancy will import risk to access standard achievement.
- Residual Cost Improvement savings are not achieved, expenditure exceeds plan or income is not achieved in line with plan – all of these issues have the potential to lead to the Trust being unable to deliver its financial plan. There are very limited contingencies within the plan to cover such eventualities and as such the focus will be unrelenting attention to financial controls and activity delivery. Further detail on financial risks is included in section 3.4 of the plan.

3.4 Our Financial Plan

3.4.1 Introduction

The financial plan narrative describes the Trust's current assessment and presents the 2015/16 position in outline. The 2015/16 financial year is extremely challenging. For the first time in 13 years, the Trust is forecasting a net income and expenditure deficit of £5m before technical items (£6.4m deficit after technical items including impairments). It should be noted that the current assessment of 2015/16 is the draft position and is based on the following key drivers:

- The Trust opted for the Enhanced Tariff Offer (ETO) under protest in March. The Trust opted for ETO with the expectation that a reasonable level of CQUIN income was earnable. The plan relies on this expectation being realised. We are concerned that this expectation is being frustrated by unreasonable Commissioner requirements re CQUINs.

- Service Level Agreement (SLA) discussions are now progressing with local Clinical Commissioning Groups (CCGs). However, discussions with NHS England are at an early stage. There is a reasonable expectation that Heads of Terms could be signed by the 27th April.

- The single biggest risk relates to CQUINs. The proposed CQUIN schemes are extremely difficult to achieve with exceptionally high trigger points for payment. Other schemes require substantial investment to deliver the CQUIN including recurrent costs, thereby mitigating the benefit of CQUIN income i.e. the net earnability (i.e. CQUIN income less the costs of delivery) is well below that anticipated both in the financial plan and the ETO tariff selection. We will not be able to agree SLAs without significant revision to proposed CQUINs for national, local, urgent care and specialised schemes.

- The Trust identifying savings plans necessary to achieve the 2015/16 saving requirement of £24.4m. The savings requirement is summarised below:

ETO National requirement	£15.7m	3.5%
Divisions underlying position c/fwd	£8.7m	2.0%
2015/16 Savings requirement	**£24.4m**	**5.5%**

Note – The percentage quoted is based on the net management budget affected e.g. excluding 'pass through' cost, R&D, hosting etc.

- The activity required to meet clinical demand and to deliver national performance targets (e.g. RTT) will be commissioned. Early indications are encouraging in this area.

- The Trust will receive adequate resilience funding from Commissioners to enable the Trust to operate effectively and prevent emergency system pressures compromising the delivery of elective activity. This has now been secured in principle. The Trust has made it clear that this funding must be included in the signed 2015/16 SLA.

3.4.2 Financial Plan

The Trust's 2015/16 financial plan is constructed as follows:

Underlying position brought forward	£9.5m	
Marginal Tariff loss at 70%	(£3.5m)	On NHS England Specialised Services
Impact of National Tariff	(£1.4m)	Other impacts of 2015/16 National Tariff
Division's CIPs shortfall	(£4.5m)	Assumes 2.5% of the 3.5% is deliverable
BRI Redevelopment	(£2.3m)	Capital charges and Facilities Management costs
Other capital charges	£0.6m	Excludes the BRI Redevelopment
PDC dividend offset	£0.7m	The loan interest reduces the PDC dividend
Dental & Medical SIFT	(£0.6m)	Due to reduction in teaching activity/student numbers
Risk reserve	(£0.7m)	Provision for Corporate cost pressures
Service Transfers – net loss	(£0.7m)	Breast Screening, Histopathology & Vascular Surgery
Reduction in contingency reserve	£1.0m	Reduction from £2m in 2014/15
Inflation contribution to capital charges	£0.9m	Capital charges growth
CNST contribution	£2.0m	Tariff funding above increases in premiums
Recurring position c/fwd	**£1.0m**	
Non Recurring costs		
Change Costs	(£1.0m)	Non recurring – redundancy/spend to save costs
Provision for performance fines	(£3.5m)	£1m is a recurring level - £3.5m includes RTT fines
Risk reserve	(£0.5m)	Provision for Corporate cost pressures
Transitional costs	(£0.2m)	Temporary revenue costs of capital schemes
Technology implementation	£0.8m	Clinical system technology implementation
Net income & expenditure deficit	(£5.0m)	**Before technical items**
Impairments	(£4.2m)	BRI Redevelopment Phase 3 and BRI Façade
Donations	£4.3m	In support of the Trust's capital programme
Donated asset depreciation	(£1.5m)	
Net income and expenditure deficit	**(£6.4m)**	**After technical items**

3.4.3 Income

The 2015/16 income plan is subject to further negotiation of SLAs with Commissioners and the resolution of the following key issues:

- The setting of enhanced baselines with NHS England to minimise the impact of the 70% marginal tariff;

- Negotiating the waiving of Referral to Treatment Times (RTT) fines with commissioners focusing on specific areas such as specialist paediatrics where the position can be ascribed to factors outside of the Trust's control;

- Agreeing an effective operational resilience plan thereby enabling the Trust to operate an urgent care service that can operate without compromising the delivery of RTT performance; an

- It is not yet clear that Commissioners will be prepared to agree SLAs at a level which enables activity convergence to be achieved. However, any divergence will be understood and explicitly described in the Heads of Terms. Any divergence is not likely to exceed 1% of SLA income.

Heads of Terms and SLAs are not expected to be signed until the end of April 2015 but, with the exception of national CQUINS, good progress is being made.

The current 2015/16 income plan is £590.3m and includes the following key assumptions:

2015/16 Rollover recurrent income	**£576.2m**	
Tariff deflation	(£6.5m)	Net of 1.9% and 3.5% national efficiency
CNST	£2.8m	Equivalent to 1.1% of the PbR baseline
2015/16 National Tariff – further impact	(£1.4m)	Impact of 2015/16 National Tariff guidance
Service Transfers	£0.1m	Histopathology, PICU and Vascular
Developments	£2.6m	Commissioner revenue proposals
Activity growth	£10.4m	Includes non- recurrent funding to clear RTT
Operational resilience	£2.6m	Anticipated funding by Commissioners
NICE, drugs & devices - RS	£5.0m	Based on 2015/16 horizon scanning
Marginal Tariff impact	(£3.5m)	Impact on specialised services at 70% rate
Performance Fines	(£3.5m)	Estimated impact of contract penalties
CQUINS	£0.7m	Net impact
Donation income	£4.3m	In support of the Trust's capital programme
Other	£0.5m	
2015/16 Proposed Income Plan	**£590.3m**	

3.4.4 Costs

The 2015/16 cost outlook for the Trust is challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2015/16. The main assumptions included in the Trust's cost projections are:

- Pay award at 1.6%, employer pension costs at 0.8%;
- Drugs at 5%, clinical supplies 1.6%, rates 2.3% and capital charges at 2%;
- Savings requirement of £24.4m;
- Payment of loan interest at £3.1m; and
- Depreciation of £20.8m pending the District Valuer's (DV) assessment of the Trust's forecast net impairments of £4.2m following completion of the ward elements of Phase 4.

The 2015/16 position includes £6.05m of non-recurring costs as follows:

- £1.0m change / invest to save costs;
- £0.25m transitional costs in support of the strategic schemes;
- £0.8m Clinical Systems Implementation Programme (CSIP);
- £0.5m risk reserve; and
- £3.5m provision for SLA fines.

3.4.5 Comparison with 2015/16 Plan submitted in June 2014

The Trust's 2015/16 Plan is a net deficit of £5.0m excluding technical items. This compares with a surplus of £5.8m submitted in June 2014. The deterioration of £10.8m is primarily due to CIP being 1.5% higher at 3.5% at £7.7m, the impact of National Tariff at £1.4m and the impact of the marginal tariff loss at 70% at £3.5m.

The Trust's plan for 2015/16 shows a deterioration in liquidity from a metric score of 4 to a metric score of 3. The deterioration is primarily due to the reduction in the Trust's planned income and expenditure net surplus (excluding technical items) from a surplus of £5.8m previously to deficit of £5.0m. An increase in stocks, adverse movement in working capital have also reduced the liquidity.

The Capital Service Cover metric has reduced from a metric score of 3 to a metric score of 2. This is due to the net surplus reduction of £10.8m. The position is summarised below:

	Liquidity £m	Score	Debt Service Cover Times	Score	CoSRR
2015/16 Plan (June 2014)	**3.5**	**4**	**2.2**	**3**	**4**
I&E deterioration 2015/16	(10.8)		(0.7)		
Increase in stocks	(0.8)				
Working capital movement	(1.7)				
Non cash backed surplus 2014/15	(6.0)				
Liquidity Restoration	8.3				
BRI Old Building	2.1				
2015/16 Plan (April 2015)	**(5.4)**	**3**	**1.5**	**2**	**3**

3.4.6 Cost Improvement Plans (CIP)

The Trust has established a Savings Board chaired by the Director of Finance, in order to improve governance and control over the delivery of CIP in 2015/16 and beyond. The delivery of CIP is an essential element in the Trust delivering its 2015/16 financial plan, including the conversion of non-recurring schemes to recurring schemes. The Trust continues to develop its savings programme, maintaining quality whilst addressing the requirement to reduce costs in line with the National efficiency requirement of 3.5% under ETO. We set Cost Improvement Plan targets in the light of:

- National efficiency requirements;
- Underlying deficits in divisions carried forward from the previous year; and
- An assessment of the requirement for investment to address risks or quality improvements it believes is necessary.

Divisional CIP targets are set at 3.5% of recurring budgets plus the assessed underlying deficit carried forward from 2014/15 generating a target of £24.4m for 2015/16. Currently, risk assessed plans exist for £15.4m. The Trust has an established process for generating CIPs. It operates an established programme of transformation, called Transforming Care.

The key transformational work streams which support CIP are as follows:

- Theatre Productivity transformation programme to focus on improving theatre efficiency. Additional objectives include reducing cancelled operations, reducing late start times to improve patient experience, reducing daily scheduling conflicts and better aligning capacity with demand in support of RTT targets.
- The Model of Care Programme is our patient flow programme and focuses on reductions in length of stay. It is well established and provides a focus on improving patient flow from presentation to discharge with specific aims of supporting strong A&E 4 hour performance, reduced length of stay, reduced numbers of patients for whom discharge is delayed and a reduction in the rate of cancelled operations arising from a lack of available beds.
- The Diagnostic Testing project addresses the processes for delivering efficient diagnostic testing across the Trust for Pathology and Radiology services. The workstream is seeking to generate cross division opportunities to improve productivity, introduce common ways of working use benchmarking and detailed analysis to identify opportunities and scope changes. The work stream is also focusing on benchmarking with other trusts to identify further opportunities for efficiencies.

The Trust has established a further group of work streams dedicated to delivering transactional CIPs, for example:

- Improving purchasing and efficient usage of non-pay including drugs and blood;

- Job Planning and links to capacity and demand for the medical workforce. We are developing specific improvement projects working jointly with the Local Negotiating Committee to generate savings projects alongside the consultant job planning process;
- Ensuring best value in the use of the Trust's Estates and Facilities This includes a review of the delivery of specific services, and further improvement s in energy efficiencies;
- Ensuring best use of technology to improve efficiency, linking productivity improvement with the introduction of new tools in clinical records management and patient administration; and
- Addressing and reducing spend on premium payments including agency spend.

The Trust's risk assessed CIP plan is summarised below:

Workstreams	**£'000**
Allied Healthcare Professionals Productivity	678
Medical Staff Efficiencies Productivity	180
Nursing & Midwifery Productivity	997
Technology / Admin & Senior Managers Productivity	368
Reducing and Controlling Non Pay	2,096
Diagnostic Testing	610
Medicines Savings	1,535
Outpatients Productivity	179
Theatre Productivity	254
Model of care	1,453
Facilities & Estates	853
Trust Services	335
Income	3,046
Corporate and other savings	2,840
To be identified	8,931
	24,355

3.4.7 Capital expenditure

The Trust has a significant capital expenditure programme investing £405.9m from April 2008 until March 2019 in the development of its estate. In 2015/16, the Trust's planned capital expenditure totals £34.2m and incorporates slippage of £11.8m at scheme level into 2016/17 to provide further liquidity headroom. The capital plan for 2015/16 is summarised below:

Source of funds	2015/16 Plan £m	Application of funds	2015/16 Plan £m
Cash	7.1	Backlog maintenance	2.2
Depreciation	20.8	IM&T	3.2
Disposals	1.1	Medical equipment	4.3
Donations	4.2	Operational capital	8.7
VAT recovery	1.0	Strategic schemes	15.8
Totals	**34.2**	**Totals**	**34.2**

The Trust's major strategic schemes in 2015/16 are:

BRI Redevelopment Phase 4 £13.1m

Phase 4 of the BRI Redevelopment is the refurbishment phase of ward areas vacated in the Queens Building and the reconfiguration of clinical space in the King Edward Building. Phase 4 enables the decommissioning and closure of the BRI Old Building by 30th June 2016.

BRI Redevelopment – Façade £2.7m

The façade scheme delivers a contemporary frontage for the Queens Building.

3.4.8 Continuity of Services Risk Rating

Liquidity

The Trust's 2015/16 forecast year end cash balance is £43.7m, a forecast reduction of £19.7m from £63.4m as at 31st March 2015. The Statement of Financial Position forecasts net current assets of £4.7m as at the 31st March 2016, a reduction of £16.9m. The forecast reduction is primarily due to: the Trust's 2015/16 planned deficit of £5m excluding technical items; £7.1m cash requirement in support of the 2015/16 capital plan of £34.2m and £5.8m loan principal repayment. It should be noted that the 2015/16 capital plan includes liquidity restoration action of £8.3m resulting in capital expenditure deferral of £7.3m into 2016/17 and a reduction in stocks of £1.0m.

Capital Servicing Capacity

The loan principal repayment of £5.8m and interest payable on the loans of £3.1m is due in full in 2015/16 for the first time therefore creating a lower metric score of 2. The Trust's forecast Continuity of Services Risk Rating (CoSRR) performance for 2015/16 is 3. The Trust's forecast liquidity at 31st March 2016 is -3.5 days giving a liquidity metric rating of 3. The Capital Servicing Cover (CSC) metric performance is 1.52 times, a metric rating of 2. The components of the CoSRR are summarised below:

	2015/16 Plan	
	Metric	**Score**
Liquidity	-3.5 days	**3**
Capital Servicing	1.52 times	**2**
Overall CoSRR		**3**

Rating 4	Rating 3	Rating 2	Rating 1
0 days	-7 days	-14 days	<-14 days
2.5 times	1.75	1.25	<1.25

3.4.9 Risks and mitigation

The key risks to the delivery of the 2015/16 net income and expenditure deficit plan of £5m are:

Risks to Contract Settlement

Whilst good progress has been made to date with both NHS England and local CCG commissioners, a small number of risks to income remain. The most significant of which is the final settlement on CQUINs with both groups of commissioners, and of note the impact of the nationally proposed CQUINs on achievability of income, in line with previous years and guidance issued alongside tariff options. This plan is predicated upon 80% net income achievement of CQUINs and any shortfall in this regard will import risk into the financial plan. This risk is assessed as ***medium***.

Risk of not delivering CIP

This includes the conversion of non-recurring savings to recurring schemes. Given the track record over the past three years this risk can be assessed as ***high***. Close monitoring of achievement and effective mitigation of any under-achievement will be in place. The 2015/16 target will be extremely challenging.

Risk that Performance Fines are imposed

Operational Delivery planning is the key to ensuring fines are not incurred. In addition there is no recurring budget set for any additional costs of measures to deliver performance targets other than those funded activity through SLAs so any such costs must be minimised and if recurring will require the delivery of self-funding improvements (e.g. length of stay, drug costs etc.). Due to performance issues experienced in 2014/15 and expected RTT breaches in 2015/16, this risk is assessed as ***high***.

Risk that activity is unfunded

This is unlikely due to the structure of the SLAs likely to be in place. There are issues with elective and out-patient activity which will be addressed. The risk is, however, assessed overall as ***high*** due to the National Tariff requirement for payment of additional specialised services activity at the marginal rate (of 70%). In addition, the Commissioners approach to CQUINs is

concerning such that the schemes proposed may not be deliverable and the income earned falls below planned levels.

Risk of Managing Cost Pressures

This includes inflation and other local/national pressures. The previous good track record of the Trust means that this risk is ***medium***. Likely factors both locally and nationally have been taken into account in assessing the 2015/16 plan.

Risk of External Factors impacting on the Financial Position

The Trust has limited exposure to this and has allowed for factors in the plan, for example, energy prices. Therefore the risk is assessed as ***low***.

Risk of not achieving a CoSRR of 3

The plan provides for headroom of £5.5m on liquidity to a liquidity metric of 2. Hence the risk of not achieving an overall CoSRR of 3 is ***high.***

3.4.10 Summary Statement of Comprehensive Income

	2015/16 Plan £m
Income Operating expenditure	590.3 (558.8)
EBITDA Non-operating expenditure	31.5 (37.9)
Net surplus / (deficit)	(6.4)
Net surplus / (deficit) (excluding technical items)	(5.0)
Year-end cash **Continuity of Services Risk Rating**	43.7 **3**

3.4.11 Conclusion

The 2015/16 financial plan will require significant measures and action in order to deliver, or improve, the planned deficit of £5m. At its meeting of 31st March 2015, the Trust Board approved the draft plan submission and recognised the risks outlined above to the Trust's financial position. It was noted that as the planning assumptions firm up, savings plans are implemented and SLA negotiations with Commissioners progress to an agreed position, the Trust may need to formulate and implement further risk mitigation measures.

Annex A - Our Performance against national standards – updated to February 2015

National standard	2012/13	2013/14	2014/15 Target	2014/15[4]	Notes
A&E maximum wait of 4 hours	93.8%	93.7%	95%	92.0%	Target failed in each quarter in 2014/15
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	57	15	15 mins	13	Target met in every quarter in 2014/15
A&E Time to Treatment (minutes) median within 60 minutes	53	52	60 mins	54	Target met in every quarter in 2014/15
A&E Unplanned re-attendance within 7 days	2.6%	1.5%	< 5 %	2.3%	Target met in every quarter in 2014/15
A&E Left without being seen	1.9%	1.8%	< 5%	1.8%	Target met in every quarter in 2014/15
Ambulance hand-over delays (greater than 30 minutes) per month	See note[5]	100.4	Zero	107.3	Target failed in every month in 2014/15
MRSA Bloodstream Cases against trajectory	10	2	Trajectory	5	Two of the five cases were contaminated samples only
C. diff Infections against trajectory	48	38	Trajectory	50[6]	Target met in every quarter in 2014/15
Cancer - 2 Week wait (urgent GP referral)	95.0%	96.8%	93%	95.8%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (First treatment)	97.0%	97.1%	96%	96.7%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94.9%	94.8%	94%	94.8%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.8%	99.8%	98%	99.7%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	98.7%	97.4%	94%	97.7%	Target met in every quarter in 2014/15
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	84.1%	80.1%	85%	79.7%	Target failed in each quarter in 2014/15
Cancer 62 Day Referral To Treatment (Screenings)	90.0%	93.8%	90%	89.4%	Target met in quarter 1 and 2 of 2014/15
18-week Referral to treatment time (RTT) admitted patients	92.6%	92.7%	90%	85.4%	Target met until June 2014, but failed thereafter
18-week Referral to treatment time (RTT) non-admitted patients	95.7%	93.1%	95%	90.4%	Target failed in every month in 2014/15
18-week Referral to treatment time (RTT) incomplete pathways	92.2%	92.5%	92%	90.4%	Target met up until July 2014, but failed thereafter
Number of Last Minute Cancelled Operations	1.13%	1.02%	0.80%	1.08%	Target failed in each quarter in 2014/15
28 Day Readmissions *(following a last minute cancellation)*[7]	91.1%	89.6%	95%	89.4%	Target failed in each quarter in 2014/15
6-week diagnostic wait	89.7%	98.6%	99%	97.4%	Target failed in each quarter in 2014/15
Primary PCI - 90 Minutes Door To Balloon Time	91.7%	92.7%	90%	92.2%	Target met in three quarters in 2014/15 (failed in Q3)

Achieved for the year and each quarter

Achieved for the year, but not each quarter

Not achieved for the year

Target not in effect

[4] Due to the timing of this report the figures shown for 2014/15 are for the year to date ending February 2015, with the exception of cancer and primary PCI, which are up to and including January 2015, and ambulance hand-over delays, which includes March 2015.

[5] Validated data not available in 2012/13.

[6] Please note, the figures quoted for 2014/15 are the total number of cases reported. However, of these, eight were deemed to be potentially avoidable against the limit of 40. For this reason this indicator is RAG rated Green.

[7] IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures emergency readmissions to hospital within 28 days *following a previous discharge*

Annex B – Our Corporate Objectives for 2015/16

We will consistently deliver high quality individual care, delivered with compassion. Specifically, we aim to:

- 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 continuing to delivering the agreed changes to our Operating Model set out in our 2014 plan.
- Achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners
- To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.
- To ensure the Trust's reputation reflects the quality of the services it provides.
- Reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.

We will ensure a safe, friendly and modern environment for our patients and our staff. Specifically, we aim to:

- To successfully complete the next phase of our Campus Redevelopment.
- Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented
- Set out the future direction for the Trust's Estate in line with our Estates Strategy published in 2014.

We will strive to employ the best and help all our staff fulfil their individual potential. Specifically, we aim to:

- Deliver a comprehensive approach to leadership and management training and development.
- Improve Staff Engagement.
- Develop a structured marketing approach which is tailored to target staff groups, improve the speed of recruitment application to appointment
- Improve the quality and application of staff appraisal
- Education, Learning and Development: Provide high quality training and development programmes to support a diverse, flexible workforce
- Improve workforce planning capability, aligning our staffing levels with capacity and financial resource, using workforce models and benchmarks which ensure safe and effective staffing levels.

We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. Specifically, we aim to:

- We will continue to deliver a programme to support the long-term vision that every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.

- 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 the National Institute of Health Research (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).
- We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR).

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

- Ensure organisation support for developments under the Better Care Fund.
- We will effectively host the Operational Delivery Networks that we are responsible for.
- We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.
- We will be an effective host to the networks we are responsible for including the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and Clinical Research Network.

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

- Deliver agreed financial plan including a minimum cash balance.
- Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.
- Deliver the annual Cost Improvement Plan (CIP) programme in line with the Long Term Financial Plan requirements
- Ensure 2015-16 Operating Plans help to address risks to sustainability.
- Continue to develop private patient offer for the Trust.

We will ensure we are soundly governed and are compliant with the requirements of our regulators. Specifically, this will involve:

- Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.
- Ensure all principles of good governance are embedded in practice and policy
- To achieve regulatory compliance against Care Quality Commission fundamental standards.
- Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways
- Improve cancer performance to ensure delivery of all key cancer targets
- Restore compliance with the A&E 4 hour standard from Q1 2015.

ANNEX C – PERFORMANCE RECOVERY PLAN

1 Introduction

This paper updates the Board about the performance recovery plan within the Trust's operating plan for 2015/16. It summarises the key challenges to be addressed, the key initiatives proposed at a Trust and Divisional level in response to those challenges and the implications for the Board's financial plan for the year. The paper has a significant focus on recovery against referral to treatment time targets, given its importance to the plan, but also addresses 4 hour performance and delivery of the cancer standards.

The Board is asked for formal approval of the plan prior to final submission to Monitor.

2 Structure of this paper

The paper is divided into the following sections:

- Context
- Approach to planning
- Demand assessment, for planned care and unplanned care (including cancer services)
- Capacity planning, for planned care and unplanned care (including cancer services)
- Capacity plan risks and mitigations
- Performance management framework
- Recommendations

3 Context

The Operating Plan for 2015/16 needs to respond to:

- demand for clinical services, both commissioned and un-commissioned
- regulatory compliance requirements, particularly with regard to quality and access standards and the Care Quality Commission (CQC) "should do" actions
- a range of internal and external factors affecting financial affordability and liquidity, including regulatory continuity of services requirements
- the Board's strategic intent and the resulting priorities set out in the Strategic Implementation Plan.

4 Approach

The process to develop the annual operating plan is managed by the corporate planning team, formally approved at the Senior Leadership Team each year and notified to the Board. It requires Divisional management teams to work to documented corporate guidelines to produce a range of outputs which in turn inform:

- contract negotiations with commissioners – both activity and contract terms
- joint priority-setting through the Service Delivery Group and the Senior Leadership Team, and the associated allocation of capital and revenue resources to support delivery of the agreed priorities
- Divisional operating plans.

This year, the process has been supplemented with enhanced executive support through director “buddying” arrangements and a fortnightly Chief Executive-chaired planning meeting with the senior Divisional leadership.

Final operating plans have been submitted and have been reviewed and risk assessed by the Executive Team. Given the financial and non-financial position presented by some Divisions, plans will continue to be iterated throughout the coming months. All divisions have been asked to present a balanced financial position (the key area of risk remaining within the plans) by the end of Quarter 1 (end of June 2015).

5 Demand assessment

Extensive trend analysis, both historic and prospective, has informed assessment of the core, predicted demand for clinical services next year, across all work-types in both planned and unplanned care specialties.

Schedules of activity required to meet demand include adjustments for national waiting time standards, in particular the 18 week referral to treatment (RTT) standard, where the Trust’s analysis has been supported by NHS Interim Management and Support (IMAS) and the Trust’s own assessment about the likely future demand for urgent care and the impact of system-wide initiatives to reduce the number of patients admitted to hospital and the number whose discharge is delayed.

The Trust and its commissioners have now reached broad agreement on planning assumptions for planned and unplanned care; where differences occur, as in previous years, these will be addressed through variable estimates in the contract.

5.1 Planned Care

The IMAS model has helped determine the specialty-level capacity needed to ensure that excess waiting list backlogs are eliminated and do not recur. The following assumptions underpin the modelling for planned care activity:

Sufficient non-recurrent activity to reduce the existing backlogs to the target level of no more than 0.7 of one week’s activity for admitted pathways and no more than 5% of non-admitted pathways exceeding 18 weeks at any time.

- Sufficient recurrent activity to sustain waits at the appropriate level by “right-sizing” predicted future demand and supply, this requires significant additional recurrent capacity in a small number of specialties.
- reduction in demand for some specialities (dental and cardiology) associated with the application of geographical access criteria
- impact of trended growth, beyond demographic, where it is well evidenced - such as endoscopy, where the Trust has seen 5% growth per annum for the last four consecutive years.

Significant validation of the waiting lists has been commissioned and is on-going. Once complete, this expected to further improve the RTT backlog position. The RTT recovery trajectories are set out in Appendix 1 and current performance against the trajectories is set out in Appendix 2.

The summary outputs from the demand analysis for planned care are as follows and reflect the contract proposal put to commissioners for 2015/16:

Additional activity, over 2014/15 forecast outturn, comprising:
- 1423 additional elective inpatients (10.1% increase)
- 3250 additional elective day cases (5.9% increase)
- 4113 additional outpatient procedures (7.4% increase)
- 15,471 additional outpatient new attendances (8.86% increase)
- 24,866 additional outpatient follow ups (7.06% increase).

Approximately 50% of the elective activity growth is non-recurrent, compared to c. 25% of the outpatient activity.

5.2 Unplanned Care

The Trust's own model has been used to model the demand for urgent care activity. The following assumptions underpin the model:

- impact of the Better Care Fund (BCF) initiatives assumed to result in a 1.75% reduction in demand for urgent care, in patients over 65 in 2015/16
- impact of predicted demographic growth, based on ONS projections.

The summary outputs from the demand analysis for planned care are as follows:

Additional activity, over 2014/15 forecast outturn, comprising:
- 253 emergency admissions (0.65% recurring increase)
- 129 non-elective admissions (1.47% recurring increase)

6 Capacity Plan

Based on the demand analysis set out above, each Division has developed capacity, workforce and associated resource plans to deliver the projected activity by service line. Whilst the detail is set out below in terms of planned and unplanned care, of particular note is the critical interdependency of the two elements. Specifically, the RTT recovery plan is reliant upon uninterrupted access to the surgical bed base and theatre suite (including recovery areas), throughout the year.

6.1 Planned care

Throughput assumptions at service line have been developed to model the requirement for bed, theatre and outpatient capacity. Divisions have identified options to maximize capacity including extended days, weekend working and productivity gains such as increasing throughput on lists, and plans have been developed that will deliver these gains.

Significant changes to the use of South Bristol Community Hospital are proposed, including the establishment of paediatric theatre lists for the first time. Other technology innovations have been introduced to optimise use of the Trust's theatre infrastructure, notably investment in equipment to extend the case-mix which can be managed at St Michael's Hospital.

Delivery plans are also reliant upon a level of outsourced activity, some delivered from within Trust estate and others from independent providers such as Nuffield Private Hospital and Care UK at Emerson's Green NHS Treatment Centre.

Bed requirements for planned care have been modelled, applying current length of stay, and reducing occupancy to 90% from current levels of c. 94%. This leads to a modelled requirement for 18 fewer adult surgical beds, as a benefit from the Planned Care Programme (which has delivered a 13% reduction in length of stay). In response, ward 605 will be closed to surgical care in early April 2015.

The RTT recovery trajectories demonstrate that Trust compliance with the 95% non-admitted standard will be achieved in December 2015 and the 90% admitted standard in March 2016. Following detailed scrutiny, the Executive team has confidence that Divisional plans are commensurate with the recovery trajectories, realistic and achievable. Detail of the Divisional capacity plans is provided in Annex 3.

In summary, the physical capacity required to deliver the planned care activity is:

- 18 fewer surgical beds, within the BRI bed base
- Additional 16.5 adult theatre sessions per week and 13.5 paediatric theatre sessions
- Additional 75 adult outpatient clinics and 14 paediatric clinics per week
- Modelled requirement for 400 waiting list initiatives, 104 paediatric

Key workforce impacts are assessed to be:

- 82.75 additional consultant sessions per week
- 41 WTE additional nursing and therapy staff (excluding paediatric theatres)
- 14.5 WTE paediatric theatre staff
- 17 WTE additional administrative staff

6.2 Unplanned care

Key to delivery of the A&E waiting time standards and related standards such as cancelled operations and readmissions, is the sizing of the bed base for unplanned care services and its operation at an occupancy level commensurate with timely patient flow and appropriate skilled, substantive staffing. Without this approach, the Trust will rely upon escalation capacity, as it has this year, with the associated impact on both cost, continuity and quality of the workforce.

Whilst the BRI Redevelopment plan assumed average bed occupancy at 90%, failure to achieve planned length of stay reductions has resulted in occupancy levels regularly in excess of 95%, with additional escalation beds being established for long periods in winter.

Medicine bed capacity has therefore been re-modelled at more conservative assumptions for length of stay and an optimal bed occupancy level of 90%, resulting in requirement for 35 additional inpatient beds. 18 beds will be established on Ward A605 which is no longer required for surgical services and a further 17 established in Ward A518.

This step effectively represents the conversion of interim escalation beds to core, permanent capacity for Medicine and is a fundamental component of the plan for 2015/16. Physically

there remains no further opportunity to create “flex” capacity at peak times and, as described above, it is an important feature of the operating model the that medical emergency patients do not outlie in surgical beds. It is proposed that for the two quarters when demand is predicted to exceed the core bed base on occasions, increases in bed occupancy will be the mechanism to manage activity in the short term, with the goal of achieving length of stay reductions over time to eliminate the need. There is good evidence that, when bed occupancy is at 90% or less, length of stay can be reduced and the four hour A&E standard is more likely to be met - this will therefore be a primary focus of transformation activities in unplanned care next year.

In order to mobilise the plan set out above, additional funding has been allocated by commissioners on a non-recurrent basis. It is expected that one of the medical wards will move from core capacity to flex capacity in 2016/17 as an output of increased efficiency within the Trust and improved patient flow across the health and social care system.

The key elements of the Trust’s plan are:

- Investment in occupancy, through the establishment of an extra ward
- Investment in 7 day working
- Investments in a range of children’s Winter initiatives, all year round
- Investments in creating more sustainable workforce solutions in key areas such A&E

The workforce implications of these bids are as follows:

- 93 additional nursing staff, registered and unregistered
- 6.6 WTE medical staff
- Therapy and ancillary staff requirements (under review)

6.3 Cancer services

The most significant risks to delivery of the plans described above concern the ability to mobilise workforce and associated capacity to deliver the level of activity required.

The Trust continues to deliver mixed performance in respect of cancer standards, notably the 62 day referral to treatment standards. The reasons for this remain multi-factorial, noting that the Trust’s unusual case mix (following the transfer out of breast and urology services) carries an in-built negative risk of c. 3.5% of performance.

The most recent breach analysis demonstrates that the majority (86%) of reasons for breach are now outside of the Trust’s control - with 52% attributable to late tertiary referrals and 13% related to complex clinical pathways that cannot, by their design, be delivered in 62 days.

Commissioners have now agreed to include a CQUIN indicator in the contracts for Bristol, North Somerset and South Gloucestershire providers which affords these providers significant financial incentive for timely cancer referrals – this affects referrals to UH Bristol from North Bristol Trust and Weston which currently account for 61% of late referrals to the Trust. The Trust has asked commissioners in BaNES and Somerset to consider a similar approach for their providers.

However, 14% of breach causes are related to factors over which the Trust has greater influence and the Cancer Performance Improvement Programme continues to work on administrative delays / errors and diagnostic delays.

High impact changes to mitigate the risk of avoidable breaches include dropping the time for first review to 7 days from 14 days, addressing diagnostic bottlenecks and reducing the risk of cancellation arising from a lack of critical care capacity – this latter being the most recent issue affecting internal performance and arising from the recent surge in Level 3 critical care activity which has impact on the availability of HDU beds to support cancer pathways.

6.4 Capacity Risks and Mitigations

The most significant risks to delivery of the plans described above concern the ability to mobilise workforce and associated capacity to deliver the level of activity required.

Particular risks include:

- known national shortages of specific staff groups including consultants and theatre nursing staff / operating department practitioners;
- constraints on mobilising sufficient physical capacity in short timeframes

Each Division has been tasked with developing a Delivery Oversight Plan to which will enable close monitoring of all the key actions necessary for success. These will form the basis of performance management in 2015/16.

6.4.1 Workforce

There are two primary risks to the workforce element of the plan; these are the supply of suitably qualified staff and the timeliness in which staff are recruited, and plans therefore able to be mobilised. In respect of the former, a range of recruitment and retention initiatives are being corporately led and supported, targeted to known ‘problem’ areas such as theatre staffing, where London-based recruitment fairs are planned. Where there are known staff shortages, alternative workforce models have been developed - for example, in restorative dentistry a new workforce model is being introduced, utilising dental nurses instead of dental consultants.

Infrastructure to support this peak in recruitment activity is being strengthened to include additional recruitment staff and appointment panels.

Finally, recruitment plans for all specialties have been developed and where recurrent posts will not be established from the outset, non-recurrent initiatives are in place to ensure backlogs do not grow.

6.4.2. Demand management

Trust activity and delivery plans do not assume significant impacts from demand management beyond geographical restrictions on referral for restorative dentistry and interventional cardiology. However, commissioners have signalled an appetite to work on further plans in year, which have the potential to provide (an unquantifiable) benefit to recovery plans through a further reduction in demand, providing they sit outside the contract proposals.

6.4.3. Alternative supply

The Trust had a Memorandum of Understanding with local Independent Sector providers based on a National contract which highlighted that a total of c. 540 patients were to be seen and discharged by 31st March 2015; this plan was broadly delivered. In 2015/16 Divisions will build upon this to place contracts with independent providers to reduce RTT backlogs, particularly in upper GI, ophthalmology, diagnostics, gynaecology and some paediatric specialties.

The Trust has established a new model of working, with an independent supplier of theatre workforce, called GLANSO, within an innovative framework that drives productivity. This was piloted in Surgery, Head and Neck in 2014/15 and is a proposed part of delivery plans for this Division as well as for Specialised Services and Women's and Children's next year.

6.4.4. Waiting list management

The Trust implemented the new Bristol, North Somerset and South Gloucestershire Access Policy in December 2014 and key elements of the policy are included in the mandatory administrative training programme launched in February 2015.

A competency-based assessment is included to ensure that all staff are fully conversant with referral to treatment times and understand how to manage and record pathways correctly. On-going oversight of this important area has been built into the new Trust-wide Outpatients function.

The Trust has completed the design of a new Patient Tracker List (PTL) that sits directly on the Medway Patient Administration System. The PTL was signed off by IMAS in February 2015 (and commended as best practice).

These initiatives bring potential benefits to the delivery plan through the impact of further validation and improved management of waiting lists.

6.4.5. Productivity improvements

Divisional plans currently make modest assumptions about the impact of further improvements in productivity. Improvements developed in the coming year will mitigate the risks inherent in such a significant and complex plan. Related to these, are the re-design of the South Bristol Community Hospital theatre timetable and some minor physical adaptations to improve throughput in outpatient areas.

6.4.6. Clinical risk

The Medical Director continues to hold Clinical Chairs of the Divisions to account for mitigation of risk of clinical harm to patients on waiting lists.

6.4.7. Quota management

The Trust's mitigation plans currently include no proposal to restore quota management as a means of managing waiting times.

7. Performance Management of the Plans

The Trust Board will receive a monthly update of delivery against the recovery trajectories and these will be performance managed by the Strategic Leadership Team with appropriate performance management at divisional or work stream level as appropriate depending on which areas require escalation. The incoming Chief Operating Officer will be reviewing the performance management regime in light of any feedback from the Deloitte Well-Led Governance Review.

8. Summary

It is noted that this report gives assurance that:

- the Executive Directors have overseen a robust approach to the development of the Operating Plan for 2015/16, and the Divisional Plans that underpin it, taking account of the need to deliver sustainable compliance against Monitor's Risk Assessment Framework in a realistic timescale
- the Executive Directors are sighted on the risks to contract settlement and operational delivery and have set out mitigations to offset the risks
- performance management arrangements exist and will be enhanced as appropriate to ensure early identification and remedy of risks to delivery next year.

Robert Woolley

Chief Executive

22 April 2015

Appendix 1a

RTT/PAS specialty	RTT ONGOING performance												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total paediatric admitted backlog	916	837	757	686	589	541	473	401	359	267	206	147	91
Total adult admitted backlog	856	874	776	662	590	529	468	419	409	394	384	374	374
Total paediatric non-admitted backlog	681	601	524	436	394	350	315	289	272	262	253	248	243
Total adult non-admitted backlog	1388	1319	1229	1180	1154	1115	1076	985	921	863	803	774	742
Total paediatric backlog	1597	1438	1281	1122	983	891	788	690	631	529	459	395	334
Total adult backlog	2244	2193	2005	1842	1744	1644	1544	1404	1330	1257	1187	1148	1116
Trust total backlog	3840	3631	3287	2964	2727	2535	2332	2093	1961	1786	1646	1543	1450
Trust total ongoing pathways (estimate)	32000	31750	31500	31300	31150	31050	31000	31000	31000	31000	31000	31000	31000
Trust level RTT Ongoing performance	88.0%	88.6%	89.6%	90.5%	91.2%	91.8%	92.5%	93.2%	93.7%	94.2%	94.7%	95.0%	95.3%

Please note: the Trust total ongoing pathways is an estimate, based upon the existing pathways numbers and the likely impact of validation each month. It should be noted that whole scale validation of pathways held on Medway is underway, and the estimate of the number of open pathways may need to be amended in light if this, and prior to the move to reporting directly off Medway.

RTT/PAS specialty	RTT NON-ADMITTED performance												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total paediatric backlog	732	633	552	459	404	359	323	296	279	269	259	254	249
Total adult backlog	1492	1388	1294	1242	1184	1144	1104	1010	945	885	824	794	761
Total paediatric backlog (less validation)	681	601	524	436	394	350	315	289	272	262	253	248	243
Total adult backlog (less validation)	1388	1319	1229	1180	1154	1115	1076	985	921	863	803	774	742
Trust total backlog	2068	1920	1754	1616	1548	1465	1391	1273	1193	1125	1056	1022	985
Forecast total non-admitted clock stops	7288	7288	6923	8017	8381	7288	8017	8017	7652	7652	7288	7652	8381
Forecast total non breaching clock stops	6501	6501	6176	7151	7476	6574	7359	7407	7162	7270	6931	7285	7979
Forecast performance	89.2%	89.2%	89.2%	89.2%	89.2%	90.2%	91.8%	92.4%	93.6%	95.0%	95.1%	95.2%	95.2%

Please see the note under Ongoing pathways, relating to the potential risk around the accuracy of the forecast performance and backlog levels.

RTT/PAS specialty	RTT ADMITTED performance												
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total paediatric backlog	916	837	757	686	589	541	473	401	359	267	206	147	91
Total adult backlog	856	874	776	662	590	529	468	419	409	394	384	374	374
Trust total backlog	1772	1711	1533	1348	1179	1070	941	820	768	661	590	521	465
Forecast total admitted clock stops	2895	2895	2750	3184	3329	2895	3184	3184	3040	3040	2895	3040	3329
Forecast total non breaching clock stops	2316	2322	2222	2573	2690	2377	2684	2754	2650	2693	2591	2729	3006
Forecast performance	80.0%	80.2%	80.8%	80.8%	80.8%	82.1%	84.3%	86.5%	87.2%	88.6%	89.5%	89.8%	90.3%

Please see the note under Ongoing pathways, relating to the potential risk around the accuracy of the forecast performance and backlog levels.

Appendix 1b

	ADMITTED - Monthly backlog size															
RTT/PAS specialty	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Paediatric ENT	342	300	260	240	180	162	139	102	76	46	30	20	13	13	13	13
Paediatric T&O	160	120	110	90	85	80	75	70	60	50	38	24	18	12	6	6
Paediatric Surgery & Urology	190	200	180	160	150	140	120	110	119	67	48	34	16	16	16	16
Paediatric plastic surgery	130	115	110	105	95	90	80	70	60	60	50	35	15	8	4	4
Paediatric Max Facs	28	28	27	25	21	17	14	10	8	8	7	4	1	1	1	1
Paediatric Cardiac Surgery	12	12	11	10	9	8	7	6	5	5	4	3	3	3	3	3
Paediatric Cleft	18	18	17	16	15	14	12	10	8	8	6	4	2	2	2	2
Gynaecology	30	50	45	28	26	26	26	26	26	26	26	26	26	26	26	26
Ophthalmology	140	180	155	126	126	126	126	126	126	126	126	126	126	126	126	126
Adult Orthopaedics	15	13	13	13	13	13	13	13	13	13	13	13	13	13	13	13
Colorectal	25	65	60	55	50	45	40	35	30	20	10	10	10	10	10	10
ENT	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Upper GI	175	118	110	100	79	53	29	15	15	15	15	15	15	15	15	15
Maxillo facial	10	18	15	12	9	9	9	9	9	9	9	9	9	9	9	9
Oral Surgery	55	77	67	57	46	46	46	46	46	46	46	46	46	46	46	46
Paediatric dentistry	14	22	20	18	12	8	4	1	1	1	1	1	1	1	1	1
Thoracic surgery	17	13	11	11	11	11	11	11	11	11	11	11	11	11	11	11
Cardiology	280	250	220	190	160	130	100	70	65	60	60	50	50	50	50	50
Cardiac Surgery	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
Dermatology	65	48	38	28	28	28	28	28	28	28	28	28	28	28	28	28
Other - paediatric	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22
Other - adult	22	20	20	20	20	20	18	18	18	18	18	18	18	18	18	18
Total paediatric	916	837	757	686	589	541	473	401	359	267	206	147	91	78	68	68
Total adult	856	874	776	662	590	529	468	419	409	394	384	374	374	374	374	374
Trust total	1772	1711	1533	1348	1179	1070	941	820	768	661	590	521	465	452	442	442

Appendix 1c

	NON-ADMITTED Monthly backlog size															
RTT/PAS specialty	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Paediatric medicine	55	45	35	25	19	19	19	19	19	19	19	19	19	19	19	19
Paediatric respiratory medicine	35	24	18	11	11	11	11	11	11	11	11	11	11	11	11	11
Paediatric T&O	190	175	155	130	115	95	75	55	45	40	35	30	25	25	25	25
Paediatric surgery and urology	60	55	55	50	45	40	35	30	26	24	22	22	22	22	22	22
Paediatric dermatology	40	35	30	24	20	16	16	16	16	16	16	16	16	16	16	16
Paediatric cardiology	45	32	24	17	17	17	17	17	17	17	17	17	17	17	17	17
Paediatric gastroenterology	52	45	40	35	25	18	10	10	10	10	10	10	10	10	10	10
Paediatric neurology	50	45	35	25	15	9	9	9	9	9	9	9	9	9	9	9
Paediatric plastic surgery	40	35	33	30	28	25	22	20	17	14	11	11	11	11	11	11
Clinical genetics	160	150	140	130	120	110	100	90	80	70	60	50	40	40	40	40
Dermatology	85	80	70	70	70	70	70	70	70	70	70	70	70	70	70	70
Gastroenterology	30	26	24	24	24	24	24	24	24	24	24	24	24	24	24	24
ENT	90	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60
Maxillo facial	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Ophthalmology	132	132	132	132	132	132	132	132	132	132	120	110	100	100	100	100
Neurology	55	60	60	60	60	60	60	25	20	20	17	17	14	14	14	14
Oral Medicine	35	31	31	31	28	28	28	24	24	24	22	22	22	22	22	22
Oral Surgery	90	83	83	83	83	83	83	83	83	83	75	65	55	55	55	55
Orthodontics	26	50	40	30	26	26	26	26	26	26	26	26	26	26	26	26
Paediatric ophthalmology	40	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22
Paediatric dentistry	35	40	35	30	27	27	27	27	27	27	27	27	27	27	27	27
Paediatric cleft	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
Periodental	31	60	45	35	26	26	26	26	26	26	26	26	26	26	26	26
Physiology	25	20	15	15	15	15	15	15	15	15	15	15	15	15	15	15
Restorative dentistry	366	320	300	300	280	260	240	200	150	100	74	74	74	74	74	74
Pain Relief	20	19	17	15	13	13	13	13	13	13	13	13	13	13	13	13
Orthopaedics	42	42	42	42	42	42	42	42	42	42	42	42	42	42	42	42
Cardiology (including GUCH)	170	150	130	110	100	90	80	75	75	75	75	75	75	75	75	75
Other paediatric	70	60	50	40	40	40	40	40	40	40	40	40	40	40	40	40
Other adult	120	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90
Expected impact of validation	-156	-101	-92	-85	-40	-38	-36	-33	-31	-29	-27	-26	-25	-25	-25	-25
Total paediatric	732	633	552	459	404	359	323	296	279	269	259	254	249	249	249	249
Total adult	1492	1388	1294	1242	1184	1144	1104	1010	945	885	824	794	761	761	761	761
Total paediatric (less validation)	681	601	524	436	394	350	315	289	272	262	253	248	243	243	243	243
Total adult (less validation)	1388	1319	1229	1180	1154	1115	1076	985	921	863	803	774	742	742	742	742
Trust total	2068	1920	1754	1616	1548	1465	1391	1273	1193	1125	1056	1022	985	985	985	985

Appendix 2a

RTT Non-admitted backlogs (over 18-week waiters)

							April	
Trajectory			2455	2044	2068	1920		

Please note - this table only shows specialties with significant backlogs, although Divisional totals show all over 18-week waiters

	End April	End Nov	End Dec	End Jan	End Feb	End March	Current week	April RTT trajectory	variance
Clinical genetics	115	147	167	151	181	205	246	150	96
Paed cardiology	25	50	57	65	70	50	49	32	17
Paed gastro	35	48	50	47	31	28	37	45	-8
Paed T&O	17	164	176	146	131	68	70	175	-105
Paed dermatology	7	64	48	37	21	38	39	35	4
Paed endocrinology	4	88	15	12	10	13	9	Inc in other	
Paed medicine	8	41	65	37	35	35	32	45	-13
Paed neurology	9	46	58	34	22	20	17	45	-28
Paed plastics	0	26	37	43	46	36	26	35	-9
Paed respiratory med	9	33	43	28	30	18	17	24	-7
Paed spinal	0	17	17	39	37	28	29	Inc in other	
Paed surgery	6	18	24	17	23	25	23	25	-2
Paed urology	24	31	31	29	20	25	27	30	-3
W&C Total	**282**	**837**	**859**	**751**	**698**	**645**	**693**		693
Colorectal Surgery	11	9	9	7	8	11	31	Inc in other	
ENT	100	101	78	44	20	31	59	60	-1
Max Facs	1	35	25	15	8	10	14	15	-1
Neurology	0	49	52	46	65	89	97	60	37
Ophthalmology	11	89	104	81	53	53	68	132	-64
Oral med	177	62	34	19	14	24	34	31	3
Oral surgery	18	66	79	54	41	37	52	83	-31
Orthodontics	41	28	29	41	49	56	66	50	16
Paed dentistry	15	54	48	39	29	37	56	40	16
Paed ophthalmology	1	56	70	59	35	11	19	22	-3
Paed cleft	0	0	47	87	16	2	3	20	-17
Periodontal	116	74	86	63	75	79	96	60	36
Pain Relief	23	2	28	15	16	10	11	19	-8
Physiology	0	7	34	59	47	40	30	20	10
Restorative	181	225	237	251	301	340	377	320	57
T&O	36	51	40	28	26	17	23	42	-19
Surgery total	**743**	**984**	**1089**	**937**	**827**	**863**	**1076**		
Cardiology	82	99	141	101	132	132	180	130	50
GUCH	19	50	44	39	20	17	15	20	-5
Specialised total	**106**	**152**	**186**	**141**	**154**	**157**	**222**		
Dermatology	8	60	67	62	72	90	99	80	19
NCC-Diab Spec Nurse	4	13	15	0	3	4	7	Inc in other	
Endocrinology	6	7	9	9	8	7	15	Inc in other	
Gastroenterology	16	42	37	36	41	39	58	26	32
Hepatology	28	19	7	4	1	4	15	Inc in other	
Medicine total	**95**	**171**	**171**	**140**	**139**	**161**	**227**		
Chemical pathology	1	2	2	2	0	0	0	Inc in other	
Diagnostics & Therapies total	**1**	**2**	**3**	**3**	**1**	**0**	**0**		
Trust Total	**1482**	**2146**	**2308**	**1972**	**1819**	**1826**	**2218**	**1871**	

Other paed		60
Other adult		90
Less validation		101
Total in trajectory	=	**1920**

Overall position	298

Appendix 2b

RTT Admitted backlogs (over 18-week waiters)

					April
Trajectory	1857	1819	1772	1713	

Please note - this table only shows specialties with unsustainable backlogs, although Divisional totals show all over 18-week waiters

	End April	End Oct	End Nov	End Dec	End January	End Feb	End March	Current week	April RTT trajectory	variance
Gynaecology	73	41	47	52	55	68	68	57	50	7
Paed T&O	98	96	92	90	92	85	73	71	120	-49
Paed ENT	96	220	267	285	260	266	243	251	300	-49
Paed plastics	49	83	87	98	93	87	75	86	115	-29
Paed urology	0	40	58	53	55	60	59	50	70	-20
Paed surgery	135	81	84	100	104	87	82	88	130	-42
W&C Total	**478**	**586**	**664**	**737**	**706**	**703**	**674**	**677**		677
ENT	27	13	14	7	5	7	19	23	10	13
Colorectal surgery	46	54	47	46	47	59	71	75	65	10
Maxillo facial	15	17	16	13	19	19	26	26	18	8
Ophthalmology	253	163	205	231	207	216	189	203	180	23
Oral surgery	39	82	99	91	78	83	68	80	77	3
Paed cleft	3	12	14	18	12	9	5	7	18	-11
Paed dentistry	5	17	17	16	23	22	25	24	22	2
Thoracic surgery	25	30	33	27	18	18	13	15	13	2
Upper GI	85	165	179	189	168	127	110	91	118	-27
T&O	21	37	27	29	11	9	11	16	13	3
Surgery total	**526**	**603**	**659**	**681**	**605**	**587**	**558**	**584**		
Cardiology	197	247	236	285	270	248	194	44	12	32
Cardiac Surgery	17	19	26	24	29	31	32	214	250	-36
Specialised total	**219**	**266**	**262**	**309**	**299**	**280**	**226**	**258**		
Interventional radiology	0	0	1	1	1	0	0	0	inc in Other	N/A
Diagnostics & Therapies	**0**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	inc in Other	N/A
Dermatology	46	42	34	79	61	57	57	59	48	11
Sleep study				7	4	0	4	9	inc in Other	N/A
Medicine total	**59**	**46**	**38**	**86**	**66**	**57**	**61**	**68**		
Trust Total	**1282**	**1501**	**1624**	**1814**	**1677**	**1627**	**1519**	**1587**	**1629**	

Other paed + paed max facs + paed cardiac surgery		62
Other adult		22
Total in trajectory	=	**1713**

Overall position	-126

Annex D – An update on our response to the report of the Care Quality Commission

Part 1 – Internal Actions and Progress. This section is a summary of internal actions taken to respond to the CQC report.

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Diagnostic and screening procedures; Treatment of disease, disorder or injury	The fracture clinic was not a safe environment in which patients were to wait for and receive treatment (risks associated with the ongoing building work).	The programme of works has been completed and the risks addressed. Continue to use the standard construction industry Health and Safety Risk Assessments/Method Statements (which include consideration for patients, staff and visitors). This will be recorded in the standard operating procedure (SOP) and will be audited by the Clerk of Works regularly	Complete	A check list has been produced and will be audited by Facility and Estates Quality Assurance & Systems Manager on a monthly basis in line with the monthly Trust audit reporting on compliance and risk. The SOP was updated on 12 January 2015 and auditing will be undertaken monthly – first audit planned for 16 February 2015.
	Not all fire exits were clear and accessible	The Fire officer now walk all corridors on a two week basis to audit the 'housekeeping' of fire exits	On-going	All fire exits have been included on an inspection schedule for inspection on a monthly basis by F&E - Quality Assurance & Systems Manager. A report will be produced with information obtained from the fire exit inspection audit; the report is to be submitted to the Director of Facilities & Estates by the end of each month for inclusion in Trust audit reporting on compliance and risk. Any failures are been addressed immediately and escalated to ward/department managers. These will be audited as per our audit plan. We continue to communicate verbally to staff the importance of keeping exists clear during our inspections. Findings from recent audits: We are still finding exits blocks and we are escalating in accordance to our SOP which involves issuing internal 'Non Compliance Notice'

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	There were not always sufficient numbers of suitably qualified, skilled and experienced staff employed on surgical wards and in operating theatres.	1. Matrons will continue to review staffing levels, across all wards, on a daily basis. 2. Monitor low staffing incidents, within Divisional and Trust governance arrangements. 3. Develop additional actions to address high vacancy rates in key areas, notably theatres and surgical wards, including: a) Appointment of Recruitment Lead Nurse for Division of Surgery, Head & Neck b) Embark upon international recruitment venture for hard to recruit posts, commencing with theatres. c) Review merits of introducing new Recruitment and Retention premia in hard to recruit areas d) Utilise advance block booking in theatres for bank and/or agency staff, to reduce risk of unfilled shifts 4. Undertake work to better understand reasons for high turnover of staff in some areas (theatres and ward 700) 5. Augment registered staffing establishment by 1wte on weekend days (ward 700) 6. Augment registered staffing establishment by 1wte on weekday nights to provide additional support (wards 602, 604, 605) to meet Trust recommendation guidelines of 1:8 7. Review adequacy of staff of evening hours (Queen's day unit recovery)	Actions 1, 2, 5 and 6 are complete. All residual actions: 31 March 2015	Action 3a: Theatres have temporarily appointed Sister and lead ward Matron. Action 3b: Working closely with our HR Business Partner and Head of recruitment and retention on this initiative – currently assessing the need across the Trust. Action 3c: Awaiting feedback from review at Trust senior level. Action 3d: This is in place in Theatres and ward areas and working well. Action 4: HR Business Partner has investigated the turnover of the staff in HGT and A700 – the theme that transpired was that some staff who have left A700 found the ward too big and wanted to work on a smaller ward. Recruitment in both areas highlighted has picked up and active recruitment continues. Action 5: complete – staff member recruited. Action 7: Surgical Trauma Assessment Unit (STAU) has moved to a new ward with increased staffing for out of hours. Queens's day unit work closely with Heygroves Theatre (HGT) to reduce the risk to the patients and a SOP has been produced to clarify the requirement for staff.
Diagnostic and screening procedures	Not all staff on medical wards were able to attend and carry out mandatory training,	During 2013/14, the Trust undertook a comprehensive review of Essential Training (Mandatory & Statutory training) and	31 March 2015	In relation to the actions, we have continued to monitor the trajectory. January compliance for the Trust was 83%; Medicine was 82% against a target of

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Treatment of disease, disorder or injury	particularly annual resuscitation training, in order to care for and treat patients effectively.	implementing revised training topics, new training programmes and a new teaching and learning portal. Given the step-change in approach, we have agreed a trajectory to achieve 90% Essential Training compliance by the end of March 2015. Progress is being monitored monthly by the Senior Leadership Team and the Service Delivery Group. The Division of Medicine has an overall plan for achieving Essential Training compliance, in line with the Trust KPI with a specific trajectory for resuscitation training. Ward sisters will now maintain their own departmental spreadsheet and ensure staff are booked on necessary training. During appraisals ward sisters will identify staff that may become non-compliant and ensure forward planning for training is in place.		81% for January. Reports showing gaps in divisional compliance will be circulated during w/c 9th February and will identify staff need to attend their update training and those who are due to become non complaint within the next month. The Trust experienced periods of black escalation during January, however training continued, with the Medicine division ensuring that staff were released for their training, in particular attending Resuscitation training. A letter was sent to all non-compliant staff week commencing 16th February from the Chief Executive reminding staff to complete their Essential training before 31st March 2015.
Management of medicines	Medicines were not always stored securely in critical care areas and on medical and surgical wards. Records of medicines administration on surgical wards were not always maintained to accurately reflect the time at which medicines were administered.	Medicines security within the Trust will continue to be audited on an ongoing basis. Results of the ongoing audits will be presented to the Medicines Governance Group (every two months) and will focus attention on those clinical areas where performance does not meet the requirements detailed in the trust 'Secure handling and safe storage of medicines' policy. The Local Security Management Specialist will be alerted to any clinical areas of concern in order to investigate potentially poor practice. A risk assessment has been completed	Secure drop box roll-out 31 March 2015 NHS Protect self-assessment 30 June 2015 Expansion of Pharmacy 'top-up' service 1 September 2015 (if approved)	The further roll-out of secure drop boxes has been undertaken and completed for the adult central site departments. The paediatric wards and SBCH will be completed by March 31st 2015. Some software problems have arisen with the bar-code scanning and these are being resolved at present. The repeat 'NHS Protect Medicines Security' self-assessment will commence in April 2015 following the present ward reorganisations, so will be completed by June 2015. Operating plan submitted for the expansion of 'top-

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
		regarding the issues raised concerning the Controlled Drugs cabinet fixings in the new building. Ongoing security improvements have been made, and the secure 'drop boxes' in clinical areas are now in regular use; these maintain medicines. This process is presently being extended to a number of clinical areas. Bar code scanning is also now being implemented for deliveries to the drop boxes and this gives a more robust audit trail for the delivery of medicines. Intermittent audit is undertaken, and the 'NHS Protect Medicines Security self-assessment' has been completed and action plan implemented within 2014/15. The goal is to further embed the principles of secure handling and safe storage of medicines into the practice of every clinical area within the trust. The Trust is currently implementing the recording of room temperature for ward and department treatment rooms. With regard to the recording of medicines administration, the NICE staffing red flag of "unplanned omission in providing patient medications" is being integrated into the incident reporting system, and will be incorporated in the real time electronic acuity and dependency system (once procured).	Trial of medicines storage will be piloted 2015/16 NICE red flag 28 February 2015	up' service 1; awaiting outcome. Major capital proposal submitted for trial of medicines storage; awaiting outcome. Ongoing – reports to be reviewed at March, May and July Medicines Governance meetings to provide assurance that process is operating effectively.
Surgical procedures	Patients whose surgery was cancelled did not always have	Develop a Standard Operating Procedure (SOP) which describes the actions required to ensure	SOP 31 January 2015	The Standard Operating Procedure was taken to the Nutrition and Hydration Group on 12 Jan 2015 and

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
Treatment of disease, disorder or injury	their nutritional needs met.	that patients, whose operation is cancelled, have their nutritional needs met. SOP to include: - Defined nutritional standards for patients in pre-operative period - The process by which the ward will be alerted to the cancellation of a patient's operation - Defined responsibility, within each ward to ensure that when cancellations occur, the house keeping team and nursing staff are made aware of the cancellation and the patient is given appropriate nutrition. - Required practice for maintaining nutritional status of a patient who needs to remain "nil by mouth" following delay or cancellation of their operation. Incorporate nutritional status into daily safety brief so that staff remain aware of the importance of maintaining nutritional needs of patients	Policy approval and dissemination February 2015	requires further amendments prior to approval. Amendments will be taken back to the March meeting for approval. Final approval is required by Clinical Quality Group – end of March/beginning April.
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Patient records in outpatient clinics were not always stored securely and were not always available to clinicians when required.	1. Reminder to be sent to all services of the need to store notes safely and out of view. 2. Develop a short training presentation for services to share with teams. 3. Measure initial compliance via a small audit. 4. Ensure that there is access to clinical records out of hours by Clinical Site Managers. 5. Review the flow of patient records within outpatient areas to ensure they are secure at all stages of the process. 6. 3-6 monthly audits to be undertaken on a Trust-wide basis (all areas of the Trust to be	31 March 2015	Action 1: All Health Records Managers within the Trust will be instructed that they must inform the appropriate management teams in their hospital(s) of their responsibility that Outpatient notes stored within their area(s) must be stored securely pre, during and post clinic. Entry to be submitted in Newsbeat on a 3 monthly basis, to remind all departments re case note security. Local managers will need to manage and monitor compliance. Action 2: PowerPoint slides Action 3: Health Records Management team to

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
		included over a 12 months period) to ensure patient notes are being stored securely in outpatient clinic areas. 7. Check patient record security in the Trauma & Orthopaedic clinic post the completion of the major refurbishment work. 8. Continue the Trust-wide 6 monthly 2 week audit of outpatient missing case notes. 9. Transition to an electronic document management system to begin in 2015 and roll out within two years – will allow access to all patient records electronically.		initiate audits within departments, that should then be reviewed locally and then by the Health Records Management team and the Trust Clinical Record Keeping Group Action 4: In progress. Action 5: This needs to be undertaken locally by appropriate Manager(s). Should form part of regular local audits. Action 6: A plan needs to be agreed. Vince Coombes will organise a 3 monthly visit to various areas. A plan will be produced. Action 7: Site visits in February (17/2) and June (4/6). A brief post visit report to be produced. Action 8: This work is already in progress. Go-live at St Michaels Hospital (STMH) is planned for 18th May. Then ongoing roll-out Trust wide.
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	The trust had not ensured that all resuscitation and safety equipment was checked regularly and available for use in the event of an emergency.	All resuscitation and safety equipment will be checked after every use, or monthly. A new daily check list has been devised, providing further clarification of requirements for items of equipment on resuscitation trolleys which require daily checks. The checklist requires a staff signature confirming that the checks have been carried out. Annual check/audits will be carried out by the Resuscitation Services Team.	Resuscitation checking on-going Issuing of daily checklist complete Annual audit 31 March 2015	Carried out by the wards and evidence of this provided by Resuscitation team. Complete. The annual audit is on track to be carried prior to 31 March 2015. Once complete a written report will be provided by Resuscitation team
Diagnostic and screening procedures Surgical	On the A&E department's observation ward, same-sex accommodation was not provided in accordance with	Single-sex accommodation, A&E: The bathroom signs within the A&E Observation Bay will be changed so that they can switch from male to female and vice versa.	Single-sex accommodation 31 January 2015	The bathroom signs are in place (action complete). Compliance is being monitored daily via the ED co-ordinator and recorded.

Regulation and activity	How the regulation was not met	Action	Date when actions will be completed	Update on actions
procedures Treatment of disease, disorder or injury	guidance from the Department of Health, to protect the dignity of patients. Patients who remained in recovery areas overnight did not always have their privacy and dignity maintained.	A request has been made to the Clinical Commissioning Group regarding a single sex exception for the A&E Observation Bay. Privacy and dignity in Recovery: Work closely with the site team to avoid patients being placed in Recovery. Ensure patients are repatriated to appropriate ward bed as a priority. If patients are placed in Recovery – ensure privacy screens are used and staff respond quickly to patient's needs.	Privacy and Dignity in Recovery completed	The draft SOP for the operational management of Single sex accommodation has been written and is being followed in Emergency Departments Observation. This SOP is currently in draft format pending feedback from CCG of their agreement.

Part 2 – Improving Patient Flow. This section is a summary of actions we are taking with others in our local health economy, in response to the report of the Care Quality Commission

Update on the progress against the CQC System Action Plan to support flow within University Hospitals Bristol

Regulation and activity: Diagnostic and screening procedures, Surgical procedures, Treatment of disease, disorder or injury

How the regulation was not met: Patients arriving by ambulance at the Bristol Royal Infirmary A&E department were frequently delayed because the department did not have the capacity to accommodate them. This delayed their assessment, care and treatment and compromised their dignity and wellbeing. Patients in the Bristol Royal Infirmary A&E department with mental health needs did not receive prompt and effective support to meet their needs from appropriately trained staff. The discharge of medical and surgical patients was not always planned effectively in order that they could leave hospital in a timely manner when they were fit to do so. Medical and surgical patients were not always nursed on the appropriate ward for their needs or medical condition. Some surgical patients were moved to an appropriate ward at night; however, this disturbed patients' sleep and could cause confusion and disorientation leading to patient safety incidents.

Process

The CQC system action plan has been incorporated into the existing and on-going whole system 4 hour recovery plan. The plan is owned and regularly monitored by the Bristol Urgent Care Working Group (UCWG) as the urgent care System Resilience Group for the local (Bristol) health community. This group links to the Strategic Resilience Group for Bristol, North Somerset and South Gloucestershire, which signed off the plan in January 2015.

There are 6 organisational elements to the action plan that address A&E queue, mental health needs, discharge and admission avoidance to deliver sustained improvement to patient flow. Initial progress against plans was reviewed by the UCWG at their January 2015 meeting and a detailed reporting mechanism agreed. Further progress against organisational actions was reviewed by the UCWG on 26th February 2015 and the progress is detailed below.

Progress

Progress has been made in securing the staff resource and capacity to deliver the workstreams and mitigation has been put in place (mainly by utilising bank staff), where recruitment has been delayed; as well as embedding and mainstreaming the new service models and functions. There has been an increase in referrals to alternative pathways to ED, better use of direct access pathways and increase in reablement. The 'Green to Go' list (medically fit patients waiting for community/social care supported discharge) was at its lowest at 40 on Wednesday, 11th March. Recognising that further improvements still need to be realised, the focus is now in removing blockages and resolving delays, and further promotion amongst staff to optimise utilisation and delivery.

Progress by organisational action plans:

Action	Who is the action?	Resource required if any?	Date when actions will be completed	Update on actions
System flow plan 1: To use a dedicated Clinical Advisor (CA) resource to review calls with A&E dispositions and ensure only appropriate onward referrals take place to reduce of A&E attendances by the utilisation of an alternate Pathway, reduce unnecessary hospital admissions via A&E, achieve more streamlined flow of care throughout the Urgent Care system, improve patient satisfaction and experience and allow for a more tailored approach to care especially those who are elderly and/or those with complex needs, achieve delivery against the target of 5% for referrals to A&E (transfers from 111 to A&E).	Head of NHS 111, SW Care UK	2 Clinical Advisors (CA) are dedicated to 'ED Line' during the peak hours to monitor all A&E dispositions from 15 December - 31 march 2014. Resource has been allocated.	15.12.2014	Since the implementation of this additional capacity (15 December), the average for A&E disposition for the Bristol North Somerset South Gloucestershire (BNSSG) service for the period of 15 December 2014 to 4 January 2015 was 4.79%, against a target of 5%. The average for the month of December 2014 was 5.18%. Overall in January, of the 351 calls to the ED intervention line, 242 patients (69%) were referred to a destination other than the original disposition of 'Attend Emergency Department'. Overall in February, out of 25,382 calls answered by NHS111 2,186 were advised to attend ED in BNSSG. This is equates to 5.5% against a target of 5%.

System flow plan 2: Increased target for direct referrals from ambulance paramedics to the GP Support Unit (GPSU) as part of an existing pilot to further reduce pressure at Bristol Royal Infirmary A&E by reducing A&E attendances and to provide patients presenting with medical conditions with the most appropriate care pathway, improve patient flow within the BRI, improve patient experiences and standardise medical assessment/admission procedure between primary care and the ambulance service. The revised target is 3 referrals/day	Head of Operations (North), SWASFT		31.01.2015	The target of 3 referrals per day has not been met consistently during December-February. Two weeks, w/c 15.12 and 5.1 referrals reached 14 and 12 respectively. The average number of referrals per week was 7 in December and 5 in January. This reduced to 4 in February, but w/c 2.3 saw referrals go up to 8. GPSU and SWASFT are working to promote the use of the service by: • Meeting regularly, reviewing data and identifying ways to increase referrals- last meeting on the 3rd March • Marketing campaign, by having posters in bases and in ED to promote the service to staff • All paramedics were given a letter and a laminate. SWASFT to send out more as new staff is recruited • To use the 'perfect week' to have a presence outside the ED to promote the service with staff and pose a challenge to conveyance to hospital 85% of PSV shifts (total for BNSSG) were covered in December. 94% of all BRI facing PSV shifts were covered in January, and 89% of shifts were covered in February; compared to 90% and 96% respectively for BNSSG. PSV provision has been extended till 10th April 2015.
Provision of dedicated Hospital Winter Pressure Patient Support Vehicles. Additional PSV grade ambulance resources have been commissioned for the winter pressure period. The dedicated Hospital Winter Pressure PSV vehicles are in place to carry out discharges and transfers for the BRI. They will also carry out Health Care Professionals (HCP) Admissions suitable for the PSV that are being admitted to the BRI (this is the secondary function of the vehicle and HCP Admissions will only be undertaken when there is no				

discharge or transfer work outstanding for the vehicle). Implementation of HALO (hospital ambulance liaison officers) Based within acute hospitals during times of increased pressure, HALOs will be responsible for the effective and efficient management of ambulance turnaround times and patient flow within A&Es. The HALO will be responsible for liaison with the A&E, Patient Flow/Bed Managers to ensure the effective and efficient use of information in relation to "Bed Status" and trolley waits. The HALO will support improved patient satisfaction, reduction in pressure on acute A&E, improved 999 resourcing due to release of crews as a result of quicker turnaround times and improved working relationship between primary and secondary care and the ambulance service. The HALO will also, where appropriate be responsible for redirection to the GPSU.				The HALO role has been implemented with 9/10th's establishment from 26/1/15.
System flow plan 3: Provision of mental health support in A&E outside of UH Bristol's Liaison Service hours, and enhanced liaison discharge support to frail and elderly people with the hospital. Timely access to inpatient mental health care off site from the Bristol Royal Infirmary when assessed as required and timely support in assessing the cognitive needs of frail and complex patients as part of the discharge process will form part of this review.	AWP Bristol CCG Bristol City Council	Additional non-recurrent resources have been secured	01.04.2015 01.04.2015	A Local Government Association (LGA)-led Peer Challenge on the Mental Health Act (MHA) Pathway has been completed and will report in April 2015, leading to an improvement action plan. A linked event will also be held to share learning and recommend improvements to the pathway from crisis to disposal of the affected person. The Bristol Crisis Care Concordat for Mental Health has been signed by partners, and sets out improvements to the experience of people with mental health problems, including A&E. The Concordat is committed to supporting the full implementation of newly commissioned mental health services in Bristol which will all commence by April 2015. The impact of the full implementation of the newly

				commissioned mental health services will be the availability of new services for people in mental health crisis to go to apart from A&E, such as the Mental Health Sanctuary, and additional support will be available in the new Mental Health Assertive Engagement Programme to support people to keep people engaged with services. The Concordat will also ensure greater awareness of carers of alternative support other than Urgent Care. The development of the Mental Health First Aid Training will be delivered to stakeholders and carers to assist with recognising the early onset of a crisis and ways of accessing help other than through A&E attendance. The local offer of two Crisis Houses will continue, and Bristol CCG is investigating the option of developing a third Crisis House. The Women's Crisis House has 10 beds and usually operates at 95% capacity; The Men's Crisis House has 10 beds and usually operates at 100% capacity. The Psychiatric Liaison Service offered in A&E at University Hospital Bristol NHS Foundation Trust has extended its hours of operation, and workforce capacity in the Emergency Department to provide greater levels of support to people with mental health problems in A&E.
			01.04.2015	
			01.04.2015	• New hours of operation From 01 October 2014 are 8am – 10pm, 7 days per week (increased from Monday to Friday 9am – 5pm • Staffing increases – an additional 4 WTE Band 7 Nurses • An WTE Consultant Psychiatrist for Older Adults in ED. This post has been filled on an interim basis since July 2014, and the substantive post holder will start in March 2015. • A Self Harm Health Integration Team has been

				established in the borough by Bristol Health Partners to drive improvements, learning and innovation in managing suicidal/self-harming patients in the borough • A new educational package on Self harm, which includes people with lived experience in the delivery, has been rolled out to all staff in ED and is delivered every two weeks • Personal support plans are in place for all patients who regularly present in ED following an episode of self -harm The Emergency Duty Team (EDT) has recently changed its operations to ensure they always respond to requests for MHA assessments out of hours, even if no bed has been identified, where admission is warranted. The EDT prioritises A&E assessments over other mental health assessments; however there are higher priorities such as safeguarding children that will gain more rapid assessments. 01.04.2015 Securing access to Bristol adult inpatient mental health beds on an emergency basis has improved following an Inpatient Redesign Project to reduce length of stay and further improvements in access are anticipated due to implementation of the newly commissioned mental health services. Demand for inpatient mental health beds has also reduced due to the implementation of those newly commissioned mental health services which have been operational since October 2014, such as the Assessment and Recovery and Crisis Services. 01.04.2015

System flow plan 4: Increase in total resource to services to support facilitated discharge for patients through additional resource to support the Community Discharge Co-ordination Centre and through in-reach services via our Rapid Response service into the A&E and Older Persons Assessment Unit (OPAU) 7 days a week providing senior community presence in the hospital to facilitate discharge decision making and provide the capacity to take patients back into community settings rapidly along a rehabilitation/reablement pathway. The teams will work with hospital teams to ensure that discharges are appropriately planned and to deliver 3 additional discharges per week from 8/12/14 and 5 additional discharges per week from 26/1/15.	Deputy Director of Operations, Bristol Community Health	2 x advanced nurse / therapy practitioner 3 x senior therapist (physiotherapy)	28.02.2015 Interim capacity from mid-December 2014.	Therapy roles implemented in December 2014, Advanced Nurse Practioner role in January 2015 Model has been agreed with the services on OPAU. Bank staff being used to support community services to manage increases in activity. Targeted adverts for required posts to speed recruitment. Since in-reach to OPAU commencement, performance data shows that the service is achieving target of an average of 5 discharges per week. Recently there has been a reduction of the number of patients identified for Rapid Response in-reach. Monitoring in place to ensure this is not an ongoing issue.
System flow plan 5: Support discharge process by increasing reablement capacity to take an additional 30 people per month in total from both acute trusts as part of the BCP action to begin in April with a phasing up to 30. April's target is 10. Social Care Practitioner working with the REACT service in A&E and in the Older Persons Assessment Unit to provide information, advice and signposting, restarting care plans and undertaking quick turnaround of assessment in order to avoid unnecessary admissions and reduce length of stay. Support Planning Coordinators to work within the Bristol Royal Infirmary as part of our Care Brokerage service focussing on specific wards in order to source care providers and expedite discharge. Additional Social Work staff in our community teams to undertake early reviews of patients being discharged from hospital in order to free up capacity which will	Joint Strategic Service Manager Intermediate Care and Reablement, BCC/BCH Service Manager, Hospital/Front Door Social Work, BCC	3 OTs 12 x21 hour Reablement workers 3x Social Care Practitioners	31.03.2015	Increased Reablement provision. Fast tracked with local CQC the registration of additional beds in reablement service. Interviewing Reablement workers w/b 9th March Advertising for Social care Practitioners in Community Discharge Co-ordination Centre. Social Care Practitioner in ED - practitioner in place and extended till end of March 2016. Brokerage staff in Hospital in place. Supporting Discharge to Assess and enabling quicker sourcing and discharge to Package of Care and placements Additional community assessment staff. 3 x OTs in place to ensure quick reduction of new home care packages and reduce double handling to free up capacity for other

reduce hospital delays for people waiting for a home care or reablement services as well as avoid any risk of readmission. Social care practitioners will reduce length of stay by assessing people where case finding by the Community Discharge Co-ordination Centre would otherwise have generated a S2 to the Social Work Department, thus reducing length of stay by a minimum of one day.				discharges. Launch 2nd March 2015 OT staff now in place.
System flow plan 6: Five key actions to promote early discharge and ensure patients are cared for in the most appropriate bed: <u>i)Reinforce the SAFER care bundles:</u> these were introduced in April 2014	Divisional Director of Medicine, UHB		31.03. 2015 (with exception of new ward block 31.08.15)	KPIs for flow, front door and discharge developed , across all Adult Divisions Communicate to Multidisciplinary team that 3 patients to be constantly identifiable as suitable for outlying on each ward at the afternoon board round (3 before 3) Plan for each medical base ward to have an empty bed by 5pm each evening to allow for admissions overnight (90% occupancy model). Communications to all clinical teams on Standard definition of Estimated Date of Discharge, re-launch of "what makes a good and effective board round" with a consultant led peer review with feedback to multidisciplinary team
<u>ii)Electronic completion of CM7 documentation:</u> This project will move from manual documentation to an electronic record that can be shared easily among the multi professional team.			April 2015	Software developed for electronic CM7, successfully piloted, Rollout across medicine to be completed by 10/04/15 . Rollout to all Adult wards to be completed in April. CM7 provides information for a safe and effective discharge of a patient to Care/Nursing home or complex patient. This will ensure that there is no lost documentation, it is legible, and timely.

iii)Patient Progress MDT Meeting: The Division of Medicine will have a weekly 'patient progress' meeting to progress chase any patients whose discharged is delayed.			February 2015	Meeting held weekly with external partners (Social Care, Bristol CCG, Bristol Community Health, Intermediate Care & Reablement) including therapists Standard agenda and meeting format agreed and in place. Attendance record maintained. Actions agreed, documented and followed up. Barriers to flow are being immediately actioned with Senior staff taking responsibility to progress those barriers which can not immediately be actioned.
iv)10 before 10: 10 patients will be identified for discharge before 10.00am in order to get patient flow moving within the hospital. This will increase from 1 February 2015, rising to 15 patients before 10.00am by 31 March.			31.03.2015	All Divisions submitting detailed plans to support earlier in the day discharges, for sign off on 16/3/15 09/03/15 Medicine Division trialling extra staff to support nursing teams on wards to prepare patient for discharge. Implementation of proactive identification of early discharges for the next day enabling Discharge Lounge to proactively "pull patients". Recording of barriers to early discharge documented, reviewed with lessons learned being fed back to ward teams. Communication plan being delivered, such as posters, screen savers, team briefings etc., See Appendix 1
v)Appropriate Ward and Reducing Unnecessary Moves: Extra capacity beds have been opened earlier than planned. Plans were in place to open 17 beds on Ward A518 on 1 January; however this was brought forward to mid-November 2014.				

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30th April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
Finance Report									
Sponsor and Author(s)									
Paul Mapson									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
To report to the Board on the Trust's financial position and related financial matters which require the Board's review.

Key issues to note

The summary income and expenditure statement shows a surplus of £6.340m (before technical items) for the year. This represents a favourable variance of £0.537m against plan for 2014/15. The values used in this month's report are 'draft – subject to audit' and there may be minor alterations as work continues on closing the Trust's Annual Accounts. This is a satisfactory outturn for the year – the twelfth year in which the Trust has achieved (before technical items) breakeven or better.

The Divisional position has deteriorated further by £0.584m in March to a cumulative overspending of £10.550m. Provision has been made against Trust Reserves for workforce costs of £1.6m. This is partially offset, in line with practice reported in recent months, by the net underspending on the corporate share of service agreement income and financing costs.

The Trust is required, in completing its Annual Report and Accounts, to recognise, where appropriate, technical accounting issues. For 2014/15, there are four items under this heading (donations and grants, asset impairments, reversal of asset impairments and depreciation on donated assets) which lead to the income and expenditure surplus becoming a loss after technical items of £16.350m.

Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
None
Impact Upon Corporate Risk
None in 2014/15
Implications (Regulatory/Legal)
None

Equality & Patient Impact
None

Resource Implications			
Finance	**x**	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	**x**	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	27 April			22 April	

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £6.340m (before technical items) for the year. This represents a favourable variance of £0.537m against plan for 2014/15. The values used in this month's report are 'draft – subject to audit' and there may be minor alterations as work continues on closing the Trust's Annual Accounts.

The divisional overspend has increased by £0.584m in March, resulting in an outturn overspending of £10.550m. This month's report includes Operational Resilience income of £0.884m that has been recognised to meet additional costs incurred in March.

A reconciliation of the variance to Plan is summarised in the table below.

	£'m
Favourable Variance (before Technical Items) to 28 February 2015	**1.587**
• Service Agreements – Corporate share (includes c£240k re waivering of RTT penalties);	0.376
• Divisional overspending (net);	(0.584)
• Reserves, after providing for workforce provisions; and	(1.600)
• Financing costs – PDC Dividend, Depreciation, Interest charges and receivables.	0.758
Favourable Variance against Plan 2014/15 (before Technical Items)	**0.537**

The underspending on Financing Costs this month follows the pattern previously reported with an increase in the rate of underspending on the PDC Dividend. The amount payable is based on net relevant assets held with an abatement for daily cash balances throughout the year. The year-end assessment has resulted in a favourable adjustment of £0.349m.

The Trust is required, in completing its Annual Report and Accounts, to recognise, where appropriate, technical accounting issues. For 2014/15, there are four items under this heading which lead to the income and expenditure surplus becoming a loss after technical items of £16.350m.

The position is summarised in the table below.

	Annual Plan £'000	Actual Income and Expenditure £'000
Income and Expenditure Surplus to 31 March – before Technical Items	**5,803**	**6,340**
Technical Items		
- Donations and Grants	8,588	8,789
- Asset Impairments	(24,204)	(32,307)
- Reversal of Asset Impairments	1,232	2,092
- Depreciation on Donated Assets	(1,219)	(1,264)
Income and Expenditure Surplus / (Loss) to 31 March – after Technical Items	**(9,800)**	**(16,350)**

The Trust has received donations and grants of £8.789m. This is £0.201m more than assumed in the Annual Plan.

An estimate of £24.204m had been made to provide for the impact of impairments in 2014/15 for the BRI New Ward block (£20.575m), the Helipad (£2.009m), the Surgical Assessment Suite (£1.266m) and other schemes (£0.860m). The actual impairment value on these schemes, as assessed by the District Valuer, is £24.710m.

In addition, the District Valuer, as part of the annual desktop valuation exercise has advised of the requirement for an impairment of £4.804m to reflect the non-operational areas of the Old BRI Building together with the donation impact on the BHOC and the valuation of 40 Southwell Street (£2.793m). The total net adverse impact of asset impairments is £30.215m, or £7.243m more than planned. It should be noted that this technical adjustment has no adverse impact on cash.

Each year the Trust anticipates the likely change (indexation) in asset values over the coming year. In line with previous practice an assumption of 2% was made at the start of 2014/15. Changes to the index are a guide for organisations to use in those years between formal asset valuation exercises. The District Valuer has advised on revaluation which results in a reversal of previous impairments to a value of £2.092m. This is a technical gain of £0.860m when compared with the Annual Plan assumption.

The Trust's Annual Plan included provision for depreciation on donated assets to a value of £1.219m. Depreciation charges of £1.264m are marginally greater than plan for the year.

The table below shows the Trust's income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £10.550m.

Divisional Variances	Variance to 28 February	March Variance	Variance to 31 March
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Pay	(3,627)	(69)	(3,696)
Non Pay	1,681	(1,183)	498
Operating Income	540	617	1,157
Income from Activities	(3,892)	(334)	(4,226)
Sub Totals	(5,298)	(969)	(6,267)
Savings Programme	(4,668)	385	(4,283)
Totals	**(9,966)**	**(584)**	**(10,550)**

Pay budgets have an overspending of £69k in the month and a cumulative overspending of £3.696m. Substantive staff pay costs decreased by £0.222m in March to £26.765m. Agency staff expenditure of £1.547m represented an increase of £0.233m when compared with February. For the Trust as a whole, bank, overtime, waiting list initiative and other payments decreased by £76k to £1.468m in March (cumulative expenditure £16.6m).

N**on-pay budgets** show an adverse variance of £1.183m in the month thereby reducing the favourable variance to £0.498m for the year. The underspending relates in the main to the proportion of contract transfer funding which has not been used – in effect offsetting the income from activities under performance.

Operating Income budgets show a favourable variance of £0.617m for the month, and a cumulative underspending of £1.157m.

Income from Activities shows a net adverse variance of £0.334m in the month. This increases the cumulative under performance to £4.226m. The principal variances are the in-month over performance recorded for Medicine (£36k) offset by activity being lower than planned for Diagnostic & Therapies (£36k), Specialised Services (£100k) Surgery, Head & Neck (£31k) and Women's and Children's Services (£0.392m).

The table below summarises the financial performance in March for each of the Trust's management divisions.

	Variance to 28 February	March Variance	Variance to 31 March
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic and Therapies	(261)	(140)	(401)
Medicine	(1,469)	67	(1,402)
Specialised Services	(1,127)	168	(959)
Surgery, Head and Neck	(5,128)	(736)	(5,864)
Women's and Children's	(2,650)	19	(2,631)
Estates and Facilities	137	2	139
Trust HQ	203	(61)	142
Trust Services	329	97	426
Totals	**(9.966)**	**(584)**	**(10,550)**

The results for the year are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 4.0, February 4.0). Further information on the financial risk rating is given in section 5 below and appendix 6.

2. Savings Programme

The Trust's Savings Programme for 2014/15 is £20.771m. Savings of £16.488m have been realised for the year (79% of Plan), a shortfall of £4.283m. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme 2014/15		
	Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000
Diagnostics and Therapies	1,759	1,922	163
Medicine	3,038	2,268	(770)
Specialised Services	2,640	2,591	(49)
Surgery, Head and Neck	4,925	2,413	(2,512)
Women's and Children's	3,580	2,413	(1,167)
Estates and Facilities	1,099	1,170	71
Trust HQ	1,039	1,055	16
Other Services	2,691	2,656	(35)
Totals	**20,771**	**16,488**	**(4,283)**

Within the total achieved savings of £16.488m for 2014/15 are non-recurring savings of £3.768m. Recurring savings total £12.720m in year with a full year effect of £16.511m.

3. Income

Contract income is £2.47m lower than plan for the year to 31 March 2015. Activity based contract performance at £409.27m is £3.78m less than plan. Contract rewards / penalties at a net income of £5.92m are £0.91m greater than plan. Income of £60.96m for 'Pass through' payments is £0.40m higher than Plan.

Clinical Income by Worktype	**Plan** £'m	**Actual** £'m	**Variance** £'m
Activity Based			
Accident & Emergency	13.70	13.34	(0.36)
Emergency Inpatients	72.30	73.87	1.57
Day Cases	37.12	35.40	(1.72)
Elective Inpatients	51.86	48.71	(3.15)
Non-Elective Inpatients	16.85	15.28	(1.57)
Excess Bed days	7.27	7.45	0.18
Outpatients	73.91	74.22	0.31
Bone Marrow Transplants	8.52	9.09	0.57
Critical Care Bed days	42.58	41.75	(0.83)
Other	88.94	90.16	1.22
Sub Totals	**413.05**	**409.27**	**(3.78)**
Contract Rewards / Penalties	5.01	5.92	0.91
Pass through payments	60.56	60.96	0.40
Totals	**478.62**	**476.15**	**(2.47)**

4. Expenditure

In total, Divisions have overspent by £0.584m in March. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

Four divisions are red rated[1] for their financial performance for the year to date. Specialised Services was previously amber / red rated for their results to 28 February.

The **Division of Medicine** has an adverse variance of £1.402m for the year, a favourable variance in the month of £67k. The Division continues to benefit significantly from the release of Operational Resilience moneys.

The Division has an overspending of £0.625m to date on pay budgets, an overspending in the month of £109k. There were overspendings on each of the staff groups with a partial in-month offset by the division's pay reserves budget. To date medical staff budgets are underspent by £0.832m whilst cumulative overspendings are recorded against nursing staff (£0.604m), clinical staff (£0.234m) and non clinical staff (£0.227m).

Non-pay budgets have a favourable variance of £131k in the month and a cumulative overspending of £0.190m. The principal in-month favourable variances were recorded against drugs (£67k) and Other Non Pay Reserves (£78k).

The Division reports a cumulative favourable variance of £0.273m on its Operating Income budgets. Income from Activities shows an over achievement of £36k in the month and a cumulative adverse variance of £90k.

[1] Division has an annualised cumulative overspending greater than 1% of approved budget.

The **Division of Specialised Service** reports an adverse variance on its income and expenditure position of £0.959m for the year, an underspending of £0.168m in the month.

Pay budgets show an overspending of £62k for the month, cumulative overspending £1.451m. The overspending in March on nursing staff was £10k, cumulatively £0.713m adverse (agency staffing, BMT services support and higher levels of activity for the Teenage and Young Adult oncology service). Medical staff costs were higher than planned £47k in the month and cumulatively by £0.570m. Agency consultant costs of £28k were incurred in Oncology to cover temporary vacancies. Junior doctor agency spend in the BHOC to cover gaps in the medical rota was £44k.

Non pay budgets have overspent by £56k in March thereby reducing the favourable variance to date to £0.678m. Adverse activity related variances were recorded in March against blood and blood products (£65k) and clinical supplies (£0.182m). The March position reflects an adverse stock movement of items under £1k in Cardiology to a value of £82k. The non pay budget heading is supported by favourable variances on the allocation of contract transfer funds (£0.356m) and Trust support funding (£1.421m).

Income from activities shows an adverse variance in month of £100k to give a cumulative adverse variance of £0.586m. Cardiac surgery was less than plan by £57k, cumulatively now £0.657m adverse. Cardiology services are estimated to have under-performed in March against the service level agreement activity thereby increasing the cumulative under performance by £50k to £0.515m. Operating income shows an underspending of £69k in March to give an underspending of £0.449m for the year.

The Surgery, Head and Neck Division reports an adverse variance of £5.864m for the year, an overspending of £0.736m in the month.

Pay budgets are overspent by £3.382m for the year, an increase of £0.278m in March. The overall position represents the pay proportion of the Division's underlying deficit (£3.810m) offset by a net underspending on other pay headings (£0.428m).

Non pay budgets are overspent by £0.353m in the month. This includes activity outsourcing costs of £0.270m as the Division works to maximise clinical activity both within the Trust and by the use of third party facilities. The cumulative overspending of £0.377m is net of the release of the non-recurring funding allocated at the start of the year, the further non recurring funding allocated and the release of reserves to offset contract underperformance.

Income from Activities shows an adverse variance in March of £31k and a favourable position of £0.226m for the year. The adverse movement reported in March reflects the estimate made using an extrapolation of activity for the April – February period as a basis of closing the year end position. The Division is reviewing actual activity data as it becomes available to see to what extent the positive pattern of the previous three months has been continued in March.

Ophthalmology services continue to record higher than planned activity in the month (£0.104m). There was an underperformance of £0.164m in the month for ITU services income with total income adversely affected by a number of high acuity patients. In total other clinical services income headings are lower than plan for the month, by a net £21k. The Division has received a higher than planned share of income (£8k) for activities provided by other Divisions in March.

Operating Income budgets show a favourable variance of £47k in the month and a cumulative underspending of £181k.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £2.631m for the year, an improvement of £19k in the month.

Pay budgets overspent by £17k in the month and now show a cumulative adverse position of £0.197m. Nursing and midwifery staff expenditure was £53k overspent. Posts are being filled in theatres, in some cases with agency staff. In those areas where pay costs are higher than planned meetings are taking place to manage them back to budget.

Non-pay budgets show an underspending of £0.228m in the month and an underspending of £2.108m for the year. 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 £3.460m for the year, a deterioration of £0.392m in the month. The principal adverse variances are shown against maternity (£0.738m), paediatric cardiac (£1.036m), paediatric medicine (£0.416m). In addition there are other significant variances such as CSP related services (£1.066m adverse), hearing implants (£0.612m favourable) and renal services (£0.244m favourable).

Income from Operations budgets show a favourable variance of £46k in March to give an underspending of £85k for the year.

One Division is amber / red rated (was amber / green rated last month)

The **Diagnostic and Therapies Division** reports an overspending for the month of £0.140m and a cumulative overspending of £0.401m. The underspending on pay budgets has increased in March by £65k to give a favourable outturn variance of £0.219m.

The overspending in March on non-pay headings of £0.441m (cumulative overspending £1.102m) includes higher than planned spend on clinical supplies, Pharmacy part pack wastage (under review by the Director of Pharmacy) and reductions in stock levels identified as part of the annual stocktaking process.

Income from Activities shows an adverse variance of £36k in the month thereby increasing the cumulative adverse variance to £0.292m. Operating income budgets were favourable to plan by £0.271m and delivered a favourable variance of £0.611m for the year.

Two divisions are green rated.

The Facilities and Estates Division reports a £2k surplus for the month thereby increasing its cumulative underspending to £139k.

Trust Headquarters Services report a £61k overspending in February and a cumulative underspending of £142k. The principal reasons for the adverse movement in March are the costs of one off additional activities such as RTT validation work, and property valuation fees.

5. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the year ending 31 March 2015 is 4. The actual financial risk rating is 4.0 (February 4.0). The actual value for each of the metrics is given in the table below together with the bandings for each metric. The improvement in the liquidity metric is principally because of the slippage on capital expenditure in the year.

Further information showing performance to date is given at Appendix 6.

	March 2014	January	February	March 2015	Annual Plan 2014/15
Liquidity					
Metric Performance	2.71	7.92	8.87	5.61	2.53
Rating	4	4	4	4	4
Capital Service Capacity					
Metric Performance	3.04	2.89	2.92	2.86	2.51
Rating	4	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**

In late 2014 Monitor consulted on a number of proposed updates to the Risk assessment framework, given it had been in place for over a year. Following consideration of the consultation responses the Risk assessment framework has been updated. The updates include:

- introducing the new nationally mandated mental health access measures as governance proxies from April 2016 with reporting commencing in late 2015/16;
- specifying an additional trigger for when Monitor may investigate financial risk at a trust;
- changing the name of quality governance indicators to organisational health indicators; including specific exception reporting requirements for providers of high secure services; and
- clarifying that Monitor may stress test providers' strategic and operational plans.

Monitor has made some updates to improve clarity and ensure recent changes to relevant policy areas such as transactions, the annual planning process, the Well-Led Framework and Care Quality Commission's (CQC) new regulatory regime have been reflected.

Of particular interest for UH Bristol is the introduction of an additional trigger for when Monitor may investigate financial risk at a trust. If a foundation trust has an overall rating of 3 but either its liquidity or its capital service capacity is rated 1 then Monitor may subsequently investigate whether it is in breach of the continuity of services licence conditions, or requires enhanced monitoring. Enhanced monitoring may require a trust to provide a limited amount of financial information on a monthly basis. The information is to be used to calculate the risk rating in between quarters and assess any additional aspects of the Commissioner Requested Services (CRS) provider's position.

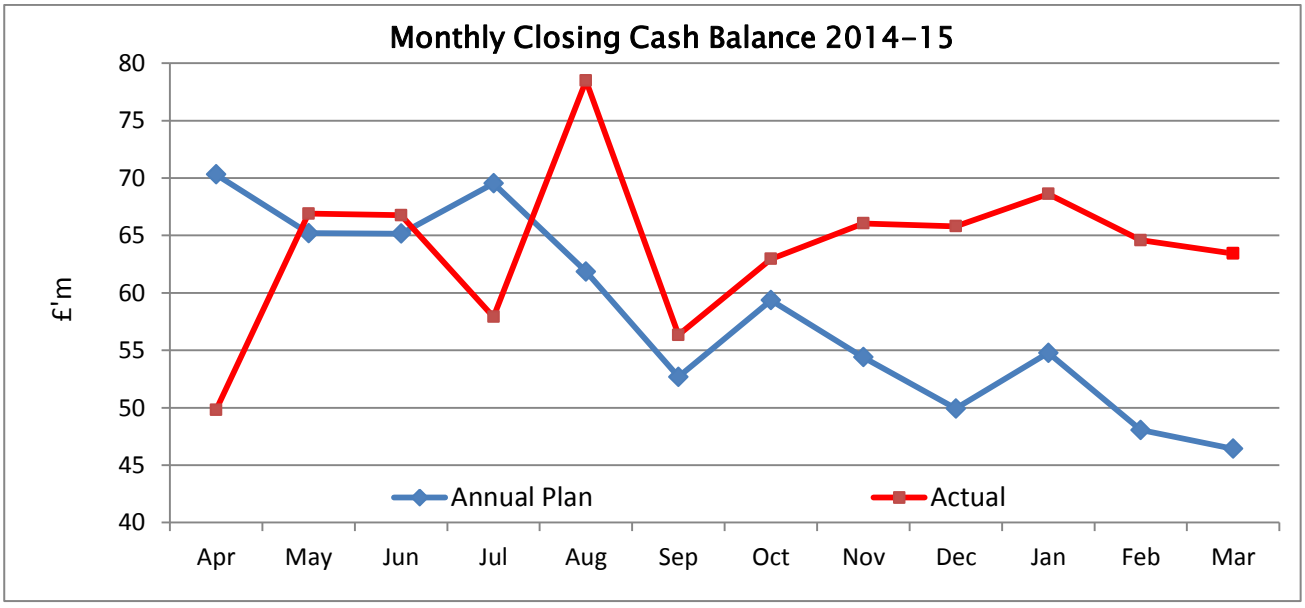
6. Capital Programme

A summary of income and expenditure is set out in the table below. Expenditure for the year of £44.290m equates to 97.4% of the January re-forecast submitted to Monitor.

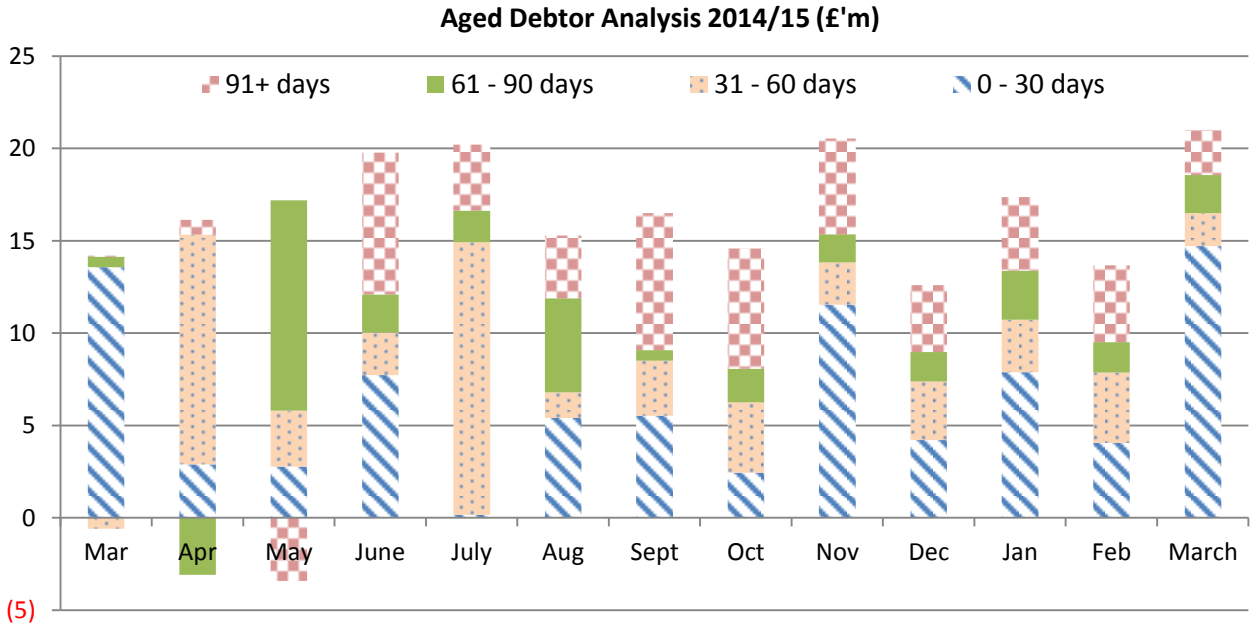
Current Annual Plan		Month ended 31st March 2015				
		Plan	Actual	Favourable / (Adverse)	Slippage into 2015/16	Under / (Over)
£'000	Sources of Funding	£'000	£'000	£'000	£'000	£'000
2,625	Public Dividend Capital	2,625	2,625	-	-	-
18,312	Retained Depreciation	18,312	18,256	(56)	-	(56)
20,000	Prudential Borrowing	20,000	20,000	-	-	-
11,036	Donations	8,733	8,733	-	(2,303)	-
700	Disposals	700	700	-	-	-
954	Grants/Contributions	-	-	-	(954)	
3,341	Cash balances	(6,446)	(6,024)	422	(9,121)	(244)
56,968	**Total Funding**	**43,924**	**44,290**	**366**	**(12,378)**	**(300)**
	Expenditure					
(29,963)	Strategic Schemes	(24,929)	(25,148)	(219)	4,815	-
(5,534)	Medical Equipment	(4,138)	(3,915)	223	1,542	77
(8,207)	Information Technology	(6,591)	(7,018)	(427)	1,181	8
(2,927)	Estates Replacement	(2,088)	(2,558)	(470)	282	87
(10,337)	Operational Capital	(6,178)	(5,651)	527	4,558	128
(56,968)	**Total Expenditure**	**(43,924)**	**(44,290)**	**(366)**	**12,378**	**300**

7. Statement of Financial Position (Balance Sheet) and Cashflow

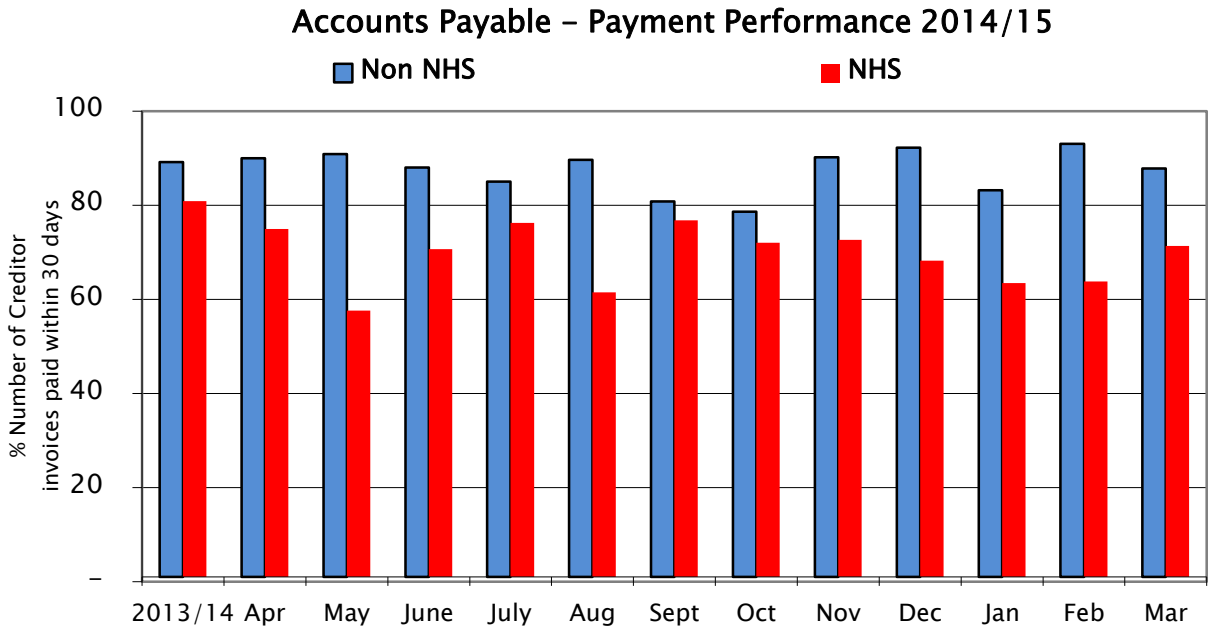
Cash - The Trust held a cash balance of £63.428m as at 31 March. The higher than forecast cash balance is due to slippage on the Capital programme and a high level of provisions (mainly re employment issues).



Debtors - The total value of invoiced debtors has increased by £7.330m during March to a closing balance of £21.016m. The total amount owing is equivalent to 13.0 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In March the Trust achieved 71% and 88% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors. The Trust continues to operate strict financial controls around supplier price increases.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Monthly Analysis of Pay Expenditure
Appendix 4 – Executive Summary
Appendix 5 – Summary of Divisional Monthly Variances and RAG Ratings
Appendix 6 – Continuity of Service Risk Rating
Appendix 7 – Release of Reserves March 2015

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report March 2015 – Summary Income & Expenditure Statement

Approved Budget / Plan 2014/15	Heading	Position as at 31st March			Actual to 28th February
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
485,522	From Activities	485,522	485,340	(182)	445,093
92,226	Other Operating Income	92,226	93,093	867	84,274
577,748	**Sub totals income**	**577,748**	**578,433**	**685**	**529,367**
	Expenditure				
(336,604)	Staffing	(336,604)	(340,574)	(3,970)	(310,795)
(197,877)	Supplies and Services	(197,877)	(202,039)	(4,162)	(184,384)
(534,481)	**Sub totals expenditure**	**(534,481)**	**(542,613)**	**(8,132)**	**(495,179)**
(3,029)	Reserves	(3,029)	–	3,029	–
40,238	**EBITDA**	**40,238**	**35,820**	**(4,418)**	**34,188**
	Financing				
(33)	Profit/(Loss) on Sale of Asset	(33)	(33)	–	(23)
(21,937)	Depreciation & Amortisation – Owned	(21,937)	(18,256)	3,681	(16,739)
150	Interest Receivable	150	251	101	230
(338)	Interest Payable on Leases	(338)	(348)	(10)	(317)
(3,117)	Interest Payable on Loans	(3,117)	(3,141)	(24)	(2,897)
(9,160)	PDC Dividend	(9,160)	(7,953)	1,207	(7,538)
(34,435)	**Sub totals financing**	**(34,435)**	**(29,480)**	**4,955**	**(27,284)**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**5,803**	**6,340**	**537**	**6,904**
	Technical Items				
8,588	Donations & Grants (PPE/Intangible Assets)	8,588	8,789	201	8,399
(24,204)	Impairments	(24,204)	(32,307)	(8,103)	(2,923)
1,232	Reversal of Impairments	1,232	2,092	860	–
(1,219)	Depreciation & Amortisation – Donated	(1,219)	(1,264)	(45)	(1,149)
(9,800)	**SURPLUS / (DEFICIT) after Technical Items**	**(9,800)**	**(16,350)**	**(6,550)**	**11,231**

Appendix 2

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report March 2015 – 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 28th February
			Pay	Non Pay	Operating Income	Income from Activities	CRES		
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements								
478,618	Service Agreements	478,611	–	–	(9)	2	–	(7)	–
(3,816)	Overheads	(605)	–	(1,471)	–	4,682	–	3,211	2,828
40,731	NHSE Income	40,731	–	–	–	–	–	–	–
515,533	**Sub Total Service Agreements**	**518,737**	**–**	**(1,471)**	**(9)**	**4,684**	**–**	**3,204**	**2,828**
	Clinical Divisions								
(48,821)	Diagnostic & Therapies	(49,222)	219	(1,102)	611	(292)	163	(401)	(261)
(69,582)	Medicine	(70,984)	(625)	(190)	273	(90)	(770)	(1,402)	(1,469)
(81,925)	Specialised Services	(82,884)	(1,451)	678	449	(586)	(49)	(959)	(1,127)
(97,309)	Surgery Head & Neck	(103,173)	(3,382)	(377)	181	226	(2,512)	(5,864)	(5,128)
(110,238)	Women's & Children's	(112,869)	(197)	2,108	85	(3,460)	(1,167)	(2,631)	(2,650)
(407,875)	**Sub Total – Clinical Divisions**	**(419,132)**	**(5,436)**	**1,117**	**1,599**	**(4,202)**	**(4,335)**	**(11,257)**	**(10,635)**
	Corporate Services								
(35,805)	Facilities And Estates	(35,666)	199	(30)	(82)	(18)	70	139	137
(24,537)	Trust Services	(24,496)	505	(650)	169	–	17	41	111
(4,049)	Other	(3,623)	1,036	(40)	(529)	(6)	(35)	426	329
(64,391)	**Sub Totals – Corporate Services**	**(63,785)**	**1,740**	**(720)**	**(442)**	**(24)**	**52**	**606**	**577**
(472,266)	**Sub Total (Clinical Divisions & Corporate Services)**	**(482,917)**	**(3,696)**	**397**	**1,157**	**(4,226)**	**(4,283)**	**(10,651)**	**(10,058)**
(3,029)	Reserves	–	–	3,029	–	–	–	3,029	4,629
(3,029)	**Sub Total Reserves**	**–**	**–**	**3,029**	**–**	**–**	**–**	**3,029**	**4,629**
40,238	**Trust Totals Unprofiled**	**35,820**	**(3,696)**	**1,955**	**1,148**	**458**	**(4,283)**	**(4,418)**	**(2,601)**
	Financing								
(33)	(Profit)/Loss on Sale of Asset	(33)	–	–	–	–	–	–	–
(21,937)	Depreciation & Amortisation – Owned	(18,256)	–	3,681	–	–	–	3,681	3,322
150	Interest Receivable	251	–	101	–	–	–	101	92
(338)	Interest Payable on Leases	(348)	–	(10)	–	–	–	(10)	(7)
(3,117)	Interest Payable on Loans	(3,141)	–	(24)	–	–	–	(24)	(77)
(9,160)	PDC Dividend	(7,953)	–	1,207	–	–	–	1,207	858
(34,435)	**Sub Total Financing**	**(29,480)**	**–**	**4,955**	**–**	**–**	**–**	**4,955**	**4,188**
5,803	**NET SURPLUS / (DEFICIT) before Technical Items**	**6,340**	**(3,696)**	**6,910**	**1,148**	**458**	**(4,283)**	**537**	**1,587**
	Technical Items								
8,588	Donations & Grants (PPE/Intangible Assets)	8,789	–	–	201	–	–	201	–
(24,204)	Impairments	(32,307)	–	(8,103)	–	–	–	(8,103)	–
1,232	Reversal of Impairments	2,092	–	860	–	–	–	860	–
(1,219)	Depreciation & Amortisation – Donated	(1,264)	–	(45)	–	–	–	(45)	(43)
(15,603)	**Sub Total Technical Items**	**(22,690)**	**–**	**(7,288)**	**201**	**–**	**–**	**(7,087)**	**(43)**
(9,800)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**(16,350)**	**(3,696)**	**(378)**	**1,349**	**458**	**(4,283)**	**(6,550)**	**1,544**

Appendix 3

Analysis of pay spend 2013/14 and 2014/15

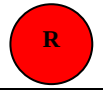
Division		2013/14	2014/15												2013/14	2013/14
		Total £'000	Q1 £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Feb £'000	Mar £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	39,526	10,162	10,066	3,356	3,317	3,364	10,037	3,362	3,398	3,446	10,206	40,471	3,373		3,294	
	Bank	306	64	91	27	26	33	86	14	32	28	74	315	26	0.8%	26	0.8%
	Agency	340	79	184	178	103	106	387	101	139	155	395	1,045	87	2.4%	28	0.9%
	Waiting List initiative	225	45	46	19	16	30	65	47	34	32	113	269	22	0.6%	19	0.6%
	Overtime	314	101	94	36	33	41	111	30	34	35	99	405	34	1.0%	26	0.8%
	Other pay	38,153	9,772	9,435	3,176	3,170	3,329	9,675	3,178	3,169	3,146	9,492	38,375	3,198	95.2%	3,179	97.0%
	Total Pay expenditure	39,339	10,062	9,850	3,436	3,348	3,540	10,324	3,370	3,407	3,396	10,173	40,409	3,367	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	187	100	216	(79)	(31)	(177)	(287)	(8)	(9)	50	33	62	5		16	
Medicine	Pay budget	44,151	11,591	11,880	3,970	4,191	4,345	12,506	4,359	4,487	4,474	13,320	49,297	4,108		3,679	
	Bank	3,305	805	870	306	316	397	1,019	229	299	344	872	3,566	297	7.1%	275	6.9%
	Agency	2,354	451	630	322	378	359	1,058	455	402	499	1,356	3,495	291	6.6%	196	4.9%
	Waiting List initiative	151	26	39	11	13	10	34	14	75	5	94	193	16	0.4%	13	0.3%
	Overtime	197	36	19	5	3	8	16	3	5	12	20	91	8	0.2%	16	0.4%
	Other pay	41,743	10,704	10,399	3,441	3,486	3,660	10,587	3,699	3,720	3,710	11,130	42,820	3,568	85.8%	3,479	87.4%
	Total Pay expenditure	47,751	12,022	11,957	4,084	4,196	4,435	12,715	4,401	4,500	4,570	13,471	50,165	4,180	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(3,600)	(431)	(77)	(114)	(5)	(90)	(209)	(42)	(13)	(96)	(152)	(868)	(72)		(300)	
Specialised Services	Pay budget	36,718	9,577	9,653	3,223	3,233	3,271	9,727	3,250	3,344	3,639	10,232	39,189	3,266		3,060	
	Bank	1,184	309	335	110	113	134	357	58	116	118	292	1,293	108	3.2%	99	3.1%
	Agency	1,882	509	664	223	218	237	677	274	273	339	885	2,735	228	6.5%	157	5.0%
	Waiting List initiative	379	91	90	48	51	34	133	44	80	70	194	508	42	1.2%	32	1.0%
	Overtime	182	55	40	8	7	6	22	11	10	9	30	147	12	0.4%	15	0.5%
	Other pay	34,079	8,813	8,894	3,017	3,025	2,986	9,028	2,968	3,079	3,164	9,211	35,946	2,995	88.8%	2,840	90.4%
	Total Pay expenditure	37,705	9,777	10,022	3,406	3,413	3,396	10,215	3,355	3,558	3,700	10,613	40,627	3,386	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(988)	(200)	(369)	(182)	(181)	(125)	(488)	(106)	(214)	(61)	(381)	(1,438)	(120)		(82)	
Surgery Head and Neck	Pay budget	70,927	17,951	18,025	6,114	6,030	6,044	18,188	6,017	6,004	6,169	18,190	72,354	6,030		5,911	
	Bank	1,859	463	511	204	152	231	587	133	167	162	463	2,024	169	2.7%	155	2.5%
	Agency	808	226	327	79	91	106	275	110	120	217	448	1,276	106	1.5%	67	1.1%
	Waiting List initiative	1,394	366	456	146	136	164	446	113	137	145	395	1,663	139	2.2%	116	1.9%
	Overtime	485	184	114	14	12	13	39	10	13	20	43	380	32	0.5%	40	0.7%
	Other pay	69,195	17,464	17,399	5,965	5,780	5,894	17,639	5,959	5,961	5,888	17,809	70,313	5,859	93.1%	5,766	93.8%
	Total Pay expenditure	73,741	18,703	18,808	6,408	6,172	6,408	18,988	6,326	6,398	6,433	19,157	75,656	6,305	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(2,814)	(752)	(783)	(294)	(142)	(363)	(800)	(309)	(393)	(264)	(967)	(3,302)	(275)		(235)	

Analysis of pay spend 2013/14 and 2014/15

Division		2013/14	2014/15												2013/14	2013/14
		Total £'000	Q1 £'000	Q2 £'000	Oct £'000	Nov £'000	Dec £'000	Q3 £'000	Jan £'000	Feb £'000	Mar £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	73,478	20,433	21,521	7,301	7,317	7,327	21,945	7,283	7,379	7,572	22,234	86,133	7,178		6,123	
	Bank	1,813	530	485	222	216	193	631	126	214	187	528	2,174	181	2.5%	151	2.5%
	Agency	1,398	384	397	145	163	104	411	175	199	275	650	1,842	154	2.0%	117	1.9%
	Waiting List initiative	365	88	87	13	27	36	76	21	57	61	139	390	33	0.4%	30	0.5%
	Overtime	226	82	79	33	34	28	95	25	32	43	99	355	30	0.4%	19	0.3%
	Other pay	70,112	19,455	20,428	7,012	6,882	6,981	20,875	6,805	6,947	7,006	20,758	81,516	6,793	94.7%	5,843	94.9%
	Total Pay expenditure	73,913	20,539	21,476	7,425	7,322	7,341	22,088	7,152	7,450	7,572	22,174	86,277	7,190	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(435)	(106)	45	(125)	(4)	(15)	(144)	131	(71)	(0)	60	(144)	(12)		(36)	
Facilities & Estates	Pay budget	18,435	4,638	4,916	1,619	1,614	1,699	4,931	1,604	1,647	1,685	4,936	19,421	1,618		1,536	
	Bank	555	227	316	96	72	103	271	84	99	69	251	1,065	89	5.6%	46	3.0%
	Agency	346	80	115	33	68	32	133	21	96	57	174	502	42	2.5%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	895	244	255	98	90	85	273	59	71	63	193	965	80	5.1%	75	4.9%
	Other pay	16,397	4,109	4,129	1,441	1,376	1,456	4,274	1,422	1,393	1,402	4,218	16,729	1,394	86.7%	1,366	90.1%
	Total Pay expenditure	18,193	4,660	4,815	1,669	1,607	1,676	4,951	1,586	1,658	1,591	4,835	19,261	1,605	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	242	(23)	101	(49)	7	23	(20)	18	(11)	94	101	161	13		20	
Trust Services (Including R&I and Support Services)	Pay budget	29,492	6,524	6,903	2,423	2,468	2,367	7,257	3,266	3,005	2,782	9,053	29,738	2,478		2,458	
	Bank	680	165	154	64	38	87	189	55	64	59	178	686	57	2.4%	57	2.4%
	Agency	375	135	139	72	47	35	154	189	86	5	280	707	59	2.7%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	114	31	27	10	10	12	33	6	7	6	19	110	9	0.4%	9	0.4%
	Other pay	27,425	6,061	6,433	2,045	2,160	2,156	6,362	2,654	2,719	2,448	7,822	26,678	2,223	94.4%	2,285	95.9%
	Total Pay expenditure	28,595	6,392	6,754	2,191	2,255	2,290	6,737	2,904	2,876	2,518	8,298	28,180	2,348	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	897	132	149	231	212	77	520	362	128	264	755	1,557	130		75	
Trust Total	Pay budget	312,726	80,876	82,964	28,006	28,169	28,417	84,592	29,140	29,264	29,768	88,172	336,604	28,050		26,060	
	Bank	9,702	2,564	2,762	1,029	933	1,178	3,140	700	990	967	2,657	11,124	927	3.3%	809	3.0%
	Agency	7,506	1,865	2,455	1,051	1,067	978	3,096	1,326	1,314	1,547	4,187	11,603	967	3.2%	625	2.4%
	Waiting List initiative	2,514	616	718	237	243	274	754	239	383	313	935	3,023	252	0.9%	210	0.8%
	Overtime	2,413	734	628	205	190	193	589	144	171	188	503	2,454	204	0.7%	201	0.8%
	Other pay	297,103	76,378	77,117	26,097	25,880	26,463	78,440	26,684	26,987	26,765	80,436	312,370	26,031	91.9%	24,759	93.1%
	Total Pay expenditure	319,238	82,157	83,680	28,619	28,313	29,086	86,019	29,093	29,846	29,780	88,718	340,574	28,381	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(6,514)	(1,281)	(716)	(613)	(144)	(669)	(1,427)	47	(582)	(12)	(546)	(3,970)	(331)		(543)	

NOTE: Other Pay includes all employer's oncosts.

<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 surplus before technical items for the year ended 31 March 2015 is £6.34m. This represents an over performance of £0.537m when compared with the planned surplus for the year. Total income of £578.433m is £0.685m higher than Plan. Expenditure at £542.613m is higher than Plan by £5.103m. Financing costs are £4.955m lower than Plan. The Trust's overall Continuity of Services financial risk rating for the year is 4 (actual score 4.0, February = 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 £2.47m lower than plan for the year to 31 March 2015. Activity based contract performance at £409.27m is £3.78m less than plan. Contract rewards / penalties at a net income of £5.92m are £0.91m greater than plan. Income of £60.96m for ‘Pass through’ payments is £0.40m higher than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Forecast Outturn Activity to 31 March</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>118,933</td><td></td><td></td><td>2,531</td><td>2.1</td></tr>
<tr><td>Emergency
Non Elective</td><td>38,515
2,443</td><td>906</td><td>2.4</td><td>
312</td><td>
11.3</td></tr>
<tr><td>Elective
Day Cases</td><td>13,753
54,070</td><td>
255</td><td>
0.5</td><td>1,292</td><td>8.6</td></tr>
<tr><td>Outpatient Procedures
New Outpatients
Follow up Outpatients</td><td>56,241
155,048
314,013</td><td>405</td><td>0.7</td><td>
11,137
21,993</td><td>
6.7
6.5</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 year total £16.488m (79% of Plan), a shortfall of £4.283m. The actual savings in 2014/15 include non-recurring items to a value of £3.802m. The full year effect of 2014/15 schemes is £16.333m.</td><td>Agenda Item 5.4</td></tr>
</table>

Key Issue	RAG	Executive Summary	Table
Diagnostic & Therapies		The Division reports an overspending of £140k for March thereby increasing the cumulative adverse variance to £0.401m. The principal areas of overspending were drug part pack losses, changes in stock holdings over the year and continued higher than planned spend on clinical supplies.	Agenda Item 5.3
Medicine		The overspending for the year is £1.402m, an improvement of £67k in the month. The principal areas of overspending are on nursing staff (£0.604m), clinical supplies (£0.295m), under performance on SLA activity (£90k) and savings (£0.770m).	
Specialised Services		An underspending of £0.168m reduces the cumulative overspending to £0.959m. The position reflects overspendings on pay budgets (nursing and medical staff include a high volume of agency staff) of £1.451m and under performance on SLAs (£0.586m). This is partially offset by net underspendings on non pay and income from operations budgets.	
Surgery, Head & Neck		The overspending for the year is £5.864m, an overspending of £0.736m in March. The outturn position is £0.230m adverse to the quarter 3 forecast. Causal factors are historical non achievement of savings programme and an underachievement of planned activity to date. The Division has delivered activity ahead of plan by £0.4m in the 3 months to 28 February. There may be some further improvement on activity and income when actual figures for March are available in lieu of the estimates made in closing the 2014/15 Accounts.	
Women's & Children's		The overspending for the year totals £2.631m, an improvement of £19k in March. Principal factors are underperformance on income from activities (£3.460m) and non achievement of savings programme (£1.167m).	
Facitities & Estates		The cumulative underspending is £139k, an improvement of £2k in the month.	
THQ		An overspending of £61k in March reduces the cumulative underspending to £142k. The overspending in the month relates to the cost of a number of one off activities e.g. Procurement Dept. audit, property valuation fees and RTT validation.	
Capital		The Monitor capital expenditure performance target is to deliver the programme within 85% -115% of the Annual Plan. Expenditure for the year totals £44.290m – this equates to 97% of the re-forecast plan for the year.	Agenda Item 6
Statement of Financial Position and Treasury Management		The cash balance on 31 March was £63.4m. The balance on Invoiced Debtors has increased by £7.330m in the month to £21.016m. The invoiced debtor balance equates to 13.0 debtor days. Creditors and accrual account balances total £81.1m. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 88% and 71% respectively. Payment performance for the year by invoice value is 86% for Non NHS and 82% for NHS invoices.	Agenda Item 7

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report March 2015 - Summary of Divisional Monthly Variances and RAG Rating 2014/15

	Favourable / (Adverse) Variance												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Totals 2014/15
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Diagnostics & Therapies	5	4	37	(18)	16	(44)	(24)	(26)	(212)	113	(112)	(140)	(401)
Medicine	(190)	(108)	(239)	(211)	(263)	4	(236)	(84)	(21)	(3)	(118)	67	(1,402)
Specialised Services	(87)	(41)	31	29	(128)	(271)	(83)	2	(198)	(173)	(208)	168	(959)
Surgery, Head & Neck	(457)	(384)	(313)	(447)	(402)	(198)	(786)	(521)	(675)	(483)	(462)	(736)	(5,864)
Women's & Children's	(335)	(285)	(318)	(112)	(210)	(60)	(30)	(296)	(442)	(321)	(241)	19	(2,631)
Estates & Facilities	2	5	36	-	2	23	19	14	10	15	11	2	139
Trust HQ	(15)	(4)	10	16	1	(12)	90	48	10	43	16	(61)	142

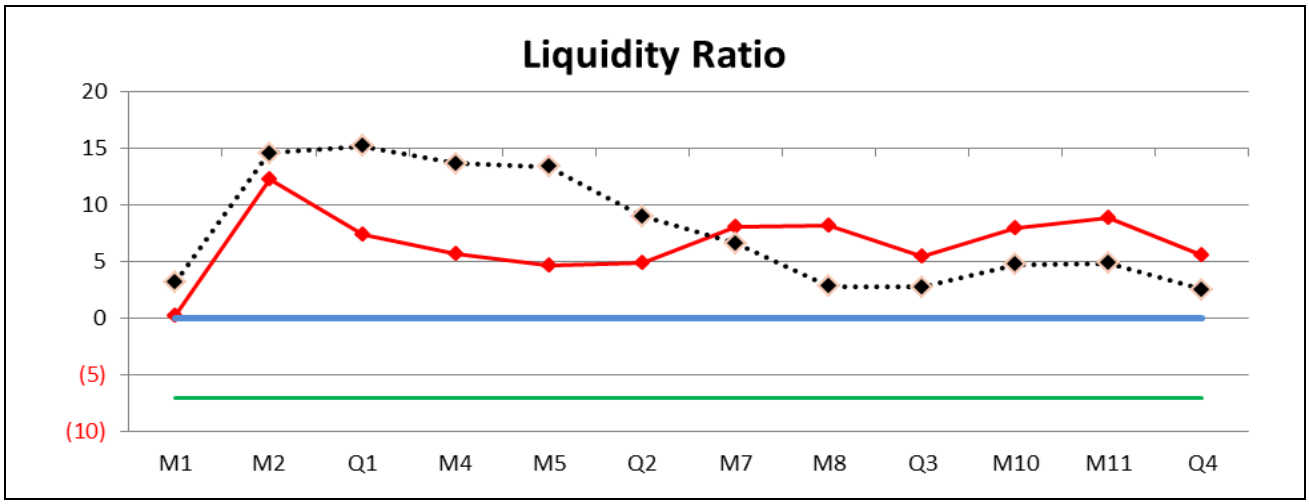
University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 6

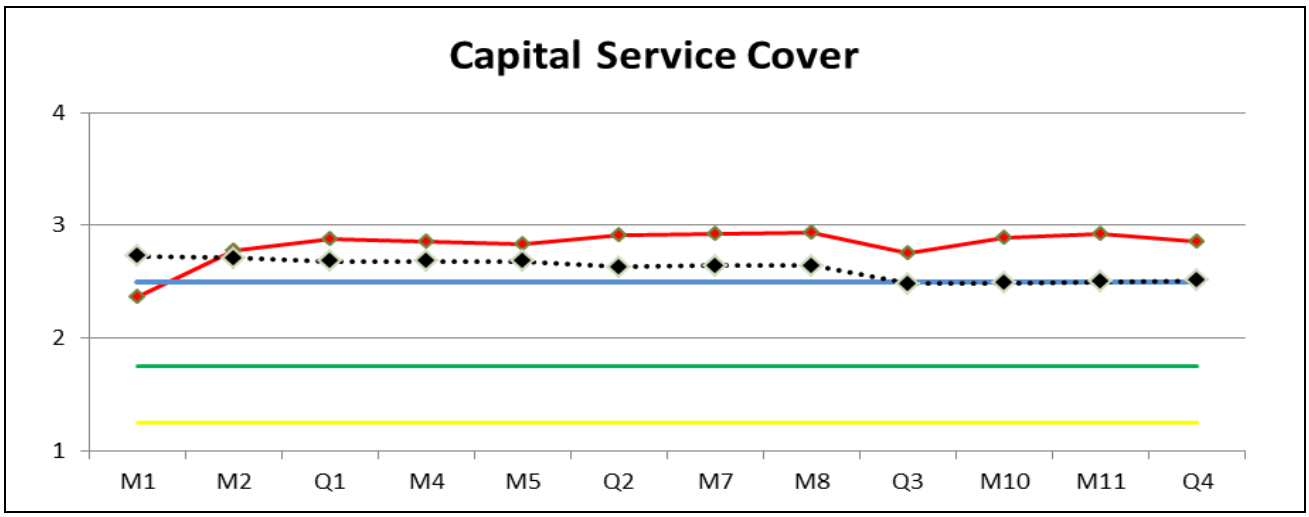
Continuity of Services Risk Rating – March 2015 Performance

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	Plan March 2015	December	January	February	March
Liquidity						
Metric Performance	2.71	2.53	5.45	7.92	8.87	5.61
Rating	4	4	4	4	4	4
Capital Service Cover						
Metric Performance	3.04	2.51	2.75	2.89	2.92	2.86
Rating	4	4	4	4	4	4
Overall Rating	**4**	**4**	**4**	**4**	**4**	**4**

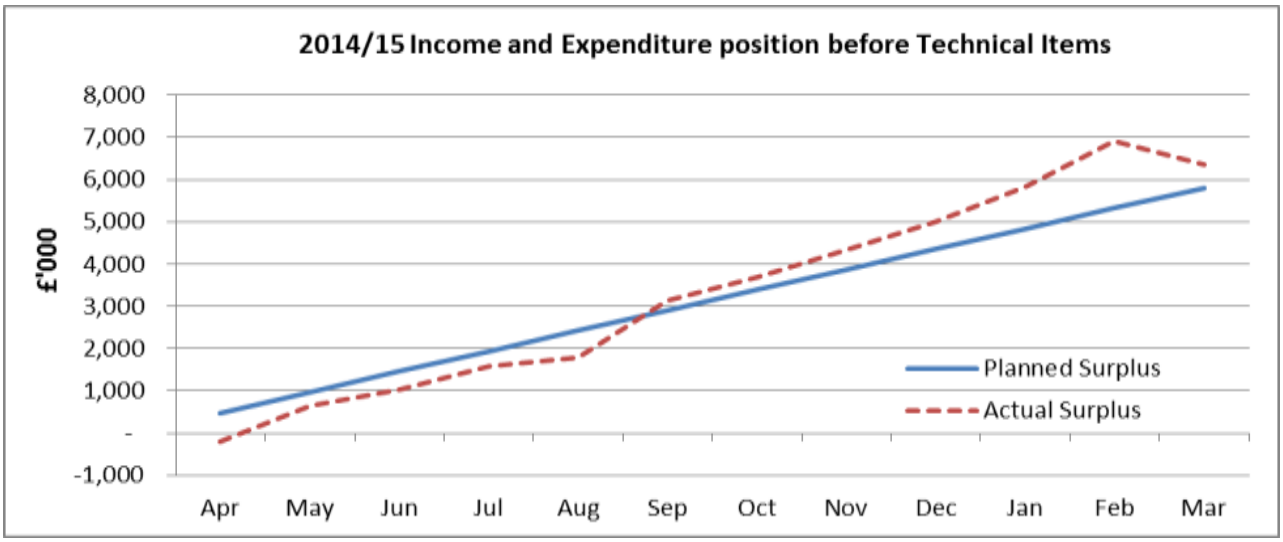


	Plan for Year £'000	February 2015 £'000	March 2015 £'000
Annual Operating Expenses	**529,358**	**540,196**	**542,613**
Current Assets	76,177	109,258	102,745
Less Inventories	(9,221)	(11,109)	(12,087)
Less Assets held for Sale	-	(1,090)	(1,090)
Current Liabilities	(63,243)	(83,750)	(81,119)
Totals	**3,713**	**13,309**	**8,449**
Metric Performance - days	**2.53**	**8.87**	**5.61**



	Plan for Year £'000	February 2015 £'000	March 2015 £'000
Revenue available for debt service			
Surplus after tax	(9,800)	11,231	(16,350)
Impairments	22,972	2,923	30,215
PDC Expense	9,290	7,528	7,953
Depreciation	17,651	17,888	19,520
Interest payable on loans and leases	3,509	3,214	3,489
Gain / loss on asset disposals	-	23	33
Donations / Grants	(8,588)	(8,399)	(8,789)
Totals	**35,034**	**34,418**	**36,071**
Capital servicing costs			
PDC Dividend	9,290	7,538	7,953
Interest on Borrowings	3,163	2,897	3,141
Interest on Finance Leases	346	317	348
Loan Principal Repayments	926	796	926
Finance Lease Capital Repayments	248	227	248
Totals	**13,973**	**11,775**	**12,616**
Metric Performance - cover	**2.51**	**2.92**	**2.86**

Income and Expenditure Surplus (before Technical Items)



Release of Reserves 2014/15

Appendix 7

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'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
May Movements	(36)	(962)	(19,133)	-	(533)	(8)	(20,672)	1,622	154	205	1,326	12,583	989	345	3,448	20,672
June Movements	(65)	117	(2,146)	-	386	(1,028)	(2,736)	(72)	113	282	124	151	51	90	1,997	2,736
July Movements	(117)	(34)	(97)	-	(339)	(24)	(611)	22	5	95	287	7	33	124	38	611
August Movements	(12)	(321)	(242)	-	(431)	(25)	(1,031)	260	86	80	140	229	74	70	92	1,031
September Movements	(68)	(131)	(1,384)	-	(574)	(14)	(2,171)	181	198	222	598	353	483	85	51	2,171
October Movements	(225)	(105)	(144)	-	378	(453)	(549)	37	218	55	112	532	19	196	(620)	549
November Movements	(35)	(90)	3,313	-	(434)	(69)	2,685	94	319	50	58	197	233	128	(3,764)	(2,685)
December Movements	(35)	(94)	(1,131)	-	32	(162)	(1,390)	114	496	68	120	232	27	143	190	1,390
January Movements	(40)	(97)	(1,032)	-	(369)	(123)	(1,661)	41	584	63	106	183	291	36	357	1,661
February Movements	(81)	(95)	(815)	-	(201)	(31)	(1,223)	96	642	168	17	195	158	88	- 141	1,223
Month 11 balances	1,087	2,719	3,890	487	2,846	761	11,790	3,737	8,801	11,189	12,256	22,129	3,110	7,463	(933)	67,752
Month 12 Movements																
Incremental drift funding		(87)					(87)	14	9	8	17	27	3	9		87
EWTD					(144)		(144)	8	34	19	27	52	1	2	1	144
CEA awards					(127)		(127)		7						120	127
BRI Redevelopment						(134)	(134)		26				108			134
Resilience Funding			(878)				(878)	48	562	54	57	115	13	29		878
Commissioner Funding			(2,500)				(2,500)								2,500	2,500
Other	(161)	(142)	(7)		(114)	(62)	(486)	4			(1)		142	207	134	486
Month 12 balances	926	2,490	505	487	2,461	565	7,434	3,811	9,439	11,270	12,356	22,323	3,377	7,710	1,822	72,108

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
13. Quarterly Capital Projects Status Report
Sponsor and Author(s)
Sponsor: Director of Strategic Development & Deputy CEO Author: Programme Director of Strategic Development

Intended Audience									
Board members	x	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To update the Board on the current status of the Trust's major capital development schemes and provide assurance that the schemes are effectively governed.

Key issues to note

The purpose of this report is to update the Board on progress, issues and risks' arising from the Trust's major capital developments which are governed through the Strategic Development Department and associated programme infrastructure.

The BRI Redevelopment construction was completed in December 2014, with the last ward move of A900 on level 9 taking place late February 2015. The final design for the Queens facade project has been agreed and planning permission granted, with contractors now onsite.

Phase 4 schemes continue with two significant milestones in this reporting period.1) The restaurant on level 9 of the Queens Building is on track to open w/c 11th May and 2) the Surgical Admissions Suite was completed at the beginning of April and is currently in the commissioning phase and due to open on the 24th April 2015.

There are no identified risks, without mitigations, to the schemes in hand. However, slippage in the move out of Public Health England's laboratory service, due to delays in their new laboratory at Southmead, have imported a risk to the overall programme and notably to the decommissioning of the Old Building. Provisional indications are that the current programme will be delayed by three months, meaning that the sale (or lease) of the site will be similarly delayed. The financial plan, presented as part of the Annual Plan, takes account of this anticipated slippage in the programme and, of note, imports a benefit to the Trust's liquidity position associated with slippage in capital expenditure (£11.8m). The impact on patients will be the continuation of outpatient based services, such as rheumatology and sleep studies, in the Old Building which is disappointing but unavoidable.

The Board will be briefed further on the Old Building transaction as discussions with the acquirer progress.

Recommendations
The Trust Board is recommended to receive this report by the Director of Strategic Development and Deputy Chief Executive for **assurance** that the capital programme is being delivered in line with the plan, and where not, that adequate mitigations and contingencies are in place.
Impact Upon Board Assurance Framework
Provides assurance regarding the delivery of the relevant strategic objective .
Impact Upon Corporate Risk
None.
Implications (Regulatory/Legal)
None.
Equality & Patient Impact
Continuation of services, from sub-optimal estate, for a further three month period over the original plan.

Resource Implications			
Finance	**X**	Information Management & Technology	
Human Resources		Buildings	**X**

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	x

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Quarter 4
30th April 2015 Trust Board

1. Introduction

This status report provides a summary update for Quarter 3 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 and the Bristol Haematology and Oncology Centre have both now completed, with final accounts settled and final submissions made to HMRC to finalise VAT recovery amounts.

BRISTOL ROYAL INFIRMARY PROJECT INCLUDING AIR AMBULANCE ACCESS, GENERATORS AND QUEEN'S FAÇADE		
1	**Decisions required**	None
2	**Progress**	**BRI Phase 3** Phase 3 is now complete. A process to dispose of the contractor's site village is in progress having confirmed the Trust has no on-going temporary use for it. **BRI Phase 4** The following refurbishment schemes have been completed • Surgical Assessment Suite – completion was delayed from February 2015 to end of March 2015 and is now complete. • Phase 2 discharge Lounge • Refurbishment of wards A515,609,604,605,602 The following schemes are in construction/planning • Refurbishment of Wards A524,525,528 • Conversion of Lecture Theatre - project recommenced following a design review. • Level 9 Restaurant - following provider fit out, target date for opening is w/c 11th May. • Refurbishment of ward A518- currently out to tender. **Queens Façade** Contractors have completed some of the enabling works and have now

		completed all final design details for the main façade. Contracts are now being executed to commence the main facade works. All planning conditions were submitted to Bristol City Council and the majority have been approved, there are a few pre-construction conditions BCC still need to formalise. The enabling scheme to rationalise all air conditioning units within the level 1 courtyard has been completed.	
3	**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 final account has been settled and final submissions made to HMRC to agree VAT recovery amounts The scheme remains within its capital budget.	
4	**Programme**	The main construction contract has achieved practical completion and has been fully operational since February.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Tendered works, exceed the budgeted sums	The budget for all phase 4 schemes is being managed as one, creating flexibility to manage both under and overspends within the total budget. Strict controls to specifying works to ensure project scope "creep" doesn't import cost pressure.
		Projects in train slip and programme is not delivered on time with resulting operational impacts	Additional external project management support has been retained to oversee largest projects to strengthen project management arrangements.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 20.04.2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
14. Changes to Monitors Risk Assessment Framework 2015-16
Sponsor and Author(s)
Sponsor: Deborah Lee, Deputy Chief Executive/ Director of Strategic Development Author: Debbie Henderson, Trust Secretary
Intended Audience

Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary
<u>Purpose</u> To report to the Board of Director on the outcome of the consultation on proposed changes to Monitors Risk Assessment Framework update in March 2015. This report provides a briefing on the amendments to the Risk Assessment Framework. <u>Key issues to note</u> There are no key issues for consideration in respect to University Hospitals Bristol NHS Foundation Trust as a result of the revised Risk Assessment Framework.
Recommendations
The Board is recommended to receive the report to note
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
There are no equality implications as a result of this report. Potential impact on patient experience as a result of the Trust's failure to meet targets.
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	**X**

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Summary

Context and background

Monitor is required by the Health and Social Care Act 2012 to assess risks to the continued provision of NHS services, and publish guidance on action they may take if risks are identified. The Risk Assessment Framework (RAF) sets out how they will carry out these tasks.

Monitor intends for the RAF to be consistent with the Regulators' Code and to be patient focused, evidence based, proportionate, transparent and co-operative. The information gathered under the RAF is used to assess two areas:

- the risk to continuity of services (Continuity of Service licence condition 3)
- non-compliance with the NHS foundation trust governance condition (Foundation Trust licence condition 4)

Monitor reviews Trust performance and assesses the risks under the RAF through the following:

- Annual Plan submission and annual statements of assurance from the Board of Directors
- Quarterly declarations of financial and quality performance
- Exception reporting within a defined framework
- Reports from other stakeholders

Proposed changes

The consultation on proposed changes to the framework, sought views on Monitor's approach to making sure NHS Foundation Trusts can continue to provide good quality services for patients. The changes consulted upon were:-

- Introducing access measures for mental health services as proxies of governance - **introduced**

- Options for use of Early Intervention in Psychosis as a proxy of governance – **reporting will commence from quarter 4 2015/16 with the indicator to be used as a formal Risk assessment framework trigger from April 2016**

- Use of Improving access to Psychological Therapies as a proxy of governance – **reporting will commence from quarter 3 2015/16 with the indicator to be used as a formal trigger from April 2016**

- Introducing access and outcome measures for high and medium secure services as proxies of governance - **high secure service providers will exception report any non-compliance with security and safety directions in line with their mandatory reporting**

- Additional financial trigger whereby if a Trust is rated either '1' on liquidity or capital service capacity, investigation may be considered to help ensure early identification and intervention for continuity of services risks - **introduced**

- Change the name of "quality governance" indicators to "organisational health" indicators, and make their use clearer – **introduced**

Issues for consideration and awareness

The Board of Directors should note that there are no significant issues for consideration; however, a continual review of compliance with the Risk Assessment Framework would be undertaken by the Trust via the annual and in-year declaration process.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
15. Q4 Risk Assessment Framework Monitoring and Declaration Report									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive Authors: Deborah Lee, Deputy Chief Executive/Director of Strategic Development Paul Mapson, Director of Finance and Information Xanthe Whittaker, Head of Performance & Business Intelligence/Deputy Director of Strategic Development									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors		Staff		Public	

Executive Summary

Purpose

All NHS Foundation Trusts require a licence from Monitor stipulating specific conditions that they must meet to operate including financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach and their use of the framework to assess individual FT compliance with two specific aspects of their work: the Continuity of Services and Governance conditions in their provider licences.

The purpose of a Monitor assessment under the framework is to highlight 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.

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

Key issues to note

This report provides an analysis of governance risk (Appendix A) and commentary on financial risk (Appendix B). Following making the necessary enquiries, the Senior Leadership Team confirmed that it is not aware of any matters arising during the quarter requiring an exception report to Monitor which have not previously been reported.

This report highlights the standards failed in quarter 4 to be, the RTT Non-Admitted, Admitted and Ongoing pathways standards, the A&E 4-hour standard, the 62-day GP and 62-day Screening cancer standards. It is also recommended that the planned ongoing failure of the RTT standards as part of the agreed recovery trajectory, is flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-day GP cancer standards, and the A&E 4-hour standard, as part of the narrative that accompanies the declaration.

Recommendations

The Trust Board of Directors is recommended to approve the following Quarter 4 declaration for submission to Monitor by 30 April 2015:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 4 to be, RTT non-admitted, admitted and ongoing pathway standards, the A&E four-hour waiting time standard, and the 62-day GP/Screening cancer standards;
- The recommendation that the planned ongoing failure of these standards are flagged to Monitor, as part of the narrative that accompanies the declaration;
- Confirmation that the Board anticipates that the Trust will continue to maintain a Continuity of Services risk rating of at least 3 over the next 12 months; and
- Confirmation that there are no matters arising in the quarter requiring an exception report (as per Diagram 6, page 22 of the Risk Assessment Framework)

Impact Upon Board Assurance Framework
To support the strategic objectives to: consistently deliver high quality individual care, delivered with compassion; ensure the Trust is financially sustainable to safeguard the quality of services for the future and that the strategic direction supports this goal; and ensure the Trust is soundly governed and are compliant with the requirements of the regulators.
Impact Upon Corporate Risk
Aligned to risk number 2344 Risk To Achievement of One or More Strategic Objectives
Implications (Regulatory/Legal)
Failure to comply with the conditions of the NHS Provider Licence could result in breach of the Health and Social Care Act 2012
Equality & Patient Impact
There are no equality implications as a result of this report. Potential impact on patient experience as a result of the Trust's failure to meet targets.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
28/04/15				22/4/15	

Monitor Quarter 4 declaration against the 2014/15 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 4 declaration of compliance with the 2014/15 Monitor Risk Assessment Framework by the 30th April 2015.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 4, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

Monitor also uses other information to signal potential Governance Concerns, using patient and staff metrics such as satisfaction rates, turn-over rates, levels of temporary staffing and other information from third party organisations.

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 4 against each of the standards in Monitor's Risk Assessment Framework. The following five standards were not achieved in the quarter:

- A&E 4-hour standard (1.0)
- 62-day GP and 62-day Screening cancer standard (combined score of 1.0)
- RTT Non-admitted pathways standard (1.0)
- RTT Admitted pathways standard (1.0)
- RTT Incomplete/Ongoing pathways standard (no score - RTT standards failure capped at 2.0)

With the cap on the failure of the three RTT standards taken into consideration, this gives a Service Performance Score of 4.0. Under the rules set-out within the Risk Assessment Framework, the failure of the RTT standards, 62-day GP standard and the A&E 4-hour standards in quarter 4 would trigger Governance Concerns for repeated failures of the same standard. Although Monitor has previously reviewed performance against these standards and restored the Trust to a GREEN rating, it has now requested further information before deciding on next steps.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of May and therefore the position shown in Table 2 remains draft.

Quarter 1 2015/16 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 4, along with the key risks to target achievement for quarter 1 2015/16. The mitigating actions that are being taken are also provided, along with the residual risk.

Good progress continues to be made in reducing the number of patients waiting over 18 weeks from Referral to Treatment on admitted and non-admitted pathways. The reductions realised in quarter 4 are consistent with the agreed recovery trajectories. The failure of the three RTT standards in the quarter was forecast, and a necessary part of the recovery plan, with record numbers of long waiting patients being treated in the period. In line with the agreed recovery trajectories, the three RTT standards are expected to be failed in quarter 1 2015/16.

Although the A&E 4-hour 95% standard was not achieved in quarter 4, the recovery trajectory of 91.7% was met (91.9% achieved for quarter 4 as a whole). The 95% standard was also achieved for the month of March. The recovery trajectory for quarter 1 2015/16 of 94.8% is forecast to be met, with the aim being achievement of the 'best case' scenario in the recovery trajectory of 95.2% for the quarter.

There continues to be the potential for failure of the 62-day Screening standard, following the transfer out of the Avon Breast Screening service. Between quarter 2 2013/14 and quarter 1 2014/15 the Trust would have achieved the 90% standard with bowel and gynaecology screening pathways alone. However, the 90% standard was failed in quarter 4 2014/15 due to patient choice, medical deferrals and delays at other providers. As noted in previous quarters, although it is expected the 90% standard will be achieved in some quarters, it is unlikely to be achieved every quarter. It is therefore recommended that the high risk of failure of this standard continues to be flagged to Monitor for quarter 1, and future quarters.

One standard is flagged as having a moderate residual risk of failure, which is the 31-day subsequent surgery cancer standard. Further details of the risks to achievement of this standard are provided in Table 2. It is recommended that the potential risk to failure of the 62-day GP cancer standard that our case-mix and late tertiary referrals brings, continues to be flagged to Monitor as part of the narrative that accompanies the declaration. These two standards, along with all those currently not being met, will remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

3. Recommendation

The recommendation to the Board is to declare the standards failed in quarter 4 2014/15 as being the three RTT standards, the 62-day GP cancer standard, the 62-day Screening cancer standard and the A&E 4-hour standard. It is also recommended that the narrative that accompanies the declaration should flag the specified potential risks to failure against the 62-day GP and 62-day screening standard, for the reasons set-out in section 3 above.

Table 2 Summary of performance in quarter 4 2014/15, and the risks to quarter 1 compliance

Indicator	Score	Achieved in Q4 2014/15?	New risks to Q1 2015/16?	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	No – failed each month, although recovery trajectory met	No – ongoing risk from Q4 of high backlogs and RTT non-admitted clearance	- Long waits for first outpatient appointments in Paediatric specialties and some dental in particular; - Additional new outpatient appointments continue to be put in place to shorten waiting times, which in time will effect shorter Admitted RTT pathways, but in the interim will continue to create a 'bulge' in the waiting list; - Admitted backlogs high and above sustainable levels in Paediatric specialties (ENT, Plastics, Surgery and T&O) Upper GI, Cardiology, and Ophthalmology in particular.	- Further additional activity planned during quarter 1 as part of agreed delivery plans, to reduce the size of the backlog as set-out in the recovery trajectory; - Waiting list transfers to other providers (e.g. Independent Sector Treatment Centre) where possible and appropriate - Internal validation team, focusing on validating long waiters and improving data quality; - Robust monitoring and escalation to optimise the number of long waiters booked each month; - Planned move to direct reporting from Medway (Patient Administration System), which will enable real time reporting and as a result improve pathway management capabilities; - RTT steering group overseeing the implementation of the recovery plans.	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.

18-weeks Referral to Treatment for non-admitted pathways (aggregate)	1.0	No – failed each month, although recovery trajectory met	No – Ongoing from Q4	- 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 - See RTT admitted also	- See RTT admitted	High	High
18-weeks Referral to Treatment for incomplete pathways (aggregate)	1.0	No – failed each month, although recovery trajectory met	No – ongoing risk of high admitted and non-admitted backlogs from quarter 4	- Same as for RTT admitted	- See RTT admitted	High	High
A&E Maximum waiting time 4 hours	1.0	No – although recovery trajectory met and 95% achieved in March.	No	- Delayed Discharges remain high - Pressure on other local Emergency Departments remains high and likely to result in diverts at times; - Changing profiles of demand with higher levels of ambulance arrivals at weekends and earlier in the day requiring a shift in the profile of bed availability.	- Wide ranging system-wide Resilience Plan, supported by additional funding; - Additional actions, both internally and from partner organisations, planned in response to CQC report; - 'Breaking the Cycle' event planned for mid April.	High	High
Cancer: 62-day wait for first treatment – GP	1.0	No – although adjusted performance,	No – continued risks from	- High levels of late tertiary referrals - High levels of medical	- Cancer Performance Improvement Group focusing on pathway redesign for high volume, lower	High	High

Referred		taking account of late referrals, remains above 85%	Q4	deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are difficult to mitigate) - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) / High Dependency Unit (HDU) bed related cancellations - Awareness raising campaigns likely to increase demand for surgical treatments (oesophago-gastric cancer campaign in Q4, which will knock on to quarter 1)	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; - Additional Thoracic Surgery theatre capacity made available from early October, continuing to reduce breaches due to a shortfall in elective capacity; - Patients on the cancer patient tracking list continue to be actively managed and any delays escalated to Divisional Directors and Chief Operating Officer; - Nursing capacity for staffing adult ITU/HDU being changed to increase flexibility; this will enable the maximum number of beds to be opened allowing for changes in patient acuity.		
Cancer: 62-day wait for first treatment – Screening Referred		No – performance expected to be reported at below 90% due to patient choice, medical deferral and shared breaches incurred by other providers	No – continued risks from Q4	- Following the transfer of the Avon Breast Screening Service in quarter 2, the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, unlike bowel which nationally performs well	- 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;	High	High

				below the 90% standard; - All bowel screening pathways originate at the Trust, and capacity constraints at other providers will have a knock-on impact on performance for shared pathways; - Patient choice in bowel screening pathway; - Numbers of cases reported under this standard are now low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact.	- All CT colon scanning and reporting delays escalated, and further work has been undertaken to reduce delays; - Patient choice and medical deferral related breaches cannot be fully mitigated, and for this reason the residual risk remains high.		
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 - See also action under 62-day GP regarding ITU/HDU bed capacity.	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		Yes	No	- No significant risks	- Continue to pro-actively manage	Low	Low

wait for subsequent treatment - subsequent radiotherapy					patients on the Cancer patient tracking list		
Cancer: 31-day wait for first definitive treatment	1.0	Yes	No	- Peaks in demand from emergencies for ITU/HDU beds, resulting in cancellations of surgery - Unpredictable shortfall in surgical capacity for certain specialties during peaks in demand - Potential increase in demand for treatment following oesophago-gastric (OG) cancer awareness campaign in Q4 - Unexpectedly high levels of medical deferrals	- Additional thoracic capacity came online early in October, following the planned transfer-out of the Vascular service, which has reduced the number of breaches; - 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; - Plans in place to manage potential increase in demand following OG awareness campaign; - Divisions to continue to pro-actively manage patients on the Cancer patient tracking list; - See also action under 62-day GP regarding ITU/HDU bed capacity.	Moderate	Low
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	1.0	Yes	Yes	- The Trust's skin cancer clinic capacity is limited at Weston, but patient demand relatively high, with patients choosing to wait over 14 days; - Very high levels of demand now being experienced in some months, for reasons not well understood.	- Patients referred with a query skin cancer to be offered an earlier appointment at the BRI first, before being offered an appointment at Weston; - Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	Yes; Total = 8	No	- Flat profiling of annual target continues to be	- Procalcitonin testing of high risk patients in the Elderly Assessment	Low	Low

		potentially avoidable cases for the year against a limit of 40 for the end of Q4.		imposed by Monitor; - Bristol community is an outlier for antibiotic prescribing	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.		
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	1.0	Yes	No	- No significant risks	See the standard set-out in Table 3, which the Trust is declaring compliance with.	Low	Low

Table 3 – 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

Table 4 - Draft declaration to Monitor for Quarter 4

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 4 Actual Performance	Achieved/Not Met	Any comments or explanations
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	1.0	No		80.4%	Not met	*80.5% for the quarter, lowest month shown.*
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	Yes		88.9%	Not met	*89.4% for the quarter, lowest month shown.*
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	1	88.9%	Not met	*89.3% for the quarter, lowest month shown.*
A&E Clinical Quality- Total Time in A&E under 4 hours	95%	1.0	Yes	1	91.9%	Not met	*Recovery trajectory met; 95% achieved for March.*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	Yes		77.9%	Not met	*Subject to final national reporting in May. No breaches reallocated.*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	No	1	80.6%	Not met	*Subject to final national reporting in May. No breaches reallocated.*
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					77.9%		*Subject to final national reporting in May. No breaches reallocated.*
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					80.6%		*Subject to final national reporting in May. No breaches reallocated.*
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No		94.7%	Achieved	*Subject to final national reporting in May.*
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		99.0%	Achieved	*Subject to final national reporting in May.*
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	0	97.1%	Achieved	*Subject to final national reporting in May.*
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	0	97.5%	Achieved	*Subject to final national reporting in May.*
Cancer 2 week (all cancers)	93%	1.0	No		94.3%	Achieved	*Subject to final national reporting in May.*
Cancer 2 week (breast symptoms)	93%	1.0	No	0	0.0%	Not relevant	
C.Diff due to lapses in care	40	1.0	No	0	8	Achieved	*All 50 cases now reviewed, 8 confirmed as potentially avoidable for the year.*
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					50		
C.Diff cases under review					0		
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	0	N/A	Achieved	*Standards continue to be met.*
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 six targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 4. These are: the A&E 4-hour standard, the RTT Non-admitted, Admitted and Incomplete pathways standards, and the 62-day GP and 62-day screening cancer standards.

The Trust performed at 91.9% against the A&E 4-hour standard in the period, achieving the recovery trajectory for the quarter of 91.7%, and achieving the 95% national standard for the month of March. The Trust is continuing to mitigate system risks through an action plan with partner organisations which was put in place during the latter half of quarter 2. The impact of the schemes within the actions plan have been assessed, from which an improvement trajectory was developed. It is estimated that 35% of the forecast improvement in performance against the 4-hour standard will arise from actions taken by partner organisations. Additional actions expected to take effect during quarter 1 2015/16 include the re-running of the Breaking the Cycle Together (BTCT) initiative, originally undertaken in quarter 1 2014/15. The Trust remains on track to deliver performance consistent with the Realistic trajectory scenario of 94.8% for the quarter, although with the added expected impacts of the BTCT initiative, is aiming for achievement of the Best Case trajectory scenario of 95.2% (continued below).

B 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. The 95% standard continued to be failed in 2014/15, despite backlog levels reaching a sustainable level (i.e. greater than 95% of patients on ongoing non-admitted pathways were waiting < 18 weeks). Over the last 12 months 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.

A decision was taken during quarter 2 2014/15, following the national request for a failure of the admitted and non-admitted standards to support backlog clearance, to have a planned failure of the three RTT standards during 2014/15. During quarter 3 2014/15, the Trust undertook detailed capacity and demand modelling, supported by the Interim Management and Support (IMAS) team, and has established delivery plans to meet the required level of both recurrent and non-recurrent capacity. Recovery trajectories for reducing the over 18-week backlogs have been developed, and the activity required to deliver these agreed with commissioners. The Trust achieved both its backlog reduction trajectories, and its three performance trajectories, during each month of quarter 4 2014/15. A further period of planned failure of the standards during 2015/16, to support backlog clearance, has been agreed (cont'd below).

C The 62-day GP cancer standard has been failed since quarter 4 2013/14, primarily due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice). Cancer pathway improvement work continues, focusing on both further minimising internal causes of breaches, but also on working with other providers to reduce late referrals. Performance for internally managed pathways was above the 85% standard in quarter 3, and remains so for quarter 4 to date (with March's performance still to be validated and reported). The case mix of patients treated (typically having a -3.5% impact on performance) and late referrals into the Trust continues to make achievement of the 62-day GP standard challenging. During quarter 2 the Avon Breast Screening service transferred to North Bristol Trust. As a result performance against the screening standard is largely being now based on a relatively small number of bowel screening treatments, which nationally performs well below 90%. In quarter 4 a total of 3 breaches of standard in accountability terms were incurred, taking performance below the 90% standard. Breach analysis demonstrates the reasons for the breaches to be patient choice and delays at other providers.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
16. Board Assurance Framework 2014 / 15 – Quarter 4 updates
Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive Author: Deborah Lee, Deputy Chief Executive Director of Strategic Development

Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

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.

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. 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.

Risks to delivery, arising from or linked to 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 Corporate Risk Register.

The BAF is a major source of assurance to the Board that the Trust is on track to meet its strategic objectives. Greater emphasis has been applied to the provision of assurance, notably from external sources, in completing the Q3 framework however, it is recognised, that this requires further emphasis.

Key issues to note

There are 4 (4) objective where the inherent risk to delivery is considered high and is therefore RED rated meaning delivery of the objective at the yearend is in jeopardy. This is:

- To deliver the annual Cash Releasing Efficiency Savings programme in line with the LTFP requirements.
- To improve cancer performance to ensure delivery of all key cancer targets.
- To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.
- To ensure 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.

All of these objectives will continue into the 2015/16 Framework with a renewed focus on recovery and sustained performance.

Finally, there are 36 (37) objectives where delivery is forecast therefore with a residual rating of GREEN and 4 (3) AMBER rated objectives.

NB. Q3 figures noted in brackets.

Recommendations
The Board is recommended to receive this report for assurance and note those objectives not achieved will be incorporated into the 2015/16 Board Assurance Framework.
Impact Upon Board Assurance Framework
Not applicable
Impact Upon Corporate Risk
Risk to delivery of objectives in the BAF are captured in the Corporate Risk Register.
Implications (Regulatory/Legal)
The BAF is an importance source of assurance to external regulators.
Equality & Patient Impact
Not applicable

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				22nd April 2015	Risk Management Group – 8th April 2015

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 (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring 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	75% - 100%	Teams have moved into the hub and joint working is developing as a consequence. For example, a single representatives of the hub at board rounds. Jointly developed pathways for the most complex patients are now coming into use, e.g. non-weight bearing patients. The enhanced recovery pilot is being extended to the Older Persons Assessment Unit. The protected beds model is operating in SH&N and Specialised Services. The method has demonstrated reduced cancellations and LoS. Protection has been maintained through periods of escalation, but maintaining flow through critical care areas remains a challenge which is now being addressed. Phase 2 of the work is addressing areas of risk to flow including the inpatient admin processes and daily flow management and escalation. The BRCH flow programme delivered the agreed scope of changes across the hospital, including the remodelling of CED, improved ward processes, better management of flow and escalation and the roll out of new real-time communications methods. The BRCH management team has stated that the programme contributed directly to the management this year's winter pressures and the activity growth due to CSP. The October BTCT week provided the impetus for further changes to daily routines which have been adopted in children's and adult divisions. A further event is being planned for April to embed additional improvements to the SAFER bundle and planning for discharges. 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. 1. Social Services, ICT and IHDT move to new clinical hub mid January 2015, weekly monitoring allocation SW 24hours following receipt of section 2 and completion assessment within 5 days, weekly multi-organisational meetings to review/progress all patients over 7 days, plans to integrate brokeridge on OPAU to reduce waits for packages of care, Out of Hospital virtual bed meetings to commence 07/01/2015. 2. Out of Hospital bed capacity reviewed daily as part of the ED recovery plan. Additional beds in place for Winter and additional interim beds available. 3.Discharge Registrar at weekends in place, Ongoing work with BCC to improve transfers to Care Homes at weekends with the support from BRISDOC professional line, 6 day Therapy cover in place. 4. Surgery/Cardiac protected bed model in place.	Risk of lack of momentum through diverse leadership causing a delay in implementation. Lack of partner responsiveness during peaks in demand. Inadequate care home/package of care capacity to meet demand.	Risk mitigated through bringing the individual projects together in coordinated themes. Through weekly operational meetings with partners, Via ALAMAC and Urgent Care Steering Board.	Regular progress and exception reports to Transformation Board Review by Emergency Care Intensive Support Team	AMBER	753	COO	Senior Leadership Team	17/12/14 Urgent Care Board
		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.	75% - 100%	Compliance achieved in all areas with eight exceptions where commissioner derogation has been granted. All areas of non-compliance are recorded on Divisional Risk Registers, none of which present as HIGH risks.	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. External Assessment of compliance by NHS England.	GREEN		D of SD	Clinical Strategy Group	24th September 2014
		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	75% - 100%	Evaluation session held in February. Changes now made to the programme as a result to ensure behaviours are more prominent in future sessions. Paper presented at NMC following RN values based recruitment pilot. Assessment centres agreed for all NQ staff. Divisions embedding principles of values based recruitment for all other RN staff. Staff focus group held. Plan to link with Divisional staff engagement work, rather than duplicate existing work, which will inform the development of a compassion resource tool kit for staff.	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/department 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	GREEN		CN	Transformation Board	Sep-14

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	We will consistently deliver high quality individual care, delivered with compassion.	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	75% - 100%	Case for increased resources approved May 2014. Recruitment to three new posts completed autumn 2014, increasing team WTE from 4.8 to 7.6 Progress with delivery of some actions in complaints work plan were initially affected by backlog of enquiries to Patient Support and Complaints Team, however the backlog was successfully removed in November 2014. The work plan is regularly reviewed by the Head of Quality (Patient Experience and Clinical Effectiveness) and the Patient Experience Group - the vast majority of objectives for 2014/15 have been achieved, with the remainder carried forward into 2015/16.	Planned increased in WTE has been achieved but risk that sick leave will reduce impact; also risk that a sustained increase in the volume of complaints being received by the Trust (50% more than 12 months ago) will reduce the impact of increased resources (i.e. 'running to stand still').	Occupational Health support.	Delivery of complaints KPIs as per monthly complaints reporting	AMBER	ref 2647	CN	Executive Directors	Patient Experience Group, throughout 2014/15
		To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Deliver the stretch and quality improvements as per 14/15 CQUIN schedule Deliver all annual quality objectives described in the Trust's quality report	50% - 75%	CQUIN. All CQUINs have been agreed with commissioners. Most CQUINs have achievement split several ways to minimise any risk from all or nothing measures. 19.6% of CQUIN money thus far achieved. Friends and Family Test (Staff) and Friends and Family Test (Early Implementation have been achieved in full. Dementia (FAIR) CQUIN is a significant challenge and 1/2 of CQUIN value has been lost due to non achievement in Q1 and Q2. Almost all CQUINs should be achieved or partially achieved. Tighter monitoring of progress is in place including SLT Sponsors, exception reporting to CQG and appropriate escalation. 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. Board-reported performance to the end of February 2015 is as follows: Last minute cancelled operations YTD is above (worse than) target (1.08% vs 0.92%) although improvements have been reported since December 2014; outlier bed days YTD is above (worse than) target, with seven of the last eight months red-rated; out of hours discharges YTD 8.1%; average number of ward moves also above (worse than) target - red-rated board-reported performance for last nine months. The fifth objective is to review and refresh the Trust's approach to patient and public partnership. 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. Q2/Q3 consultation with partners to develop preferred option for new approach to working with patients, members and wider public; pilot work re. experience based co-design (e.g. BRI ED; congenital heart patients with learning disabilities). Q4 - recommendation to SLT for future model of working including proposals for new Citizen's Assembly. Implementation Q1/2 2015/16.	CQUINs potentially at risk -Dementia (FAIR) -Weight Management Support in Maternity for Obese Women -Older People's Rehabilitation -End of Life (low confidence) -7 day working (low confidence) Friends and Family (increased response rate) - 50% achieved, other 50% at risk due to winter pressures in A&E Risk of not achieving flow-based corporate quality objectives.	Nominated SLT leads to oversee delivery of individual CQUINs, robust governance of delivery of CQUIN monitored via SLT and CQG, robust monitoring of annual quality objectives, delivery of flow projects. For flow-based quality objectives, see first BAF objective above.	CQUINs supported by SLT leads, exception reports to CQG, reviewed by Trust quality team. Escalation to Execs as necessary. Delivery against flow-based quality objectives is reviewed monthly via Flow Group, QOC and Trust Board.	RED		MD / CN	SLT and CQG for CQUINs Clinical Quality Group for quality objectives;	CQUIN Dec CQG Quality objectives - January CQG;
		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	75% - 100%	OPD / day case FFT implemented from 1st October, as per national schedule. Strong early uptake for day cases. OPD approach includes trialling use of technologies including touchscreen kiosks, SMS texting, QR codes, etc. (touchscreens have provided majority of feedback to date). Recent monthly response rates for inpatient and ED FFT indicate that achievement of 2014/15 national CQUIN targets will be marginal - data will be available in April. Dramatic improvement in maternity FFT response rates during summer 2014. Monthly FFT results are now being displayed on wards across the Trust (professional, colour A3 laminates).	FFT performance is difficult to predict and is affected by service pressures. OPD FFT is based on giving patients the *opportunity* to participate, i.e. impossible to personally target every outpatient due to scale. OPD response rates have initially been low, as predicted, however CQUIN does not stipulate a minimum required response rate for 2014/15. Overall BAF target (upper quartile performance) is dependent upon the performance of all other providers. Current position is that FFT scores are above average but fall short of upper quartile; response rates reflect the national average.	For ED, maternity, inpatient and day case FFT, constant reinforcement and vigilance to maintain response rates. For OPD FFT, initial close monitoring of take-up rate; use of targeted paper-based surveys (now rescheduled for Quarter 4) to provide 'guaranteed' foundation response.	Patient Experience Group monitors FFT (meets bi-monthly).	GREEN		CN	Patient Experience Group	Dec-14

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		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	50% - 75%	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	AMBER		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	75% - 100%	Programme Director continues to manage relationships with Eleanor Gray QC and her team. Timings for staff interviews and final report remain unknown. Proactive working with media continues, notable highlights include the BRCH featuring in the documentary The Miracle and the developing in-depth coverage by a national newspaper.	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. Overview of media activities through Paediatric cardiac Steering Group. Significant external assurance of quality of service provided through CQC Inspection Report.	GREEN		D of SD	Senior Leadership Team	16th September 2014
			Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities										
		To achieve upper quartile performance standards for all nationally benchmarked patient safety measures	Monitor performance and take corrective action when appropriate.	50% to 75%	Patient safety group function review completed. Trust signed up to Sign up for Safety. No significant variance on key safety measures.	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		GREEN		MD	Senior Leadership Team	
			Review Patient Safety Group function within Trust governance apparatus.										
2		To successfully deliver phase 3 and 4 of the BRI Redevelopment	Helideck operational May 2014	50% to 75%	Integrated Discharge hub operational Q4. Slippage on phase 4 schemes due to impact of delayed ICU move to Feb 15. Ward moves programme revised to accommodate, slippage - version 22. Remaining inpatient reprovision for medicine to complete July/August 15. Surgical Assessment POD delayed to April 15 Level 9 Queens Lecture delayed to April 15. Queens Facade project delayed to complete Q3 15-16. Staff restaurant to be opened Q1 15/16.	Risk that Length of Stay will not reduce to planned levels.	Additional capacity opened ahead of Q4 with winter/resilience monies. Operational planning round considering revised bed capacity model and how to deliver this for 15-16 year	Office of Governance and Commerce (Green rating received in May 2014). Regular feedback into System Resilience Group	GREEN	2525, 2741, , 3126, 2476 & 759	COO	Senior Leadership Team	24/02/2015
			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										
	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	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. Outstanding issues resolved 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. Current Trust Resilience manager retires in June 2015	Risk mitigated through changing the staff mix in the COO office.	Internal and External Audits	GREEN		COO	Senior Leadership Team	January 2015 progress reviewed against EPRR audit by CCG Annual report presented to SLT 02/15
			Six month review following EPRR audit completed										
			Major Incident Plan revised to reflect new BRI build by end of Q4										
		Set out the future direction for the Trust's Estate	Estates and Asset Management Strategy agreed by Board June 2014	75% - 100%	Estates Strategy approved by Board and approach to Old Building site considered and approved by Board in November. Campus Phase V "long listing" exercise complete, now pending subject to clarification of capital programme for future years. Delays to laboratory estate at Southmead recently confirmed, with likely impact on BRI Phase IV and possible risk to disposal timing of Old Building.	Overall financial position, and liquidity position in particular provides constraint to available capital.	Prioritisation, aligned to risk, will mitigate impact of some schemes being delayed.	Strategy and BCs delivered to Board. External assurance for direction of work forthcoming from Capita who have been retained as advisers on the project. Agents retained to provide assurance on Old Building site values and sale/ lease approach.	GREEN		D of SD	Senior Leadership Team	June 2014. September update deferred to October to reflect OBC timeline.
			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										
		Deliver against the National Quality Board 10 safe staffing expectations for Trust Boards	Deliver expectations 1,3,7,8 (June 2014)	75% - 100%	Expectations completed. Internal solution developed for recording acuity / dependency daily.	No risks at present.	Clear project plan/close working with IT/procurement and supplier (for IT element once identified)		GREEN		CN	Workforce and Od group - bimonthly. SLT and QOC monthly.	WFODG Sept 14
			Deliver remaining expectations										
3		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	75% - 100%	A detailed programme of work is underway within Divisions. The programme focusses on: improve two-way communications, including a programme of listening events, focussed action to reduce the incidence of work-related stress and bullying and harassment.	We will not achieve a year on year improvement in staff engagement.	Comprehensive delivery programme.	Review by Transformation Board Quarterly Report on Progress at October 2014 QOC. Review of engagement activity at Workforce and OD Committee. Measurements in National Staff Survey are also used as a measure of			DWOD	Workforce and OD Committee 13 November 2014, QOC 27 October 2014.	Quarterly update received at: COC, SLT, T&L SG, and Workforce and OD group. Workforce and OD Group have requested updates on Engagement

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			To create a cohesive performance management framework for all staff groups, enabling staff to delivery high quality patient care		Improved team based working using the Michael West evidence-based approach. First cohort of Aston Team Journey programme commenced in February 2015. Review and develop our 'values' training to focus on treating everyone with respect, strengthen partnership working with staff side representatives and trade unions. A full census staff survey and introduce more regular pulse checks - including staff FTT.			progress against the Agenda. Staff survey summary to Executive in February and to Senior Leadership Team on 18th March.	RED				plan at each meeting. Staff survey findings to Executive Board in February 2014, to Senior Leadership Team on 18th March. Speaking Out revisions to Executive at end of March.
			Development and implementation of a Staff Recognition and Suggestion Scheme		It also includes work on recognising success, and a complete review of the Speaking Out process.								
			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		Pilot the Healthcare Leadership Model in January which describes the key skills and behaviours for all managers and leaders across the organisation.								
			Ensure managers build their skills to enable high quality appraisals and objective setting		Work continues on t he revision of the training for building skills to enable high quality appraisals and objective setting.								
	We will strive to employ the best and help all our staff fulfil their individual potential.	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	50% to 75%	Health and Safety Executive standards to manage the risk of work related stress are used as best practice for all new managers on induction and for those that are promoted to managerial roles. Since 2012 this has been subject to compliance held by the Safety Department and is 92% in March 2015. The use of the HSE questionnaire process has been used in 2013 in 23 depts. and 27 departments in 2014 (25% of the trust departments). Some wards and departments are on their second cycle and a marked improvement has been made in some departments for example Catheter Laboratories in Bristol Heart Institute, Specialised Services. Each ward and department has an action plan produced out of the analysis and feedback to focus groups which is then handed over to the department manager to implement, if practical to do so. There is some reduction in the category of sickness absence where work related stress is recorded due in part to the actions taken above and the mitigation in place.	We will not significantly impact on work related stress.	Comprehensive delivery programme of initiatives including: resilience building (Lighten Up) and enhancement of 2 modules - Managing change and Identifying and Managing Stress has commenced in March 2015 and will rollover into April 2015. Staff health and wellbeing framework drafted and approved upon at Workforce and Organisational Development Group. The repainting of the trust boundary line and insertion of the wording 'no smoking' and signs to state 'thank you for not smoking' enables staff to challenge both other staff, visitors and patients and move them on. Schwartz rounds are currently taking place and being well received and evaluated	Internal - Review by Health and Safety/Fire Safety Committee on January 2015 and Workforce and Organisational Development Group in March 2015.	AMBER		DWOD	Risk Management Group	6 January 2015 at Health & Safety/ Fire Safety Committee and 26th March at Workforce and OD group.
			Health & Safety - evaluate policy and practice to focus high quality patient care to support the reporting learning from incidents including physical violence		British Safety Council Independent audit in October 2014 led to a four (out of five) star rating. We will evaluate Health and Safety Policy to ensure learning from all incidents especially focusing on those where the impact of violence and aggression is high or moderate. We have reviewed staff support post incident equipping managers and referrals to other support as required. We have developed a themed report in the area of violence and aggression, manual handling and incidents reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, so that risk reduction training in these topics can be targeted to high risk staff in these areas as a priority.		To mitigate further a RIDDOR focused campaign will be taken to the hospital sites by the Safety Department team. A trust action plan for both violence & aggression and work related stress in response to the staff survey has been drafted and cascaded to Divisions. There is also a corporate action plan in place which covers these areas of concern.					
			Discrimination - review and scope opportunities for revised e-learning package to support managers		Reviewed several e-learning packages to meet with UH Bristol's requirements. Scoping procurement and purchase of e-learning package for implementation and roll out								
		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.	75% - 100%	The exercise to determine who is a leader was completed, but requires further verification. The project plan for this commences in December and concludes end of March 2015.	Verification of leaders may not be completed by March 2015.	Whilst we have identified leaders and managers across the organisation, it does require further verification. This work will not impact on the roll out of the leadership programme for managers.	Review by Transformation Board Workforce and OD Group Teaching and Learning Group	GREEN		DWOD	Senior Leadership Team	Update on Leadership Development was presented to Workforce and OD Group 11/02/15 Transformation Board November 2014. T&L Steering Group 24/02/15
			Introduce comprehensive programme of quarterly leadership forums, annual leadership conference and access to learning sets - to ensure leaders understand the opportunities and challenges facing the Trust, share experiences, offer support and learn from best practice.		New style leaders forum has been developed with the first session in February 2015 and leadership conferences is planned for the 3rd June - Action Learning Set facilitators have been trained this year and Action Learning Sets will commence in March 2015.								
			Revise appraisals to include feedback on leadership competencies and behaviours - to include 360 or staff feedback.		A working OD group has been set up to review the appraisal system including 360 and Talent Management. A pilot of the appraisal system will be conducted between June and September 2015.								
			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.		Workforce and Organisational Development Strategy has been agreed with clear objectives within the leadership capability section, a detailed plan has been developed.								

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		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	75% - 100%	An interim project lead has commenced in the Trust to further develop the following three key priorities as defined through Teaching and Learning Steering group: Development of a revised Teaching and Learning Strategy which reflects the Trust's strategic vision and review the strategic priorities. The draft strategy has been developed and presented at a number of forums, final draft is underway, due to be signed off at Board in the new financial year. Development of a Trust-wide training plan that aligns to the operating plans. Completed and presented to the Teaching and Learning Sub Group in February 2015. A review of governance for Teaching and Learning will be presented to SLT on 18th April 2015. All of these objectives will be delivered by March 2015.	No risks at this stage, as interim resource has been secured and work has commenced on the completion of the objectives.	Interim resource not able to complete within timescales/resource exits the organisation ahead of March 2015.	Review by Teaching and Learning Group, December 2014. SLT update December 2014. Workforce and OD Group	GREEN		DWOD	Senior Leadership Team	Update provided to T&L SG in December 2014. Workforce and OD Group 11th February. Teaching and Learning Steering Group 24th February. SLT 18th March. Board Seminar 20th March.
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	GREEN		DoF	Information Management and Technology Committee	13/02/2015
		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.	75% - 100%	a) Progress is being maintained and continuous analysis undertaken of performance through regular reporting and KPI reviews, 75-100% achieved on this element of the objective. b) Progress on track to deliver by 31/3/15 - 100% c) On track with workforce plan. W&C element addressed; other divisional work to start April 2015. d) On track; standard performance information provided via TRG; 75-100% e) 100%	(a) failure to engage with services which can influence our performance in meeting the benchmark. (b) Failure to agree appropriate governance structures (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) N/A	(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)Meeting planned early January to discuss structure and governance (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	GREEN		MD	Trust Research Group -Last meeting 29/01/2015	(a) KPI review with Director of Research 19/03/15 and monthly KPI reviews with Head of Research & Innovation. (b) Review every week with DW and through project steering group (c)Project steering group every week (d) & (e) TRG 29/01/2015
		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.	75% - 100%	a) and b) - appointed to a new post within R&I to support Research Grants Manager, allowing her to focus on these activities. Post holder started January 2015.	(a) and (b) training of new post holder may take resource away from grants manager. (c) focus solely on UH Bristol opportunities may detract from allocating time to collaborative work	(a) and (b) new appointment has significant relevant experience therefore anticipate training needs to be low. Post holder will be integrated into department and will be supported during induction by all team members, who will also provide training as required. (c) use cross-organisational networks currently in existence to maintain awareness of opportunities	Progress reports to Trust Research Group	GREEN		MD	Trust Research Group-Last meeting 29/01/2015	(a) 2-monthly review with Director of Research ongoing 03/02/15 (b) and (c) Ongoing rolling review feeding into 2-monthly review with Director of Research
		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)	75% - 100%	a) rolling programme of review in place. b) dissemination work stream ongoing which has implemented a successful process to capture case studies which are disseminated via the website and through internal good news stories.	(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 and outside 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 divisions and partner organisations a), b), c): initiate series of targeted one to one meetings with key researchers to draw out relevant information about impact of their research.	Progress reports to Trust Research Group	GREEN		MD	Trust Research Group-Last meeting 29/01/2015	KPI in place and reviewed monthly (19/3/15)
		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	75% - 100%	Scope and aims of each project are approved by Transformation Board and renewed when required. Teams have been mobilised against each. A detailed review of progress is held monthly	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	GREEN		COO	Transformation Board	
			Establish structured progress monitoring by PMO reporting monthly to Transformation Board	75% - 100%	Milestone plans are in place for each project. A monthly cycle of monitoring and reporting is in place to allow intervention by exception	Do not intervene to keep progress on track	Structured review by Transformation Board	Progress updates to Trust Board	GREEN		COO	Transformation Board	

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 (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
			Mobilise delivery at pace; Communicate intentions to build organisation engagement and buy in	75% - 100%	Each project has clear near term milestones to get actions underway and to build momentum, and a communications plan	Do not act with pace	Transformation Board to hold to account for delivery	Progress updates to Trust Board	GREEN		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	75% - 100%	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.	GREEN		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	GREEN		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.	50% - 75%	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	GREEN		MD	Senior Leadership Team	
		We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network	Establish robust internal governance including Board reporting for the CRN and CLARHC	50% - 75%	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	GREEN		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	75% - 100%	SLA signed in line with Heads of Terms	Under performance of activity	Monthly Divisional Reviews	Oversight by operational planning core group	GREEN		DoF	Finance Committee	23/02/2015
		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 14/15 by Christmas 2014	Delivery of cost improvements.	Risks not yet mitigated particularly re Medicine Division.		GREEN		DoF	Finance Committee	23/02/2015
		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.	GREEN		DoF	Finance Committee	23/02/2015
		Deliver the annual Cost Improvement Plan (CIP) programme in line with the LTFP requirements	Ensure robust in year oversight of Divisional CRES plans through monthly Finance & Operations Review. Develop recurrent CIP plans to ensure all non-recurrent CIP is secured recurrently by Q4 2014 and delivery 14/15 CRES requirement on a normalised basis	75% - 100%	As at 31st August 2014 82% of the 2014/15 target has been identified on a risk assessed basis The Trust has a savings target for 2014/15 of £20.770m the current identified plans amount to £17.56m. 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 £17.56m there remains non recurring savings identified of £3,540m. 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 31st August 2014 the value associated with these schemes was £7.854m	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.	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	RED	741	COO	Finance Committee	24/11/2014
		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. Strategic Implementation Plans finalised and presented to SLT and key initiatives now located in Campus Phase V where applicable and 2015/16 Divisional Operating Plans.	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. Internal Audit Review of Commissioning & planning Function in 2013 and planned for 2014 as part of Annual Audit Plan. Monitor self-assessment of strategic planning function undertaken as part of Monitor Plan submission. Monitor feedback on plan rated as AMBER due to risks associated with savings delivery.	GREEN		D of SD	Senior Leadership Team	16th September 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 (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
		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.	50% - 75%	Clinical Strategy Group leading work and reporting to SLT. Weston strategic analysis completed and considered at September Board resulting in decision not to proceed to final bid. Children's Community Health tender delayed though bid preparation continues. Strategic Review of SBCH concluded and final report now being reviewed.	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. No external assurance available in this period.	GREEN		D of SD	Senior Leadership Team	16th September 2014
		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	50% - 75%	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. 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. Responsibility for Private Patients has been incorporated into the Delivery and Service Improvement Manager post which will be recruited in January 2015.	Private Patients Steering Group	GREEN		COO	Senior Leadership Team	SLT 3rd September 2014
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	75% - 100%	COSRR of 4 in 2014/15.	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.	GREEN		DoF	Finance Committee	24/11/2014
		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.	50% - 75%	Structure agreed and successfully consulted upon. All key posts now recruited to and new team bedding in.	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.	Well-led Governance Review key source of external assurance on fitness of structure for its purpose.	GREEN		Deputy CEO	Risk Management Group	9th July 2014
			Develop and deliver actions arsing from on-going external governance reviews e.g. Lawson Review, W&C Governance Review	75% - 100%	Actions from external reviews largely complete. Internal Well Led Governance Review now in hand and external assessors appointed. Review commenced Feb 2015 and report to Board in May 2015.	Failure to secure staff support for proposed structure and/or recruitment to vacant posts is not achieved in a timely fashion.	Establish satisfactory interim arrangements and commence recruitment as soon as practical with aim of new TS starting in October 2014.	Well-led Governance Review key source of external assurance on fitness of structure for its purpose.	GREEN		Deputy CEO	Risk Management Group	9th July 2014
			To scope and develop Terms of Reference for work programme to address current shortcomings in approach to Procedural Document Management.	75% - 100%	Option appraisal concluded, for consideration at April Risk Management Group.	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. CQC reviewed area of policy and document management with some immediate recommendations for action which have been implemented. Final report due April 2015.	GREEN		Deputy CEO	Risk Management Group	9th July 2014
		Robustly prepare for the planned Care Quality Commission inspection.	Develop and coordinate delivery of an action plan to coordinate preparation for CQC visit. To develop a clear communicational support plan for staff.	75%-100%	CQC inspection announced for 10th-12th September 2014. Action plan developed and monitored via short term CQC Inspection Steering Group, with agreement of SLT. Included plans for communications and on-site logistics. CQC project manager appointed as internal secondment, commencing mid-July. 'Delivering Best Care' week in August 2014 formed key part of preparation - focus on key risks. Positive feedback from CQC about how the inspection was managed and organised. Quality Summit 28 November; inspection report published 2nd December - overall "Requires Improvement"; compliance action plan submitted by 12th January as required; implementation is being monitored via SLT. Implementation of other actions in response to CQC recommendations is being monitored via Clinical Quality Group.	No risks - objective achieved.	Not applicable	Regular reports to CQC steering group, SLT, Execs, RMG, CQG	GREEN		CN CN	Senior Leadership Team Senior Leadership Team	Continuous throughout Q4

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 (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
	We will ensure we are soundly governed and are compliant with the requirements of our regulators	Prepare for and achieve successful outcome from proposed Monitor investigation into performance concerns with the aim of reverting to a GREEN rating by Q2	To provide all necessary information, in a comprehensive and robust fashion, in advance of visit	75%-100%	Initial objective completed. Monitor now considering further formal investigation pending outcome of system wide CQC action planning.	Workforce capacity constraints	Prioritisation of this work, above lower priorities	Regular updates to Executive team through work programme oversight. Monitor investigation completed and governance rating restored to GREEN but now reverted to "consideration of further investigation" as a result of non-compliance with recovery trajectories.	GREEN		Director of SD	Executive Directors	n/a
			Ensure team are adequately prepared for Monitor visit and key messages are appropriately develop and clearly communicated throughout the process.	75%-100%	Completed 16 June 2014.	Lack of preparation and availability of key personnel.	Adequate preparation	Monitor rating.	GREEN		Chief Executive	Executive Directors	31/07/2014
		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 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	50% - 75%	IST report and action plan presented to and approved by Senior Leadership Team in October 2014. There has been a significant increase in the number of admitted patients treated >40 weeks. The further extension of the period of planned failure to 30th November 2014, will enable the Trust to make a further significant reduction in the admitted backlog for patients >30 weeks. 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. The Trust has completed the IMAS Demand and Capacity modelling and the outputs have been shared with Monitor, CCGs and NHSE. A number of specialties are in the process of 'outsourcing' a number of patients to be seen and treatment in the Independent Sector. A 2 months contract has been awarded to an external validation team, who will support the Trust with the RTT data cleansing programme and in preparation for validation and reporting on Medway.	Activity is not as yet on track against plan. The admitted and non-admitted backlog are not reducing as per previous trajectory. Aggregate/Trust level achievement of the standards is at risk until end Q4 at the earliest because most paediatric specialties have deteriorated. The main factor is insufficient theatre capacity to deliver both non-elective and elective activity. Many specialties continue to receive 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. Additional 1st OP activity in place +/- reduction in 1st OP wait for specific specialties. Waiting list initiatives to reduce admitted backlogs. Significant resource allocated to validate the RTT PTLs and all patients are currently 'on hold'. Where possible, patients will be treated by independent providers. Revised by show us hitting non-admitted in Q3 15/16 and admitted in Q4 15/16. All waiting lists are clinically reviewed.	RTT Steering Group RTT Operational Group Divisional PTL Meetings Elective Care (ECIST) external review Service Delivery Group	GREEN	1967	COO	Senior Leadership Team	RTTSG December 2014.
		Improve cancer performance to ensure delivery of all key cancer targets	Establishment of monthly Cancer Performance Steering Group 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	75% - 100%	Cancer Performance Improvement Group is well established and meets fortnightly The Cancer Action Plan is regularly updated and many actions have been successfully completed. However the impact of some of these has not yet been fully felt. Several of the most challenging areas such as late referrals require longer term strategies to address but work is progressing well Performance for 62 day GP cancer currently not on target against recovery trajectory and achievement in quarter 3 is very unlikely. However improving performance is seen and attainment in quarter 4 remains possible. The breast screening transfer was successfully completed in July with no problems identified with transferred records to date.	Cancellations of surgery, particularly due to acuity of patients on HDU/ITU causing a lack of critical care beds Delayed impact of some key actions e.g. first appointment waits Rising numbers of late referrals - work underway to influence this but still largely out of the Trust's control National awareness campaign for oesophago-gastric cancer forecast to cause 50% increase in upper GI endoscopy demand. Rising complexity of treatments, pathways and patients	Moving to new ITU in February is forecast to improve some of the challenges, also it is felt November was an exceptional month for acuity on critical care and not representative of the likely situation in future months Impact of first appointment wait reduction should start to be seen in pathways ending from around December A number of initiatives are underway to improve timeliness of referrals, such as agreeing improved pathways, improving communication, and seeking commissioner support GP education event planned to manage demand in campaign, plus plans for increased capacity Continual review of pathways and processes to identify new challenges due to complexity etc. and find ways to address them. Ensuring that the standard is met when adjusted for late referrals.	Cancer Board Cancer Performance Improvement Group Cancer PTL Meeting Service Delivery Group Progress on actions and risks regularly discussed with commissioners. External systems resilience group (Cancer Sub-Group).	RED	1412	COO	Senior Leadership Team	22/12/2014, next review 05/01/2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
17. Corporate Risk Register

Sponsor and Author(s)
Sponsor: Debbie Henderson, Trust Secretary Author: Sarah Wright, Risk Manager

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The Corporate Risk Register contains risks identified as having a potential impact on corporate objectives, including risks identified in and escalated from divisions.

Escalated risks from divisions may be reassessed against corporate objectives.

Risks are formally approved for inclusion on and removal from the Corporate Risk Register by the Senior Leadership Team.

This is an summary update of activity since the last report dated 21/01/2015.

Key issues to note

New Corporate Risks:

- None

Risks De-escalated to Divisions

- 2126 Reputational damage arising from Adverse Media coverage of Trust activities – To Trust Services Divisional Risk Register

Risks Closed

- None

Amendments to Corporate Risks

- 2344 Risk Reviewed and likelihood increased from 'likely' to 'Certain'. (from High 12 to Very High 16)
- 2126 Risk Reviewed and likelihood decreased from 'Certain' to 'Possible' (from Very High 15 to High 9)

The Board of Directors is also asked to note that the Risk Management Group has requested a review of the on-going appropriateness of the Corporate Risk Register only capturing risks of 15 and above. With improvements in the assessment and rating of risks, very few risks now appear on the CRR which has resulted in some concerns about SLT and Board sightedness on the organisations principle risks. Of note, this is not a proposal to migrate all Divisional risks of 12 and above to the CRR as the same process of re-assessment in the corporate

context will be required.
Recommendations
The Board of Directors is asked to review the content of the risk register.
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
There are no equality or patient experience implications as a result of this report.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Risk Management Group**
				23/04/2015	08/04/2015

Corporate Risk Register 23/04/2015

Number	Risk Title	Executive Lead	Risk Rating
741	Savings Programme	Chief Operating Officer - James Rimmer	Very High (Red)
1704	Potential increased harm to patients queuing outside the main Emergency Department in the corridor	Chief Operating Officer - James Rimmer	Very High (Red)
2344	Risk To Achievement of One or More 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)

Corporate Risk Register Report

Risk Number: 741 **Status:** Action Required **Date:** 01/09/2006 **Risk Title:** Savings Programme

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	06/07/2015	16 Very High (Red)	12 High (Amber)

BAF Reference and details of strategic objective:

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
	Risk is partially mitigated by slippage on reserves.	High

Action Plan for Risk: 741 **Action Number:** 10 **Responsibility Of:** Dean Bodill **Target date:** 01/05/2015

Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.

Action Plan for Risk: 741 **Action Number:** 9 **Responsibility Of:** Dean Bodill **Target date:** 01/05/2015

Trust is working to develop savings plans to meet 2015/16 target.

Corporate Risk Register Report

Risk Number: 1704 **Status:** Action Required **Date:** 05/11/2010 **Risk Title:** Potential increased harm to patients queuing outside the main Emergency Department in the corridor

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	13/05/2015	16 Very High (Red)	6 Moderate (Yellow)

BAF Reference and details of strategic objective:

Risk Description

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. However the controls in place ensure all patients are reviewed and observed on arrival to the department.

Patients could potentially wait up to two hours without assessment, treatment or care if the current mitigating controls were to fail. The frequency of ambulance conveyances is variable and not always within the receiving Trusts control. There is a lack of availability of oxygen, suction, privacy and dignity. However the controls in place mitigate the risk as either the patient will be transferred into the department or oxygen/suction will be supplied.

Patient experience could be compromised from being nursed in a public area, and the possibility of having to discuss confidential information in a public thoroughfare.

Patient may not have basic needs met and may be at an increased risk of developing pressure damage if the current controls fail.

Patients queuing in the corridor outside ED are likely to be delayed in transferring to the department and will therefore experience delays in starting treatment and will likely breach the 4 hour target.

Other recognised risk is the delay in releasing ambulance crews therefore risk to general public not having timely access to 999 ambulance support.

Details of Control or Assurance	Effectiveness
SHINE Project will contribute toward reducing crowding in the ED	No Effect
CSMT to attend the ED as soon as a queue starts to form to progress flow throughout the hospital and reduce queuing	High
Essential nursing care and treatment, including the supply of oxygen and suction delivered by the queue nurse.	High
Ring fence cubicle in ED to use as rolling cubicle for toileting, undressing and immediate medical review.	Medium
Well tested escalation process and early liaison with SWAST bronze control.	Low
Patients in the queue are booked onto the ED system and will be visable on the ED tracker.	Low
RATTing protocol in place which ensures all queuing patients will be seen and assessed by a Senior Doctor and prioritised by clinical need.	Medium
-ED nursing planned over recruitment to ensure nurse available immediatly to attend the queue patients. -Night duty pool nurse prioritised for the queue. -Nurses allocated from each Division and names recorded in site office.	High
Standard Operating Procedure-managing the ambulance queue developed and ratified	High
The extended MAU in the new build opened on 04/11/2014, with 7 extra spaces. The function of the MAU is to receive all appropriate expected patients to prevent these patients defaulting to ED and increasing the overcrowding.	Medium

Action Plan for Risk: 1704 **Action Number:** 27 **Responsibility Of:** Julia Wynn **Target date:** 31/03/2015

The Integrated Discharge project aims to reduce the number of patients in acute hospital beds by early placement into appropriate community care

Action Plan for Risk: 1704 **Action Number:** 17 **Responsibility Of:** Rowena Green **Target date:** 31/03/2015

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.

Action Plan for Risk: 1704	***Action Number:*** 25	***Responsibility Of:*** Janice Sutton	***Target date:*** 30/04/2015

Additional 5.2 WTE band 5 nurses business case developed and awaiting approval.

Action Plan for Risk: 1704	***Action Number:*** 29	***Responsibility Of:*** Rowena Green	***Target date:*** 30/04/2015

Deliver the whole system ED recovery plan.

Action Plan for Risk: 1704	***Action Number:*** 23	***Responsibility Of:*** Richard Jeavons	***Target date:*** 10/06/2015

Additional ED Consultants business case to provide extended cover in ED awaiting approval.

Action Plan for Risk: 1704	***Action Number:*** 33	***Responsibility Of:*** Michelle Jarvis	***Target date:*** 16/03/2016

Establish handover monitoring and subsequent fining liability of delays in ambulances transporting medically expected patients.

Action Plan for Risk: 1704	***Action Number:*** 30	***Responsibility Of:*** Michelle Jarvis	***Target date:*** 31/03/2016

Financial implications of ambulance patients not being handed over to the ED within 30 minutes of arrival to be discussed at fortnightly ED management mtgs

Action Plan for Risk: 1704	***Action Number:*** 32	***Responsibility Of:*** Michelle Jarvis	***Target date:*** 31/03/2016

Regularly review SWAS handover processes for improvement.

Corporate Risk Register Report

Risk Number: 2344 ***Status:*** Accepted ***Date:*** 08/01/2014 ***Risk Title:*** Risk To Achievement of One or More 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	Debbie Henderson	Deborah Lee	Director Of Strategic Development - Deborah Lee	08/01/2014	21/07/2015	9 High (Amber)	2 Low (Green)

BAF Reference and details of strategic objective:

Risk Description	*Details of Control or Assurance*	*Effectiveness*
Risk of failure to achieve one or more strategic objectives within the Board Assurance Framework.	Executive Director ownership and accountability for each stratgeic objective with responsibility for ensuring delivery and devloping remedial action plans where necessary	Medium
	Seek and describe external assurance to support assessment of progress towards objective	Medium

Action Plan for Risk: 2344 ***Action Number:*** 1 ***Responsibility Of:*** Deborah Lee ***Target date:*** 30/04/2015

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.

Action Plan for Risk: 2344 ***Action Number:*** 2 ***Responsibility Of:*** Deborah Lee ***Target date:*** 30/04/2015

Evidence of external assurance tp be sought and described

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	Anne Gorman	James Rimmer	Chief Operating Officer - James Rimmer	05/03/2014	14/05/2015	16 Very High (Red)	4 Moderate (Yellow)

BAF Reference and details of strategic objective:

Risk Description	*Details of Control or Assurance*	*Effectiveness*
Prolonged failure of one of the following performance indicators, or concurrent failure of 4 or more indicators leading to loss of green status in Monitor risk rating:	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:*** 2 ***Responsibility Of:*** Anne Gorman ***Target date:*** 30/09/2015

Monitoring of trajectories (activity and waiting list) to ensure first outpatient waiting times are reduced in line with target for end of quarter 2

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30th April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
18. Board of Directors Code of Conduct (including Fit and Proper Person Test Declaration)									
Sponsor and Author(s)									
Sponsor – John Savage, Chairman Author – Debbie Henderson, Trust Secretary									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose

This report contains the Board of Directors' Code of Conduct and declaration of the Fit and Proper Persons requirement in line with the Care Quality Commission Fundamental Standards of Care, and provides assurance that all members of the Board have signed the annual declaration of compliance with these standards.

Key issues to note

All members of the Board of Directors have completed and signed the annual declaration against the standards of the Code of Conduct and Fit and Proper Persons requirement. Copies of signed declarations are available to the public on request from the Trust Secretariat.

Recommendations

The Board is recommended to receive this report to note

Impact Upon Board Assurance Framework

N/A

Impact Upon Corporate Risk

N/A

Implications (Regulatory/Legal)

Compliance with statutory requirements for members of NHS Board of Directors

Equality & Patient Impact

N/A

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	**X**

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

University Hospitals Bristol NHS Foundation Trust

Board of Directors Annual Code of Conduct Declaration

1. Introduction

High standards of corporate and personal conduct are an essential component of public services. As a Foundation Trust, University Hospitals Bristol NHS Foundation Trust is required to comply with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice.

The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all Directors (in addition to the standard for employees set out in the policy defined in Standards of Business Conduct). This document therefore includes the Department of Health Code of Conduct/Code of Accountability for Boards, specifically for Chairs and Non-Executive Directors, and the Code of Conduct for NHS Managers specifically the Chief Executive and Executive Directors.

This code, with the Code of Conduct for Governors and the NHS Constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour.

2. Principles of public life

All Directors and employees are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

Selflessness - Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity - Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity - In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

Accountability - Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness - Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty - Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

3. General principles

Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public. The Board of Directors therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct. The Board of Directors expects that this Code will inform and govern the decisions and conduct of all Directors.

4. Confidentiality and access to information

Directors and employees must comply with the Trust's confidentiality policies and procedures and must not disclose any confidential information, except in specified lawful circumstances. The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be adhered to at all times.

5. Register of interests

Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the constitution. It is the responsibility of each Director to update their register entry if their interests change. A pro forma is available from the Trust Secretary. Failure to register a relevant interest in a timely manner will constitute a breach of this Code.

6. Conflicts of interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a Director or for doing (or not doing) anything in that capacity.

If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the Director must declare the nature and extent of that interest to the other Directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

The Chair and Trust Secretary will advise Directors in respect of any conflicts of interest that arise during Board and Committee meetings, including whether the interest is such that the

Director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board to decide whether a Director must withdraw from the meeting.

7. Gifts & hospitality

The Board will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Trust funds for hospitality and entertainment will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector.

The Trust has adopted a policy on register of interests and gifts and hospitality which will be followed at all times by Directors and all employees. Directors and employees must not accept gifts or hospitality other than in compliance with this policy.

8. Whistle-blowing

The Board acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The Board has adopted a Speaking Out policy on raising matters of concern which will be followed at all times by Directors and all staff.

9. Personal conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically Directors must:

- Act in the best interests of the Trust and adhere to its values and this Code of Conduct;
- Respect others and treat them with dignity and fairness;
- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- Be honest and act with integrity and probity;
- Contribute to the workings of the Board as a Board member in order for it to fulfil its role and functions;
- Recognise that the Board is collectively responsible for the exercise of its powers and the performance of the Trust;
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate;
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Executive Directors and Non-Executive Directors;
- Make every effort to attend meetings where practicable;
- Adhere to good practice in respect of the conduct of meetings and respect the views of others;
- Take and consider advice on issues where appropriate;
- Acknowledge the responsibility of the Council of Governors to represent the interests of the Foundation Trust's members and partner organisations in the

governance and performance of the Trust, and to have regard to the views of the Council of Governors;
- Not use their position for personal advantage or seek to gain preferential treatment nor seek improperly to confer an advantage or disadvantage on any other person; and
- Accept responsibility for their performance, learning and development

10. Compliance

The members of the Board will satisfy themselves that the actions of the Board and individual Directors in conducting Trust business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code of Conduct including their compliance with; the Department of Health Code of Conduct and Accountability (Appendix 1); Code of Conduct for NHS Managers (Appendix 2); and the Nolan principles of governance.

Board members will be required to re-affirm their compliance with the Codes on an annual basis.

Please could you sign and return this document to confirm your continued compliance with these codes and support to the Nolan principles of governance.

Signed:…….. (signature) ……Date:

Print Name:…… (CAPITALS)

Designation:……(CAPITALS)

Changes to CQC Regulations – Fit and Proper Person Test

1. Introduction

Regulation 5 of the CQC fundamental standards: the Fit and Proper Persons requirement came into force on 27th November 2014 and will become law as of 1st April 2015. This stipulates that the Chair of all NHS Trusts is responsible for ensuring that members of the Trust Board meet the requirements of the 'Fit and Proper Person Test' (the test) and for establishing processes to underpin this.

University Hospitals Bristol NHS FT (UHB) is committed to ensuring the highest standards of safety, quality and governance and with this in mind, in addition to undertaking the standard pre-employment checks, members of the Trust Board will be asked to make a declaration upon appointment and an annual declaration thereafter, around their fitness to execute these roles, in order that there is assurance on an on-going basis. Those subject to the test are also expected to notify the Chair of the Trust in the event of any change of circumstances as and when they arise.

2. Applicability

Staff required to complete this self-declaration are:

- All members of the Trust Board; and
- Senior staff in regular attendance at the Board with significant influence in reporting information for decision making. For the purpose of UHB, this is defined as Executive Directors, Non-Executive Directors, and those regularly in attendance at Trust Board

A central register will be held by the Trust Secretary and will be made available for inspection by the Care Quality Commission as and when required.

3. Recruitment Processes

As part of the recruitment process for the defined staff group as detailed in section 2 above, a number of checks will take place:

- Checks on individuals will be:
  - Qualifications;
  - Competence, skills required, relevant experience; and ability; and
  - Good character
- Consideration of physical and mental health in line with the role, and good occupational health practice;
- Ensure, as far as possible, the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying on a regulated service; this includes any allegations of such;
- Disclosure and Barring Service (DBS) checks will be carried out on all individuals to whom the test applies as part of the pre-employment check process. Only individuals who will be acting in the role that falls within the definition of a 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for an enhanced DBS check.

4. Executive Directors, Chairman and Non-Executive Directors

Recognising the responsibility of the Chair as set out in the regulations and as a reflection of the seriousness with which the Trust treats this matter, all UHB Board members will be required to complete a declaration upon appointment and on an annual basis thereafter. These declarations will be reported to a Board of Directors meeting held in public to ensure regular assurance can be provided to the public and the wider community in relation to appropriate responsibility and accountability of the organisation.

5. Appraisal

Through the annual appraisal process, persons subject to the test will be monitored to ensure that they meet the requirements to hold the office of their appointment in terms of competence and skills. In the event that they do not, action will be taken by the Chief Executive, Trust Chair, relevant Executive Director and/or Senior Independent Director. Where appropriate this will be done in consultation with the Remuneration Committee (for executive Directors of the Board), and/or the Governors' Nomination and Appointments Committee for (the Chair and Non-Executive Directors of the Board).

Board of Directors Fit and Proper Person Test
Annual Self-Certification – April 2015

I declare that I am a Fit and Proper Person to carry out my role, I am of good character, I have the qualifications, competence, skills and experience which are necessary for me to carry out my duties. I am capable by reason of health of properly performing tasks which are intrinsic to the position. I am not prohibited from holding office (e.g., directors disqualification order), within the last 5 years I have not been convicted of a criminal offence and sentenced to imprisonment of 3 months or more, been undischarged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangements/compositions with creditors and has not discharged it, nor is it on any 'barred' list.

The legislations states, for those required to hold a registration with a relevant professional body to carry out their role, they must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where the person no longer meets the requirement to hold the registration, and if they are a health care professional, social worker or other professional registered with a health care or social care regulator, they must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the Chair of UHB.

Print Name……

Job Title/Role……..

Professional Registrations held……..

……

……

Signature……..

Date…….

Please return this signed declaration to Debbie Henderson, Trust Secretary, University Hospitals Bristol NHS Foundation Trust, Trust Head Quarters, Marlborough Street, Bristol, BS1 3NU or e-mail at Debbie.henderson@uhbristol.nhs.uk

Appendix 1

Code of Conduct/Code of Accountability for NHS Boards

CODE OF CONDUCT

1. Public service values

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is funded from public money, it must be accountable to Parliament for the services and for the effective and economical use of taxpayers' money. There are three crucial public service values that must underpin the work of the NHS:

Accountability – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgments on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.

Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

2. General principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from Boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all Board directors.

3. Openness and public responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that there is a consultation on major changes before decisions are reached. Information supporting those decisions should be made available to the public in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As large employers in the local community, NHS organisations should forge open and positive relationships with

the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisations activities on the environment.

The confidentiality of personal and individual patient information must be respected at all times.

4. Public service values in management

It is unacceptable for the Board of any NHS organisation, or any individual within the organisation for which the Board is responsible, to ignore public service values in achieving results. Chairs and Board Directors have a duty to ensure that public funds are properly safeguarded and that at all times, the Board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS Boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the Board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports published in good time and made publically available, to allow full consideration by those wishing to attend public meetings on health issues.

5. Public business and private gain

Chairs and Board Directors should act impartially and not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the Board minutes, and entered into a register which is available to the public. When a conflict of interest is established, the Board Director should withdraw and play no part in the relevant discussion or decision.

6. Hospitality and other expenditure

Board Directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS Boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered action can damage respect for the NHS in the eyes of the community.

7. Relations with suppliers

NHS Boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS Boards should be aware of the risks of incurring obligations to suppliers at any stage of a contracting relationship.

8. Staff

NHS Boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The Board must establish a climate:

- That enables staff who have concerns to raise these reasonably and responsibly with the right parties;
- That gives clear commitment that staff concerns will be taken seriously and investigated; and
- Where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation

9. Compliance

Board Directors should satisfy themselves that the actions of the Board and its Directors in conducting Board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Board Directors of NHS Trusts are required, on appointment, to subscribe to the Code of Conduct.

CODE OF ACCOUNTABILITY

This Code is the basis on which NHS Trusts should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

1. Status

NHS Trusts are established under statute as corporate bodies to ensure that they have separate legal personalities. Statutes and regulations prescribe the structure, functions, and responsibilities of their Boards and prescribe the way their Chairs and Directors are to be appointed.

2. Code of Conduct

All Chairs and Non-Executive Directors of NHS Boards are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct should be drawn to the attention of the Regulator.

NHS Managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and Non-Executive Directors of NHS Boards are responsible for taking firm, prompt, and fair disciplinary action against any Executive Director in breach of the Code of Conduct for NHS Managers.

3. Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS Trusts that are thus accountable to him and to Parliament.

NHS Trusts provide services to patients (these may be acute services, ambulance services, mental health or other specialist services i.e., for children) and must ensure that they are of high quality and accessible.

4. National standards of quality and safety

NHS Trusts providing care in hospitals are required to register with the Care Quality Commission (CQC). The CQC ensure that hospitals provide people with safe, effective, caring, responsive and well-led, and ensure services meet fundamental standards of quality and safety. Boards are required to ensure that hospitals continue to meet these fundamental standards of care.

5. Financial accountability

NHS Trusts are subject to external audit. NHS Boards must cooperate fully with the Regulators and the Auditors when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State.

6. The Board of Directors

NHS Boards comprise Executive Directors together with Non-Executive Directors and an independent Non-Executive Director Chair. Together, they share corporate responsibility for all decisions of the Board. Boards are required to meet regularly and to retain full and effective control over the organisation. Monitor, Independent Regulator of NHS Foundation Trusts, provides the line of accountability from local NHS Foundation Trusts to the Secretary of State for the performance of the organisation.

The duty of an NHS Board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation. The role of the Board is to:

- Be collectively responsible for adding value to the organisation for promoting the success of the organisation by directing and supervising the organisations affairs;
- Provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Set the organisations strategic aims, ensuring that the necessary financial and human resources are in place for the organisation to meet its objectives and review management performance;
- Set the organisations strategy, values and standards and ensure that its obligations to patients and the local community are understood and met

Further information is provided in the Healthy NHS Board: Principles of Good Governance.

7. The role of the Chair

The overarching role of the Chair is one of enabling and leading, so that the attributes and specific roles of the Executive Directors and the Non-Executive Directors are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the Chair are:

- Leadership of the Board, ensuring its effectiveness on all aspects of its role and setting its agenda;
- Ensuring the provision of accurate, timely and clear information to Directors;
- Ensuring effective communication with staff, patients and the public;
- Arranging the regular evaluation of the performance of the Board, its committees and individual Directors;
- Facilitating the effective contribution of Non-Executive Directors and ensuring constructive relations between Executive and Non-Executive Directors

A complementary relationship between with the Chair and Chief Executive is important. The Chief Executive is accountable to the Chair and Non-Executive Directors of the Board for ensuring that the Board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.

Further information is provided in the Healthy NHS Board: Principles of Good Governance.

8. Non-Executive Directors

Non-Executive Directors are appointed by the Council of Governors to bring independent judgment to bear on issues of strategy, performance, key appointments and accountability. The duties of the Non-Executive Directors are to:

- Constructively challenge and contribute to the development of strategy;
- Scrutinise the performance of management in meeting agreed goals and objectives and monitor reporting of performance;
- Satisfy themselves that quality and financial information is accurate and that controls and systems of risk management are robust and defensible;
- Determine appropriate levels of remuneration of Executive Directors and have a prime role in appointing, and where necessary, removing senior management, and in succession planning; and
- Ensure the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses

Non-Executive Directors also have a key role in a small number of permanent Board committees such as the Audit Committee, Remuneration and Nominations Committee, Quality and Outcomes Committee, and Finance Committee.

Further information is provided in the Healthy NHS Board: Principles of Good Governance.

9. Reporting and controls

It is the Boards duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisations performance to:

- The Department of Health
- Monitor
- Care Quality Commission
- External Auditors
- Council of Governors
- The Local Community

Detailed financial guidance, including the role of the internal and external auditors, issued by Monitor must be observed. The Standing Orders and terms of reference of the Board should prescribe the terms on which committees and sub-committees of the Board may be delegated functions, alongside the schedule of decisions reserved by the Board.

10. Declarations of interest

It is a requirement that the Chair and all Board Directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS Trusts maintain a register of members' interests to avoid any danger of Board Directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All Board members are therefore expected to declare any personal or business interest which may influence, or may be perceived to influence, their judgment. This should include, as a minimum, personal direct and indirect family interests, and should normally also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

11. Employee Relations

NHS Boards must comply with legislation and guidance from Department and Health and regulators, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the Board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The Board should ensure through the appointment of a Remuneration and Nominations Committee, that executive Board Directors remuneration can be justified as reasonable. Board Directors remuneration for the NHS Foundation Trust should be published in its annual report.

Appendix 2

Code of Conduct for NHS Managers
Department of Health, published October 2002

1. Introduction

As part of the response to the Kennedy Report, the Code of Conduct for NHS Managers has been produced by a Working Group chaired by Ken Jarrold CBE

The Code sets out the core standards of conduct expected of NHS managers. It will serve two purposes:

- to guide NHS managers and employing health bodies in the work they do and the decisions and choices they have to make.
- to reassure the public that these important decisions are being made against a background of professional standards and accountability.

The environment in which the Code will operate is a complex one. NHS managers have very important jobs to do and work in a very public and demanding environment. The management of the NHS calls for difficult decisions and complicated choices. The interests of individual patients have to be balanced with the interests of groups of patients and of the community as a whole. The interests of patients and staff do not always coincide. Managerial and clinical imperatives do not always suggest the same priorities. A balance has to be maintained between national and local priorities.

The Code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity.

2. Code of Conduct for NHS Managers

As an NHS manager, I will observe the following principles:

- make the care and safety of patients my first concern and act to protect them from risk;
- respect the public, patients, relatives, carers, NHS staff and partners in other agencies;
- be honest and act with integrity;
- accept responsibility for my own work and the proper performance of the people I manage;
- show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community;
- take responsibility for my own learning and development

This means in particular that I will:

- respect patient confidentiality;
- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public and patients;

- be guided by the interests of the patients while ensuring a safe working environment;
- act to protect patients from risk by putting into practice appropriate support and disciplinary procedures for staff; and
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly

I will respect and treat with dignity and fairness, the public, patients, relatives, carers, NHS staff and partners in other agencies. In my capacity as a senior manager within the NHS I will seek to ensure that no one is unlawfully discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social and economic status or national origin. I will also seek to ensure that:

- the public are properly informed and are able to influence services;
- patients are involved in and informed about their own care, their experience is valued, and they are involved in decisions;
- relatives and carers are, with the informed consent of patients, involved in the care of patients;
- partners in other agencies are invited to make their contribution to improving health and health services; and
- NHS staff are:
    - valued as colleagues;
    - properly informed about the management of the NHS;
    - given appropriate opportunities to take part in decision making.
    - given all reasonable protection from harassment and bullying;
    - provided with a safe working environment;
    - helped to maintain and improve their knowledge and skills and achieve their potential; and
    - helped to achieve a reasonable balance between their working and personal lives

I will be honest and will act with integrity and probity at all times. I will not make, permit or knowingly allow to be made, any untrue or misleading statement relating to my own duties or the functions of my employer. I will seek to ensure that:

- the best interests of the public and patients/clients are upheld in decision-making and that decisions are not improperly influenced by gifts or inducements;
- NHS resources are protected from fraud and corruption and that any incident of this kind is reported to the NHS Counter Fraud Services;
- judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and are properly founded; and
- open and learning organisations are created in which concerns about people breaking the Code can be raised without fear

I will accept responsibility for my own work and the proper performance of the people I manage. I will seek to ensure that those I manage accept that they are responsible for their actions to:

- the public and their representatives by providing a reasonable and reasoned explanation of the use of resources and performance;

- patients, relatives and carers by answering questions and complaints in an open, honest and well researched way and in a manner which provides a full explanation of what has happened, and of what will be done to deal with any poor performance and, where appropriate giving an apology; and
- NHS staff and partners in other agencies by explaining and justifying decisions on the use of resources and give due and proper consideration to suggestions for improving performance, the use of resources and service delivery

I will support and assist the Accountable Officer of my organisation in his or her responsibility to answer to Parliament, Ministers and the Department of Health in terms of fully and faithfully declaring and explaining the use of resources and the performance of the local NHS in putting national policy into practice and delivering targets. For the avoidance of doubt, nothing in paragraphs two to four of this Code requires or authorises an NHS manager to whom this Code applies to:

- make, commit or knowingly allow to be made any unlawful disclosure;
- make, permit or knowingly allow to be made any disclosure in breach of his or her duties and obligations to his or her employer, save as permitted by law

If there is any conflict between the above duties and obligations and this Code, the former shall prevail.

I will show my commitment to working as a team by working to create an environment in which:

- teams of frontline staff are able to work together in the best interests of patients;
- leadership is encouraged and developed at all levels and in all staff groups; and
- the NHS plays its full part in community development

I will take responsibility for my own learning and development. I will seek to:

- take full advantage of the opportunities provided;
- keep up to date with best practice; and
- share my learning and development with others

3. Implementing the Code

The Code should be seen in a wider context that NHS managers must follow the 'Nolan Principles on Conduct in Public Life', the 'Corporate Governance Codes of Conduct and Accountability', the 'Standards of Business Conduct', the 'Code of Practice on Openness in the NHS' and standards of good employment practice.

In addition many NHS managers come from professional backgrounds and must follow the code of conduct of their own professions as well as this Code. In order to maintain consistent standards, NHS bodies need to consider suitable measures to ensure that managers who are not their employees but who manage their staff or services; or manage units which are primarily providing services to their patients, also observe the Code.

It is important to respect both the rights and responsibilities of managers. To help managers to carry out the requirements of the Code, employers must provide reasonable learning and development opportunities and seek to establish and maintain an organisational culture that values the role of managers. NHS managers have the right to be:

- treated with respect and not be unlawfully discriminated against for any reason;
- given clear, achievable targets;
- judged consistently and fairly through appraisal;
- given reasonable assistance to maintain and improve their knowledge and skills and achieve their potential through learning and development; and
- reasonably protected from harassment and bullying and helped to achieve a reasonable balance between their working and personal lives

4. Breaching the Code

Alleged breaches of the Code of Conduct should be promptly considered and fairly and reasonably investigated. Individuals must be held to account for their own performance, responsibilities and conduct where employers form a reasonable and genuinely held judgement that the allegations have foundation. Investigators should consider whether there are wider system failures and organisational issues that have contributed to the problems. Activity, the purpose of which is to learn from and prevent breaches of the Code, needs to look at their wider causes.

Local employers should decide whether to investigate alleged breaches informally or under the terms of local disciplinary procedures. It is essential however that both forms of investigation should be, and be seen to be, reasonable, fair and impartial. If Chief Executives or Directors are to be investigated, the employing authority should use individuals who are employed elsewhere to conduct the investigation. The NHS Confederation, the Institute of Healthcare Management and the Healthcare Financial Management Association are among the organisations who maintain lists of people who are willing to undertake such a role.

5. Application of the Code

This Code codifies and articulates certain important contractual obligations that apply to everyone holding management positions. These include Chief Executives and Directors who as part of their duties are personally accountable for achieving high quality patient care. The Department of Health will in the next few months issue a proposed new framework of pay and contractual arrangements for the most senior NHS managers. Under this framework the job evaluation scheme being developed as part of the 'Agenda for Change' negotiations is likely to be used as the basis for identifying which other managerial posts (in addition to Chief Executives and Directors) should be automatically covered by the Code. The new framework will also specify compliance with the Code as one of the core contractual provisions that should apply to all senior managers.

For all posts at Chief Executive and director level and all other posts identified as in paragraph 6 above, acting consistently with the Code of Conduct for NHS Managers Directions 2002, employers should:

- include the Code in new employment contracts;
- incorporate the Code into the employment contracts of existing postholders at the earliest practicable opportunity

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 30th April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
19. Register of Seals									
Sponsor and Author(s)									
Sponsor – Robert Woolley, Chief Executive Author – Debbie Henderson, Trust Secretary									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose

To report applications of the Trust Seal as required by the Foundation Trust Constitution.

Key issues to note

Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing.

The attached report includes all new applications of the Trust Seal to April 2015 since the previous report on Thursday 29 January 2015.

Recommendations

The Board is recommended to receive this report to note.

Impact Upon Board Assurance Framework

N/A

Impact Upon Corporate Risk

N/A

Implications (Regulatory/Legal)

Compliance with the Trust's Constitution and Standing Orders

Equality & Patient Impact

N/A

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval		For Information	**X**

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Register of Seals – January 2015 – April 2015

Reference Number	Date signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness	Date Received
748	31/03/15	Engrossment contract and transfer in relation to The Grange, 1 Woodland Road - disposal to University of Bristol. Land Registry - transfer of whole of registered title document.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance and Information	Debbie Henderson, Trust Secretary	31/03/15
749	31/03/15	Engrossment contract and transfer in relation to the Grange, 1 Woodland Road - disposal to University of Bristol (contract agreement £1,100,000)	Paul Mapson, Director of Finance and Information		Debbie Henderson, Trust Secretary	31/03/15
750	16/04/15	Boots Licence for alterations (work inside and outside the premises), BRI Welcome Centre	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance and Information	Debbie Henderson, Trust Secretary	16/04/15

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 30th April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
20. Governor's Log of Communications									
Sponsor and Author(s)									
Sponsor: John Savage, Chairman		Author: Amanda Saunders, Head of Membership & Governance							
Intended Audience									
Board members	**X**	Regulators		Governors	**X**	Staff	**X**	Public	**X**
Executive Summary									
Purpose: The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. Key issues to note: There are no key issues to note for the period.									
Recommendations									
The Board is asked to receive this report to note.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	**X**		
Date the paper was presented to previous Committees									

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
					Executive Directors 29.04.15

Governors' Log of Communications

22 April 2015

ID Governor Name

118 Clive Hamilton **Title: Infusion Pumps**

Query **21/04/2015**

I have been made aware by my constituents of concern regarding the availability and use of Infusion Pumps for treatment. Can you provide appropriate assurance that there are sufficient infusion pumps, readily available, in good repair and with an adequate pool of trained staff to ensure safe use?

Response **21/04/2015**

Notified to Exec, awaiting response.

Status *Assigned to Executive Lead*

117 Mo Schiller **Title: Performance & Finance - Waiting List Initatives**

Query **21/04/2015**

In the financial year 2014/2015 how many surgical Waiting List Initiatives were undertaken across the Trust by Speciality, including Lists that were outsourced to other Providers? What is the cost of running a WLI list against a 'normal list'? Finally, when is it determined that a Waiting List Initiative is required and what is the criteria for patient selection?

Response **21/04/2015**

Notified to Exec, awaiting response.

Status *Assigned to Executive Lead*

116 Wendy Gregory **Title: Never Event and Serious Incident**

Query **17/04/2015**

What is the criteria used to define an incident as a "never event" and/or "serious incident"? How does the Trust define the two categories of incident intelligently so that the term is proportionate to the incident both in the short and long term. Also, what is the policy regarding the time taken to respond to incidents of this type?

Response **17/04/2015**

Pending response

Status *Assigned to Executive Lead*

115 Brenda Rowe **Title: Safeguarding in relation to hospital visitors**

Query **03/03/2015**

In the wake of the Jimmy Saville and Stoke Mandeville Hospital scandal, what measures does the Trust Board have in place/ or will introduce to provide assurance that our patients are safeguarded appropriately and what background checks are currently carried out in relation to those individuals (i.e., carers, celebrities, external advisors) who frequent our hospitals?
(Brenda Rowe, Public Governor)

Response **01/04/2015**

Safeguarding Arrangements:
The Trust has robust arrangements for Safeguarding Children within University Hospitals Bristol NHS Foundation Trust, under-pinned by the statutory requirements detailed in 'Section 11' of the Children Act 2004, including clear lines of accountability with a designated Executive Lead. These arrangements and safeguarding activities are overseen internally by the Safeguarding Children Steering Group and monitored externally by the Local Safeguarding Children's Boards and NHS Commissioners. All Trust staff have a responsibility to safeguard children and are required to complete safeguarding children training at a level appropriate to their role and responsibility. The Trust also has a comprehensive set of Safeguarding Children policies and procedures which are regularly reviewed and updated in response to changes in legislation and best practice. These policies are in line with the South West Child Protection Procedures.

The Trust has robust arrangements for Safeguarding Adults within University Hospitals Bristol NHS Foundation Trust, including clear lines of accountability with a designated Executive Lead. These arrangements and safeguarding activities are overseen internally by the Safeguarding Adults Steering Group and monitored externally by the Local Safeguarding Adult Boards and NHS Commissioners. All Trust staff have a responsibility to safeguard adults and are required to complete safeguarding adult training at a level appropriate to their role and responsibility

Volunteer and celebrity access to patients:
The Trust has in place a robust system to monitor volunteers' access to patients, which includes a detailed recruitment, selection and supervision process, as specified within the Volunteer Policy. Volunteers are expected to commit to a minimum of six months' service. Prior to commencement of their placement, all volunteers have a DBS check (enhanced for the Children's Hospital). All volunteers have to complete safeguarding children and adults training.

The Trust has a VIP and celebrity visitor procedure which is there to protect the privacy of patients, families and staff. The Trust takes reasonably practical measures to:
•Handle external visits safely and minimise the disruption they may have on the Trust's hospitals.
•Advise staff of potential visits in their areas where appropriate and work with them to minimise impact of visits on wards and other clinical areas.
•Ensure all media activity and handling during visits adheres to the procedures set out in the Trust's media policy.
•Ensure robust procedures are in place to organise

Status *Awaiting Governor Response*

ID	Governor Name		
114	**Angelo Micciche**	**Title:**	**Ward moves - transfer of cystic fibrosis nursing staff**

Query **10/02/2015**

With regard to the move of Ward C808 specialising in the care of cystic fibrosis patients to the new ward A900, it does not appear that the existing experienced cf ward nursing staff are being moved at this stage. Are patients aware of the transfer of nursing staff? For regular inpatients after many years of care, this may have a significant impact.

The nursing team have formed strong rapport and knowledge of each of their patients over many years and have been well trained and built extensive experience in cf. Could we receive assurance that this body of knowledge and experience will not be lost in the move, as it provides invaluable care to patients, built over a significant period of time?

There is anecdotal evidence that there was a lack of clarity at consultation stage which led to the nursing staff making a decision to move to a different ward. Could you please provide some detail of the rationale behind the decision not to move experienced nursing staff for this particular speciality to ensure there is no deterioration in standards of care due to a lack of specialist knowledge and experience on the new ward?

Response **16/03/2015**

A consultation was carried out with all Divisional nursing staff in medicine to support them in expressing their preference when the wards in medicine are reconfigured. Some staff chose to stay with their specialties and some chose to stay with their Ward Sister and remain as part of a team, even if it meant changing specialties. The ward sisters were all offered all the new wards and configurations and invited to express their 1st, 2nd and 3rd preference. Without exception, every ward sister got their first preference for wards.

In the new bed model, the cystic fibrosis service moved to A900 because the environment is most suited for the care of patients with CF (12 single side rooms with en suite bathrooms) and accommodated the additional beds the service required following the expansion and centralisation of services. The Division recognised that a change in ward leadership and in members of the nursing team could be risk to continuity of care and knowledge and skills in the speciality, they therefore put extensive and detailed plans in place to ensure the team on A900 were as prepared as possible for the service transfer and mitigate any risks associated with the change.

Specific actions put in place ahead of the planned change:
•The CF Clinical Nurse Specialists (CFCNS) set up a band 5 nurse rotation to allow staff from the inpatient ward to rotate for half their hours between the ward and the CF nursing team. This was to develop their skills and knowledge in CF and allow them to feed these skills back into the ward where they worked. This worked well and it also meant that patients that may not be regularly admitted also became familiar with the ward staff in the outpatient setting. This 'placement' recognised the need to prepare the RN's who would be working on A900 for their role as the specialist CF ward in the future
•One of the band 5 nurses from C808 was successful at interview and moved to be the Senior Staff Nurse a number of months before the ward moved to share clinical skills and CF models of care
•During the opening week on A900 the CF nurses planned their workload to ensure there was at least one CFCNS present on the ward to welcome patients and work alongside the ward staff. Two of the CF CNS' came in out of hours at the weekend to support the staff with IV antibiotics and in addition have drawn up a detailed user guide of regular IV antibiotics and their administration specifically for CF patients
•Since A900 opened there has been a CF CNS up on the ward on a daily basis and the ward made aware they are contactable Monday to Friday. When there are teaching opportunities such as port training, the CFCNS support nursing staff to become competent and where possible, organise this to allow these opportunities to fall within working hours
•A week before the actual move there was multi-professional study day for all Ward A900 staff of which all but 2 staff attended from the A900 team. It was organised as 2 half day sessions to allow maximum attendance. The physiotherapy team are also delivering weekly teaching. There are additional planned teaching sessions with input from all members of the MDT on a rotational basis
•2 RN's from ward C808 have been allocated to work on A900 until the end of the summer on a rotational basis (1 on nights and 1 days)
•During the first few weeks following the move and for as long as required, senior staff from C808 have made themselves available on a daily basis to support A900 staff, either by visiting or on the telephone
•A weekly operational meeting has been set up to review the progress of the transfer and manage any issues (should they arise) swiftly

To ensure we hear the views of all the patients on the ward since it opened, including the CF patients, we have been running a programme for inpatients to submit comment cards for ideas of improvements and suggestions and then responding to these weekly with a plan, when the request is deliverable and reasonable.

Status *Assigned to Executive Lead*

113	**Angelo Micciche**	**Title:**	**Staffing levels**

Query **06/02/2015**

Within the last 18 months the board took the decision to "over recruit" across the wards to help cover holiday and sickness and improve general staffing levels thereby improving patient safety, staff moral, reduce bank usage, etc.

Whilst I acknowledge the current challenges faced with recuritment, please could all governors have an update on what has progress has been made in this period and the impacts achieved accordingly.

Response **11/02/2015**

Response from Chief Nurse: 'Over recruiting' against establishment is not formally taking place within the Trust. Our funded nursing establishments are set to take into account of annual leave, sickness absence, study leave and maternity leave, they have a 21% uplift to cover these areas. The Trust's aim is to always ensure that our staffing numbers match these agreed establishments. To mitigate the impact of turnover nursing staff numbers may be slightly higher than actual vacancies at a point in time, as we know that further vacant posts will have arisen at the point the new starter is ready to take up post. We are currently have a registered nurse vacancy factor of 6.9% (end of December) , which benchmarks 9% against our peers.

Status *Responded*

ID Governor Name

112 Mo Schiller **Title: Nursing staff question to patients: 'Are we getting the care right'?**

Query 30/01/2015

When nursing staff do rounding do they ask ,"Are we getting the care right" to patients?.Doing the Face to Face interviews gave me the impression especially last year in St Michaels post natal ward that maybe complaints would not proceed if we enquired on patients satisfaction at the time they were with us.

Response 11/02/2015

Response from Chief Nurse:
The key aspects that are usually checked during comfort rounds in acute care areas include the “Four P’s” , Positioning: Making sure the patient is comfortable and assessing the risk of pressure ulcers , Personal needs: Scheduling patient trips to the bathroom to avoid risk of falls , Pain: Asking patients to describe their pain level on a scale of 0 - 10 , Placement: Making sure the items a patient needs are within easy reach. During each round the nurse will ask the patient if there is anything else that they need. Reported evidence based improvements in clinical outcomes include: pain management, decrease in falls and pressure ulcers reported improvements in patient reported outcomes include: better patient experience and satisfaction, reduction in patient complaints reduction in the frequency of call bell usage and the length of time patients wait to have their call bells answered. Maternity services are not an area where comfort rounds are common, however recognising the benefits that they can bring they have been introduced into maternity services 3 times a day where women are told about facilities on the ward and asked if they have any issues that they are concerned about and how the staff can help them with these.

Status *Responded*

111 Mo Schiller **Title: OPD appointments problems**

Query 30/01/2015

OPD complaints highlight the continuing problem booking appts./changing appts via the telephone,waiting times in clinic and updating the white boards info system.Despite the work carried out this does not appear to be resolved.Are there plans for electronic booking in and updating waiting time and online booking in the future?

Response 25/03/2015

The Trust invited the Elective Care Intensive Support Team (ECIST) to review Referral to Treatment pathways, systems and processes. The review included aspects of the Outpatient service.

ECIST made a number of recommendations to improve patient access and experience, including the patient facing “front end” booking process, e.g. strengthening the Appointments Centre to adopt a broader Referral Management Centre approach, the receipt of all electronic referrals (Choose and Book); paper referrals; registration on PAS; tracking of all referrals; and to act as a single point of contact for patients.

Some specialties had unacceptable first appointment times and / or long delays in clinic. One of the key underlying drivers is insufficient capacity to manage demand for new and follow up appointments. ECIST supported the Divisions to carry out detailed demand and capacity modelling across all specialties. The outputs of the modelling have helped the Divisions to gain a much better understanding of their services, and to quantify what additional capacity is required to offer a high quality, sustainable service for our patients. Specialty level proposals have been included in the Trust’s operating plans for 2015/16 and are currently under discussion.

An interim Outpatient Services Manager has started to implement agreed changes in the management of core Outpatients services. She will also support the specific RTT actions referred to earlier. The priority actions include an increase in the uptake of Choose and Book; simplification of booking and changing of appointments via the telephone; reduction in waiting times in clinics and working with Divisions to ensure there is sufficient capacity to manage advance bookings.

A substantive Outpatients Manager has been appointed and will be in post mid June 2015.

Status *Responded*

110 Mo Schiller **Title: Paediatric Cardiac Surgery - 3D imaging**

Query 30/01/2015

Are the paediatric cardiac surgeons planning to use 3D imaging,printing and using a resin cast of the child's heart to create patches to repair holes in the heart on young children with complex cardiac deformities? Recent reports show that this is a way forward to safer surgery and it also reduces the operation time.

Response 16/02/2015

Paediatric cardiac surgeons are now planning to use 3D imaging.
Response from Aidan Fowler, Fast-track Executive.

Status *Closed*

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30th April 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
21. Speaking Out (Whistleblowing) Policy									
Sponsor and Author(s)									
Sponsor: Sue Donaldson Author: Trish Ferguson-Jay									
Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose For the Board to receive the updated Speaking Out Policy following a response to the recommendations from the Francis Freedom to Speak Up Review (February 2015). Key issues to note There has been wide stake holder involvement around the recommendations from the Francis Review and the required amendments within the Policy. This has been discussed at the Workforce & OD Group (which includes our Staff Side partners) and Senior Leadership Team. In support of the Policy revisions, the Senior Leadership Team agreed to publish a one page summary of the Speaking Out Policy into a simple guide and agreed a timeline for implementation and re-launch across the Organisation.									
Recommendations									
The Board is recommended to receive this Policy for approval									
Impact Upon Board Assurance Framework									
Completion of objective within 2014/15 Board Assurance Framework – BAF reference 3									
Impact Upon Corporate Risk									
Revision and update of Policy only									
Implications (Regulatory/Legal)									
Meets regulatory requirements									
Equality & Patient Impact									
The Equality & Patient Impact has been undertaken as part of the Policy review and is attached									

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	√	For Information	

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
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University Hospitals Bristol NHS
NHS Foundation Trust

Speaking Out (Whistleblowing) Policy

Document Data		
Subject:	Speaking Out (Whistleblowing) Policy – Including PREVENT (Safeguarding from extremist and terrorist exploitation)	
Document Type:	Policy	
Document Status:	Draft	
Document Owner:	Trish Ferguson-Jay, Head of Organisational Development	
Executive Lead:	Director of Workforce and Organisational Development	
Approval Authority:	Senior Leadership Team	
Estimated Reading Time:	10 minutes	
Review Cycle:	24 months	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
[Next Review Date]	01/06/2015	01/06/2015

Document Abstract
The purpose of this policy is to provide a safe mechanism for anyone who works for the Trust to come forward and raise any concerns they have about any aspect of the Trust's work, and to be able to do so without fear of detriment or reprisal.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
January 2010	V1	Medical Director / Head of Communications	Major	Scheduled Revision
April 2011	V2	Head of Communications/ Director of Workforce & Organisational Development	Minor	Scheduled Revision
May 2013	V3	Director of Workforce and Organisational Development	Major	Revision to reflect change in the law arising from the Enterprise and Regulatory Reform Bill
April 2015	V4	Head of Organisational Development	Major	Response to recommendations from The Francis Freedom to Speak Up review, February 2015

Table of Contents

Contents and page numbers to be finalised following completion of review and approval.

1. Introduction

University Hospitals Bristol NHS Foundation Trust recognises that there may be times where you personally feel that there is something seriously wrong within the organisation. In some cases however you may feel intimidated or disloyal to colleagues if you speak out when noticing something is in your view 'untoward'. You may also fear intimidation, harassment or victimisation if you reveal your observations. In these circumstances you may feel it easier to ignore concerns rather than report what may be a suspicion of malpractice.

The Trust is committed to developing a culture of openness and accountability and takes all forms of alleged malpractice, fraud, corruption or abuse very seriously. We are very concerned about the potential effect of these matters on the services we provide.

It is important, therefore, that you feel comfortable raising issues which concern you. If you have any concerns about possible criminal offences being committed; failures to comply with legal obligations; healthcare matters including suspected maltreatment/ abuse of service users or staff. The health and safety of any individual; harm to the environment; or the concealment of information about any of the above, it can be very difficult to know what to do. You may be worried that by reporting issues of concern, exposing yourself to possible victimisation, disciplinary action or putting your job at risk. The Trust understands these concerns, and this policy is implemented to reassure you that this is not the case.

This policy is laid down in accordance with the Public Interest Disclosure Act 1998, national best practice and the Trust's own quality standards. It brings together existing guidelines and sets out the responsibilities of staff and the procedure to be followed should there be issues of concern raised.

The policy complements various professional or ethical guidelines and codes of conduct or freedom of speech such as those produced by the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Health & Care Professions Council (HCPC), and is not intended to restrict the publication of clinical or scientific opinions on any matter, including the provision of healthcare in the Trust.

2. Purpose and Scope

2.1 PURPOSE OF THE POLICY

The purpose of this policy is to provide a safe mechanism for anyone who works for the Trust to come forward and raise any concerns they have about any aspect of the Trust's work, and to be able to do so without fear of detriment or reprisal. The policy aims to:

- Allow you to have confidence to raise matters of concern
- Encourage you to feel confident in raising concerns and to question and act upon concerns about practice
- Provide avenues for you to raise concerns and receive feedback on any actions taken
- Ensure you receive a response to your concerns and that you are aware how to pursue them if you are not satisfied
- Provide reassurance that you will be protected from possible reprisals or victimisation.

2.2 SCOPE OF THE POLICY

This policy applies to all staff employed by University Hospitals Bristol NHS Foundation Trust. This policy also applies to staff who have left the Trust within a three month period i.e. three months from the last working day at the Trust; bank and agency staff; staff seconded to work in the Trust; students on placement; volunteers and sub-contracted staff and those on honorary contracts.

If you have a complaint against your own personal circumstances, please refer to the Grievance and/or the Tackling Harassment and Bullying Policies.

2.3 KEY PRINCIPLES

The Trust positively encourages any member of staff who has a particular concern about malpractice at work, patient safety or any other unacceptable way of working, to speak out to us. If you have serious concerns about any aspect of the responsibilities of the Trust you are entitled to - and should - raise them. You need to reasonably believe that such a disclosure is true, and is made in the public interest. The kind of things you might speak out about include:

- **Patient care and patient safety – including safeguarding the child / adult**
- **Health and safety issues** e.g. that the health or safety of any person has been, is being or is likely to be endangered
- **Financial matters** including fraud
- **Unlawful conduct** – e.g. that a criminal office has been committed, is being committed or is likely to be committed (including, but not limited to, fraud and corruption
- **Breaches of the NHS Codes of Conduct on Governance**
- **Breaches of legal obligations** e.g. that a person has failed, is failing or is likely to fail to comply with a legal obligation which s/he is subject to.
- **Damage to the environment** - e.g. that the environment has been, is being or is likely to be damaged
- That information relating to any of the above has been, is being or is likely to be **deliberately concealed**

This policy can be used to raise any issue or issues of concern, in the public interest[1], relating to UH Bristol staff, or any other member of staff working within the NHS.

Should the concern relate to another organisation, the manager hearing the concern will raise this with an Executive Director who will contact an appropriate Director at the other organisation to request that the matter is investigated.

You will not be discriminated against or victimised for raising concerns which you reasonably believe to be in the public interest under this policy either at the time or subsequently.

[1] "In the public interest" has a number of definitions but broadly means anything affecting the health, the rights or the finances of the public at large.

Victimisation of a person who raises concerns which they reasonably believe to be in the public interest is a disciplinary matter and will be fully investigated in line with the Trust's Disciplinary Policy

You have the right to be accompanied by a trade union representative, or a colleague or friend at any time during the procedure.

Both the person raising concerns and those who are potentially the focus of a concern will be treated with fairness and openness.

The Speaking Out Policy should always be read in conjunction with other relevant Trust policies and procedures, such as:

- Tackling Harassment and Bullying at Work Policy
- Counter Fraud Policy and Procedure
- Standing Orders
- Standing Financial Instructions
- Equality and Diversity Policy
- The Trust Staff Conduct Policy
- Safeguarding Children, Young People and unborn babies from Abuse Policy
- Safeguarding Adults Policy
- The Trust Disciplinary Policy and Procedure
- The Trust's Performance Management Policy and Procedure

It should also be considered alongside professional or ethical guidelines and codes of conduct or freedom of speech such as those produced by the GMC and NMC and the Public Interest Disclosure Act.

All managers are responsible for ensuring that staff are aware of the policy and its application, and for creating an environment in which staff are able to express concerns freely and without fear of reprisal.

Every member of Trust staff has a responsibility to raise concerns providing s/he has a reasonable belief that malpractice and/or wrongdoing has occurred.

2.4 OUR ASSURANCE TO YOU

The Trust will:

- **NOT** attempt to conceal evidence of poor or unacceptable practice.

- Take disciplinary action if an employee destroys or conceals evidence of poor or unacceptable practice or misconduct.

- Ensure confidentiality clauses in employment contracts do not restrict, forbid or penalise speaking out.

- Ensure that a person who speaks out receives support and that all reasonable steps area be taken to ensure that the individual raising the concerns is not subject to victimisation

- Treat victimisation of whistleblowers as a serious matter by fully investigating and taking appropriate disciplinary action, against any members of staff who it is found have victimised or tried to victimise a person raising a legitimate concern

In addition:

- If you wish to keep your identity confidential then, as far as is possible, it will not be disclosed without your consent.

- If the situation arises where the concern cannot be resolved without revealing your identify then whether and how to proceed will be discussed with you. Confidentiality cannot be maintained if the manager or person to whom the concerns are expressed considers that there is an immediate risk to patient safety and that, therefore, the matter must be addressed immediately. In such circumstances you would be informed of this course of action and a support plan would be mutually agreed.

3. PROCEDURE – HOW TO RAISE CONCERNS

You can raise concerns under the Speaking Out policy either **informally** or **formally.**

So that your concerns can be assessed and investigated at any informal or formal stage, it would be helpful if you could be as clear as possible with the details. The person you are meeting with will need to understand the following:

- what happened – the nature of the incident(s)
- who was involved
- when it happened – dates and times
- where it happened – locations
- who was present/involved when the incident(s) took place
- why you think it occurred (if possible)
- any effects on you (including those which may have been experienced outside of work)
- the frequency of any incidents
- If possible, explain how you think the matter may be best resolved or start thinking about it in preparation for any meetings you may be required to attend (if you have shared your identity)
- Any steps you have already taken (e.g. whether you have already raised the matter informally or at an earlier formal stage and with whom).
- any other issues relating to the concern.
- If you feel comfortable sharing your identity then please provide us with your name, your work location and contact details

3.1 Informally

You can raise your concerns informally with:

- The manager who is responsible for the area of work which you are concerned about.
- Your own manager (if this is somebody different)
- Another manager/senior person in the Trust.
- By telephone - calling the Raising Concerns telephone number extension 24487 or 0117 342 4487.
- By email - raisingconcerns@uhbristol.nhs.uk

If the concern relates to fraud you may raise it with the Trust's Local Counter Fraud Specialist.

You will need to make it clear that you are raising a concern under the Speaking Out policy.

Make sure that you say if it is important for you to remain anonymous.

If you do not feel strongly that your concern must be raised anonymously but you would like your identity to be kept confidential (not disclosed without discussing it with you first) then explain this, when raising your concern.

You can involve your trade union representative or specialist advisor in helping you raise the matter.

If you speak with a manager in the Trust then they will arrange for the concerns to be investigated. If you raise your concerns through the Raising Concerns email or telephone line, then this will be passed to a relevant manager for them to arrange for the matter to be investigated and the Trust Secretary will be advised that a concern has been raised.

3.2 Formally

We would like to encourage you to raise your concerns informally, in the first instance. However, if the informal action (however you choose to raise it) does not address your concerns or if you feel strongly that the matter is too serious to be dealt with through an informal process, then you should use the formal steps of the Speaking Out Policy:

Step One – Formal Process

You can raise your concerns with the Divisional Director, Head of Nursing/Midwifery, or Divisional Clinical Chair of the Division you work in (in the case of the Trust Services Division, this would be the relevant Executive Director or other relevant Director – for example, the Directors of IM&T or Facilities and Estates) or the Divisional Director/Clinical Chair of the Division where the issue given concern has arisen.

If it is not appropriate to raise the matter with your Divisional Director/Clinical Chair – for example, if your concern relates to them – then you should go straight to Step Two of the formal process.

S/he will meet with you within five working days of receipt of your communication. The contents of the meeting will be recorded in writing and a copy given to you within three working days of the meeting. S/he will also arrange for the concerns you are raising to be investigated and will discuss with you how you will receive feedback.

You can raise your concerns either verbally or in writing. If you are raising a concern formally, and you don't want anybody other than the person you are telling to know about this yet, it isn't recommended that the concern is raised via email because in some cases staff other than the named recipient have permission to view emails.

You will need to make it clear that you are formally raising a matter of serious concern in the public interest and if you wish to keep your identity confidential you should also make that clear and this will be discussed with you. [2]

As with the informal process, you can involve your trade union representative or specialist advisor in helping you raise the matter.

We hope that this process will resolve your concerns. If it does not then you should move to step two.

NB If the concern relates to fraud you may raise it with the Trust's Local Counter Fraud Specialist.

Step Two – Formal Process

If you are not satisfied with the response you have received through the first stage of the formal process, then you should raise your concerns with the Chief Executive or any other Executive Director. You will need to explain that you have already followed step one, and who you met with, so that the notes of that meeting and investigation can be reviewed.

S/he will meet with you within five working days of receipt of your communication. The contents of the meeting will be recorded in writing and a copy given to you within three working days of the meeting. S/he will also arrange for the concerns you are raising to be investigated further and will discuss with you how you will receive feedback, wherever practicable.

As before, you will need to make it clear that you are formally raising a matter of serious concern in the public interest and if you wish to keep your identity confidential you should also make that clear and this will be discussed with you.
You can involve your trade union representative or specialist advisor in helping you raise the matter.

If this does not resolve your concerns then you should move to step three.

[2] NB If an n issue goes to court, the Trust will not be able to guarantee that the judicial system will be able to maintain confidentiality of identity.

Step Three – Formal Process

If you are still not satisfied with the response which you have received through step two then you should:

Take your concerns to the Chairman, Management Office, Trust Headquarters, Marlborough Street, Bristol BS1 3NU).

or (if either you do not wish to raise the matter with the Chairman **or** you have done so, and remain dissatisfied)

To the Senior Independent Non-Executive Director by writing to: The Senior Independent, Non-Executive Director, c/o Management Office, Trust Headquarters, Marlborough Street, Bristol BS1 3NU.

The Chairman, or the Senior Independent Non-Executive Director will meet with you within ten working days.

You will need to explain that you have already followed step one, and who you met with, so that the notes of that meeting and investigation can be reviewed.

The outcome of the meeting will be recorded in writing and a copy given to you within three working days of the meeting. S/he will also arrange for the concerns you are raising to be further investigated and will discuss with you how you will receive feedback, wherever practicable.

As before, you will need to make it clear that you are formally raising a matter of serious concern in the public interest and if you wish to keep your identity confidential you should also make that clear, and this will be discussed with you.

You can involve your trade union representative or specialist advisor in helping you raise the matter.

Escalating Concerns – moving directly to step three

If you believe there are strong reasons why you should not approach your Manager, Divisional Director, Head of Nursing/Midwifery, Divisional Clinical Chair and/or the Chief Executive (step one and two) then you can approach the Senior Independent Non-Executive Director directly without following the earlier stages of the procedure.

As before, you will need to make it clear that you are formally raising a matter of serious concern in the public interest and if you wish to keep your identity confidential you should also make that clear, and this will be discussed with you.

FURTHER OPTIONS

If you remain dissatisfied with the response to your concerns and are worried that your concern has not been taken seriously or has not been dealt with appropriately, you may

wish to seek further advice from your trade union at local or full time official level and/or from a recognised professional regulatory body.

You may also wish to escalate your concerns externally by:

- Seeking further specialist guidance including discussing the matter further with professional advisors
- Contacting the Secretary of State for Health.
- Consulting your Member of Parliament
- Contacting the NHS Fraud & Corruption Reporting Line 0800 028 4060 if your concern is about fraud, or the National Whistleblowing Hotline **08000 724 725**. http://wbhelpline.org.uk/
- Referring the matter to the Health Service Ombudsman who may investigate complaints by staff on behalf of a patient; provided that s/he is satisfied there is no-one more appropriate such as an immediate relative to act on the patient's behalf.

It is strongly recommend that you seek further advice before escalating concerns externally. Extensive guidelines on how to raise a concern and how to escalate a concern with professional regulatory bodies, can also be found on the following websites:

- British Medical Association (BMA) - guidance for doctors and medical students
- General Medical Council (GMC) - guidance for doctors on raising and acting on concerns
- Nursing and Midwifery Council (NMC) - guidance and toolkits for nursing and midwifery
- Health and Care Professions Council (HCPC) - guidance for health care professionals
- Care Quality Commission (CQC) - guidance for health and care staff about how you can escalate a concern with the CQC.
- The Royal College of Surgeons (RCS) - guidance Acting on Concerns: Your Professional Responsibility was published on 19 February 2013, providing advice to clinicians on how to act if they consider patients are receiving poor care.

Disclosure to the media - Guidance

The Trust recognises that the public and staff have the right to know extensive details of how it operates. The Trust Board has made a commitment to be open and honest in how it runs the organisation. As a publicly accountable organisation, the Trust must ensure that its business is reported fairly and accurately.

The Trust does, however, hold highly confidential information about patients/clients and staff. Every employee of the Trust must respect this confidentiality.

When the media enquire about the Trust or its services, the inquiry should be forwarded straight away to the communications team – communications@uhbristol.nhs.uk or internal telephone extension 23629.

The Trust's media handling protocol sets out how the Trust works with the media, and within that, explains that staff are not authorised to represent the Trust to the media without first contacting the Communications department. This applies equally to contact by phone, email or in person at Trust premises, to approaches made at events or meetings or in staff members' personal interactions using new/social media. In the first instance all media enquiries should be directed to the Communications department.

However, as a Trust employee, you have the right to speak out against failures or mistakes in service. This, of course, includes the right to speak to the media and democratically elected representatives. It is not encouraged that any of us make a disclosure to the media as the **first** response to a concern. The reason for this is that it can adversely affect any investigations and evidence related to the concern. If all other routes have been exhausted and you want to consider an approach to the media, then please refer to the Trust Media Protocols, available on Connect or from the Communications Team, based at Trust Headquarters. Please be aware that information must not defame other members of staff, or breach regulations on confidentiality as laid down through the Caldicott Guardian or Data Protection Act.

As a member of NHS staff and in accordance with professional codes of practice, you have a duty of confidentiality to patients. Subject to the provisions of the Public Interest Disclosure Act, unauthorised disclosure of personal information about any patient will be regarded as a most serious matter**.** You should always therefore act in a way which minimises the chance of any individual patient being identified. The Trust Caldicott Guardian can provide advice:

Caldicott Guardian
University Hospitals Bristol NHS Foundation Trust
Marlborough Street
Bristol BS1 3NU
Tel : 0117 342 3610
Email: caldicottguardian@uhbristol.nhs.uk

4. OTHER USEFUL SOURCES OF INFORMATION AND SUPPORT

National Whistleblowing Helpline for staff

You can seek independent advice from the National Whistleblowing helpline. This service offers free, confidential advice to all staff within the NHS and Social care. The helpline will be able to clarify whether you have a whistleblowing concern and talk you through the processes to raise your concern; or will advise you on how to escalate the concern, if you feel that the issues raised have not been dealt with appropriately. It can also advise you of your rights under the Public Interest Disclosure Act 1998 (PIDA) which is aimed at protecting those who raise a patient safety, or other issue in the public interest by following the correct procedures.

To speak to a helpline advisor you should telephone: **08000 724 725**. The phone line is open Monday -Friday between 8 am- 6 pm. If calling out-of-hours or on a bank holiday, there is also an answering service where you can leave a message for an advisor to call you back at a convenient time. Alternatively, you can send an email to: enquiries@wbhelpline.org.uk

All messages are treated in strict confidence.

Further information is obtainable through the National Whistleblowing helpline website.

Public Concern at Work

You can also contact the independent charity Public Concern at Work, which runs a free help line for people who are worried about wrong doing in the workplace but who are unsure whether or how to raise the concern. Contact 020 7404 6609, or www.pcaw.co.uk for free confidential advice at any stage about how to raise a concern about serious malpractice at work.

NHS Employers Website

The NHS Employers website also has useful information about raising concerns in the public interest.
This can be accessed on the following website:

http://www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentpractice/raisingconcerns/Pages/Whistleblowing.aspx

Guidance for staff is also available on the following site:
http://www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/RaisingConcerns/Pages/GuidanceAndSupportforNHSStaff.aspx

OTHER RELEVANT POLICIES/GUIDANCE (Associated Documentation)

UH Bristol Grievance Policy (on HR Web)

UH Bristol Tackling Harassment and Bullying Policy (on HR Web)

UH Bristol Disciplinary Policy (on HR Web)

UH Bristol Conduct Policy (on HR Web)

UH Bristol Equality and Diversity Policy

UH Bristol Counter Fraud Policy and Procedure (on FinWeb)

UH Bristol Media Protocol (on Communications page of Connect)

Standing Orders (on FinWeb)

Standing Financial Instructions (on FinWeb)

Medical staff should read this policy in conjunction with 'Raising and Acting on Concerns about Patient Safety' issued by the General Medical Council and the BMA guidance Practical steps when raising a concern.

Medical staff who have concerns about patient safety can raise them with the General Medical Council through the confidential helpline (0161 9236399).

Nursing staff should read this policy in conjunction with Raising Concerns about Nurses or Midwives' issued by the Nursing and Midwifery Council.

5. Duties, Roles and Responsibilities (Leads and Key Contacts for the Speaking Out Policy)

- The Trust's leads for the Speaking Out Policy are the *Chief Executive* and the *Trust Secretary* who will ensure that concerns are investigated effectively and are in line with the formal procedure described within this policy. They will have the responsibility to ensure that there is adequate communication and support for those individuals whom the allegations have been made against.

- All Speaking Out Concerns will need to be recorded and details should be forwarded, under confidential cover to the *Trust Secretary*

- All anonymous letters and other anonymous communications should be referred, in strictest confidence, directly to the *Trust Secretary*, who will share the information with the *Chief Executive* and *Chair of the Trust Board* and use joint discretion in how to deal with the information.

5.1 Trust Board of Directors

- The *Trust Board* and the Audit Committee will receive a report of all Speaking Out cases raised within the Trust, via the *Trust Secretary* in order to monitor progress of investigations and summary outcomes of individual cases at least annually.

5.2 Executive Directors

- In cases of alleged fraud, the *Director of Finance* and the Local Counter Fraud Specialist Team should be advised.
- The *Director of Finance* with advice from the Local Counter Fraud and Security Management Services/NHS Protect will ultimately make the decision as to whether a case should be referred to the police. The protocol for the interaction between the Local Counter Fraud Specialist and Human Resources must be followed in cases when there may have been fraud by a member of staff

5.3 All Staff

- Where a member of staff believes an act has occurred which affects the provision of Trust Security Management, e.g. theft, criminal damage, the Trust's *Local Security Management Specialist* must be informed for further investigation as required by the Local Security Management Specialist/Security Advisor/ in conjunction with other relevant people or departments.

- Where the concern raised relates to the care and treatment of children or vulnerable adults the *Safeguarding Children / Adults Leads (or Safeguarding Team*) must be informed by the manager who the issue has been raised with. This also applies to knowledge of an individual's personal circumstances which may mean that they are not suitable to work with children or adults i.e. from a safeguarding perspective it is not just what happens in the Trust but outside the Trust as well. Such concerns should also be raised with the *Trust Local Authority Designated Lead - the Associate Director of HR.*

- Where a member of staff has any concerns that an individual may be susceptible to violent extremism or engaged in terrorist activity the *Safeguarding Adults Lead* must be informed by the manager.

5.4 Responsibility for Monitoring Compliance

- The *Trust Board* and the Audit Committee will receive a report of all Speaking Out cases raised within the Trust, via the *Trust Secretary* in order to monitor progress of investigations and summary outcomes of individual cases at least annually.

6. Standards and Key Performance Indicators

6.1 These will be measured through the Audit Committee.

Appendix A – INVESTIGATIONS INTO SPEAKING OUT CONCERNS

During informal and formal stages of the policy:

- if the matter relates to alleged fraud the manager should seek advice from the Local Counter Fraud Specialist.
- where an allegation constitutes a safeguarding concern then a referral must be immediately made to either children's or adults safeguarding team as appropriate.
- where an allegation constitutes a criminal offence then it should be referred to the police by the manager to whom it is reported.

Informal Stage of the Policy

A member of staff with concerns can raise her/his concerns informally with:

- The manager who is responsible for the area of work which you are concerned about.
- Their own manager (if this is somebody different)
- Another manager/senior person in the Trust.
- By telephone - calling the Raising Concerns telephone number extension 24487 or 0117 342 4487.
- By email - raisingconcerns@uhbristol.nhs.uk

Where the concern is highlighted through Raising Concerns telephone or email then this will be passed on to an appropriate manager to look into. Where the identity of the person raising the concern is known, s/he will be contacted to advise who will be looking into the issue which has been raised, and permission will be sought to pass the name and contact details of the person raising the concern to this manager. Where the person speaking out wishes to remain anonymous this will, of course, not be possible.

Whether a manager has been contacted directly by the person speaking out or has been passed the concern through Raising Concerns, s/he will then need to make every effort to resolve the matter informally by:

(a) Meeting or having a telephone conversation with the member of staff who has raised the concern, in strict confidence to establish the facts and to discuss how the matter can be resolved.
(b) Keeping notes of the discussion with the member of staff and passing the typed notes of the discussion to her/him (where possible) for agreement that this is a correct record.
(c) Carrying out an informal investigation into the allegations by making further enquiries in the area where the concern has been raised, and making recommendations to resolve the matter. If the manger thinks it is appropriate, they may ask another manager to investigate informally.

(d) Communicating (where possible) with the member of staff who raised the issue, to advise on what steps have been taken and the resolution.
(e) Advising the member of staff about the terms of the Speaking Out Policy and where s/he can raise the matter further, if s/he is dissatisfied with the response.

NB If a manager remains uncertain whether the concern being raised is "speaking out" or raising a complaint, then advice can be sought from another senior manager, from the Divisional HR Business Partner or from the Employee Services Team. The manager will need to explain to the person who has raised the concern that s/he will need to seek advice, and tell them when this will be done and when s/he will get back to them

If, on informal investigation, it is clear that there is a serious concern then the manager will need to escalate the concern to the Divisional Director and to the HR Team to request a formal investigation under the terms of the Speaking Out Policy.

If, considering all the facts the manager thinks that a formal investigation is required, s/he should also contact the person who has raised the concerns again and agree as to what and to whom the information will need to be given.

In cases of suspected fraud or corruption the manager will need to report the concerns to the Trust Local Counter Fraud Specialist and the Director of Finance.

If the concern raised is that an individual may be susceptible to violent extremism or engaged in terrorist activity the Safeguarding Adults Lead must be informed by the manager. Further liaison with other partner agencies may be required.

Where the concern raised relates to the care and treatment of children or vulnerable adults the Safeguarding Children's or Adults Leads must be informed by the manager who the issue has been raised with.

It is vital that the manager maintains the confidentiality of the person who has raised the issue and does not disclose her/his identity without seeking permission first.

The meeting/discussion with the member of staff should take place within five working days of receipt of the concern. The contents of the meeting will be recorded in writing and a copy given to the member of staff within three working days of the meeting.

Formal Stages of the Policy – Step One and Two

Under Steps one and two of the policy, a member of staff may, if dissatisfied with the response s/he has received to her/his concerns, raise the matter further, as follows:

(a) Step One - to the Divisional Director or Divisional Clinical Chair of the Division you work in (in the case of the Trust Services Division, this would be the relevant Executive Director or other relevant Director – for example, the Directors of IM&T or Facilities and Estates).

(b) Step Two - to the Chief Executive or any other Executive Director.

On receipt of the formal disclosure, the Director/Clinical Chair/Executive Director/Chief Executive should inform the Trust Secretary that they have received a disclosure under this policy. Where fraud is alleged, the Director of Finance should also be informed.

S/he will then need to:

a) Arrange for an interview, in the strictest confidence, with the employee making the allegation within five working days of receipt of the communication raising a concern.

b) The contents of the meeting will need to be recorded in writing and a copy given to the member of staff within three working days of the meeting to ensure that there is agreement that the concerns have been accurately recorded.

c) Wherever possible (and with the permission of the person speaking out) an independent witness should be present at interview.

d) Review the steps taken so far to resolve the concern i.e. when and to whom has this concern already been raised – whether informally or through a previous formal stage, what steps have been taken to resolve the issue.

e) Read and review any previous investigation to establish whether the matter has been correctly investigated and appropriate steps put in place to prevent any recurrence of the issues giving rise to the concern.

f) Consider whether a further formal investigation is required or whether other action is more appropriate, e.g. further implementation of recommendations, a review of staffing, a change to practice, escalation of the matter to a specific manager or a referral to the Counter Fraud Specialists or to the Safeguarding Team.

g) If, considering all the facts the manager thinks that an investigation is required, s/he should also contact the person who has raised the concerns again and agree as to what and to whom the information will need to be given.

h) Where it is considered that a further formal investigation needs to take place then an appropriate investigating team of two people (one of whom should be a member of the HR team) should be appointed to carry out a full investigation. It must be made clear that this is an investigation under the Speaking Out Policy – therefore (a) the person raising the concern is a potential witness, rather than a complainant and (b) that the identity of the person who has raised the concern cannot be disclosed without permission.

i) In cases of suspected fraud or corruption the concerns will need to be reported to the Trust Local Counter Fraud Specialist and the Director of Finance. The investigating team must be made aware of this, since it may impact on the way in which the investigation is carried out.

j) The investigation may - specifically in the case of alleged fraud or corruption - need to be carried out under the terms of strict confidentiality i.e. by not informing the

subject of the complaint until it becomes necessary to do so. In certain cases, however, such as allegations of ill-treatment of patients/clients, suspension from work may have to be considered immediately. Protection of patients/clients is paramount in all cases.

k) If the result of the investigation is that there is a case to be answered by any individual, the Trust's Disciplinary Policy will be used and the details discovered by the formal investigation, transferred to that process

l) Where there is no case to answer, but the employee held a genuine concern and was not acting maliciously, the Director/Clinical Chair/Executive Director/Chief Executive will need to ensure that the employee suffers no reprisals

m) If there is no case to answer but there is evidence that the allegation was made frivolously, maliciously or for personal gain, disciplinary action against the person raising the allegations will need to be considered.

n) If the concern raised is that an individual may be susceptible to violent extremism or engaged in terrorist activity the Safeguarding Adults Lead must be informed by the Director/Clinical Chair/Executive Director/Chief Executive

o) Where the concern raised relates to the care and treatment of children or vulnerable adults the Safeguarding Children / Adults Leads must be informed by the Director/ Clinical Chair/Executive Director/Chief Executive with whom the issue has been raised.

p) The Director/Clinical Chair/Executive Director/Chief Executive will need to communicate (where possible) with the member of staff who raised the issue, to advise on what steps have been taken and the resolution.

q) The Director/Clinical Chair/Executive Director/Chief Executive will also need to advise the member of staff about the terms of the Speaking Out Policy and where s/he can raise the matter further, if s/he is dissatisfied with the response.

r) At all stages it is vital that the Director/Clinical Chair/Executive Director/Chief Executive and the Investigating Team maintain the confidentiality of the person who has raised the issue and do not disclose her/his identity without seeking permission first.

Formal Stages of the Policy - Step Three

A member of staff who remains dissatisfied with the response s/he has received to her/his concerns, may raise the matter further, as follows:

(a) To the Chairman,
or (if either s/he do not wish to raise the matter with the Chairman **or** s/he has done so, and remains dissatisfied)
(b) To the Senior Independent Non-Executive Director

On receipt of the formal disclosure, the Chairman/Senior Independent Director' should inform the Trust Secretary that they have received a disclosure under this policy.

It will then be necessary to:

a) Arrange for an interview, in the strictest confidence, with the employee making the allegation within ten working days of receipt of the communication raising a concern, to seek clarification of the concerns and to subsequently make recommendations.

b) The contents of the meeting will need to be recorded in writing and a copy given to the member of staff within three working days of the meeting to ensure that there is agreement that the concerns have been accurately recorded.

c) Wherever possible (and with the permission of the person speaking out) an independent witness should be present at interview.

d) Review the steps taken so far to resolve the concern i.e. when and to whom has this concern already been raised – whether informally or through a previous formal stage, what steps have been taken to resolve the issue.

e) Read and review any previous investigation to establish whether the matter has been correctly investigated and appropriate steps put in place to prevent any recurrence of the issues giving rise to the concern.

f) Consider whether a further formal investigation is required – and if so, whether this should be an internal or external investigation, or whether other action is more appropriate, e.g. further implementation of recommendations, a review of staffing, a change to practice, escalation of the matter to a specific manager or a referral to the Counter Fraud Specialists or to the Prevent or Safeguarding Teams. The recommendations of the Chairman and/or Senior Independent Non-Executive Director should be considered and implemented and compliance with this should be reported to the Trust Secretary.

g) If, considering all the facts, it is considered that a further investigation is required, s/he should also contact the person who has raised the concerns again and agree as to what and to whom the information will need to be given.

h) Where it is considered that a further formal internal investigation needs to take place then an appropriate investigating team of two people (one of whom should be a member of the HR team) should be appointed to carry out a full investigation. It must be made clear that this is an investigation under the Speaking Out Policy – therefore (a) the person raising the concern is a potential witness, rather than a complainant and (b) that the identity of the person who has raised the concern cannot be disclosed without permission. NB if it is concluded that an external investigation is required then

this should be discussed with the Chief Executive and the Trust Secretary in the first instance

i) In cases of suspected fraud or corruption the concerns will need to be reported to the Trust Local Counter Fraud Specialist and the Director of Finance. The investigating team must be made aware of this, since it may impact on the way in which the investigation is carried out.

j) The investigation may - specifically in the case of alleged fraud or corruption - need to be carried out under the terms of strict confidentiality i.e. by not informing the subject of the complaint until it becomes necessary to do so. In certain cases, however, such as allegations of ill-treatment of patients/clients, suspension from work may have to be considered immediately. Protection of patients/clients is paramount in all cases.

k) If the result of an investigation is that there is a case to be answered by any individual, the Trust's Disciplinary Policy will be used and the details discovered by the formal investigation, transferred to that process

l) Where there is no case to answer, but the employee held a genuine concern and was not acting maliciously, the Chairman/Senior Independent Non-Executive Director will need to ensure that the employee suffers no reprisals

m) If there is no case to answer but there is evidence that the allegation was made frivolously, maliciously or for personal gain, disciplinary action against the person raising the allegations will need to be considered.

n) If the concern raised is that an individual may be susceptible to violent extremism or engaged in terrorist activity the Safeguarding Adults Lead must be informed by the Chairman/ Senior Independent Non-Executive Director.

Where the concern raised relates to the care and treatment of children or vulnerable adults the Safeguarding Children / Adults Lead must be informed by the Chairman/ Senior Independent Non-Executive Director with whom the issue has been raised.

o) The Chairman/Senior Independent Non-Executive Director will need to communicate (where possible) with the member of staff who raised the issue, to advise on what steps have been taken and the resolution.

The Chairman/Senior Independent Non-Executive Director will also need to advise the member of staff about the terms of the Speaking Out Policy and where s/he can raise the matter further, if s/he is dissatisfied with the response.

p) At all stages it is vital that the Chairman/Senior Independent Non-Executive Director and the Investigating Team maintain the confidentiality of the person who has raised the issue and do not disclose her/his identity without seeking permission first.

The Senior Independent Non-Executive Director should remain impartial in the process acting as a conduit for staff who feel it necessary to raise their concerns in line with this process. The Non-Executive Director shall remove themselves from any discussion undertaken by the Board as a whole in relation to the concerns raised until the point that the issue has been resolved in full.

If a manager to whom a Speaking Out concern is raised considers that there is a conflict of interest in reporting this to the Trust Secretary then s/he should report it, in the first instance, to the Senior Independent Non-Executive Director.

The Trust Secretary will, where necessary, support the Senior Independent Non-Executive Director. The level of support required will depend on the complexity of the concerns. The Trust Secretary will ensure the Senior Independent Non-Executive Director is advised in respect of applying the policy in line with the timescales, and assisting in the production of any documents, reports and or minutes taken as a result of meetings held between the Non-Executive Director and the member of staff who is speaking out.

Appendix B – FREQUENTLY ASKED QUESTIONS

Be the one who makes a difference
Stand Up
Speak Out

What is Speaking Out (Whistleblowing)?

Speaking Out (Whistleblowing) means that a member of staff raises a concern about a possible risk, wrong-doing or malpractice that has a public interest aspect to it - usually because it threatens or poses a risk to others (e.g. patients, colleagues or the public).

Whistleblowing concerns are different from grievances, which by contrast are about the staff member's own employment position and have no **additional** public interest.

What, exactly, is the difference between making a complaint and Speaking Out (Whistleblowing)?

When someone speaks out they are raising a concern about a risk, wrongdoing or malpractice or an illegal act that affects others (e.g. patients, members of the public, other staff or the Trust). The person speaking out is usually not directly, personally affected - they are simply trying to alert others.

This is very different from a complaint. When someone complains, they are saying that they have personally been poorly treated. This poor treatment could involve a breach of their individual employment rights or bullying and the complainant is seeking redress or justice for themselves (or sometimes for a colleague when, for example, they have seen someone else being bullied). The person making the complaint therefore, has a vested interest in the outcome of the complaint.

For these reasons, it is not in anyone's interests if the Trust's Speaking Out policy is used to pursue a personal grievance. Instead, people should seek advice from their manager or the Human Resources team about using the Trust's Grievance Policy, or Tackling Harassment and Bullying policy to address their concerns.

Why should I speak out?

All staff who work for the NHS have a contractual right and duty to raise genuine concerns, which they consider to be in the public interest, with their employer.

Speaking Out (Whistleblowing) can inform the people who need to know about health and safety risks, concerns about the care of vulnerable people, potential environmental risks, fraud, corruption and many other problems. Often it is only through speaking out that this information comes to light and can be addressed before real damage is done.
Speaking Out is a valuable activity which can positively influence our working lives and the lives of our patients and colleagues.

Will I risk being disciplined or dismissed for speaking out?

The Trust Board are committed to running UH Bristol in the best way possible and to do so we need your help. The Speaking Out policy is in place to reassure you that it is safe and acceptable to speak up and to enable you to raise any concern you may have at an early stage and in the right way. Rather than wait for proof, we would prefer you to raise the matter when it is still a concern.

If you raise a genuine concern, in the public interest, under this policy you will not be at risk of losing your job or suffering any form of retribution as a result. The Board of UH Bristol will not tolerate anyone attempting to stop you, harass, bully or victimise you or otherwise take action against you in any way.

Provided you are acting in good faith (effectively this means honestly), it does not matter if you are mistaken or if there is an innocent explanation for your concerns. So please do not think we will ask you to prove it – only to tell us about it and explain what has happened and why you are concerned. Of course we do not extend this assurance to someone who **maliciously** raises a matter they know is **untrue**. This would be regarded as a serious disciplinary offence and would be investigated in accordance with the Disciplinary procedure.

The Public Interest Disclosure Act (PIDA) also protects staff who raise a genuine concern (a "qualifying disclosure") in the public interest.

What is the Public Interest Disclosure Act?

The Public Interest Disclosure Act (PIDA) came into force in 1998 and is known in the UK as the whistleblowing law. This Act gives employees protection under the law and means that employers must not victimise any employee who raises a genuine concern in the public interest either internally or to a prescribed regulator. The Act covers all workers including temporary agency staff, people on training courses and self-employed staff who are working for and are supervised by the NHS. It does not cover volunteers – although the Trust's policy does apply to volunteers.

Where a person is subject to a detriment by their employer for raising a concern or is dismissed in breach of PIDA, they can bring a claim for compensation.

What is a "Qualifying Disclosure"? What kind of things should I speak out about?

A "qualifying disclosure" means any disclosure of information which, in reasonable belief of the person making the disclosure, shows concerns about one or more of the following things (therefore, these are the kind of things which you might speak out about):

- **Patient care and patient safety –** for example, malpractice, or ill treatment of a patient/client by any member of staff, or repeated ill treatment despite a complaint having been made.
- **Health and safety issues** e.g. that the health or safety of any person (patient, member of the public or member of staff) has been, is being or is likely to be endangered or disregard for legislation – particularly in respect of health and safety at work.

- **Financial matters** including fraud, corruption or abuse of position or a breach of standing financial instructions or standing orders
- **Unlawful conduct** – e.g. that a criminal office has been committed, is being committed or is likely to be committed
- **Breaches of the NHS Codes of Conduct on Governance**
- **Breaches of legal obligations** e.g. that a person has failed, is failing or is likely to fail to comply with a legal obligation which s/he is subject to.
- **Damage to the environment** - e.g. that the environment has been, is being or is likely to be damaged
- That information relating to any of the above has been, is being or is likely to be **deliberately concealed**

It can also include:
- Other financial irregularity
- Unethical practice
- Negligence
- Maladministration (lack of care, judgment, or honesty in the management of something)
- Showing undue favour over a contractual matter or to a job applicant.
- A breach of a professional code of conduct
- Failure to comply with a statutory obligation, e.g. Safeguarding

The Public Interest Disclosure Act (PIDA) 1998 says that, to be covered (and therefore protected) by the act, information disclosed by a concerned person needs to be a "qualifying disclosure".

Can I speak out anonymously?

With the assurances detailed here and in the policy, we hope you will raise your concern openly. However, we recognise that there may be circumstances when you would prefer to speak to someone in confidence first. If this is the case, please say so at the outset. If you ask us not to disclose your identity, we will not do so without your consent unless required by law.

You should understand that there may be times when we are unable to resolve a concern without revealing your identity, for example where your personal evidence is essential. In such cases, we will discuss with you whether and how the matter can best proceed.

If you feel strongly that you want to remain anonymous you can do so – you can ring the Raising Concerns telephone number extension 24487 or 0117 342 4487 or email raisingconcerns@uhbristol.nhs.uk making it clear that you are raising a concern but that you wish to remain anonymous. If you are using email then you will need to use an email account which lets you stay anonymous.

Please remember that if you do not tell us who you are it will be much more difficult for us to properly investigate and look into the matter. If you remain anonymous you will not be able to receive any feedback on the outcome of the investigation into the concern and it is more difficult for us to protect your position – since we will not know who you are.

If you raise a concern under either the informal or the formal stages of the Speaking Out Policy then, you can make it clear to the person you speak out to that you want to keep your identity confidential.

What is the difference between anonymity and confidentiality?

A person raises a concern confidentially if he or she gives his or her name only on condition that it is not revealed without their consent. A person raises a concern anonymously if he or she does not give his or her name. Usually, the best way to raise a concern is to do so openly.

If you wish to keep your identity confidential it will not be disclosed without your consent, other than in the circumstances below:

If, exceptionally, the situation arises where the concern cannot be resolved without revealing your identify then whether and how to proceed will be discussed with you. Confidentiality cannot be maintained if the manager or person to whom the concerns are expressed considers that there is an immediate risk to patient safety and that, therefore, the matter must be addressed immediately. In such circumstances you would be informed of this course of action and a support plan would be mutually agreed.

(i) If I want to speak out, what information will I need to provide?

So that your concerns can be assessed and investigated at any informal or formal stage, it would be helpful if you could be as clear as possible with the details. The person you are meeting with will need to understand the following:

- what happened – the nature of the incident(s)
- who was involved
- when it happened – dates and times
- where it happened – locations
- who was present/involved when incident(s) took place
- why you think it occurred (if possible)
- any effects on you (including those which may have been experienced outside of work)
- the frequency of any incidents
- If possible, explain how you think the matter may be best resolved or start thinking about it in preparation for any meetings you may be required to attend (if you have shared your identity)
- Any steps you have already taken (e.g. whether you have already raised the matter informally or at an earlier formal stage and with whom).
- any other issues relating to the concern.
- If you feel comfortable sharing your identity then please provide us with your name, your work location and contact details

(ii) What happens after I have spoken out?

An investigation will be arranged and you may be contacted for a further interview. There will be no pressure on you to **prove** that the concern you have raised is true – what is needed is for you to tell us what you have seen/heard and what your concerns are.

(iii) Who should I talk to, if I want to speak out?

There are lots of ways in which you can raise concerns under the Speaking Out policy and you can do so informally or formally:

During informal and formal stages of the policy:

- if the matter relates to alleged fraud you/ the manager you speak with should seek advice from the Local Counter Fraud Specialist.
- where an allegation constitutes a safeguarding concern then a referral must be immediately made to either children's or adults safeguarding team as appropriate.
- where an allegation constitutes a criminal offence then it should be referred to the police by the manager to whom it is reported.

Informally

You can raise your concerns with:

- The manager who is responsible for the area of work which you are concerned about.
- Your own manager (if this is somebody different)
- Another manager/senior person in the Trust.
- By telephone - calling the Raising Concerns telephone number extension 24487 or 0117 342 4487.
- By email - raisingconcerns@uhbristol.nhs.uk.

You will need to make it clear that you are raising a concern under the Speaking Out policy.
Make sure that you say if it is important for you to remain anonymous.

If you do not feel strongly that your concern must be raised anonymously but you would like your identity to be kept confidential (not disclosed without discussing it with you first) then explain this, when raising your concern.

You can involve your trade union representative or specialist advisor in helping you raise the matter.

If you speak with a manager in the Trust then they will arrange for the concerns to be investigated. If you raise your concerns through the Raising Concerns email or telephone line, then this will be passed to a relevant manager for them to arrange for the matter to be investigated and the Trust Secretary will be advised that a concern has been raised. Your identity will not be disclosed without your permission.

Formally

We would like to encourage you to raise your concerns informally, in the first instance. However, if the informal action however you choose to raise it) does not address your concerns or if you feel strongly that the matter is too serious to be dealt with through an informal process, then you should use the formal steps of the Speaking Out Policy by:

Step One

- Raising your concerns with the Divisional Director, or Divisional Clinical Chair of the Division you work in (in the case of the Trust Services Division, this would be the relevant Executive Director or other relevant Director – for example, the Directors of IM&T or Facilities and Estates).

S/he will meet with you within five working days of receipt of your communication. The contents of the meeting will be recorded in writing and a copy given to you within three working days of the meeting. S/he will also arrange for the concerns you are raising to be investigated and will discuss with you how you will receive feedback.

You can raise your concerns either verbally or in writing. If you are raising a concern formally, and you don't want anybody other than the person you are telling to know about this yet, it isn't recommended that the concern is raised via email because in some cases staff, other than the named recipient, have permission to view emails

You will need to make it clear that you are formally raising a matter of serious concern in the public interest and if you wish to keep your identity confidential you should also make that clear.

As with the informal process, you can involve your trade union representative or specialist advisor in helping you raise the matter.

Step Two - What if I am not satisfied with the response I receive?

If you are not satisfied with the response you have received through the first stage of the formal process, then you should raise your concerns with:

- The Chief Executive or any other Executive Director.

S/he will meet with you within five working days of receipt of your communication. The contents of the meeting will be recorded in writing and a copy given to you within three working days of the meeting. S/he will also arrange for the concerns you are raising to be investigated and will discuss with you how you will receive feedback.

Step Three - What if I am still not satisfied with the response I receive?

If, after this, you are still not satisfied with the response which you have received then you can:

- Take your concerns to the Chairman **or** (if either you do not wish to raise the matter with the Chairman or you have done so, and remain dissatisfied) to the Senior Independent Non-Executive Director (by writing to either (a) The Chairman or (b) The Senior Independent, Non-Executive Director, c/o Management Office, Trust Headquarters, Marlborough Street, Bristol BS1 3NU)

The Chairman, or the Senior Independent Non-Executive Director will meet with you within ten working days. The outcome of the meeting will be recorded in writing and a copy given to you within three working days of the meeting. S/he will also arrange for the concerns you are raising to be investigated and will discuss with you how you will receive feedback.

As before, you will need to make it clear that you are formally raising a matter of serious concern in the public interest and if you wish to keep your identity confidential you should also make that clear.

You can involve your trade union representative or specialist advisor in helping you raise the matter.

Do I always have to follow all the steps in the informal and formal procedure ?

If you believe there are strong reasons why you should not approach your Manager, Divisional Director, Divisional Clinical Chair and/or the Chief Executive then you can approach the Senior Independent Non-Executive Director directly without following the earlier stages of the procedure.

What if I have completed the formal process and I am still dissatisfied with the response I have received?

If you are not satisfied with the response to your concerns and are worried that your concern has not been taken seriously or has not been dealt with appropriately, you may wish to seek further advice from your trade union at local or full time official level and/or from a recognised professional regulatory body.

You may also wish to escalate your concerns externally by:

- Seeking further specialist guidance including discussing the matter further with professional advisors
- Contacting the Secretary of State for Health.
- Consulting your Member of Parliament
- Contacting the NHS Fraud & Corruption Reporting Line 0800 028 4060 if your concern is about fraud, or the National Whistleblowing Hotline **08000 724 725**.

It is strongly recommend that you seek further advice before escalating concerns externally. Extensive guidelines on how to raise a concern and how to escalate a concern with professional regulatory bodies, can also be found on the following websites:

- British Medical Association (BMA) - guidance for doctors and medical students
- General Medical Council (GMC) - guidance for doctors on raising and acting on concerns

- Nursing and Midwifery Council (NMC) - guidance and toolkits for nursing and midwifery
- Health and Care Professions Council (HCPC) - guidance for health care professionals
- Care Quality Commission (CQC) - guidance for health and care staff about how you can escalate a concern with the CQC.
- The Royal College of Surgeons (RCS) - guidance Acting on Concerns: Your Professional Responsibility was published on 19 February 2013, providing advice to clinicians on how to act if they consider patients are receiving poor care.

Can I disclose my concerns to a Regulatory Body?

All concerns should normally be raised internally. However, you may disclose information to a regulatory body where the issue in question relates to that specific regulatory body (e.g. to the Health and Safety Executive if you have concerns relating to the health and safety of an individual).

For these disclosures to be protected the following requirements must be met:
(i) the concern falls within the ambit of that regulatory body; and
(ii) you must reasonably believe that the information is substantially true; and
(iii) the disclosure is being made in good faith and in the public interest.

Can I disclose my concerns to the Media?

It is not encouraged that any of us make a disclosure to the media as the **first** response to a concern. The reason for this is that it can adversely affect any investigations and evidence related to the concern. If all other routes have been exhausted and you want to consider an approach to the media, then please refer to the Trust Media Protocols, available on Connect or from the Communications Team, based at Trust Headquarters. If you want to raise a concern you should always follow the Speaking Out policy and procedure first.

What if my concerns are about Fraud or Corruption?

If you believe that a fraud or corruption has taken place, these concerns will need to be reported to the Local Counter Fraud Specialist, based at Whitefriars, or the Director of Finance, based at Trust Headquarters. You may prefer to do this by raising your concerns formally or informally as above and explaining to the manager/director you are speaking to that you have a concern relating to fraud/corruption which they will need to speak with Counter Fraud or the Finance Director about.

You may also choose to contact the NHS Fraud and Corruption Hotline. They are trained to handle calls confidentially and will pass the information to the relevant authorities. The hotline number is: 0800 0284060.

Can I get independent advice from outside the Trust about raising a concern?

Yes, anybody who works within the NHS and Social Care can seek free, independent and confidential advice at any time from the National Whistleblowing Helpline. This can be particularly helpful if you are unsure about whether to speak out, whether your concern is a "qualifying disclosure" or if you would like some independent support and advice.

The helpline number is **08000 724 725**, advice can also be sought via email at enquiries@wbhelpline.org.uk
The helpline is available weekdays between 08.00 and 18.00 with an out of hours answering service on weekends and public holidays.

You can also contact the independent charity Public Concern at Work, which runs a free help line for people who are worried about wrong doing in the workplace but who are unsure whether or how to raise the concern. Contact 020 7404 6609, or www.pcaw.co.uk for free confidential advice at any stage about how to raise a concern about serious malpractice at work.

Additional guidance and support has also been provided for staff by a number of the Professional Regulatory Bodies, as follows:

- British Medical Association (BMA) - guidance for doctors and medical students
- Nursing and Midwifery Council (NMC) - guidance and toolkits for nursing and midwifery
- Health Professions Council (HPC) - guidance for health care professionals
- General Medical Council (GMC) - guidance for doctors on raising and acting on concerns
- The Care Quality Commission (CQC) has also produced guidance for health and care staff about how you can contact CQC if you do not feel able to report your concern internally or if you feel your concern has not been acted upon.

What if my concerns are not about this Trust, but about another NHS Organisation?

If you have a concern about another NHS Trust or organisation then please contact your line manager or another senior manager in the Trust to explain the concerns you have. This manager will then contact an Executive Director at UH Bristol who will make contact with the appropriate Executive Director in the other NHS Organisation.

Appendix C – GUIDANCE FOR MANAGERS / STAFF WHEN A CONCERN IS RAISED TO YOU UNDER THE SPEAKING OUT (WHISTLEBLOWING) POLICY

Introduction

Handling and investigating concerns raised under the Speaking Out (Whistle-blowing) Policy and Procedure is very different from dealing with a complaint or grievance raised by an individual. The key differences are:

- A concern is not the same as a grievance. Under the grievance procedure the complainant has to make a case and normally has a personal interest in the outcome. In cases reported under the Speaking Out Policy the whistleblower is a **witness** not a complainant and is raising the concern for others to investigate.

- The person speaking out to you may be raising the issues in confidence and it is important that the difference between confidentiality and anonymity is made clear to the whistleblower (see Frequently Asked Questions which clarifies this).

The Public Interest Disclosure Act (PIDA) protects staff who raise a genuine concern (a "qualifying disclosure") in the public interest.

Qualifying Disclosures

A "qualifying disclosure" means any disclosure of information which, in reasonable belief of the person making the disclosure, shows concerns, in the public interest, about one or more of the following things (therefore, these are the kind of things which people may speak out about):

- **Patient care and patient safety –** for example, malpractice, or ill treatment of a patient/client by any member of staff, or repeated ill treatment despite a complaint having been made.
- **Health and safety issues** e.g. that the health or safety of any person (patient, member of the public or member of staff) has been, is being or is likely to be endangered or disregard for legislation – particularly in respect of health and safety at work.
- **Financial matters** including fraud, corruption or abuse of position or a breach of standing financial instructions or standing orders
- **Unlawful conduct** – e.g. that a criminal office has been committed, is being committed or is likely to be committed
- **Breaches of the NHS Codes of Conduct on Governance**
- **Breaches of legal obligations** e.g. that a person has failed, is failing or is likely to fail to comply with a legal obligation which s/he is subject to.
- **Damage to the environment** - e.g. that the environment has been, is being or is likely to be damaged
- That information relating to any of the above has been, is being or is likely to be **deliberately concealed**

It can also include:

- Other financial irregularity
- Unethical practice
- Negligence
- Maladministration (lack of care, judgment, or honesty in the management of something)
- Showing undue favour over a contractual matter or to a job applicant.
- A breach of a professional code of conduct
- Failure to comply with a statutory obligation, e.g. Safeguarding

***See** the* Speaking *Out Policy and Frequently Asked Questions for further details.*

Responding to a concern

If somebody raises a concern about wrongdoing, a risk or a potential risk, you will need to take it seriously and deal with it immediately.

If a concern is raised with you under the terms of the Speaking Out Policy and Procedure it is important that you:

- support the individual who raises the concern;

- assure the person raising the concern that the Trust will not allow them to be victimised or retaliated against for bringing the issue into the open (and discuss with them how they can tell you if they experience any victimisation or retaliation);

- listen to the complaint, keeping an open mind - remember that there are different perspectives to every story - you will always need to be aware that there may be other issues that are either the real cause for concern OR which are running concurrently to the concern raised.

- explain that feedback will be given on any investigation of the concerns raised and that if the concern is raised confidentially their identity will not be disclosed without their consent.

- Remember that there are different perspectives to every story - you will always need to be aware that there may be other issues that are either the real cause for concern OR which are running concurrently to the concern raised.

- keep a written and dated record of the initial conversation and if possible (unless the complaint is anonymous) agree the accuracy with the individual – by asking them to sign the written record (which should be typed and kept under confidential cover);

- ensure that you understand what they are saying by clarifying facts. These should include:

    - what happened – the nature of the incident(s)

  - who was involved
  - when it occurred – dates and times
  - where it occurred – locations
  - who was present when incident(s) took place
  - why it occurred (if possible)
  - any effects on the whistleblower (including those which may have been experienced outside of work)
  - any reaction of the person(s) concerned at the time of the incident
  - the frequency of any incidents
  - any other issues relating to the concern.

- ensure that the person concerned understands the Speaking Out: (Whistle-blowing) Policy and Procedure and that raising a genuine, even if unfounded, concern in the public interest will not expose them to disciplinary action but that maliciously raising false concerns, which are known to be untrue, is a disciplinary offence;

- consider whether the concerns being raised to you fall under the Speaking Out policy – when someone speaks out under this policy they are raising a concern about a risk, wrongdoing or malpractice or an illegal act that affects others (e.g. patients, members of the public, other staff or the Trust). The person speaking out is usually not directly, personally affected - they are simply trying to alert others.

- If the concerns being raised are not of this kind, but the person is complaining that they, personally, have been poorly treated, e.g. they are raising a personal grievance or a complaint of harassment and bullying then you will need to discuss how they can take this forward (e.g. through the Grievance or Tackling Harassment and Bullying Policy).

- If you remain uncertain whether the concern being raised is “speaking out” or raising a complaint, then advice can be sought from another senior manager, from your Divisional HR Business Partner or from the Employee Services Team. You will need to explain to the person who has raised the concern that you will need to seek advice, and tell them when you will do this and when you will get back to them.

- After considering all the facts you may feel it necessary to contact the whistleblower again and agree as to what and to whom the information will need to be given. This should normally be to someone who can be seen as impartial and who is also bound by the rules of confidentiality e.g. your Divisional Director/Clinical Chair.

- Consider discussing the concern to your Divisional Director/Divisional Clinical Chair/other member of your Divisional board and/or another appropriate manager or executive in the organisation, in strictest confidence, to seek help. Remember that you must not disclose the identity of the person who has spoken out, without their permission.

- Once you are clear that the person who is raising the concern to you is "speaking out" and not raising a personal complaint, you will need to follow the steps in the Speaking Out Policy Appendix A *"Investigations into speaking out concerns"*

- If the concern is potentially very serious or wide-reaching, consider whether you are best placed to handle the investigation or whether you need to involve somebody else (for example, a more senior manager or a manager with specific knowledge of the area of concern) should handle the investigation and know when to ask for help.

- If another individual is the person identified as the cause for concern they have rights which you should also consider. If you have been able to resolve the concern immediately to the satisfaction of the person raising the concern, you may not need to inform the second party. But if you need to pursue the concern further and involve other parties to assess the risk as part of an **informal** investigation, for example, that second party has a right to be informed (unless there is a suspected fraud/corruption when the Local Counter Fraud Specialists may advise against this in the first instance). Every effort should be made to do this in a sensitive manner and still protecting the interests of the person raising concerns.

- Concerns about potential fraud, theft or corruption will need to be raised with the Local Counter Fraud Specialist Team and the Director of Finance will need to be advised.

- Where the concern raised relates to the care and treatment of children or vulnerable adults the Safeguarding Children / Adults Leads must be informed by the manager who the issue has been raised with. This also applies to knowledge of an individual's personal circumstances which may mean that they are not suitable to work with children or adults i.e. from a safeguarding perspective it is not just what happens in the Trust but outside the Trust as well.

- Where a member of staff has any concerns that an individual may be susceptible to violent extremism or engaged in terrorist activity the Safeguarding Adults Lead must be informed.

- Remember that you need to advise the Trust Secretary of any Speaking Out concerns which are raised to you. This needs to be done in confidence, and without identifying the person who has spoken out, unless you have her/his permission to do so.

Appendix D – PREVENT (safeguarding from extremist and terrorist exploitations)

PREVENT is part of the Government's counter terrorism strategy. Healthcare staff may work with, meet and treat people who are vulnerable to radicalisation. Where there are signs that someone has been or is being drawn into terrorism healthcare staff may notice and be able to act prevent someone from becoming a terrorist. This is no different from safeguarding vulnerable individuals from other forms of exploitation

Should any staff member have a concern relating to an individual's behaviour which may indicate that they may be being drawn into terrorist related activity they should raise a concern in line with the Prevent team.

Indicators may include:

Graffiti symbols, writing or artwork promoting extremists messages or images
Patients or staff accessing terrorist related material online, including through social networking sites
Parental/ family reports of changes in behaviour, friendships or actions and requests for assistance
Patients voicing opinions drawn from terrorist related ideologies and narratives
Use of extremist or hate terms to exclude others or incite violence

Raising Concerns

Concerns can be raised by:

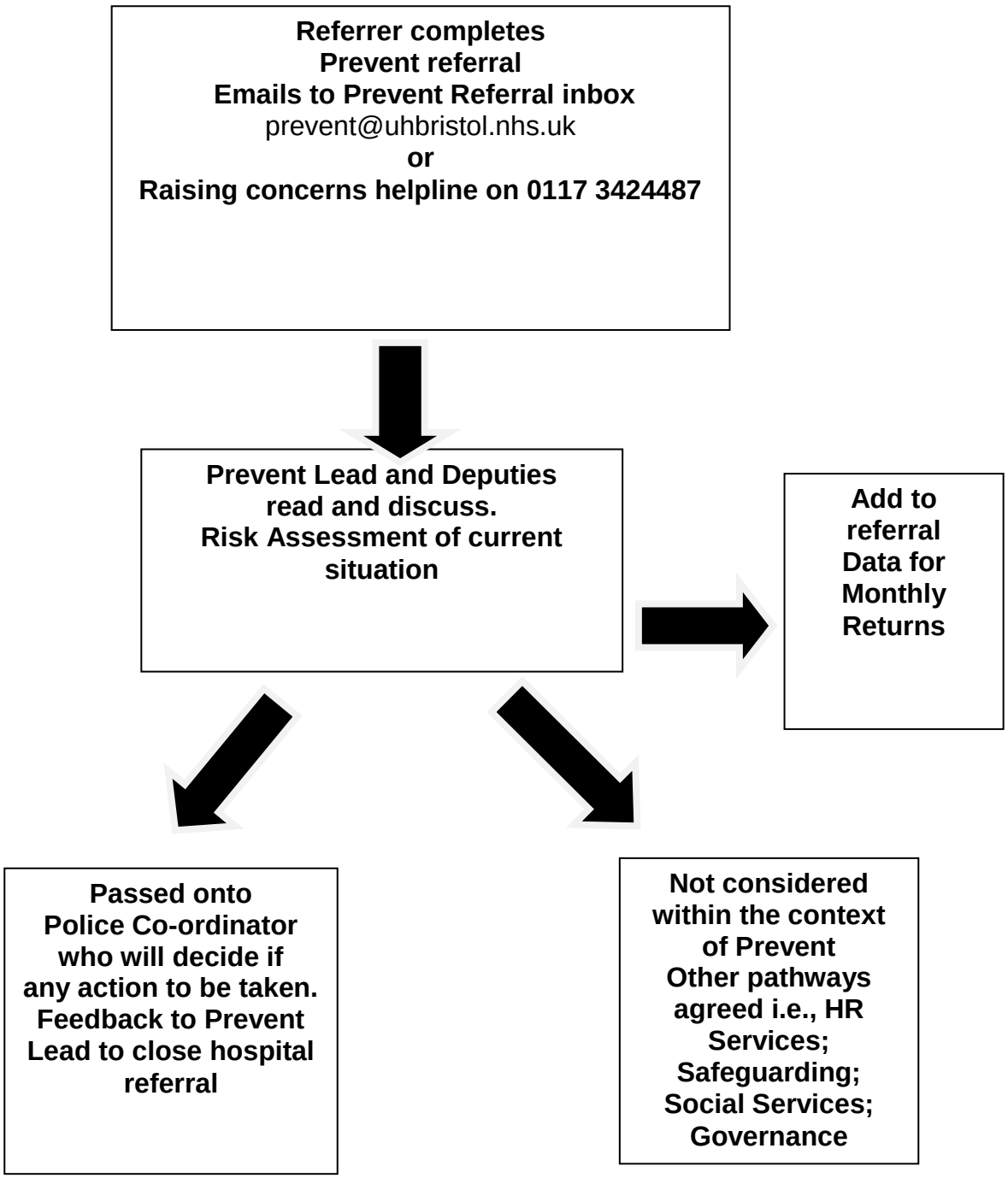
Emailing prevent@uhbristol.nhs.uk
Phoning the Raising Concerns helpline 0117 342 4487 (calls can be made anonymously)

The Safeguarding Adults Lead can decide to pass the concern to the police or deal with the matter internally.

Prevent contacts

NAME	JOB TITLE	PHONE	EMAIL
Linda Davies	Safeguarding Adults Lead	0117 3421696	Linda.Davies2@UHBristol.nhs.uk
Cass Sandman	Resilience Manager	0117 3421340	Cass.Sandmann@UHBristol.nhs.uk
Ian Britton	Local Security Management Specialist	0117 3422995	Ian.Britton@uhbristol.nhs.uk
Deborah Tunnell	Employee Services Manager	0117 3425000	Deborah.Tunnell@uhbristol.nhs.uk

PREVENT Referral Process Flowchart



Appendix E – Monitoring Table for this Policy

Item	Method	Frequency	Monitored by
All Speaking Out cases raised within the Trust, including progress with investigations and summary outcomes	Report by Trust Secretary	Annually	Audit Committee Trust Board

Appendix F – Dissemination, Implementation and Training Plan

6.2 The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Organisational Development
This document replaces existing documentation:	Yes
Existing documentation will be replaced by:	Rescinding of superseded document
This document is to be disseminated to:	Divisional Directors, Clinical Leads, Heads of Service, HR Business Partners and all staff via HR Web
Training is required:	Not Applicable

Additional Comments
[DITP - Additional Comments]

Appendix G – Document Checklist

6.3 The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct (i.e. Strategy, Policy, Protocol, Procedure, etc.):	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation (e.g. 'Personal Data' as defined in the Data Protection Act 2000):	No
	All terms used are explained in the 'Definitions' section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Yes
	The following were consulted:	Senior Leadership Team; Staff Side via Joint Union Committee, Policy Group and Workforce & Organisational Development Group
	Suitable 'expert advice' has been sought where necessary:	Yes
Evidence Base	References are cited:	Yes
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	[DCL - Trust Objectives]
Equality	The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	Yes
Monitoring	Monitoring provisions are defined:	Yes

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
	There is an audit plan to assess compliance with the provisions set out in this procedural document:	Yes
	The frequency of reviews, and the next review date are appropriate for this procedural document:	Yes
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Yes

Additional Comments
[DCL - Additional Comments]

EQUALITY IMPACT ASSESSMENT SCREENING FORM			
Title: Speaking Out (Whistleblowing Policy)			
Author: Trish Ferguson-Jay		**Division: Trust Services**	**Date: 12th March 2015**
Document Class: Policy	**Document Status:**	**Issue Date:**	**Review Date: April 2017**

What are the aims of the document?

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To communicate the commitment of the Trust to sustain a culture of openness, accountability and probity and inform all Trust staff of the process to follow if they should wish to raise any concerns about Health service, issues, Trust Activities, misconduct within the organisation or provide information about illegal and/or inappropriate practices. Advice and guidance is also offered for those to whom concerns are raised.

What are the objectives of the document?

To be able to give staff clear guidance on the correct process to follow when wish to raise a concern and to enable them to do so without fear of victimisation or of suffering detriment.

To be able to advise staff on the meaning and status of a 'protected disclosure'

How will the effectiveness of the document be monitored? Through regular review of Speaking Out Concerns and via Audit Committee.

Who is the target audience of the document (which staff groups)? All staff

Which stakeholders have been consulted with and how?

Staff Side, Counter Fraud, Safeguarding, Security, Key managers across the Trust, the HR Community/

Who is it likely to impact on?

√	Staff		Patient	√	Visitors		Carers		Other (please specify):

Does the policy/strategy/function or proposed change affect one group more or less favourably than another on the basis of:	Yes or No	Give reasons for decision	What evidence was examined?
Race	No	The confidential formal process will support all staff/groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Ethnic Origin (including gypsies and travellers)	No	The confidential formal process will support all staff/groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Nationality	No	The confidential formal process will support all staff/groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Gender (including transgender)	No	The confidential formal process will support all staff /groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Culture	No	The confidential formal process will support all staff/groups.	Consideration of Trust's workforce profile.

			Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Religion or belief	No	The confidential formal process will support all staff/groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Sexual Orientation (including lesbian, gay, bisexual and transgender)	No	The confidential formal process will support all staff /groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Age	No	The confidential formal process will support all staff /groups.	Consideration of Trust's workforce profile. Review of/Benchmark against other Whistleblowing policies in other organisations. Consideration of existing data on staff concerns (e.g. national staff survey)
Disability (including learning disability, physical, sensory impairment and mental health)	No	The confidential formal process will support all staff/groups. However, the following should be noted: Some staff with disabilities (depending on the nature of that disability) may need an interpreter or a support worker with them when whistleblowing – a factor which potentially impacts on confidentiality,	
Socially excluded groups (e.g. offenders, travellers)	No	The confidential formal process will support all staff/groups.	Review of/Benchmark against other Whistleblowing policies in other organisations.

Human Rights	No		Review of/Benchmark against other Whistleblowing policies in other organisations.
Are there opportunities for promoting equality and/or better community relations? If YES, please describe: The Policy provides a robust, confidential process for staff to take action, and offer those staff protection from victimisation or detriment for so doing.			
Please state links with other relevant policies, strategies, functions or services: Staff Conduct Policy, Grievance Policy, Disciplinary Policy			
Action Required:			
Action Lead:		To be delivered by when:	
Progress to date:			
Next steps:			
How will the impact on the service/policy/function be monitored and evaluated?			
Person completing the assignment:		Date: Review Date:	