University Hospitals Bristol NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS HELD IN PUBLIC

Date: Wednesday 27 May 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
	Jill Youds	Non-executive Director
	Sue Donaldson	Director of Workforce and Organisational Development
	Paul Mapson	Director of Finance and Information
	Carolyn Mills	Chief Nurse
	Sean O'Kelly	Medical Director
	James Rimmer	Director of Strategy and Transformation
In attendance:	Debbie Henderson	Trust Secretary
	Isobel Vanstone	Corporate Governance Administrator (Minutes)
Apologies:	Robert Woolley	Chief Executive
	Deborah Lee	Chief Operating Officer and Deputy Chief Executive
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 27 May 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 30 April 2015	Chairman	4
4. Matters Arising (Action log) To review the status of actions agreed	Chairman	15
5. Chief Executive's Report To receive the report from the Director of Finance & Information in the absence of the Chief Executive to note	Director of Finance & Information	16
Delivering Best Care and Improving Patient Flow		
6. Patient Experience Story To receive the Patient Experience Story for review	Chief Nurse	20
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	Associate Director of Performance / Deputy Chief Operating Officer	24
8. Terms of Reference for Quality and Outcomes Committee To receive the terms of reference for approval	Chair of Quality & Outcomes Committee	104
9. Quarterly Workforce Report To receive the report for assurance	Director of Workforce & OD	115
10. Speaking Out Policy To receive the policy for approval	Director of Workforce & OD	152
Delivering Best Value		

11. Finance Report (including Finance Resource Book 2015/16) To receive the report for assurance	Director of Finance & Information	206
12. Finance Committee Chair's Report To receive the verbal report for assurance	Finance Committee Chair	
13. Capital Investment Policy To receive the policy for approval	Director of Finance & Information	226
14. Treasury Management Policy To receive the policy for approval	Director of Finance & Information	239
Compliance, Regulation and Governance		
15. Audit Committee Chair's report To receive the verbal report for assurance	Audit Committee Chair	
Information		
16. Governors' Log of Communications To receive the Governors' log to note	Chairman	241
17. 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: 30 June 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 30 April 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
Alex Nestor – Deputy 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
Alison Ryan – Non-Executive Director
Lisa Gardner – Non-Executive Director

Present or in attendance:
Debbie Henderson – Trust Secretary
Isobel Vanstone – Corporate Governance Administrator (Minutes)
Aidan Fowler – Fast-Track Executive
Amanda Saunders – Head of Membership and Governance
Alison Grooms – Deputy Chief Operating Officer
Bob Bennett – Public Governor
Wendy Gregory – Carer/Patient Governor
Fiona Reid – Head of Communications
Sharon Lim Kong – Paediatric Registrar
Florence Jordan – Staff Governor
Sylvia Townsend – Appointed Governor
Neil Harrison – BT Representative
Anne Skinner – Patient Governor
Bob Skinner – Trust Member
Tony Tanner – Public Governor
John Steeds – Patient Governor
Jeannette Jones – Appointed Governor
Clive Hamilton – Public Governor
Ray Phipps – Patient Governor

01/04/15 Chairman's Introduction and Apologies
Apologies for absence were received from Sue Donaldson (Director of Workforce and Organisational Development) and Jill Youds (Non-Executive Director).

02/04/15 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 interest were received.

03/04/15 Minutes and Actions from Previous Meeting
The Board considered the minutes of the meeting of the Board of Directors held in public on 31 March 2015 and approved them as an accurate record, subject to the following:

Carolyn Mills confirmed that the improvement of the '*quality'* of complaint responses had been included in the Trust Quality Objectives.

John Moore and Robert Woolley confirmed that the increase in the number of hospital acquired pressure sores had been acknowledged by Robert. It was:

RESOLVED:

- **That the minutes of the meeting held 31 March 2015 be agreed as an accurate record of proceedings, subject to amendments outlined in the minutes**

04/04/15 Matters Arising
Matters arising and actions complete were noted by the Board.

05/04/15 Chief Executive Report
Robert Woolley took an opportunity to reflect on the Trust's achievements in 2014/15 and made particular reference to the Trust's achievement of performance against the recovery trajectories for quarter 4. Robert noted that this had been welcomed by Monitor at a meeting which took place to discuss the performance recovery plan and submission of the Trust's annual plan for 2015/16.

Robert reported progress against the Trust's action plan following the comprehensive inspection undertaken by the Care Quality Commission (CQC) in September 2014. Members of the Board were briefed on the recent Quality and Risk Profile outlined in the quarterly CQC Intelligence Monitoring report which confirmed that the UH Bristol risk rating had substantially improved since the last review in December. The report detailed five risks, none of which were elevated and reflected a move to a Band 5 rating (Band 6 reflecting the lowest risk).

UH Bristol had exceeded the planned surplus at £6.3m for 2014/15 before the exceptional items, but Robert emphasised the challenging year ahead for all NHS providers. A significant amount of work had been undertaken to develop the plan in order to give the Trust the best chance of success.

Robert confirmed the recent senior management changes, previously approved by the Board of Directors and Remuneration and Nomination Committee, to take effect from 1st May 2015. James Rimmer had been appointed as Director of Strategy and Transformation, responsible for shaping the future of local health and social care services in line with the strategy of the Trust Board, working with relevant system agencies and voluntary and independent sector partners, and for all aspects of strategic development, business planning and service transformation in the Trust. Deborah Lee had been appointed as Chief Operating Officer, responsible for delivery of clinical services to contractual standards, facilities and estates, business continuity planning and oversight of the Clinical Divisions. Deborah would also retain the role of Deputy Chief Executive.

Robert briefed members of the Board on a recent successful 'Breaking the Cycle' programme. The programme reaffirmed the Trust's commitment to excellent standards of

care and staff from across the Trust, and from partner agencies, volunteered to help on wards to address issues which impact on patient flow and providing excellent care. The programme had a significant effect with patient flow improving dramatically.

Emma Woollett reflected on her time as a ward liaison officer for the programme and felt it to be an inspirational experience both in terms of the information and check lists that had been provided, demonstrating a clear understanding of the issues to be addressed. Emma had also been heartened by the level of commitment, compassion and efficiency of all staff involved.

Robert Woolley reported that Dr Sarah Caine, Consultant would be retiring on 30th April 2015 and reflected on her dedication and commitment to the care of the elderly service. It was acknowledged that Dr Caine's leadership in the Stroke Service would be missed and the Board took an opportunity to wish Dr Caine best wishes for the future.

Emma Woollett requested an update on the transfer of the Cellular Pathology service. Robert Woolley reminded Board members that the transfer of Cellular Pathology to North Bristol Trust had been agreed in principle, subject to the development of a robust Service Level Agreement, and noted inter-dependencies with regard to physical and system infrastructure at North Bristol Trust which could result in delays to implementation. UH Bristol had continued to work with colleagues in North Bristol Trust to understand these issues in detail and the associated risks. Robert advised that as the Trust receives clarity on the timetable the Board would continue to receive regular updates on progress.

John Moore sought further clarity regarding the group partnership arrangements as outlined in the report. Robert Woolley confirmed that the Trust had a formal partnership framework in place underpinned by a formal review of the status of the individual partnerships and progress against their objectives. A majority of the partnerships had been rated as low or medium risk; however the Trust's assessment of the system leadership arrangements in Bristol, North Somerset and South Gloucestershire had been rated as high risk. Meetings of the Director and operational leads from all providers are taking place to establish a common view of the vision for the leadership agenda.

In response to a query from John Moore regarding regular reviews of those organisations hosted by the Trust, Robert noted that differential arrangements are in place with regard to reporting and agreed the need for clarity regarding expectations and regular reviews of hosting arrangements. Sean O'Kelly had continued to work with the Clinical Research Network with regard to developing a mechanism by which the Board can receive this clarity. It was:

RESOLVED:

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

06/04/15 Patient Experience Story

Carolyn Mills referred to a video presentation which represented the perspective of a junior doctor providing care to an elderly palliative care patient. The video reflected issues of continual focus of the Board particularly the challenges of delivering clinical care in a caring and compassionate way. The video highlighted the challenges faced by newly qualified staff in the first years of their career and the progression toward patient centred care.

Sean O'Kelly advised that technical competence is an iterative process as is the development toward a holistic approach to delivering clinical care. Sean felt that this had been a very effective portrayal of the professional's journey through their training. Sean also noted training as being interdependent with other disciplines including assistance and support from nursing teams.

Emma Woollett queried the appropriateness of medical students undertaking procedures for the first time on a palliative care patient. Sean O'Kelly stated that training is reliant on understanding of the team and the circumstances, supported by professional judgement, and referred to the current review of medical training.

Clive Hamilton queried the acknowledgement that the patient would not survive and subjecting them to further interventions as a preferred course of action. Sean O'Kelly stated that the Trust's end of life care pathway had been attuned to that perspective and noted the importance of understanding that death is not failure and helping to support the process in a dignified way with as little pain as possible.

Guy Orpen stated that as Vice Chancellor of the University of Bristol he had liaised with patients and their representatives with regard to medical training and stated that the video had provided a true reflection of training in progress. Wendy Gregory emphasised the acknowledgement of vulnerable patients who may not be supported by family or carers. It was:

RESOLVED:

- **That the Board receive the Patient Experience Story**

07/04/15 Quality and Performance Report

Overall Performance

Deborah Lee presented the report and noted changes in performance against the quality metrics from the previous month, and continuing progress against the recovery trajectory and access standards. With regard to access standards Deborah confirmed that the Trust achieved the A&E 4 hour waiting time target of 95% against the national standard in March. It was also acknowledged that the Trust achieved A&E 4 hour waiting time performance against the recovery trajectory standard of 91.7% for the quarter as a whole. The Trust had remained on track to achieve the Quarter 1 trajectory for 2015/16.

With regard to mortality outcomes, performance remained within normal range but Deborah also noted progress in relation to the percentage of research studies meeting the standard for patients entering into clinical trials.

With regard to Referral to Treatment Times (RTT), there had been further reductions in the number of patients waiting over 18 weeks and the Trust remained on trajectory. The 6 week wait for diagnostic testing had also been consistent with the recovery trajectory, but Deborah highlighted risks around achieving the 6 week wait recovery trajectory in April and May, with particular pressure relating to capacity for stress echo testing.

Deborah summarised the report and confirmed that Trust had failed six of the standards in Monitor's Risk Assessment Framework, giving the Trust an overall Service Performance Score of 4.0, but noted the achievement of A&E 4 hour waiting time target against the national standard for March and achievement against the recovery plan for the quarter.

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Deborah noted Monitor's informal advice that they had received assurance to re-consider the Trust's Governance Rating with the exception of data quality assurance previously discussed at the Board meeting held in private.

Quality and Outcomes Committee Chair's Report

Alison Ryan reported on the business of the Quality and Outcomes Committee held on 28 April 2015 and noted that the Committee had received assurance with regard to data quality in relation to Referral to Treatment Times.

Alison advised that the Committee continued to focus on serious incidents and noted the downgrading of the wrong tooth extraction never event at South Bristol Community Hospital. The Commissioners had accepted the report undertaken by the Deputy Medical Director on never events in their entirety within the Bristol Dental Hospital. A further never event had been reported during the period and the root cause analysis had been commenced and would be reported to the Committee in due course.

Alison reported on progress of the task and finish group established to review the format and content of the Quality and Performance which would give the Committee and the Board additional assurance and noted that the initial revised report would be presented to the Committee from June.

The Committee noted that key performance indicators relating to workforce had not demonstrated the expected level of improvement and raised their concern in terms of the impact on delivery of the Trust's Operating Plan and recovery trajectory. It had been acknowledged that the Committee would explore options to dedicate a bigger focus in the future on the workforce agenda.

The Committee reviewed and approved the Trust's Quality Objectives for 2015/16 which would form part of the Trust's Annual Report and Accounts 2014/15. The Committee also received updates on: CQC action plans; monthly nurse staffing report; quarterly infection control report; and the work of the Clinical Quality Group.

Alison referred to a review of the Committee Terms of Reference undertaken by Debbie Henderson and noted a positive discussion had taken place. A final version of the Terms of Reference would be submitted to the Board of Directors for approval in May 2015.

John Moore referred to hospital acquired pressure sores and noted an upward trend during quarter 4. John queried the adequacy, and embedding of, procedures. Carolyn Mills advised that the focus should be on the two Grade 3 pressure sores and stated these were not defensible. Carolyn advised that investigations had been undertaken to provide assurance with regard to standards of care. Other incidents related to the Neo-Natal Intensive Care Unit and a review had been undertaken at divisional level.

Clive Hamilton referred to issues relating to fractured neck of femur and the appropriateness of referral of patients to the BRI by the ambulance service. Sean O'Kelly referred to ongoing work with regard to capacity and confirmed that following a visit to theatres he had observed significant progress which would allow further flexibility to enable admission of patients to orthopaedic theatre without delay. Sean confirmed that during the previous period, 16 patients had surgery within 36 hours, two patients had been deemed clinically unfit for

surgery and three patients experienced delays. Sean emphasised the balance of ensuring patients are clinically appropriate for surgery and timeliness of treatment. Sean provided further assurance by confirming that the Trust's average time taken to transfer patients to theatre for fracture neck of femur had been below the national average.

Deborah Lee confirmed that some cases of delays had been as a result of previous cases overrunning as a result of their complexity and advised that flexibility would need to be created to support overruns which would include weekend staffing. Deborah also provided assurance that the standing operating procedure had been disseminated via the Surgery Governance Committee, reinforcing the focus of this issue within the Division.

David Armstrong referred to the governance arrangements at operational level with regard to the management of action plans by the Clinical Quality Group and the management of associated risks. Carolyn Mills, Sean O'Kelly and Alison Ryan expressed confidence in the current arrangements and reporting mechanisms and oversight of the Quality and Outcomes Committee.

Access

John Moore referred to the access dashboard and exception reports and noted that the delayed discharges remained red rated, although green to go numbers remained above plan, and suggested that a monthly update be included as an exception report on actions taken in the future.

Workforce

Alex Nestor noted that the bank and agency action plan had been finalised. During March, temporary staffing had reduced to 7.2% of total staffing numbers. Vacancies levels remained at 5.2% of total staffing numbers against a target of 5%. Targeted recruitment events continued to take place, and improvement had been evident with regard to nursing, portering and domestic staff.

It was acknowledged that the workforce agenda was underpinned by key performance indicators relating to agency, retention and recruitment and Alex referred to the significant activity ongoing in relation to these areas. The divisions had dedicated recruitment managers in place and Alex confirmed that during March, the Trust reported a net gain in terms of staff recruitment.

Alex referred to an increase in staff turnover related to retirement and pension changes. The Above and Beyond charity had agreed to support the recruitment and retention programme, particularly in relation to the incentive scheme. Alex noted a reduction in sickness absence but this would still remain a key area of focus during 2015/16.

Alison Ryan felt that this was the most significant risk to the Trust in terms of delivering the Operating Plan and recovery trajectory and John Savage queried if further support was required from the Board of Directors. It was:

RESOLVED:

- **That the Board receive the Quality and Performance Report for assurance**
- **That an exception report on delayed discharges be included in the revised Quality and Performance report**

08/04/15 Terms of Reference for Quality and Outcomes Committee
Following an in-depth discussion at the Quality and Outcomes Committee in April, it was agreed to defer this item until the May meeting of the Board. It was:

RESOLVED:
- **That the Board defer the Terms of Reference for the Quality and Outcomes Committee to the May meeting**

09/04/15 Transforming Care Report
Robert Woolley presented the report and highlighted the work that had been undertaken on the operating model and the management of patient flow through the Trust's hospitals. The changes to planned care, reconfiguration of the bed base, progress toward real time reporting and administration training and refinement had resulted in significant progress.

Robert referred to the intention to incorporate the activity relating to staff experience into the programme and noted that the Senior Leadership Team are exploring options to take this transformation activity forward.

John Moore suggested liaising with other Trusts who had positive outcomes with regard to the use of information technology. Robert Woolley felt that UH Bristol were progressing well with regard to this agenda and had been looking at information systems to provide a real time perspective of patient flow from admission to discharge. It was:

RESOLVED:
- **That the Board receive Transforming Care report for assurance**

10/04/15 2015/2016 Annual Plan
Deborah Lee presented the Operating Plan for 2015/16. The Trust are required by Monitor, to provide an operational plan covering the financial year 2015/16, which addresses the issues set out in Monitor's drafting guidance. The drafting requirement had changed from the previous year. Monitor required Trusts to submit one operational plan and to produce a public facing version of the plan for publication on the Monitor website. Deborah confirmed that this would be produced following submission on 14th May.

Deborah also noted the requirement to declare where the Trust would be in the coming year in relation to regulatory standards and these were outlined within the plan. In contrast to previous years where the Trust had to declare those standards perceived to be at risk in the year, the 2015/16 plan declared these risks by quarter. The plan reflected risks to quarter 3 and quarter 4. Deborah drew the Board's attention to the risk in quarter 3 as achievement of the A&E 4-hour waiting time in the Children's Hospital as a result of increased presentation of respiratory illness. Deborah felt that despite plans to prepare for this period in the past, the Trust had not achieved the trajectory, hence the proposal to flag this risk to Monitor.

Following a request from John Moore, Paul Mapson provided clarity and detail with regard to the figures in relation to the 5.5% savings plan. Emma Woollett referred to capacity planning and Deborah Lee stated this planning had been based on the activity forecast for 2015/16 as opposed to work undertaken. The bed model had been based on delivering levels of activity that included the increase and the reduction in the bed base took account of the need for increased activity.

Clive Hamilton raised the issue of car parking provision and Deborah Lee confirmed that a report would be submitted to a future Board meeting outlining the proposed plans. It was:

RESOLVED:
- **That the Board receive the 2015/16 Annual Plan subject to minor changes for approval**
- **That a report with regard to car parking be submitted to the July Board meeting**

11/04/15 Finance Report
Paul Mapson reported the end of year financial report and noted that the detail would be subject to external audit prior to submission of the end of year accounts. Paul reported a surplus of £6.3m before technical items. Paul confirmed that this had represented the twelfth year of surplus for UH Bristol. The Trust had achieved a saving plan of £16m and delivery of the Capital Programme of approximately 80% of the original plan. The Trust reported a cash balance at the end of the year of £63m. The Trust had reported a financial risk rating of 4 and had ended the year in a good position. It was:

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

12/04/15 Finance Committee Chair's Report
Lisa Gardner provided a verbal report with regard to the business of the Finance Committee in April which had focussed largely on the financial planning for 2015/16. Lisa felt that Committee members had been satisfied with progress to develop the plan and had found confidence in the commitment from divisions to meet the challenges identified in 2015/16.

Lisa note that discussions remained ongoing with Commissioners with regard to CQUINs, but confirmed that the Trust's draft Accounts for 2014/15 had been submitted to Monitor. It was acknowledged that the savings target had remained at approximately 80% and work remained ongoing to secure savings in 2015/16. Lisa confirmed that this Trust remained within the top quartile of NHS Foundation Trusts for financial performance.

John Moore referred to the saving achievement and the increase to pay costs by 10% and Paul Mapson advised that the pay cost increase was largely due to transfers of services from North Bristol Trust in early 2014/15 and the receipt of resilience funding for additional ward staff. It was:

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

13/04/15 Quarterly Capital Projects Status Report
Deborah Lee reported that phase 3 had been completed and phase 4 had progressed significantly. Deborah made particular reference to delays to the transfer of the Microbiology Laboratories to the new laboratory complex at Southmead. Deborah stated that the delays were still unquantified but could potentially be up to six months, with implications for the vacation of the Old Building which was planned to take place in June 2016 for out-patients, sleep studies and rheumatology. It was:

RESOLVED:

- **That the Board receive the Quarterly Capital Projects Status Report to note**

14/04/15 Briefing on amendments to Monitors' Risk Assessment Framework
Robert Woolley confirmed that this item was for information only. It was:

RESOLVED:

- **That the Board receive the Briefing on amendments to Monitors' Risk Assessment Framework briefing to note**

15/04/15 Q4 Risk Assessment Framework Monitoring and Declaration Report
Robert Woolley referred to the proposed declaration against Monitor's Risk Assessment Framework for quarter 4 and highlighted 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. The report also recommended that the planned ongoing failure of the RTT standards as part of the agreed recovery trajectory be 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. It was:

RESOLVED:

- **That the Board receive the Q4 Risk Assessment Framework Monitoring and Declaration Report**

16/04/15 Board Assurance Framework 2015/16
Robert Woolley presented the revised Board Assurance Framework. Following a refresh of the Trust's Strategy, the strategic objectives had 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 objectives. The framework also described any risks to delivery that had been identified to date and described the actions being taken to control such risks so as to ensure delivery is not compromised.

Robert referred to the four red rated objectives as: delivery of the savings plan; delivery of cancer standards; action to address shortcomings in the quality of care; and staff engagement. Robert confirmed that Deloitte had been asked specifically to comment on the use and presentation of the Board Assurance Framework as part of the Well Led Governance Review and this would be incorporated as part of the ongoing organisational improvements with regard to governance. It was:

RESOLVED:

- **That the Board receive the Board Assurance Framework 2015/16 for assurance**

17/04/15 Corporate Risk Register
Robert Woolley presented the Corporate Risk Register and noted changes to the risks during the period. Risk 2344 had been upgraded from high to very high with regard to achievement of the strategic objectives. Risk 2126 had been downgraded from very high to high with regard to reputational damage arising from adverse media coverage.

Robert took an opportunity to bring the Boards attention to a forthcoming review of the appropriateness of the Corporate Risk Register. As a result of improvements made Trust wide and at divisional level on assessment and rating of risks, there had been concern about the impact this has had on the Corporate Risk Register. The review would be undertaken in May, reported to the Senior Leadership Team in June for divisional feedback and reported into the Board of Directors cycle of business from July 2015. It was:

RESOLVED:
- **That the Board receive the Corporate Risk Register for assurance**

18/04/15 Board of Directors Code of Conduct Declaration (including Fit and Proper Person Test Declaration)
The Chair reported that the Board of Directors Code of Conduct Declaration including the Fit and Proper Test Declaration, had all been received. It was:

RESOLVED:
- **That the Board receive the Board of Directors Code of Conduct Declaration (including Fit and Proper Person Test Declaration) for assurance**

19/04/15 Register of Seals
Robert Woolley reported that the Register of Seals was for information only. It was:

RESOLVED:
- **That the Board receive the Register of Seals to note**

20/04/15 Governor's Log of Communications
The Chairman presented the Governor's log for information. Debbie Henderson referred to a revised procedure for the Governor's Log which included a commitment to respond within 10 days. This would be presented to the next meeting of the Council of Governors. It was:-

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

21/04/15 Speaking Out Policy (Whistleblowing Policy)
Alex Nestor reported that this paper had been presented and reviewed by a number of stakeholder groups. The policy reflected changes as result of the Francis Report and Freedom to Speak Up review. John Moore thought it was very important that a brief was made available to staff. He and other Directors felt the document was very repetitive and could be condensed substantially. It was agreed to review the document further and submit the final version to the May meeting of the Board. It was:

RESOLVED:
- **That the Speaking Out Policy be revised and submitted to the May Board of Directors meeting for approval**

22/04/15 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 at 1230 pm
The next meeting of the Trust Board of Directors will take place on Wednesday 27 May 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 30th April 2015
Action tracker

Outstanding actions following meeting held 30th April 2015					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**10/04/15**	Report regarding car parking provision and proposed plans to be submitted to the Board	Chief Operating Officer/ Deputy Chief Executive	July 2015	N/A
2	**07/04/15**	Exception reports relating to delayed discharges to be incorporated into future Q&P reports	Chief Operating Officer/ Deputy Chief Executive	June 2015	To be incorporated into the revised Quality & Performance reporting
3	**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	Clarification to be provided to the May meeting
4	**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
5	**33/11/14**	Review of structure and format of the Quality and Performance Report to ensure it remains fit for purpose	Chief Operating Officer/ Deputy Chief Executive	June 2015	Initial proposal delivered to Board members on 8th May. First revised report to be presented to June meeting
Completed actions following meeting held 30th April 2015					
6	**08/04/15**	Quality and Outcomes Committee terms of reference review to be submitted to the May meeting of the Board	Trust Secretary	May 2015	Complete – agenda item 8
7	**21/04/15**	Speaking Out policy to be revised and submitted to the Board for approval at the May meeting	Director of Workforce and OD	May 2015	Complete – agenda item 10

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Wednesday 27 May 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)
Author - Robert Woolley, Chief Executive Sponsor – Paul Mapson, Director of Finance and Information
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 considered by the Senior Leadership Team in the month.
Recommendations
The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.
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 – MAY 2015

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **received** an update on the financial position for the first month of 2015/2016.

The group **received** a further update on the 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 **approved** a proposal for a unique visual identity for the Bristol Royal Hospital for Children which had been developed working within the nationally-set NHS brand guidelines.

The group **approved** the Annual Quality Report 2014/2015 for onward submission to the Audit Committee and Trust Board.

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

The group **supported** proposals on the next steps and on-going governance arrangements for Phase 2 of the Signage and Way-Finding scheme.

4. RISK, FINANCE AND GOVERNANCE

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

The group **noted** a quarterly workforce report prior to submission to the Quality and Outcomes Committee and Trust Board.

The group received an update on Equality and Diversity activities, noting the new NHS Workforce Race Equality standards, and **supported** the revised action plan.

The group received and **noted** an update on the positive position in respect of essential training including plans in place to sustain the position.

The group **noted** a low impact Internal Audit Report in relation to the Divisional Vacancy Control Process and a medium impact Internal Audit Report in relation to the Data

Storage Review. Progress on Internal Audit recommendations that remained outstanding was **noted.**

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

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

The group **noted** the summary outcomes from the quarterly Divisional Review meetings that had been undertaken in April.

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
May 2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27 May 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 – PPI Lead

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

Executive Summary

Purpose

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

- Set a patient focussed context for the meeting
- For Board members to understand the impact of the lived experience of patients accessing UHBRistol's services and for Board members to reflect on what the story reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

Patient 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. Naomi Whittingham who is presenting her story to the Trust Board was approached by the Patient Experience Team to share their story following her making contact with the Trust to proactively feedback her experience.

Following a discussion with the PPI lead, she agreed to share her story via the attached narrative with the Trust Board, furthering the ambition to move towards the Board receiving first- hand accounts of patient's experience of our services.

Key issues to note

The proactive and positive response of the Dermatology team to meeting Naomi Whittingham' s specific needs related to her underlying condition which made what could have been a traumatic and stressful experience a positive one.

Recommendations
To receive the story
Impact Upon Board Assurance Framework
No link to 15/16 BAF

Impact Upon Corporate Risk
No link to corporate risk register
Implications (Regulatory/Legal)
Feedback, learning from and taking actions to address concerns from patients supports compliance with the Care Quality Commission's Fundamental Standards: Regulation 4 – Person-Centred care, Regulation 5 – Dignity and Respect, Regulation 7 – Safe and appropriate care and treatment, Regulation 12 – Good governance.
Equality & Patient Impact
Nil

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)**

Thank you for giving me the opportunity to share my experiences with you today. Unfortunately I am not well enough to be here in person, but I hope that my writing will speak for me.

I recently had a very positive experience at the Bristol Royal Infirmary, when I visited rheumatology outpatients for a DEXA scan and consultation with Dr Matthew Roy. I would like to tell you more about this and why it was so helpful, but in order to do so it is necessary to give some background information.

My name is Naomi Whittingham and I am 38 years old. For the first 12 years of my life I was a happy and healthy child. I was doing well at school and played the piano and flute. I was bright and active, with good friends and a very close family. [Photos 1 - 5 with this paragraph]

In January 1990, two months before my 13th birthday, life changed forever when I became ill with ME. I deteriorated rapidly and within months was so ill that I was bed bound and unable to move any part of my body. I lost the ability to sit up, speak, and even to open my eyes. I was in constant agony and so ill that my family and GP feared I would die at any time. [Photos 6 - 8 with this paragraph]

Twenty-five years on I have made considerable progress from my worst years, but remain severely ill with ME. The impact on my life has been devastating, but I am a determined and positive person, and I aim to make the very most of what I have. [Photos 9 - 11] In my many years of suffering, the hardest thing of all has been encountering a lack of understanding of my condition, particularly among the medical profession. Instead of receiving the compassion I needed as a desperately sick young person, I have often been made to feel responsible for my illness. It saddens me to say that the spectrum of medical responses to my illness has ranged from irritation to outright hostility. The impact of this has been even more destroying than the illness itself. I am pleased to say that none of these experiences took place at the BRI, but it is necessary for me to mention them to set the context for the excellent treatment I received there.

There are certain features of ME, and severe ME in particular, that make any kind of hospital treatment extremely difficult. For those of us severely affected, simply leaving the house and travelling in a car is a major undertaking. The hospital environment itself poses huge challenges because sensory stimulation of any kind causes a dramatic worsening of symptoms. For me that might mean intense pain, vomiting and whole body tremors. For others it could mean paralysis and difficulty swallowing and breathing. While it is impossible to entirely eliminate the risks involved in a hospital visit, there are simple steps that can be taken to transform the experience for the patient. I am pleased to say that this is where the BRI rheumatology department excelled themselves. Of particular help to me were the following:

- I was phoned on a couple of occasions prior to my appointment, so that my needs could be discussed, and solutions found where possible. This made me feel that my condition was being taken seriously, and gave me confidence that everything was being planned as carefully as possible.

- I was given an appointment in the middle of the day, as this is when my symptoms are most manageable and I am at my best. It also allowed me to avoid rush hour traffic, and so reduce travelling time.

- I was seen quickly upon arrival and not kept waiting. Ten minutes spent in the waiting room may be insignificant to most people, but to someone with severe ME it is a drain on very limited resources. The department staff were aware of this and made sure I wasn't delayed.

- I was given a bed to rest in on the day ward between my two appointments, and the consultant came to speak to me there so that I didn't have to get up and move to another room. [Photo 12] Orthostatic intolerance is a classic feature of severe ME, and being able to recline or lie flat can reduce symptoms. For me it made the difference between being able to hold a conversation with the consultant, and being too ill to participate.

- Sources of sensory stimulation were kept to a minimum wherever possible. For instance, the DEXA technician turned off the lights in the part of the room where I was. At my request she also directed many of her questions to my mother, to spare me the effort of speaking. The bed I was given was as removed as possible from the main activity of the ward.

- All members of staff appeared to be aware of my condition and to know the planned order of events for the day. For instance, after my scan I was taken straight to the ward by the DEXA technician. This cohesion spared me vital time and energy.

- At all times, and by every person I encountered (receptionists, nurses, the DEXA technician and the consultant), I was treated with respect and courtesy. In an ideal world this would not be something to remark upon, but given my past experiences it was a source of surprise and relief.

I am extremely grateful for the way I was treated. Had the visit been handled differently, I could have faced a significant relapse in my condition. Unfortunately I was diagnosed with osteoporosis, another consequence of my many years of ME. But the blow of the diagnosis was considerably softened by the care and understanding shown to me.

Hospital visits and admissions are a major cause of deterioration in those severely affected by ME, to the extent that many of us would risk our lives rather than face admission to hospital. With consideration and some advance planning, the risk factors can be significantly reduced. I have only given a brief overview of the way in which those with ME can be helped, and would be happy to provide more detailed information to anyone wishing to learn more. It is impossible to overstate the difference that understanding medics can make. Thank you to everyone who made my trip to the BRI memorable for all the right reasons, and for giving me the opportunity to share my experiences with you all today.

Naomi Whittingham
May 2015

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27 May 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 (Chief Operating Officer/Deputy Chief Executive) • 'Quality' – Carolyn Mills (Chief Nurse) & Sean O'Kelly (Medical Director) • 'Workforce' – Sue Donaldson (Director of Workforce & Organisational Development) • 'Access' – Debora Lee (Chief Operating Officer/Deputy Chief Executive) Report authors: • Xanthe Whittaker (Associate Director of Performance/Deputy Chief Operating Officer) • Anne Reader (Head of Quality (Patient Safety)) • Heather Toyne (Head of Workforce Strategy & Planning)
Intended Audience

Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards. Key issues to note 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)**
26/05/15					

University Hospitals Bristol NHS
NHS Foundation Trust

SUMMARY QUALITY & PERFORMANCE REPORT

May 2015

CONTENTS

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 – 2 indicators

- Same sex accommodation breaches – no reported breaches of the standard in the month
- Hospital Acquired Pressure Sores (grade 3 and 4) – no reported cases in the month

Deteriorations in the period:

Moving from AMBER to RED –2 indicators

- Savings Plan achievement – reflecting the early stage in the financial year and plans still being embedded; see separate Finance Report for further details
- Outpatient Hospital Cancellation Rate – the reason for this rise in the hospital cancellation rate is currently being explored

Moving from GREEN to RED – 1 indicator

- A&E 4-hours – performance 94.8% in the period, with the best case scenario of the recovery trajectory achieved.

Please note: the change to performance against the Percentage of Studies Meeting the 70-Day standard was reported last month; as updates are only provided quarterly, it is not noted again in the above summary of changes.

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 dipped marginally below the 95% standard in April. However, the best case scenario recovery trajectory of 94.7% was achieved. There was a slight deterioration in performance against the 4-hour standard within the BRI, although bed occupancy was lower than in the previous month. The decrease in bed occupancy was related to a reduction in the number of patients staying over 14 days, including delayed discharges. Performance against the 4-hour standard at the Bristol Children's Hospital improved to above 95%, despite levels of emergency admissions being un-seasonally high, even with transfer volumes taken into account. Other measures of patient flow, including ambulance hand-over delays, and the number of bed-days patient spent outlying from their specialty wards, sustained the improvements seen in previous months, or showed further improvements in the period.

PERFORMANCE OVERVIEW

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 May, in line with the agreed trajectories for recovery of performance against the RTT standards during 2015/16.

For quarter 1 to date, the Trust is failing 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 Service Performance Score for the quarter to date 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, and the Trust is awaiting a decision on 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	90	89	N/A	Green: >= 86 Red: < 85	↓	Current month is March 2015
A02	Patient Complaints as a Proportion of Activity	0.273%	0.266%	0.266%	Green: <0.21% Red: >0.25%	↓	
A03	Same Sex Accommodation Breaches (Number of Patients Affected)	4	0	0	Green: 0 Red> >0	↓	

Delivering High Quality Care

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
B01	Incidence of Hospital Acquired Pressure Sores (Grades 3 or 4)	2	0	0	Green: 0 Red: >= 1	↓	No RAG rating for YTD.
B02	Number of Inpatient Falls Per 1,000 Beddays	4.53	3.61	3.61	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)	6	6	6			
C02	Cumulative Number of Avoidable C.Diff cases	7	-	-	Below Trajectory		Previous is full year 14/15. First month 15/16 not confirmed yet.

Being Accessible

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
D01	18 Weeks Admitted Pathways	80.5%	79.9%	79.9%	Green: >=90% Red: <85%	↓	
D02	Number of Cancer Standards Failed	2	2	2	Green: 0 Red: >=2	→	Previous is confirmed Q3. Current and YTD is confirmed Q4.
D03	A&E 4 Hour Standard	95.01%	94.8%	94.8%	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	60.9	63.2	63.2	Green: <65 Red: >=75	↑	Previous is February 2015 and Current is March 2015
E02	30 Day Emergency Readmissions	296	347	3791	Below 13/14 Readmission Rate	↑	Previous is February's discharges where there was an emergency Readmission within 30 days. Current is March's discharges.

Being Efficient

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
F01	Overall Length of Stay (Spell)	4.36	4.41	4.41	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. 2014/15 targets have been extended into 2015/16, as we are above trajectory.
F03	Theatre Productivity - Percentage of Sessions Used	87.3%	89.2%	89.2%	Green: >= 90% Red: < 90%	↑	
F04	Outpatient appointment hospital cancellation rate	9.4%	11.6%	11.6%	Green: <=6.0% Red: >=10.7%	↑	

Valuing Our Staff

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
G01	Turnover	13.9%	13.8%	13.8%	Green: < target Red: >=10% above target	↓	
G02	Staff Sickness	4.3%	4.2%	4.2%	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	4,071	6,643	6,643	Green: Above 2013 Red: Below 2013		Current (and YTD) is rolling Calendar YTD position. Previous is Jan 2015 and Current is Jan-Feb 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. Please note that Monitor is still to confirm the Trust's official rating for quarters 3 and 4.

Delivering Our Contracts

The Previous column represents the 2014/15 position reported for the accounts. Current (and YTD) represents Month 1 2015/16

ID	Indicator	Previous	Current	YTD	Thresholds	Change from previous	Notes
K01	Financial Performance Against CQUINs (£millions)	£7.99	£7.97	£7.97	> 50% Green < 50% Red		To date in 2015/16 no assessment of performance has been carried out. Assumption in monitoring data has been that plan=actual (based on an assumed performance of 80%) - to be updated when estimate of actual performance is known. YTD and Current is Potential year-end rewards. Previous is 2014-15 per accounts.
K02	Contract Penalties Incurred - Variance From Plan (£millions)	£0.51	£0.03	£0.03	Green: Below Plan Red: Above Plan		Data is variance above (+) or below (-) plan, with a higher negative value representing better performance.YTD and Current is variance reported for April - The only penalty assessed in April is Readmissions, all others assumed on plan - to be updated when estimate of actual performance is known. Previous is variance reported in 2014/15 accounts.

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	3.0	4.0	Green: >=3.0 Red: <2.5	⬇	
L04	Savings plan achievement	79%	68%	68%	Green: >=90% Red: < 75%	⬇	

Notes

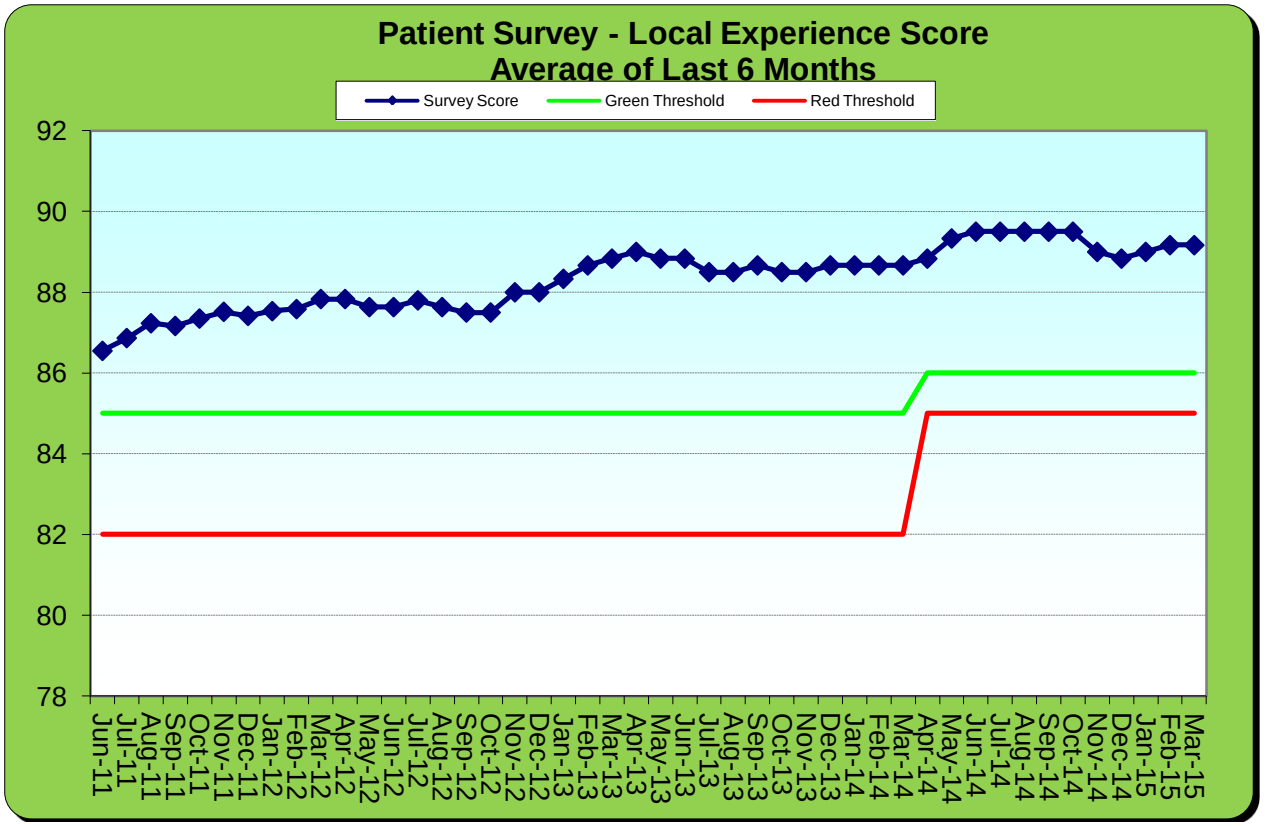
Unless otherwise stated, Previous is March 2015 and Current is April 2015

YTD (Year To Date) is the total cases/cumulative score for the year so far, from April 2015 up to and including the current month

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

Organisational Health Barometer – exceptions summary table

Indicator in exception	Exception Report	Additional information
Patient complaints as a proportion of activity	In *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 4, 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 *Access* section (4-hour report)	
Theatre productivity	See Additional Information	Overall theatre utilisation continues to be lower than planned, despite a significant improvement in theatre staffing levels; performance against this indicator is being investigated.
Outpatient appointment hospital cancellation rate	See Over-view section	
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*	
Savings plan achievement	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
Aug-12
Sep-12
Oct-12
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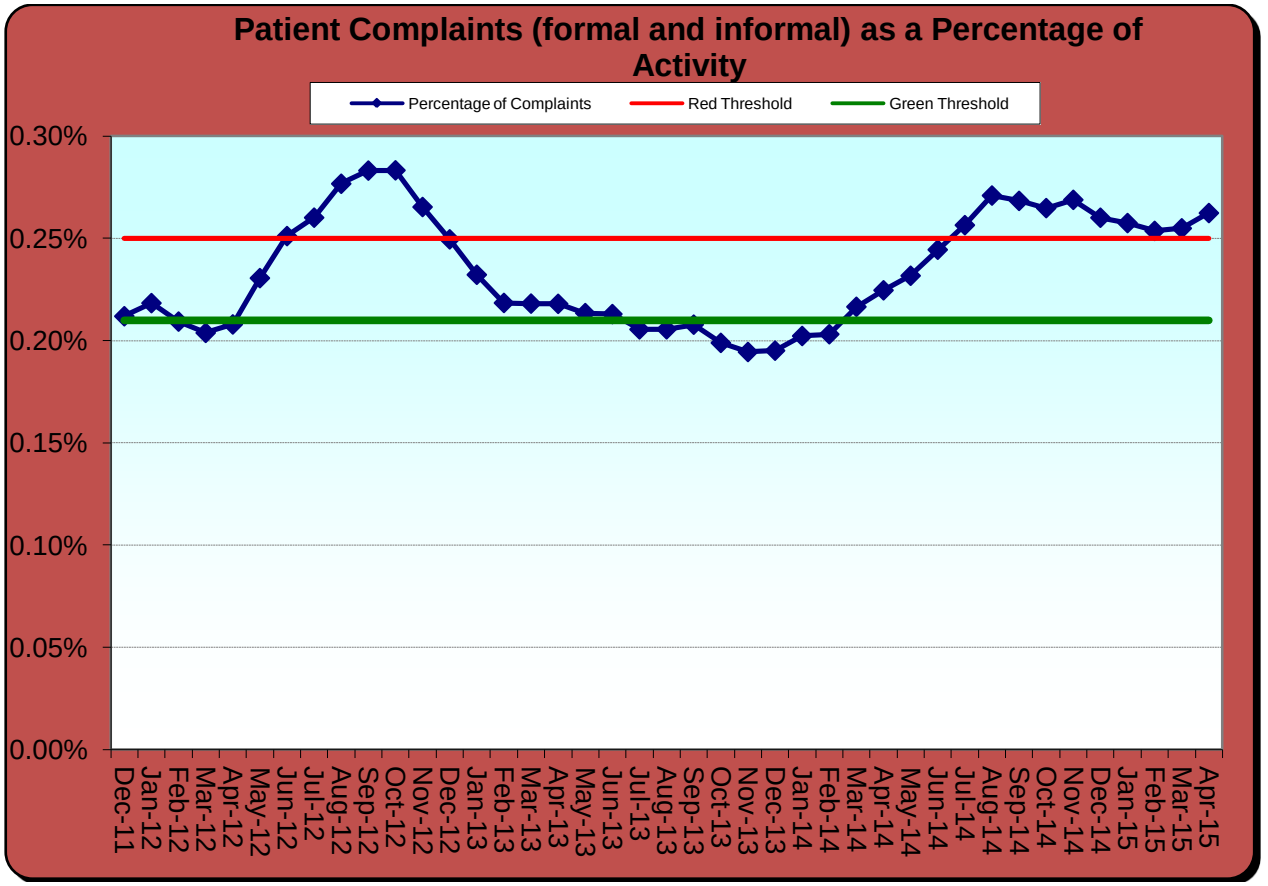
Feb-15
Mar-15


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
Jul-13
Aug-13
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Mar-14
Apr-14
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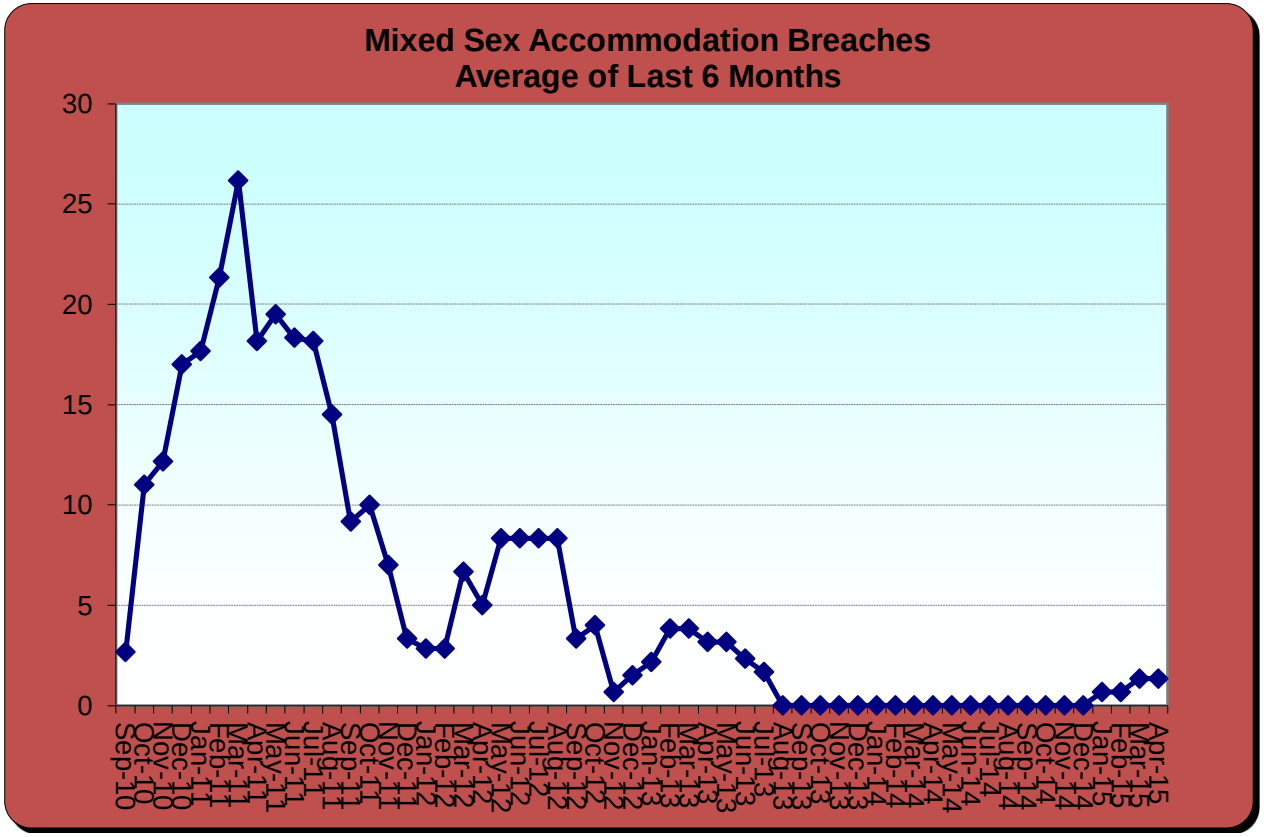
Mar-15
Apr-15


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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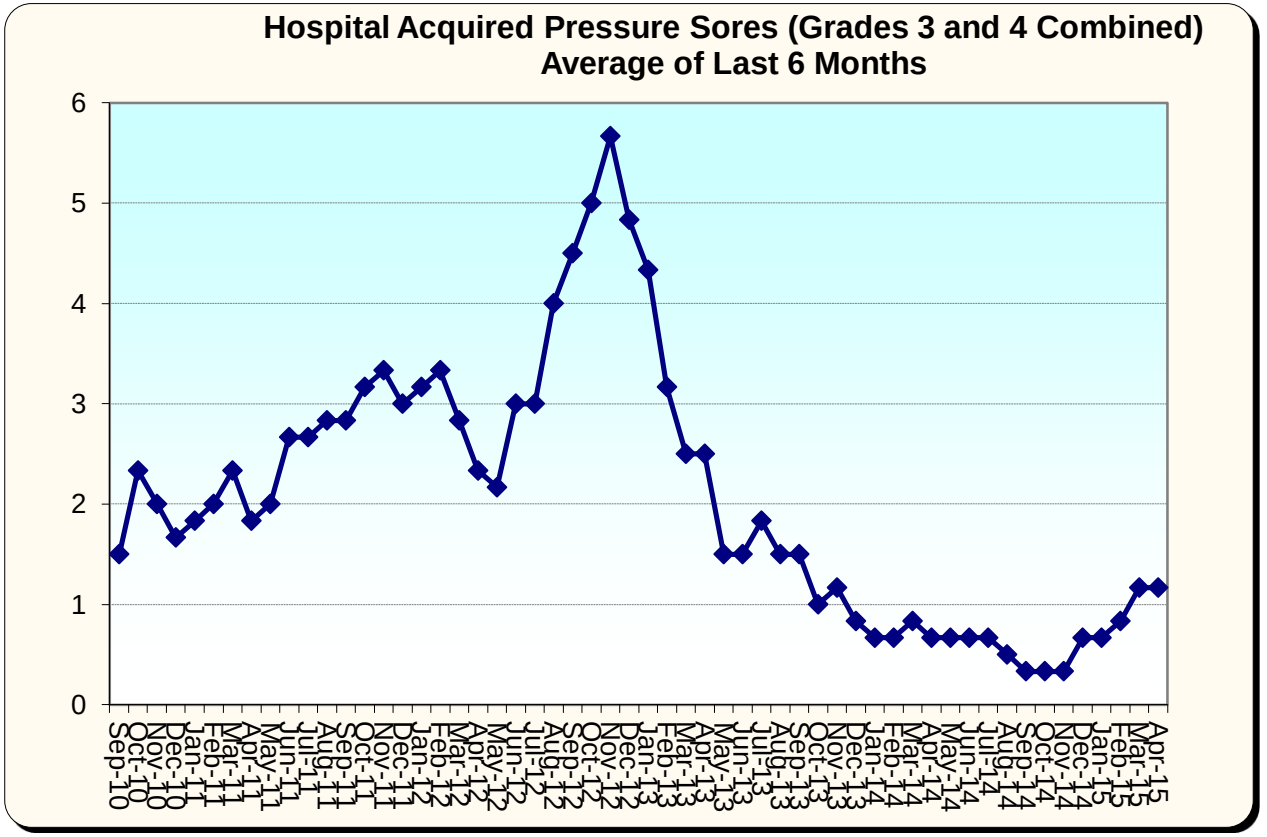
Hospital Acquired Pressure Sores (Grades 3 and 4 Combined)
Average of Last 6 Months
6
5
4
3
2
1
0
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
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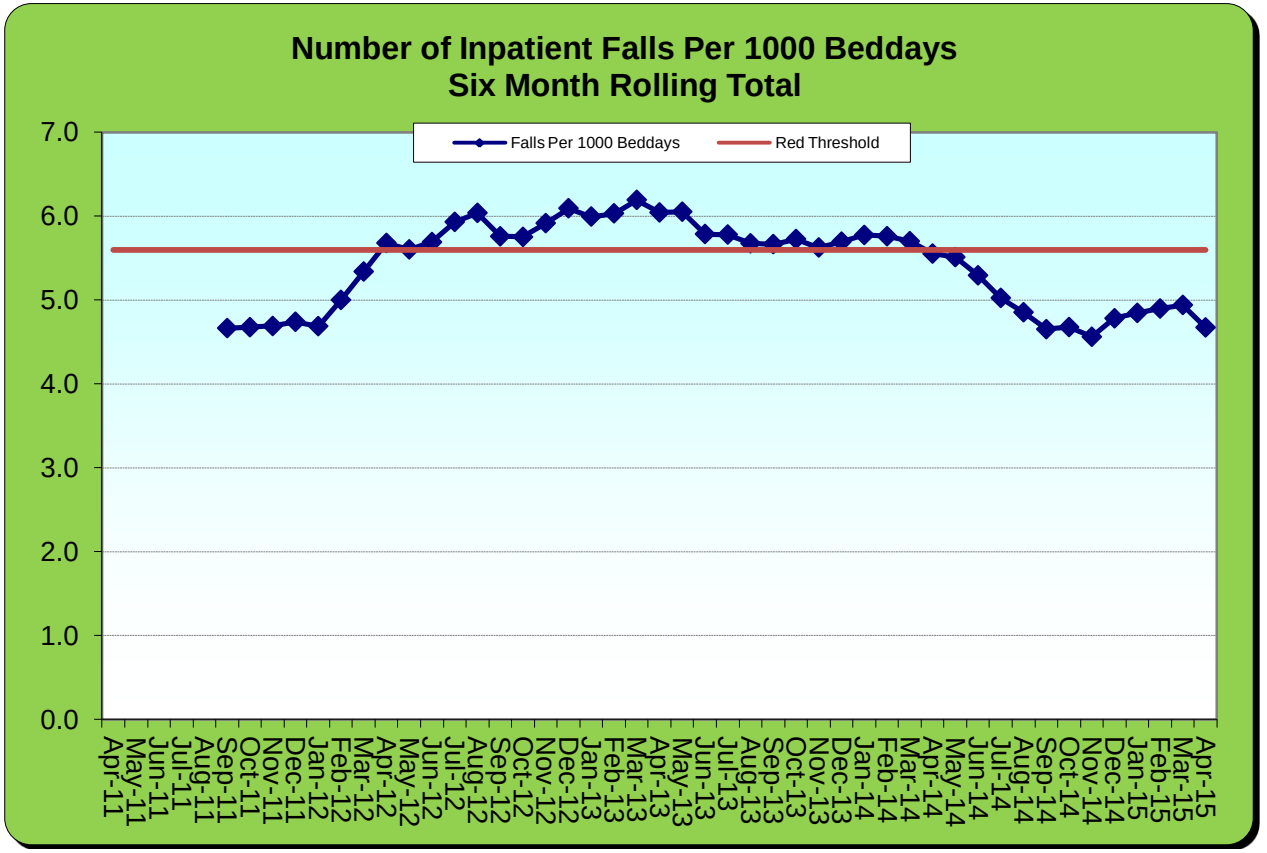
Number of Inpatient Falls Per 1000 Beddays
Six Month Rolling Total
Falls Per 1000 Beddays
Red Threshold
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
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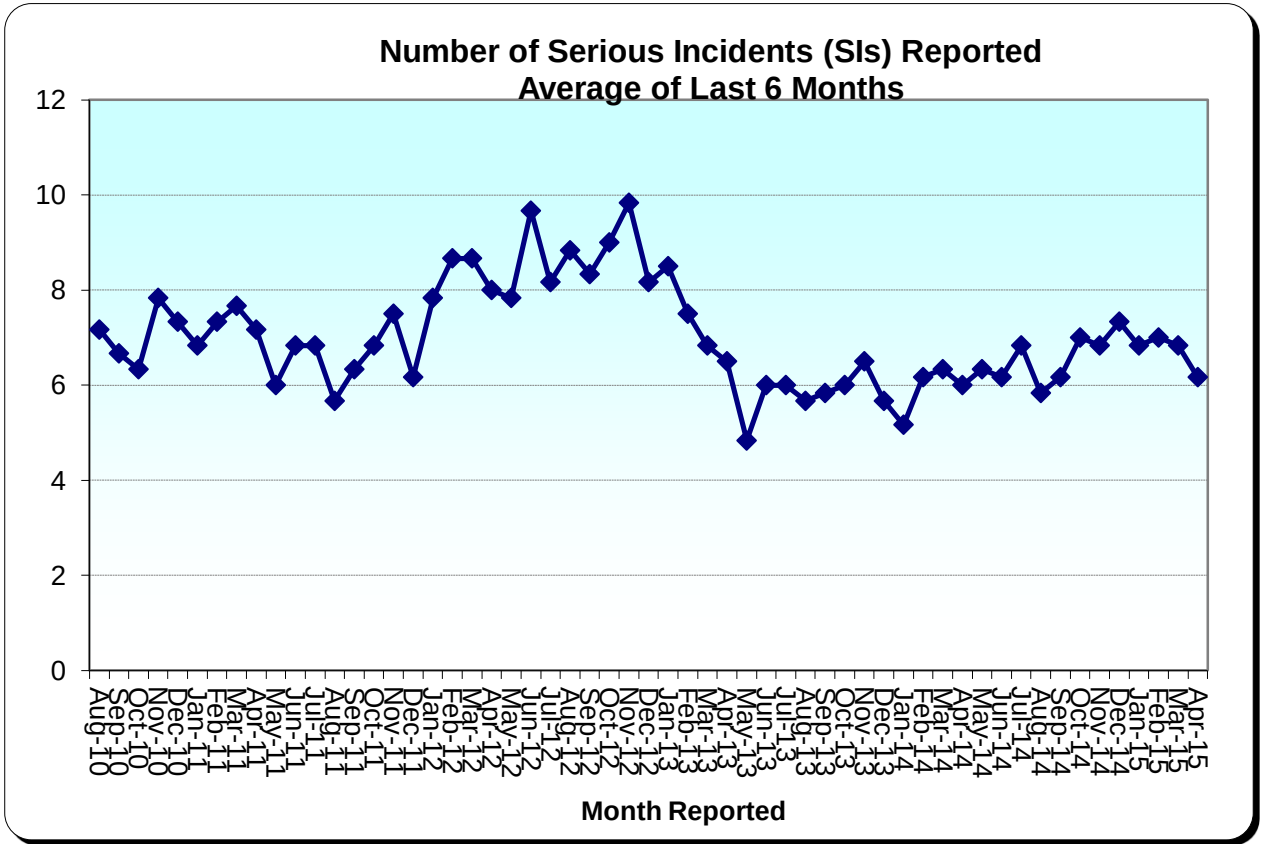
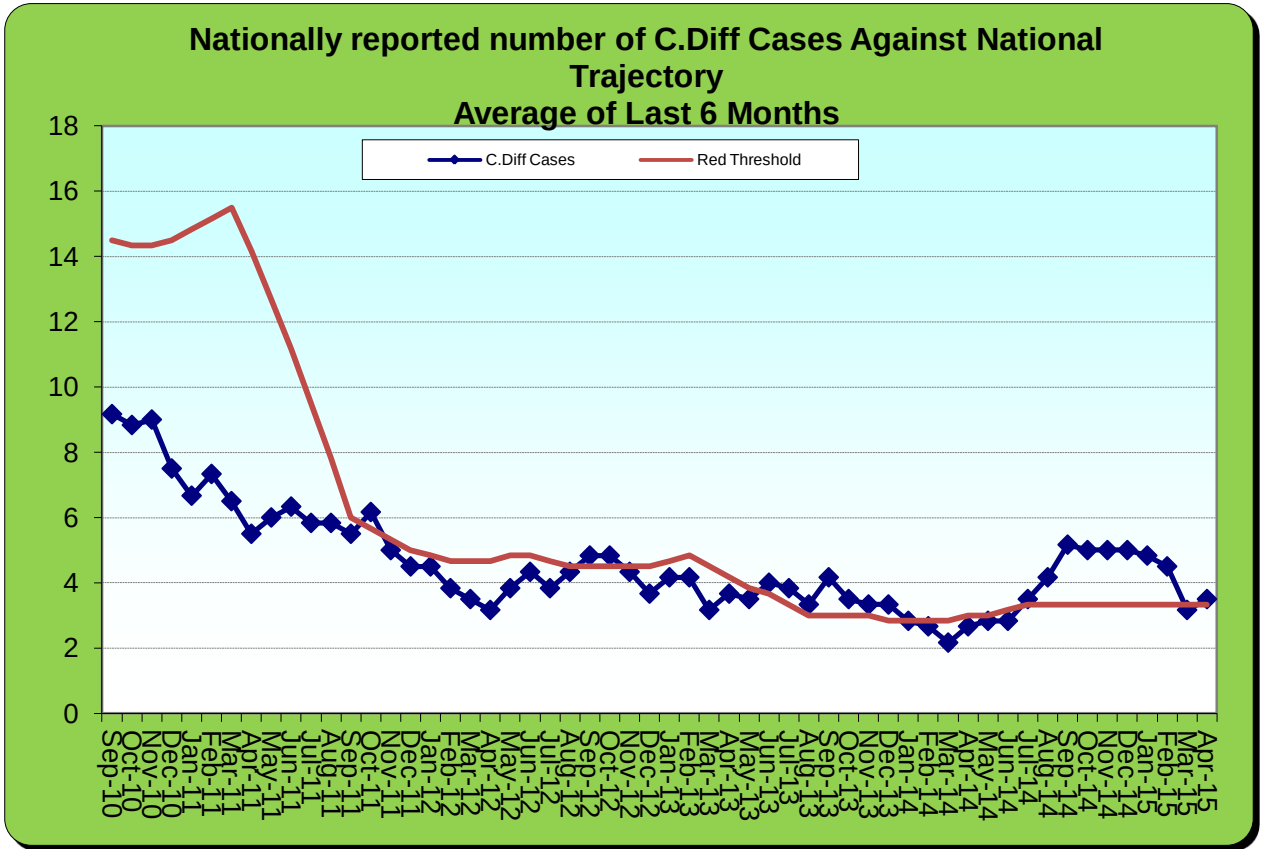
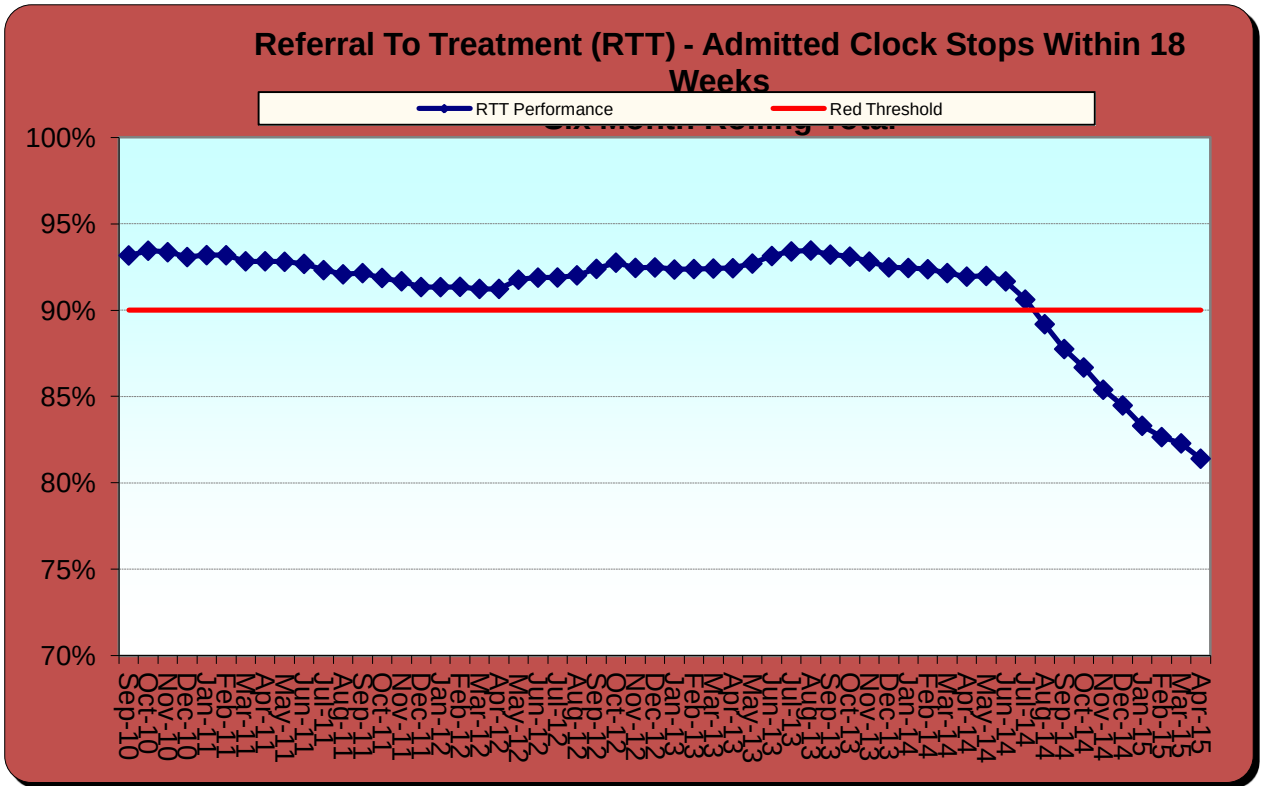

Number of Serious Incidents (SIs) Reported
Average of Last 6 Months
12
10
8
6
4
2
0
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
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
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
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
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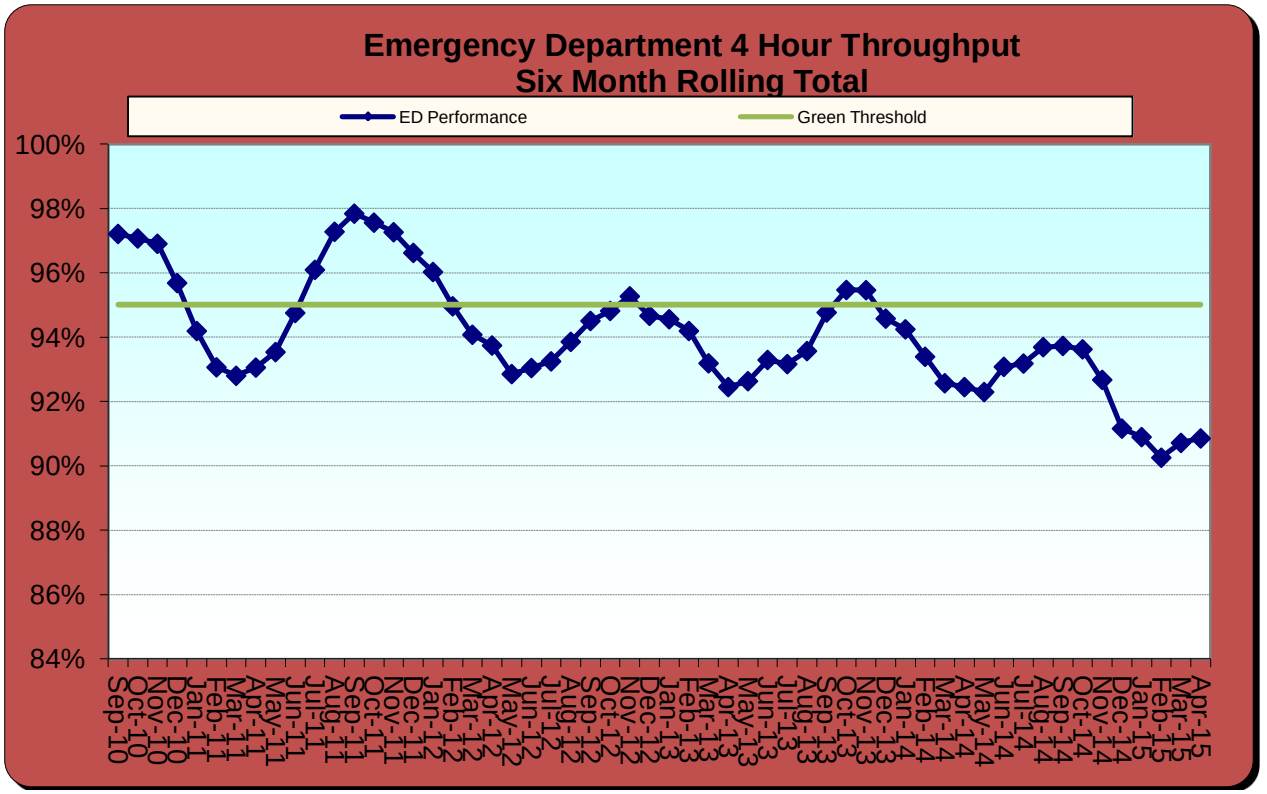
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15


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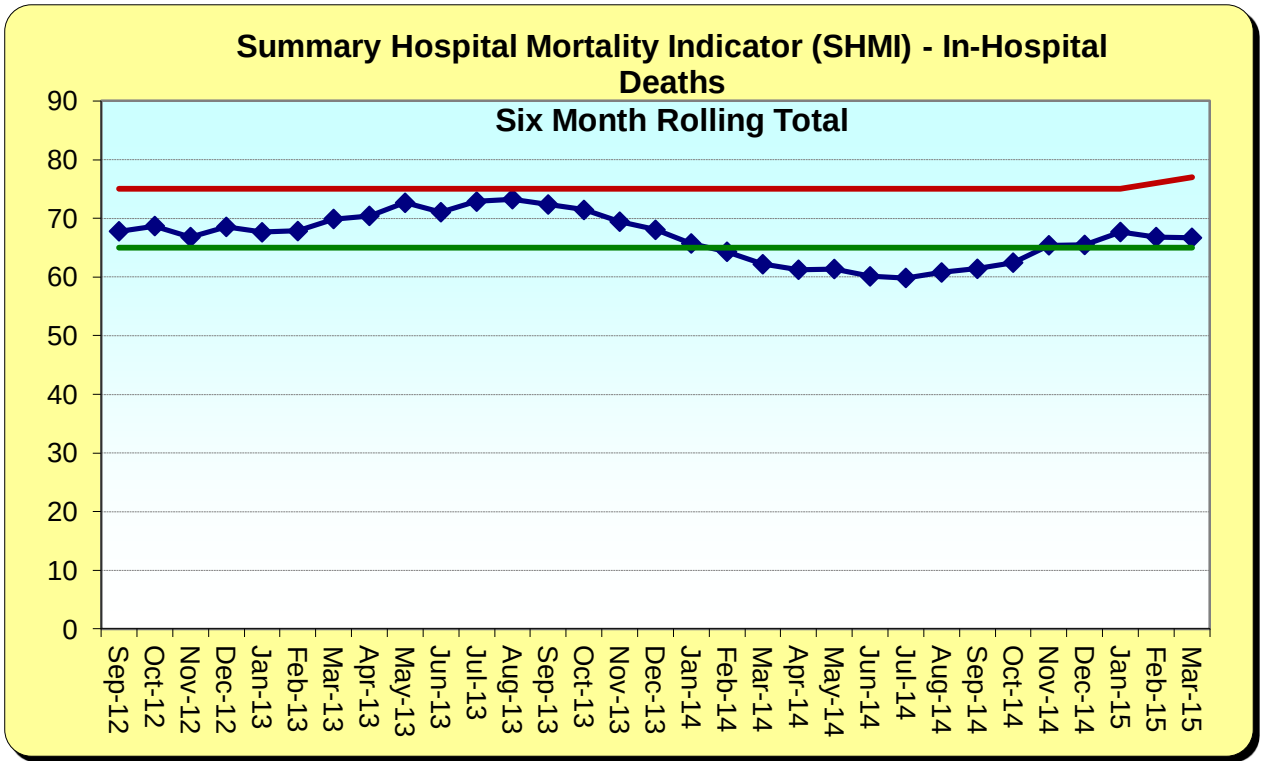
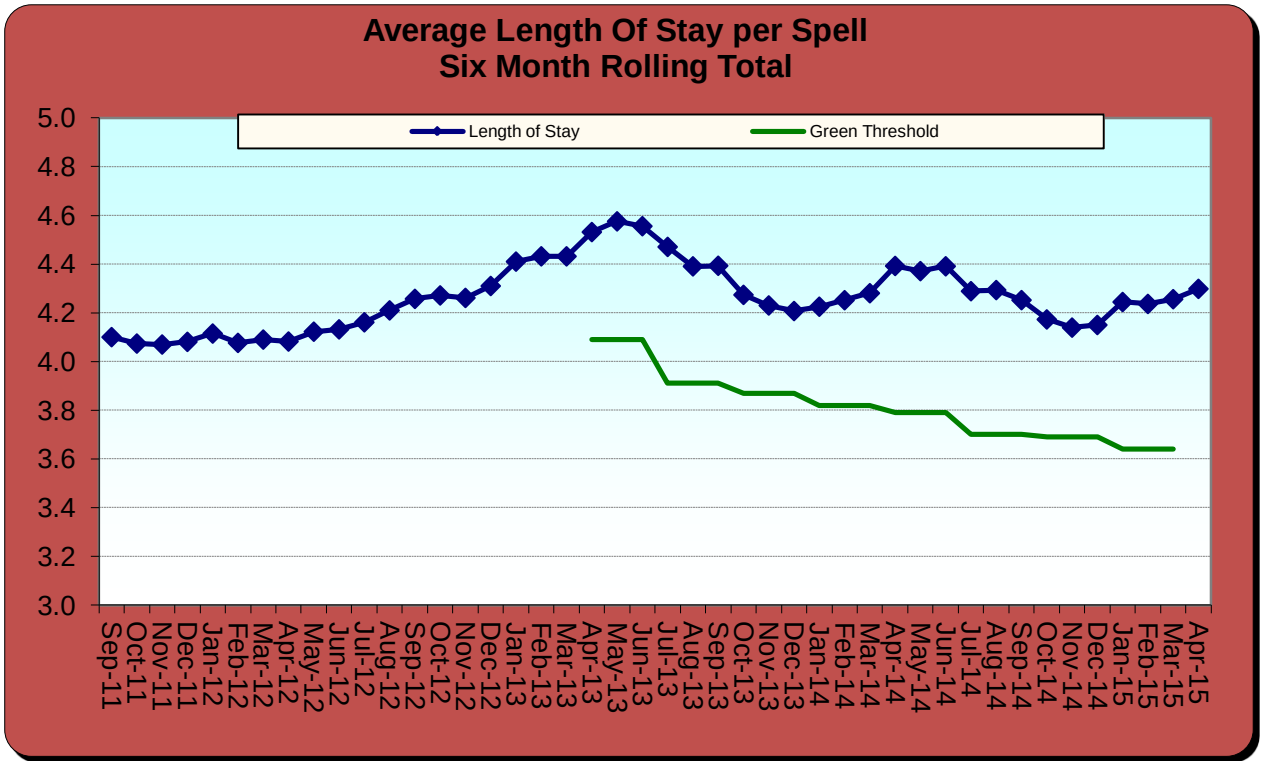
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15


Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths
Six Month Rolling Total
90
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
Mar-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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Jan-14
Feb-14
Mar-14
Apr-14
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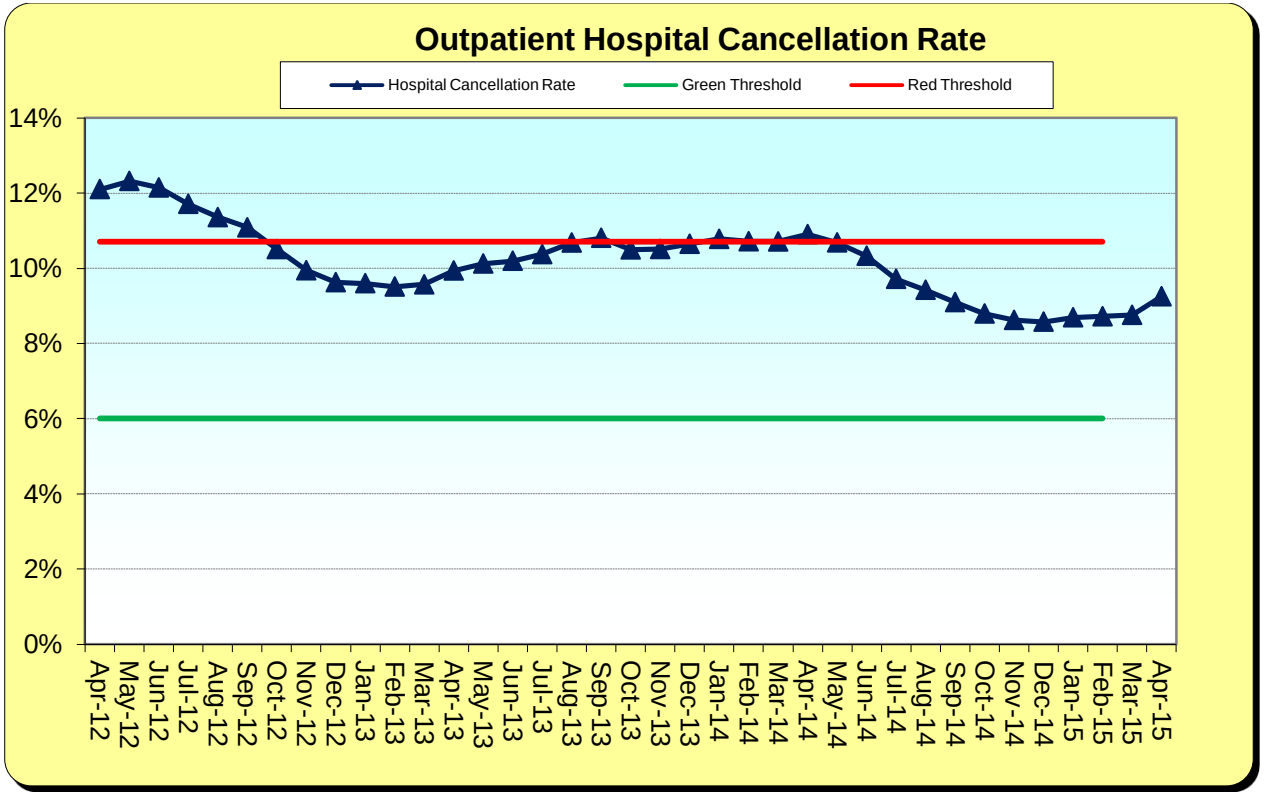
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15


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
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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
Apr-15

SECTION C – Monitor Risk Assessment Framework

During the first month of quarter 1, the Trust failed to meet six of the standards in Monitor's 2015/16 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) – *Access section*

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 confirming the decision on next steps.

Please see the Monitor dashboard on the following page, for details of reported position for quarter 1 2015/16.

PERFORMANCE OVERVIEW

Monitor's Risk Assessment Framework - dashboard

	Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework: Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16*	Q1 forecast*	Notes	Q1 Forecast Risk Assessment Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	TBC	✓	✓	✓	✓	TBC	✓	Limit 45 cases. 6 cases awaiting commissioner review.	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	TBC	✓	✓	✓	✓	98.2%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	TBC	✓	✓	✓	✓	94.0%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	TBC	✓	✓	✓	✓	97.5%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	TBC	✗	✗	✗	✗	75.2%	✗	62-day screening standard at risk, but still could be achieved.	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	TBC	✓	✓	✗	✗	84.6%	✗		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	79.9%	Achieved each month	Not achieved	Not achieved	Not achieved	79.9%	✗		Not achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	90.2%	Not achieved	Not achieved	Not achieved	Not achieved	90.2%	✗		Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.5%	Achieved each month	Not achieved	Not achieved	Not achieved	90.5%	✗	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%	TBC	✓	✓	✓	✓	97.1%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	TBC	✓	✓	✓	✓	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%	94.8%	✗	✗	✗	✗	94.8%	✗	Trajectory expected to be met	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	Triggers further investigation	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.

***Q1 Cancer figures based upon draft figures for the April and May to date.**

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

1.1 QUALITY TRACKER

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Quarterly Totals 14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	5	1	1	2	3	3	3	3	3	4	4	5	5	1	3	4	5	1
	DA03	C.Diff Cases - Monthly Totals	50	6	4	4	4	6	8	4	4	4	3	4	0	6	18	12	7	6
	DA03c	C.Diff Avoidable Cases - Cumulative Totals	8	1	1	1	2	3	5	6	6	6	7	8	8	-	5	6	8	1
	DA02	MSSA Cases - Monthly Totals	33	4	0	3	7	1	4	1	3	4	3	2	4	4	12	8	9	4
MRSA Screenings	DD01	MRSA Pre-Op Elective Screenings	100%	-	100%	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	100%	-	100%	99.9%	100%	-
	DD02	MRSA Emergency Screenings	94.7%	-	95.5%	94.9%	94.3%	95.3%	91.4%	95.8%	94.4%	93.4%	95.5%	94.4%	95.9%	-	93.6%	94.5%	95.3%	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.2%	97%	96.9%	97.8%	96.8%	96.9%	97.1%	96.3%	97.2%	97.6%	97.1%	97.4%	97.6%	97%	97%	97%	97.4%	97%
	DB02	Antibiotic Compliance	89.3%	90.7%	88.2%	87.9%	89.6%	86.2%	88.5%	90.3%	91.2%	89.1%	90.6%	88.8%	88.8%	90.7%	88.2%	90.3%	89.4%	90.7%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	95%	-	95%	96%	93%	96%	96%	95%	95%	94%	95%	96%	96%	-	95%	95%	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	96%	-	97%	95%	96%	97%	97%	97%	98%	98%	98%	98%	98%	-	97%	97%	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	95%	-	96%	96%	91%	96%	95%	95%	96%	95%	95%	96%	96%	-	94%	95%	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	78	6	7	5	10	3	7	10	6	8	7	4	6	6	20	24	17	6
	S02a	Number of Confirmed Serious Incidents	63	-	7	5	8	3	6	8	5	7	5	2	2	-	17	20	9	-
	S02b	Number of Serious Incidents Still Open	10	6	-	-	-	-	-	1	0	1	2	2	4	6	-	2	8	6
	S03	Serious Incidents Reported Within 48 Hours	88.5%	100%	57.1%	80%	100%	100%	100%	80%	83.3%	100%	100%	100%	83.3%	100%	100%	87.5%	94.1%	100%
	S04	Percentage of Serious Incident Investigations Completed Within Timesca	73.3%	75%	50%	83.3%	70%	85.7%	100%	50%	66.7%	37.5%	80%	66.7%	100%	75%	81.8%	46.7%	76.2%	75%
Never Events	S01	Total Never Events	6	0	1	0	0	0	0	0	1	0	1	1	1	0	0	1	3	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	12712	-	954	1010	1104	1038	1258	1151	1028	1073	1017	1022	1124	-	3400	3252	3163	-
	S06a	Patient Safety Incidents Per 100 Admissions	9.4	-	8.56	9.07	9.14	9.52	10.48	9.84	9.45	9.7	8.92	9.72	9.6	-	9.72	9.67	9.41	-
	S07	Number of Patient Safety Incidents - Severe Harm	89	-	6	8	5	4	16	3	12	6	12	7	6	-	25	21	25	-
Patient Falls	AB01	Falls Per 1,000 Beddays	4.8	3.61	5.18	4.28	4.51	4.59	4.26	5.23	4.5	5.59	4.89	4.91	4.53	3.61	4.45	5.11	4.77	3.61
	AB06a	Total Number of Patient Falls Resulting in Harm	28	2	5	2	0	3	5	2	4	1	2	1	2	2	8	7	5	2
Falls (CQUIN Improvement)	AB07a	Number of Inpatient Falls (CQUIN)	1476	92	136	109	116	116	108	134	114	144	132	120	118	92	340	392	370	92
	AB07b	Inpatient Falls (CQUIN) - Improvement from Baseline	-311	-51	-8	-35	-44	-33	-43	-22	-26	-8	-23	-15	-42	-51	-120	-56	-80	-51
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.387	0.353	0.343	0.314	0.427	0.396	0.394	0.312	0.553	0.388	0.37	0.45	0.269	0.353	0.406	0.417	0.361	0.353
	DE02	Pressure Ulcers - Grade 2	110	9	8	8	10	10	10	8	13	8	9	10	5	9	30	29	24	9
	DE03	Pressure Ulcers - Grade 3	9	0	1	0	1	0	0	0	1	2	1	1	2	0	1	3	4	0
	DE04	Pressure Ulcers - Grade 4	0	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	98.8%	99.1%	98.7%	98.1%	98.4%	98.6%	98.9%	98.7%	99%	99%	99.1%	99.4%	99.2%	99.1%	98.7%	98.9%	99.2%	99.1%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.4%	93.9%	94.3%	94%	95.3%	96.6%	93.2%	92.6%	92.3%	96.7%	92.4%	92.9%	96%	93.9%	95.1%	93.8%	93.8%	93.9%
Nutrition	WB05	Nutrition: Screening Tool Completed	93.7%	94.4%	-	-	92.8%	91.8%	94.2%	93.4%	95.1%	93.8%	91.3%	94.6%	96%	94.4%	92.9%	94.1%	93.9%	94.4%
	WB03	Nutrition: Food Chart Review	88.9%	86.8%	87.4%	87.7%	89%	89.3%	93.1%	88.3%	87.2%	87.8%	87.4%	88.4%	87.9%	86.8%	90.4%	87.8%	87.9%	86.8%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.9%	99.6%	99.4%	99.5%	99.7%	99.6%	99.7%	99.6%	99.4%	100%	100%	100%	99.9%	99.6%	99.6%	100%	99.9%

QUALITY

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Patient Safety																				
Medicines	WA01	Medication Errors Resulting in Harm	0.45%	-	0%	0.78%	1.09%	0.52%	0.56%	0%	0.57%	0%	0%	0%	0.54%	-	0.72%	0.2%	0.21%	-
	WA10a	Medication Reconciliation Within 1 Day (Assessment and BHI Wards)	96.5%	93.3%	100%	96.5%	93.3%	97.4%	97.6%	98.6%	97.1%	95%	90%	95.3%	95.6%	93.3%	96%	97.7%	93.8%	93.3%
	WA10b	Medication Reconciliation Within 1 Day (BHOC and Gynae Wards)	95.5%	100%	99.1%	90.9%	86.4%	94.7%	98.8%	98.3%	98.2%	95%	98.4%	-	100%	100%	92.6%	97.8%	99%	100%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.01%	0.63%	0.55%	0.38%	1.41%	1.42%	0.69%	1.21%	0.86%	0.37%	1.55%	1.54%	0.52%	0.63%	1.19%	0.84%	1.23%	0.63%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	96.6%	97.5%	96.7%	96%	96.7%	96.9%	96.5%	96.1%	96.7%	97%	96.7%	97.9%	96.5%	97.5%	96.7%	96.6%	97%	97.5%
	AK04	Safety Thermometer - No New Harms	98.4%	98.9%	98.4%	98.5%	98.9%	98.7%	98%	97.9%	97.8%	98.5%	98.4%	99.3%	98.7%	98.9%	98.5%	98.1%	98.8%	98.9%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	89%	90%	83%	91%	91%	96%	88%	88%	86%	83%	92%	96%	88%	90%	92%	85%	91%	90%
	CA01	Number of Verified Crash Calls from Adult General Wards	51	7	5	5	4	9	3	2	2	3	6	5	4	7	16	7	15	7
Discharges	TD04	Out of Hours Discharges	8.1%	7.4%	9%	8.2%	8.6%	7.6%	8.1%	7.7%	7.3%	7.6%	8.2%	7.1%	8.8%	7.4%	8.1%	7.5%	8.1%	7.4%
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	97.9%	100%	-	-	-	90%	100%	85.7%	100%	100%	100%	100%	100%	100%	96.4%	97%	100%	100%
	CS03	Number of CAS Alerts Overdue At Month End	0	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	64.1	-	64.5	57.3	56.1	66.5	64.1	65.9	85.4	58.5	68.9	60.9	63.2	-	62.2	68.7	64.8	-
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	95.8	-	-	95.8	-	-	95.8	-	-	-	-	-	-	-	95.8	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	68.4	-	66	63.1	58.1	74.7	73.9	70.4	89.7	63.3	71.3	57.6	68.6	-	69	73.1	66.4	-
Learning Disability	AA03	Learning Disability (Adults) - Percentage Adjustments Made	89%	76.5%	78.9%	100%	76.2%	82.4%	91.3%	90.5%	85%	100%	83.9%	95.5%	83.3%	76.5%	83.6%	92.3%	86.7%	76.5%
Readmissions	C01	Emergency Readmissions Percentage	2.82%	-	2.97%	3.03%	2.51%	2.95%	2.96%	2.45%	2.39%	2.99%	3.06%	2.83%	2.96%	-	2.8%	2.61%	2.95%	-
Maternity	G04	Percentage of Normal Births	61.5%	60.9%	58.9%	62.4%	64.7%	61.4%	63.8%	58.9%	65.5%	59.6%	60%	59.8%	57.9%	60.9%	63.4%	61.3%	59.3%	60.9%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	76%	71.4%	70%	82.6%	82.1%	71.4%	61.3%	77.8%	73.3%	70%	78.3%	89.7%	72.7%	71.4%	71.3%	73.6%	81.1%	71.4%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	93.4%	77.1%	93.3%	95.7%	100%	96.4%	93.5%	88.9%	86.7%	93.3%	95.7%	93.1%	86.4%	77.1%	96.6%	90.3%	91.9%	77.1%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.1%	57.1%	66.7%	78.3%	82.1%	67.9%	54.8%	70.4%	60%	66.7%	78.3%	82.8%	50%	57.1%	67.8%	66.7%	71.6%	57.1%
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	56.5%	-	53.6%	36.8%	48.6%	53.7%	61.1%	62.8%	59%	62.8%	55%	66.7%	60%	-	54.4%	61.6%	61.2%	-
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	86.4%	-	96.4%	81.6%	97.3%	78%	86.1%	88.6%	87.2%	79.1%	75%	87%	92.5%	-	86.8%	84.9%	85.1%	-
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.2%	69.2%	30%	57.1%	25%	72.2%	66.7%	58.8%	73.3%	64.7%	50%	57.1%	50%	69.2%	61.4%	65.3%	52.8%	69.2%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	65%	83.9%	52.3%	49%	62.1%	67.5%	66.6%	61.4%	63.7%	62.9%	78.3%	77.3%	81.6%	83.9%	65.4%	62.6%	79.3%	83.9%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	84.1%	98.6%	78.3%	59.5%	84.7%	81.7%	87.3%	87.1%	92.2%	82.2%	90.7%	88.5%	94.2%	98.6%	84.7%	86.3%	91.7%	98.6%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	58.5%	90%	56.5%	22.7%	55.2%	50%	35.9%	78.3%	73.3%	68%	82.4%	81.3%	90.5%	90%	44.8%	74.3%	85.2%	90%
	AC04	Percentage of Dementia Carers Feeling Supported	75.2%	90.9%	62.5%	90%	-	-	70%	80%	88.9%	64.3%	87.5%	81.8%	-	90.9%	57.1%	78.7%	85.2%	90.9%
Outliers	J05	Ward Outliers - Beddays	11216	647	951	769	659	749	908	1338	876	1169	1364	847	889	647	2316	3383	3100	647

QUALITY

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Quarterly Totals 14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	90	88	89	89	89	89	89	89	90	89	-	89	89	89	-
	P01g	Patient Survey - Kindness and Understanding	-	-	94	93	92	93	94	93	93	94	93	93	93	-	93	93	93	-
Friends and Family Test	P03a	Friends and Family Test Inpatient Coverage	38.7%	28.2%	39.5%	39.5%	35.5%	32.9%	33.1%	36.1%	41.3%	29.5%	37.9%	33.9%	59.3%	28.2%	33.8%	35.5%	44%	28.2%
	P03b	Friends and Family Test ED Coverage	20.8%	5.1%	21.4%	19.2%	16.1%	22.7%	26.2%	20.2%	14.9%	16%	17.3%	22.5%	37.1%	5.1%	21.6%	17.1%	26.1%	5.1%
	P04a	Friends and Family Test Score - Inpatients	75.8	78	73.3	73.5	72.4	75	76.8	73.6	73.4	81.8	79.9	73	77.1	78	74.8	75.8	76.9	78
	P04b	Friends and Family Test Score - ED	69.5	67.6	71.4	69.3	72.4	69.7	67.1	67	69.5	69.8	70.9	65.2	68.8	67.6	69.4	68.6	68.3	67.6
Patient Complaints	T01a	Patient Complaints as a Proportion of Activity	0.261%	0.266%	0.226%	0.277%	0.282%	0.321%	0.266%	0.224%	0.251%	0.224%	0.267%	0.291%	0.273%	0.266%	0.288%	0.232%	0.277%	0.266%
	T03a	Complaints Responded To Within Trust Timeframe	85.9%	89.5%	82.5%	83.3%	91.5%	88.3%	88.1%	84.4%	82.9%	82.9%	84.8%	83.7%	85.3%	89.5%	89.5%	83.4%	84.7%	89.5%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	93%	86%	91.7%	76.1%	83.3%	81.4%	77.9%	78.6%	87.1%	87.9%	81.4%	92.6%	93%	80%	81.1%	88.1%	93%
	T04a	Complainants Disatisfied with Response	84	7	4	11	8	4	2	7	9	8	11	7	7	7	14	24	25	7
Ward Moves	J06	Average Number of Ward Moves	2.32	2.31	2.3	2.33	2.34	2.38	2.42	2.32	2.37	2.25	2.24	2.28	2.24	2.31	2.38	2.31	2.25	2.31
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.08%	1.2%	0.96%	1.1%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.16%	1.16%	0.97%	1.2%
	F01a	Number of Last Minute Cancelled Operations	749	66	54	64	84	54	68	52	108	41	58	46	66	66	206	201	170	66

1.2 SUMMARY

The annual review of quality metrics which are presented in the quality dashboard is underway and will align with our 2015/16 quality objectives, quality improvement priorities and key CQUINs for 2016/15.

In April 2015 we have seen our lowest ever incidence of inpatient falls at 3.61 per 1,000 bed-days, which equates to 92 falls in April compared with an average of 127 a month over the previous six months. There have also been no grade 3 and 4 pressure ulcers in April, and we have seen further improvements in our dementia metrics.

We continue to be challenged by the need to improve timely surgery for patients with fractured neck of femur; actions in train are described in the relevant exception report. We have also seen a reduction in Friends & Family Test coverage, both in the Emergency Department and inpatient areas, following a surge towards the end of 2014/15.

Achieving set threshold (38)	**Thresholds not met or no change on previous month (9)**
- Hand Hygiene Audit - Antibiotic prescribing compliance - Cleanliness monitoring: overall Trust score - Cleanliness monitoring: very high risk areas - Cleanliness monitoring: high risk areas - Serious Incidents reported with 48 hours - Never Events - Inpatient falls incidence per 1,000 bed days - Falls resulting in harm - Falls improvement from baseline - Total pressure ulcer incidence per 1,000 bed days - Number of grade 3 hospital acquired pressure ulcers - Number of grade 4 hospital acquired pressure ulcers - 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 (Oncology and Gynaecology wards) - Reduction in medication errors resulting in moderate or severe harm	- Percentage adult in-patients who received thrombo-prophylaxis - Deteriorating patient- appropriate response to an Early Warning Score of 2 or more. - 72 hour Food Chart review - WHO surgical checklist compliance - Learning disability (adults)-percentage adjustments made - Stroke care: percentage receiving brain imaging within 1 hour - Dementia admissions-case finding applied - Friends and Family Test (FFT) coverage: Inpatients - Percentage of complaints resolved within agreed timescale

QUALITY

- Non-purposeful omitted doses of listed critical medication - NHS Safety thermometer- harm free care - NHS Safety thermometer-no new harms - Deteriorating patient- reduction in cardiac arrest calls from adult general ward areas - Out of hours discharges - 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) - Stroke care: percentage spending 90% + time on a stroke unit - High risk TIA (Transient Ischaemic Attack) patients starting treatment with 24 hour - Dementia admissions-assessment completed - Dementia admissions-referred on to specialist services - Ward outliers bed-days Patient experience local patient experience tracker - Average number of ward moves - Monthly patient survey: kindness and understanding - FFT Score: Inpatients - FFT Score: Emergency Department - Number of complainants dissatisfied with our response (not responded in full)	
Quality metrics not achieved or requiring attention (10)	**Quality metrics not rated (15)**
- MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory - MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory - Serious incident investigations completed within required timescale	**Change in reporting to quarterly:** - MRSA screening – emergency - MRSA screening – elective **Metrics/thresholds under review:**

QUALITY	
- Medicines reconciliation performed within one day of admission (Assessment and cardiac wards) - 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 - Patient complaints as a proportion of all activity - Friends and Family Test (FFT) coverage: Emergency Department - Last minute cancelled operations: percentage of admissions	- Trust apportioned Clostridium difficile cases against national trajectory - Percentage of normal births - Dementia-carers feeling supported **Metrics for information** - 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

Details of CQUINs for 2015/16 are currently being agreed with our commissioners.

1.4 CHANGES IN THE PERIOD

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

- Hospital acquired grade 3 pressure ulcers down ↓ from 2 in March to 0 in April;
- High risk Transient Ischaemic Attack (TIA) patients staring treatment within 24 hours up ↑ from 50% in March to 69.2% in April;
- Friends & Family Test coverage in the Emergency Department down ↓ again from 37.1% in March to 5.1% in April;
- Friends & Family Test coverage for in patient areas down ↓from 59.3% in March to 28.2% in April;
- Dementia metrics: "Assess" up ↑ 94.2% in March to 98.6% in April.

Exception reports are provided for ten RED rated indicators and one amber rated indicator*, eleven indicators in total. The Exception Report for Last Minute Cancelled operations is provided in the Access section of this report.

1. MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias against trajectory
2. MSSA (Meticillin Sensitive Staphylococcus aureus) cases against trajectory
3. Serious incident investigations completed within required timescale
4. Medicines reconciliation performed within one day of admission (Assessment and cardiac wards)
5. 30 day emergency re-admissions
6. Fractured neck of femur patients seeing an ortho-geriatrician within 72 hours
7. Fractured neck of femur patients treated with 36 hours
8. Friends and Family Test (FFT) coverage: Inpatients*
9. Friends and Family Test (FFT) coverage: Emergency
10. Patient complaints as a proportion of all activity

QUALITY

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

Description of how the standard is measured:

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

Performance in the period, including reasons for the exception:

There was one Trust apportioned case of MRSA bacteraemia in April 2015.

Division	Monthly Objective	Number of cases in the month
Specialised services	0	0
Surgery Head and Neck	0	0
Women's and Children's	0	1
Medicine	0	0

Widespread screening for MRSA is undertaken in the Trust.

Recovery plan, including expected date performance will be restored.

- A Post Infection Review has to be undertaken, as part of the internal governance process, and as required by Public Health England;
- A Post Infection Review meeting has been set up with the multidisciplinary team to discuss any actions that may need to be implemented;
- An action plan will be put in place and a full report will go to Infection Control Group in July.

QUALITY

Q2. 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 April 2015, as follows:

- One case in the Division of Women's & Children's
- One case in the Division of Medicine
- One case in the Division of Specialised Services
- One case in the Division of Surgery, Head & Neck.

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

Q3. EXCEPTION REPORT: Serious incident investigations completed within timescale	RESPONSIBLE DIRECTOR: Medical Director/Chief Nurse

Description of how the standard is measured:

Serious incidents investigations are required to be completed within timescales set-out in the NHS England's Serious Incident Framework (March 2015). Investigations for incidents which were identified prior to April 2015 are required to be completed within 45 working days for a grade 1, and 60 working days for a grade 2 serious incident.

The contractual target is 80% compliance with the investigation timescales, which is measured quarterly.

Performance in the period, including reasons for the exception:

Four serious incident investigations were completed during April. Of these, one investigation breached the 45 working day timescale resulting in performance of 75%. The reason is described below:

SI number	Incident	Division	Reason for investigation timescale breach
2014 37759	Water leak and flooding in the Bristol Royal Infirmary leading to closure of the main hospital water supple to some areas.	Trust Services	There was a dual approach to investigation: an estates investigation into the cause of the leak and its initial management and a business continuity debrief as to the management of the impact of the leak on patient care and service provision and learning arising from it. The debrief was delayed due to the required staff dealing with flow issues. The estates investigation was conducted in a timely manner, but there was a delay in producing the report.

Recovery plan, including expected date performance will be restored:

- Feedback on serious incident metrics, both good performance and otherwise, is given to divisions via serious incident reports at several levels: Patient Safety Leads at Patient Safety Group, Heads of Nursing at Clinical Quality Group and Divisional Directors and Clinical Chairs at the Senior Leadership Team meetings;
- There is an escalation route via the Chief Nurse or Medical Director for incident investigations that risk breaching the deadline which will be used sooner going forward.

QUALITY

Q4. EXCEPTION REPORT: Patients with medication reconciliation performed within 1 working day of admission.	**RESPONSIBLE DIRECTOR: Medical Director**

Description of how the standard is measured:

An audit is conducted every month to check the number of patients with medication reconciliation documented as performed within one working day of admission.

There are two groups of patients monitored: Group one: wards A300, A609, C603, C705, C708 and C805 (assessment wards and Bristol Heart Institute) and Group two: wards D603, D703 (oncology) and 78 (gynaecology).

Performance in the period, including reasons for the exception:

Overall the Trust target of 95% is met for aggregated results:

Number of patients in sample:	242
Number of patients with medication reconciliation documented	234
Percentage	96.7%

However the score for Group 1 wards (assessment and Bristol Heart Institute wards) was 93.3% The individual ward breakdown is shown in the table below:

Ward	Reviews	Number of patients with reconciled medication	Apr-15
A609 Surgical and Trauma Assessment Unit	25	25	100.0%
A300 Medical Assessment Unit	20	17	85.0%
C603 Coronary Care Unit	20	20	100.0%
C705 Cardiology /Cardiac surgery	21	18	85.7%
C708 Cardiac surgery	25	25	100.0%
C805 Cardiology	25	25	100.0%
D603 Oncology	50	50	100.0%
D703 Oncology	30	28	93.3%
78 Gynaecology	26	26	100.0%

QUALITY

Medical Assessment Unit (A300): Full achievement is possible when 1 whole time equivalent (WTE) pharmacist and 1 WTE pharmacy technician are present. The technician is currently on a short-term secondment to Bristol Clinical Commissioning Group, finishing end of June 2015. It has, unfortunately, not been possible to recruit into this gap and internal replacement is only possible for around 2 hours a day. There are a number of vacancies in the pharmacy technician workforce limiting backfill possibilities. A restructure of pharmacy dispensary staff has just been finalised, recruitment into these vacancies is underway.

C705: This is primarily workload-related with the pharmacist visiting the ward also having to cover our anticoagulation dosing service. These patients were admitted onto ward C705 on a Friday after the pharmacist had left the ward. Thus the medication would not have been reconciled until Monday.

Recovery plan, including expected date performance will be restored:

- The full-time Medical Assessment Unit Pharmacy Technician will return on 28th July 2015;
- The Pharmacy service to Bristol Heart Institute wards is only staffed for morning visits from the pharmacist. One full time technician is employed to cover the three wards. Meeting to be scheduled with Cardiac Pharmacy team to discuss how we can capture patients admitted after the pharmacist visits.

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 March there were 347 emergency readmissions within 30 days of discharge, which equates to 2.96% of discharges. The rate of readmissions is 0.12% above the 2.7% target for the year as a whole, and 0.25% 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;
  - The results of the most recent review of higher than peer rates of emergency readmissions, are expected by the end of June.

QUALITY

Q6-7. 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 April for time to theatre was 72%. Ten of the thirty-five patients did not receive surgery within 36 hours. Activity was exceptionally high in the period which contributed to the poor performance.

Performance for April for ortho-geriatrician review was 77%. Eight of the thirty five patients did not have an Ortho-geriatric review within 72 hours.

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

- Of the eight patients that were not reviewed by an ortho-geriatrician within 72 hours: three of them were admitted over the bank holiday weekend when we were unable to secure ortho-geriatrician cover due to absences in the team. The other five were admitted during a week when two of the three ortho-geriatricians were absent (one due sickness) and despite significant attempts to secure a locum doctor, this was not achieved.
- Of the ten patients that did not receive surgery within 36 hours:
  - Four patients were not fit to proceed with surgery within 36 hours;
  - One patient was a missed fracture which was detected after the 36 hour window;
  - One patient was delayed as their MRI scan was delayed;
  - The remaining four were not able to be admitted due to lack of theatre capacity, following a peak in emergency activity (both for fractured

neck of femur and general trauma). A contributing factor to reduced theatre capacity is a bottleneck in recovery which is being addressed as a matter of priority.

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 now includes running these lists on Bank Holidays;
- 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. Recruitment is in train and this is not yet routinely in place;
- Delivery of a range of actions to address the theatre recovery bottleneck to improve throughput;
- We are in communications with North Bristol Trust regarding their ortho-geriatricians doing locum shifts at UHB;
- Clear escalation plan in place when theatre capacity is a reason to delay patients with fractured neck of femur getting to theatre;

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

Month (of patient discharge)	**Apr-15**	**May-15**	**June-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Total patients (predicted)	24	32	29	29	31	30	24	19	36	29	28	22
Expected 36 hour breaches	**2**	**3**	**2**	**2**	**3**	**3**	**2**	**1**	**3**	**2**	**2**	**2**
Performance trajectory	**91.7%**	**90.6%**	**93.1%**	**93.1%**	**90.3%**	**90%**	**91.6%**	**94.7%**	**91.6%**	**93.1%**	**92.8%**	**90.9%**
Total patients (actual) not just BPT patients	35											
Actual 36 hour breaches	10											
Actual performance	**71.4%**											

QUALITY

Q8-9. Friends and Family Test survey response rate: Emergency Department and In-patient wards	RESPONSIBLE DIRECTOR: Chief Nurse

Description of how the standard is measured:

The Friends and Family Test is a short exit survey, where patients are asked whether they would recommend the care they received to their Friends and Family. The response rate is calculated as the number of discharged patients relative to the number of questionnaire cards returned.

In 2014/15 there was a CQUIN target attached to the achievement of a 15% Emergency Department (ED) response rate in Quarter 1 (April-June 2014), rising to 20% in Quarter 4 (January-March 2015). For adult inpatient wards the respective targets were 25% rising to 30%.

There is no CQUIN target for 2015/16, but the thresholds in the Trust Board Quality Dashboard currently remain at the stretched (Quarter 4) target levels pending a review of metrics in the dashboard.

Performance in the period, including reasons for the exception:

In April 2015, the ED response rate was disappointing at 5.1%. This is not reflective of usual performance, as the EDs achieved both of their CQUIN targets in 2014/15 (18.9% in Quarter 1 and 26.1% in Quarter 4).

The April 2015 adult inpatient ward response rate was 28.2%, slightly below the 30% target. Again, the adult inpatient wards achieved all of their CQUIN targets in 2014/15 (41.6% in Quarter 1; 44.0% in Quarter 4).

Given the huge amount of focus on successfully delivering the CQUIN targets in Quarter 4, it appears that focus slipped immediately following this in April 2015. This issue will be raised with the Divisions so that satisfactory response rates are attained once again.

Recovery plan, including expected date performance will be restored:

The performance is discussed and monitored at the Patient Experience Group, chaired by the Chief Nurse. On behalf of the Divisions, the Heads of Nursing will discuss the April performance with ward and ED staff.

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 April 2015, complaints received represented 0.27% of clinical activity (approximately one in every 376 patient episodes of care). This is equal to the percentage of 0.27% reported in March 2015; although the actual number of complaints received decreased from 181 in March to 158 in April 2015. Of the complaints received in April, 72 are being progressed through formal resolution. There were no notable changes to the numbers of complaints received by each Division compared to March, and all Divisions saw an increase in the number of complaints received compared with the same period last year (April 2014).

The divisional breakdown is shown below:

Division	**Total complaints received in April 2015**	**Percentage of patient activity**	**Areas with highest number of complaints in April 2015**
Diagnostics & Therapies	2 (11 in March)	Not recorded for this Division	Orthotics x 1 X-Ray x 1
Surgery, Head & Neck	76 (72 in March)	0.30%	Bristol Eye Hospital x 23 Bristol Dental Hospital x 12 ENT Outpatients x 10
Medicine	30 (39 in March)	0.23%	Emergency Department x 7 Dermatology x 3
Women & Children	20 (29 in March) Bristol Children's Hospital – 14 St Michael's Hospital – 6	0.14%	Emergency Department & Ward 39 x 5
Specialised Services	23 (24 in February) Bristol Heart Institute – 20 Bristol Haematology & Oncology Centre - 3	0.31%	Bristol Heart Institute Outpatients x 11 Chemo Day Unit (Outpatients) – BHOC x 2 Ward C708 x 3

QUALITY

In the Division of Surgery Head & Neck, the number of complaints received by Bristol Eye Hospital remained high (23 complaints in April compared with 26 in March). Of these 23 complaints, 12 were in respect of cancelled or delayed appointments/operations, 5 were about failure to answer the telephone and 3 were in respect of attitude of medical and nursing staff.

12 complaints were received by the Bristol Dental Hospital in April, compared to 11 in March. Among these 12 complaints, there were no discernible trends, with just 2 regarding cancelled/delayed appointments.

In the Division of Medicine, the number of complaints received by the Emergency Department remained the same, with 7 being received in April 2015 (7 in March). Three complaints were received by the Dermatology Department. No discernible patterns noted.

In the Division of Specialised Services, the number of complaints received by the Bristol Heart Institute Outpatients Department remained high at 20, compared with 19 in March. Of these 20 complaints, 8 were about cancelled or delayed appointments, 3 were in respect of unanswered telephones. There were no other discernible patterns noted in respect of the complaints received for Specialised Services.

Complaints about the Division of Women's & Children's services reduced from 29 in March to 20 in April. There was also a significant reduction in complaints about the Division of Diagnostics & Therapies – from 11 in March to 2 in April.

Recovery plan, including expected date performance will be restored:

March and April 2015 complaints data will be discussed in detail by Heads of Nursing at the Trust's Patient Experience Group meeting on 25th June 2015.

1.6 SUPPORTING INFORMATION

1.6.1 QUALITY ACHIEVEMENTS

This month's quality achievements are from the **Division of Medicine:**

- The Division has reduced the number of falls and hospital acquired pressure ulcers to below the green threshold sustained this for more than twelve months;

- The Division has achieved a significant reduction in divisional outliers; these were at the lowest ever in April 2015 at 289 bed-days compared to more than 1000 at its peak. Having patients located within the correct division reduces the risk of harm through better access to clinical teams, and being cared for by staff who are more familiar with the patient's condition;

- Nurses from the Division were recognised at our Nurses Day celebrations: Cally Preece, Sister in the Bristol Royal Infirmary Emergency Department won the "Above and Beyond Nursing and Midwifery Award", Gary Hodder, Nurse Assistant in the Bristol Royal Infirmary Emergency Department was highly commended in the "Nursing/Midwifery Assistant of the Year" category and Ann Steele-Nicholson, Lead Nurse for Genito-urinary Medicine, Contraception & Sexual Health, won the "Inspirational Leader Award";

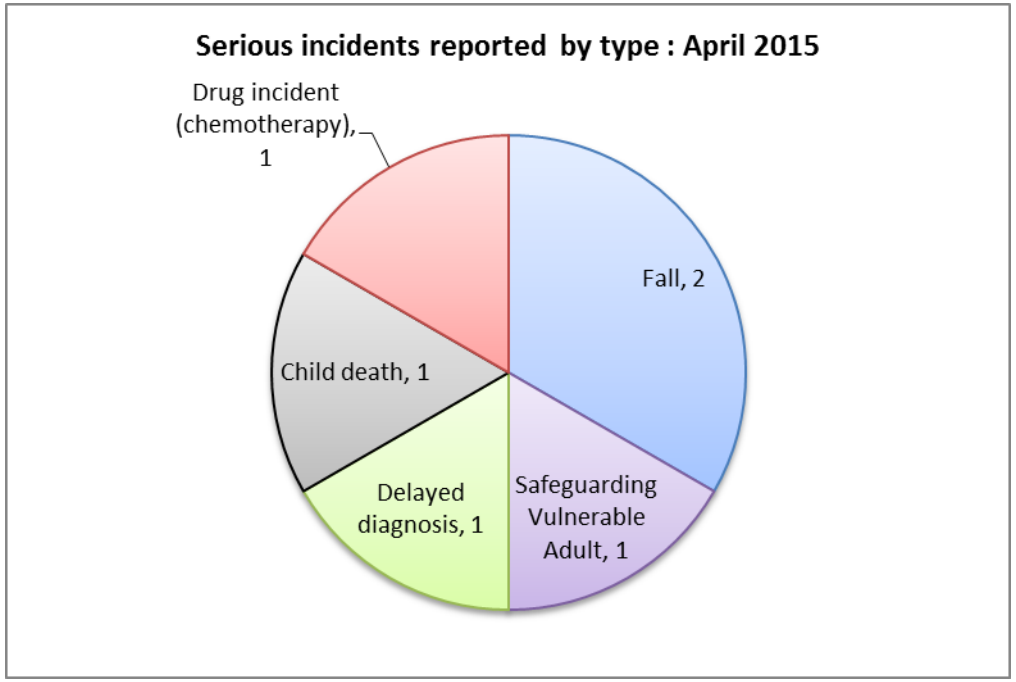
- The Independent Domestic Violence Advisor team in the Bristol Royal Infirmary Emergency Department were filmed for Channel 4 News (media footage to be shared with 5 Live and Good Morning Britain) as part of the Co-ordinated Action Against Domestic Abuse rebranding to "Safe Lives" and 10 year anniversary;

- Following a local patient survey, 99% of patients who had used our sexual health services and responded to our survey said would recommend our service to their friends;

- Patient survey scores in the Bristol Royal Infirmary Emergency Department continue to show patients reporting high levels of satisfaction with their experience of care and treatment received. The scores benchmark highly against national comparators.

1.6.2 SERIOUS INCIDENT THEMES

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



Further details are provided in the table below:

Date of Incident	SI Number	Division	Incident Details	Investigation
23/01/2015	2015 12369	Medicine	Safeguarding: Patient discharged home without ensuring district nursing aware of discharge. Patient found collapsed at home three days later and subsequently died.	Investigation underway

QUALITY

Date of Incident	SI Number	Division	Incident Details	Investigation
13/04/2015	2015 13372	Medicine	Patient fall resulting in fracture	Investigation underway
15/04/2015	2015 13900	Surgery, Head & Neck	Patient fall resulting in fracture.	Investigation underway
24/12/2014	2015 14311	Surgery, Head & Neck	Delayed appointment follow-up led to missed opportunity to intervene in progression of glaucoma leading to sight loss	Investigation underway
27/04/2015	2015 15443	Women's & Children's	Unexpected child death in the Emergency Department. Child had presented twice in the preceding four days.	Investigation underway
09/04/2015	2015 15472	Specialised Services	Drug incident: Cancer patient with poor prognosis given incorrect dose regime (carboplatin/etoposide). Patient died four days later.	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 April 2015 were as follows:

- Workforce expenditure – compared with budget
- Workforce numbers - compared with budgeted establishment
- Bank and agency usage – compared with target
- Sickness – compared with target

Although we have produced an exception report for workforce expenditure; workforce numbers and bank and agency usage, it is important to recognise that during month one there is ongoing work on budget allocation and the profiling of financial plans with the Divisions. This may alter the position once this work concludes. The impact of this will be described in month two.

Key Performance Indicators (KPIs) in the quarterly workforce report 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. 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.

The KPI thresholds in this report have been revised this month as part of the annual workforce planning process, in which workforce indicators are agreed as part of an integrated process. The workforce planning process includes an assessment of supply factors including projected sickness absence, recruitment, turnover and associated bank and agency usage. In setting workforce KPIs this year, Divisions have aimed to strike a balance between challenging targets which are in line with relevant benchmarks, but which are also appropriate given the UH Bristol context and recent performance. The Trust-wide targets are built from an aggregation of divisionally agreed targets.

As part of the workforce planning process, we have also refined certain aspects of workforce reporting to improve the way we measure our KPIs. Changes include the following:

- Vacancy reporting now excludes the component of the funding and FTE (Full Time Equivalent) which is being reserved for temporary staffing to cover sickness, maternity, annual and study leave. The vacancy measure now includes only posts which are intended to be filled by recruitment, and is no longer simply the gap between budgeted establishment and staff in post. This aligns with the way our Finance Department measures vacancies;
- As in 2014/15, there has been a re-basing of the turnover trajectory. This means that the straight line trajectory starts from the out-turn of March 2015, and assumes the cumulative Trust-wide target of 11.5% is reached by March 2016. Turnover this month is amber rated at 13.8%.

WORKFORCE

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

Description of how the standard is measured: Workforce expenditure in £'000 including substantive, bank and agency staff, waiting list initiative and overtime compared with budget.

Performance in the period, including reasons for the exception:

During April, there was an adverse variance on the pay expenditure compared to budget of 1.6% compared with a variance 0.0% in March. The pay overspend for 2014/15 was 1.2%.

	UH Bristol	Diagnostics and Therapies	Medicine	Specialised Services	Surgery Head and Neck	Women's and Children's	Trust Services (exc Estates and Facilities)	Facilities and Estates
April 2015	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Planned Expenditure	28,593	3,419	4,284	3,347	6,275	7,378	1,929	1,726
Actual Expenditure	29,048	3,412	4,381	3,416	6,478	7,568	1,827	1,697
variance target +/-	(455)	8	(97)	(70)	(203)	(190)	102	30
Percentage variance	1.6%	(0.2%)	2.3%	2.1%	3.2%	2.6%	-5.3%	(1.7%)

Trust-wide, there was an adverse variance of £455k compared with £12k in March. The pay budget of has reduced by £1.175M compared with last month. This is associated with adjustments at the beginning of the year, including building in the requirement to make savings. Some of the funding, including some Education funding and adjustments due to contracts, may not yet be fully reflected in the budget and will be applied to May budgets. Total spend on agency was £507K lower than in March at £1.04M and bank spend increased slightly by £74k to £945k.

All bed holding Divisions had an adverse variance in pay spend in month, largely due to bank and agency costs. Reasons are provided below:

Surgery Head & Neck: An adverse variance of £203k was reported compared with £264k last month. Medical and dental agency costs of £111k this month have resulted from a number of vacancies and £144k was spent on nursing agency of which £45k was attributable to Critical Care Bank spend also remains high at £120k, with £40k attributable to Trauma. Trajectories have been produced, phasing bank and agency reductions over the year, in line with plans to reduce vacancies.

Women`s and Children`s Division: There was an adverse variance of £190k compared with no variance last month. This is largely due to agency costs

including £49k to cover Neonatal Intensive Care consultant gaps, which will reduce as locums have been appointed, and £35k nursing agency related to one to one mental health nursing support, as well a general usage of agency nursing.

Medicine Division: There was an adverse variance of £97k compared with £96k last month. Agency nursing expenditure has reduced by £126k in month, which is encouraging in terms of trajectory. Pay budgets remain overspent as a result of a deficit budget created to fund additional baseline wards which will be funded by over achievement on savings plans. Substantive nurses employed have increased by circa 17 WTE, a continuing trend that is encouraging in a challenging market. Current projections suggest that net of current turnover rates, inpatient wards will be fully established towards the end of the summer. The cost of Junior Doctors in April is higher than in March as locum shifts have been utilised to cover the additional wards on a formalised basis.

Specialised Services: An overspend of £70k was reported, compared with £60k in March, largely due to bank and agency spend. This includes £61k relating to the Cardiac Intensive Care Unit to cover staffing shortages due to sickness, supernumerary staff/vacancies and additional required staff to cover ventilated bed demands due to the acuity of patients, and one to one nursing in a range of other wards. There were also costs of £23k for agency staff in perfusion, to cover vacant posts which are essential to perform cardiac surgery cases.

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

The recovery plan is described in the bank and agency section in Exception Report W3 below.

WORKFORCE

W2. 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 budgeted establishment.

Performance in the period, including reasons for the exception:

Total workforce numbers (substantive and bank and agency) variance reduced from 2.2% to 2.0% above budgeted FTE in April. Variance continues to be largely due to the continued high usage of bank and agency staff.

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
April 2015	FTE	FTE	FTE	FTE	FTE	FTE	FTE	FTE
Actual Employed	7546.1	923.5	1097.1	799.3	1644.8	1729.7	631.0	720.8
Bank and Agency	591.7	26.0	194.4	76.1	103.9	93.1	37.0	61.3
Total Workforce Numbers	8137.8	949.5	1291.4	875.4	1748.7	1822.8	668.0	782.0
Budgeted Numbers	7976.8	968.0	1233.4	834.4	1698.6	1814.3	640.9	787.2
variance target +/-	(161.0)	18.5	(58.0)	(41.0)	(50.1)	(8.4)	(27.1)	5.2
Percentage variance	2.0%	(1.9%)	4.7%	4.9%	3.0%	0.5%	4.2%	(0.7%)

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

W3. EXCEPTION REPORT: Bank and Agency compliance	RESPONSIBLE DIRECTOR: Director of Workforce & Organisational Development

Performance in the period, including reasons for the exception:

During April, temporary staffing comprised 7.3% of total staffing numbers (FTE) compared with 7.2 % last month, and an annual average of 6.8%. Agency staffing accounted for 2.0% of total staffing for April, compared to an annual average of 1.6%. Agency usage has reduced by 4.5 FTE and bank usage has increased by 9.7 FTE. The overview below by Division shows usage for bank and agency against the thresholds set by Divisions.

Bank (% Total Staffing)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Target set by division	4.7%	1.2%	10.1%	4.7%	4.2%	3.5%	2.0%	6.3%
Bank April 2015	5.2%	1.2%	11.0%	6.0%	4.3%	3.8%	4.3%	5.9%
Variance from target (FTE)	0.5%	0.0%	1.0%	1.3%	0.1%	0.3%	2.3%	-0.3%
WTE Bank April 2014	303.5	8.2	97.3	31.4	64.8	43.3	31.7	26.9
WTE Bank April 2015	426	11.4	142.4	52.2	75.7	69	28.8	46.5

Agency (% Total Staffing)	UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services (exc. Facilities & Estates)	Facilities & Estates
Target set by division	1.6%	1.1%	4.3%	2.2%	0.9%	0.5%	0.8%	1.7%
Agency April 2015	2.0%	1.2%	11.0%	6.0%	4.3%	3.8%	4.3%	5.9%
Variance from target (FTE)	0.5%	0.2%	6.8%	3.7%	3.5%	3.2%	3.5%	4.3%
WTE Agency April 2014	79.7	2.7	23.8	19.4	6.5	10.8	8.0	11.1
WTE Agency April 2015	165.8	14.6	52	23.9	28.2	24.1	8.2	14.8

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

- Workload/clinical needs, increased acuity, extra capacity and administrative workload;
- Cover for vacancies;
- Cover for sickness absence;
- Nursing assistant one-to-one care

During April, there was a marked change in Medicine in the use of bank and agency for extra capacity beds, which are now being recruited to substantively.

WORKFORCE

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)
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
April 2015	556.12	24.82	159.90	76.09	103.94	93.09	61.27	37.01

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

During the next two weeks, the bank and agency plan will be refreshed by the Recruitment & Retention Group, to extend to all staff groups and to cover a number of operational activities which will support improved rostering and bank processes. Progress this month is summarised below:

Enhanced Rostering, Operational and Workforce Planning:

Ward dashboards will include workforce information from a range of sources, including staffing activity, E rostering KPIs, Department of Health reported staffing and Acuity & Dependency data. Initially this will be for inpatient wards only, but will extend to other areas over the summer. This will be implemented using May staffing figures that will be reported in June.

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

- An innovative marketing campaign went live which included the use of local radio to encourage experienced registered nurses to apply to the Bank; this has already resulted in 6 new RN applications to the bank which are now going through the recruitment process;
- 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. We have been using this since April 1st and we are monitoring levels of engagement with the service, which have been particularly positive with ancillary staff, and to an increasing extent with nursing staff;
- As agreed with the Senior Leadership Team and Pay Assurance Group the intensity bonus for bank-only staff was increased from April 1st;
- Divisions continue to monitor long term bank assignments to ensure an appropriate use of temporary staff, releasing staff into other assignments where more appropriate. Each long-term agency assignment for administrative & clerical roles is flagged with Divisions at 10 weeks, and is subject to a longer term review.

WORKFORCE

W4. 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 4.3% to 4.2%. Across Divisions, there is a mixed picture; in Surgery Head & Neck sickness has dropped 0.9 percentage points to 4.1%. Rates have also reduced slightly in Diagnostics & Therapies, Medicine and Trust Services, but there have been small increases in all other Divisions.

The most significant change this month was a 30% reduction in colds and flu related absence, and although psychological reasons continue to be the top cause of sickness absence (see section 2.2.1), there was a 10% reduction in days lost for this reason. There was a 15% increase in back 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 April 2014	3.7%	2.1%	4.2%	3.7%	3.6%	3.7%	3.0%	6.7%
Target April 2015	3.7%	3.0%	4.2%	3.7%	3.5%	3.6%	2.6%	5.2%
Absence April 2015	**4.2%**	**2.9%**	**5.2%**	**3.6%**	**4.1%**	**4.0%**	**3.2%**	**6.7%**
Cumulative absence April 2015	4.2%	2.9%	5.2%	3.6%	4.1%	4.0%	3.2%	6.7%
	0.54%	-0.08%	0.99%	-0.14%	0.64%	0.35%	0.56%	1.51%

Progress against recovery plan

Progress against recovery plan

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

Stress Management/ Health and well-being

- 67 staff have attended the extended modules of 'Making Change' and 'Identifying and Managing Work Related Stress' as part of a resilience building initiative and a further 50 have booked for the remaining sessions. This concludes at the end of April 2015 when a full evaluation will

be completed;

- A Staff Health & Wellbeing framework was approved by the Workforce & Organisational Development Group at the end of March and an action plan has since been drafted covering the 9 domains of wellbeing;
- The Wellbeing Charter (Public Health England), has been applied for and is subject to self-assessment with an assigned person from Public Health England to guide the Trust through the process;
- Smoke free secondary care practitioners have been recruited for a fixed term of a year from June 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).

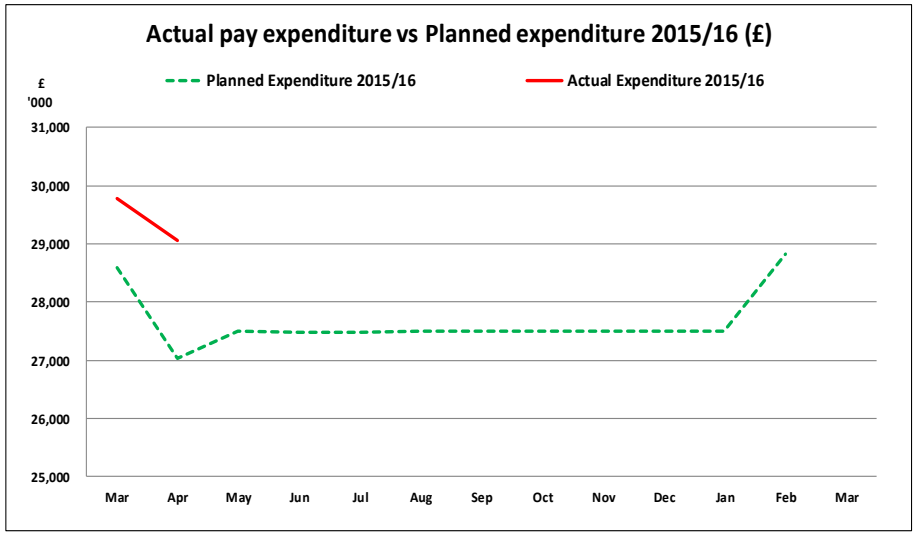
Musculo-skeletal

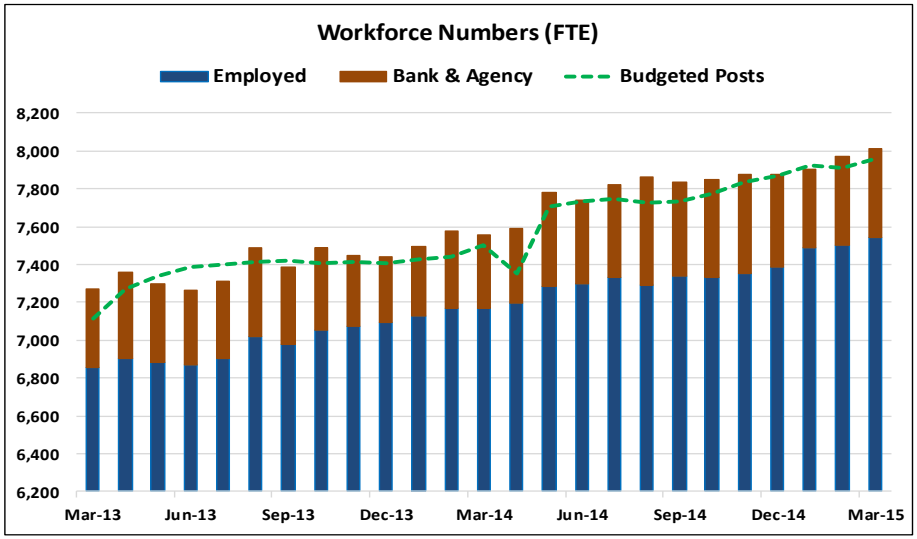
- Physio Direct consultations were at similar levels to the previous month - 73 in April, compared with 76 in March;
- Musculo skeletal clinics are at full capacity with additional clinics scheduled in April and May, aiming to reduce waiting times for manager referrals;
- The Manual Handling Team provided more than 166 follow-up visits, providing advice and assessments in relation to best practice, musculoskeletal wellbeing, patient safety, equipment and workstation /office space advisory visits. This figure includes an increase in Inductee Risk Reduction follow-up due to improved procedures;
- Occupational Health and the Health & Safety teams have been working in partnership to target disorders associated with working practice and environment. They have formalised partnership working with a communication meeting and terms of reference including working with the wellbeing lead;
- 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.





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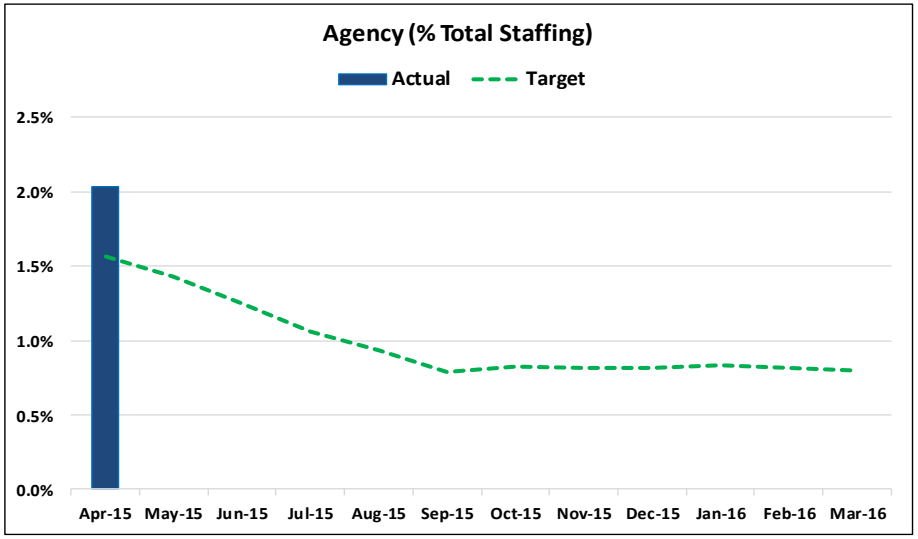
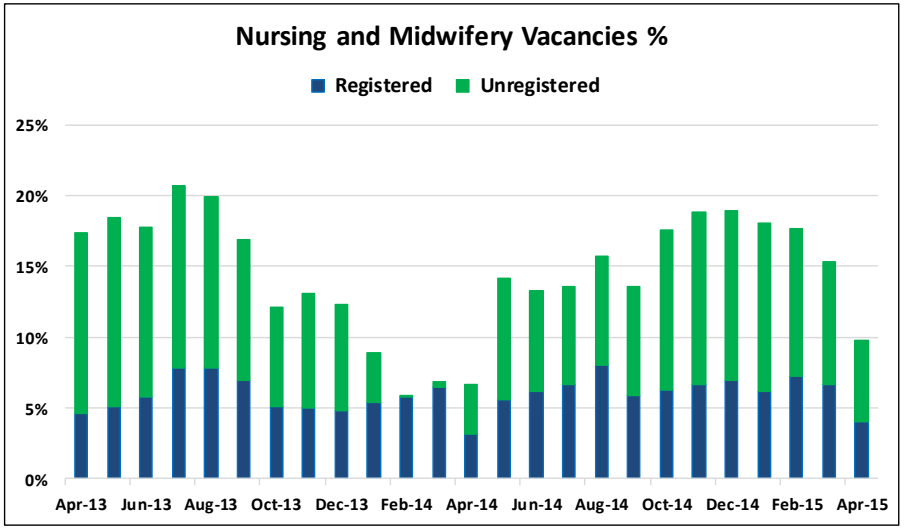
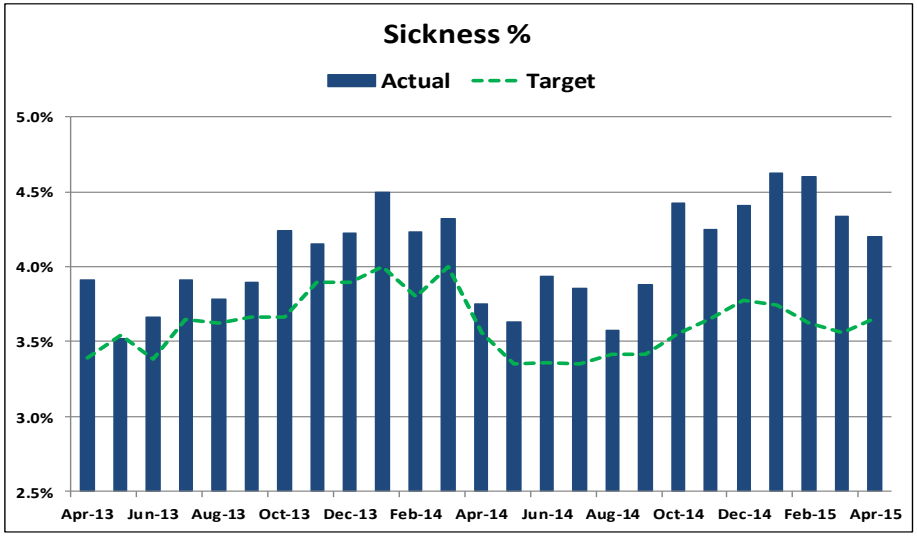
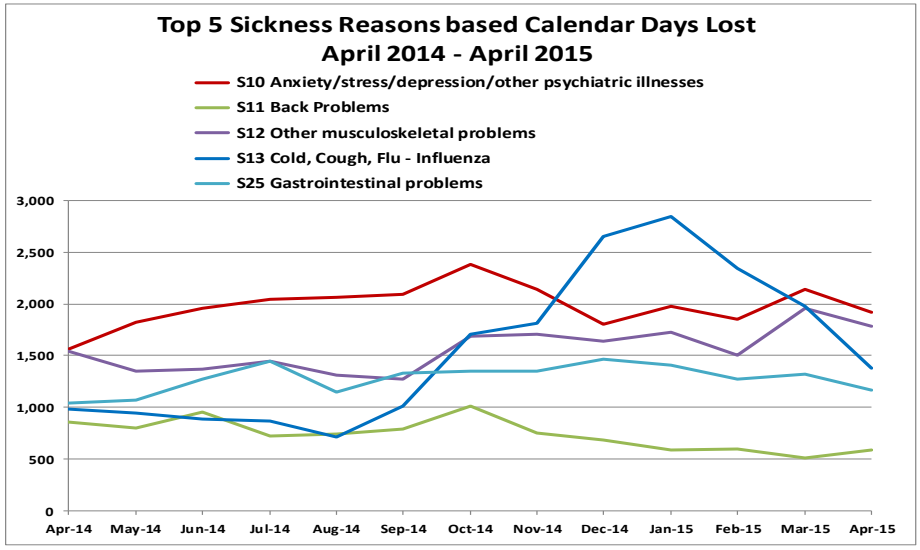
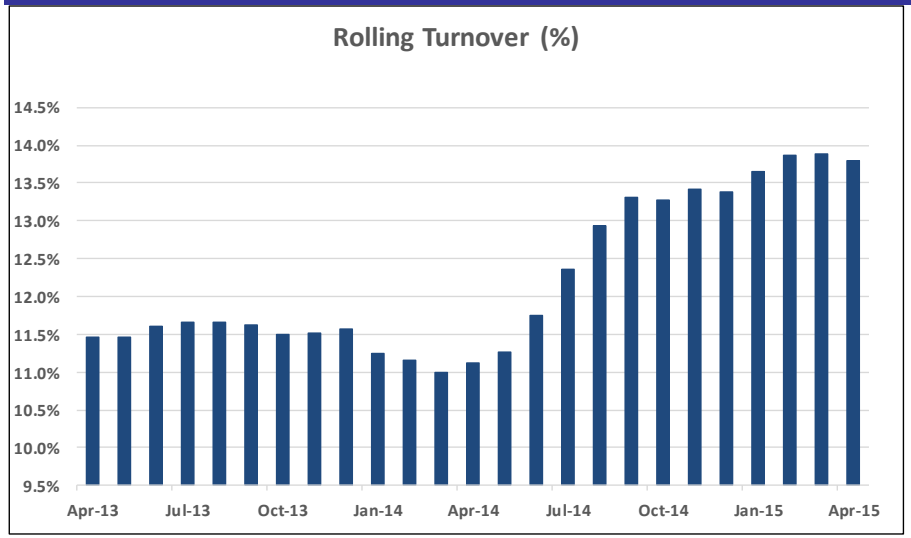

Agency (% Total Staffing)
Actual
Target
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16


Nursing and Midwifery Vacancies %
Registered
Unregistered
25%
20%
15%
10%
5%
0%
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15


Sickness %
Actual
Target
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
Oct-14
Dec-14
Feb-15
Apr-15

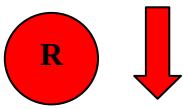
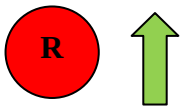
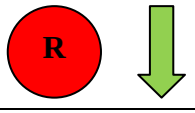
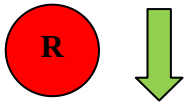
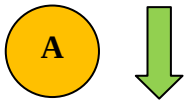
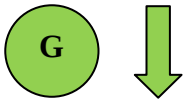

Top 5 Sickness Reasons based Calendar Days Lost
April 2014 - April 2015
S10 Anxiety/stress/depression/other psychiatric illnesses
S11 Back Problems
S12 Other musculoskeletal problems
S13 Cold, Cough, Flu - Influenza
S25 Gastrointestinal problems
3,000
2,500
2,000
1,500
1,000
500
0
Apr-14
May-14
Jun-14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

WORKFORCE


Rolling Turnover (%)
14.5%
14.0%
13.5%
13.0%
12.5%
12.0%
11.5%
11.0%
10.5%
10.0%
9.5%
Apr-13
Jul-13
Oct-13
Jan-14
Apr-14
Jul-14
Oct-14
Jan-15
Apr-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[1]	Commentary	Notes
Workforce Expenditure (£)		Workforce expenditure adverse variance from budget increased from 0.04% below budget to 1.6% above budget in month compared with March 2015.	See summary, supporting information and exception report.
Workforce Numbers (FTE)		Total workforce numbers including bank and agency increased by 7.2 FTE compared with the previous month. Workforce numbers were 2.0% above budgeted FTE, compared with 2.2% above budget in March 2015.	See summary, supporting information and exception report.
Bank (FTE)		Bank increased by 9.7 FTE to 426.0 FTE, and comprised 5.2% of total staffing FTE (compared with a target of 4.7%) in April 2015. Operational Resilience Pressures funding equated to 1.3% (5.6 FTE) of total bank FTE in April 2015.	See summary, supporting information and exception report.
Agency (FTE)		Agency reduced by 4.5 FTE to 165.8 FTE, and comprised 2.0% of total staffing FTE (compared with a target of 1.6%) in April 2015. Operational Resilience Pressures funding equated to 18.1% (30.0 FTE) of total agency FTE in April 2015.	See summary, supporting information and exception report.
Sickness absence (%)		Sickness absence reduced to 4.2% in March; compared to 4.3% in March. This is 0.5 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) reduced to 13.8% compared a target this month of 13.6% and down 0.1 percentage points compared with March (based on updated figures).	See summary, supporting information and exception report.
Vacancy (%)		Vacancies reduced to 4.2% 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	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	April 15 Target
Budgeted Posts (FTE)	7355.2	7709.5	7732.9	7744.9	7729.1	7733.4	7775.8	7833.6	7872.4	7927.2	7912.4	7958.8	7976.8	8009.1
Total Staffing (FTE)	7588.1	7780.7	7739.6	7821.9	7864.8	7835.5	7859.9	7910.8	7954.2	8004.1	8088.6	8130.6	8137.8	8135.2
Bank (FTE) Admin & Clerical	71.3	89.2	83.7	88.8	103.5	86.4	95.8	93.5	102.5	89.1	101.0	101.4	97.1	
Bank (FTE) Ancillary Staff	38.0	54.6	51.8	51.9	73.3	59.0	55.6	47.5	57.4	51.5	62.7	51.7	51.7	
Bank (FTE) Nursing & Midwifery	203.6	249.5	220.8	241.8	274.2	233.7	247.2	245.0	254.8	227.2	257.5	253.7	265.8	
Agency (FTE) Admin & Clerical	23.4	22.4	21.1	19.3	27.7	26.4	29.9	49.0	52.9	25.2	39.2	44.5	28.9	
Agency (FTE) Ancillary Staff	0.0	6.8	4.9	15.0	12.1	7.6	7.9	14.3	9.7	12.1	11.5	19.9	12.2	
Agency (FTE) Nursing & Midwifery	39.2	52.4	41.6	49.1	58.3	65.0	68.9	83.7	71.9	87.2	89.3	93.9	97.4	
Overtime	1.0%	0.6%	0.8%	0.6%	0.9%	0.8%	1.0%	0.8%	0.9%	0.6%	0.8%	1.1%	0.8%	0.7%
Sickness absence[1] Rate (%)	3.7%	3.6%	3.9%	3.9%	3.6%	3.9%	4.4%	4.2%	4.4%	4.6%	4.6%	4.3%	4.2%	3.6%
Appraisal (%)	87.1%	86.3%	87.2%	86.3%	86.9%	85.3%	84.4%	83.5%	85.1%	83.7%	84.4%	85.6%	86.3%	85.0%
Consultant Appraisal[5] (%)	89.1%	89.2%	83.0%	85.5%	88.8%	89.1%	88.4%	90.3%	89.0%	89.7%	90.6%	89.3%	91.5%	85.0%
Rolling Average Turnover[2] (all reasons) (%)	11.1%	11.3%	11.7%	12.4%	12.9%	13.3%	13.3%	13.4%	13.4%	13.7%	13.9%	13.9%	13.8%	
Vacancy[4] Rate (%)	2.2%	5.5%	5.6%	5.4%	5.6%	5.1%	5.7%	6.1%	6.1%	5.5%	5.2%	5.2%	4.2%	≤5%

1. Sickness absence is expressed as a percentage of total whole time equivalent staff in post. Reporting of previous months is updated to ensure any late sickness reporting is captured.
2. Turnover measures the number of leavers expressed as a percentage of the average number of staff in post in the rolling year period and excludes bank, locum and honorary staff.
3. Vacancy measures the number of vacant posts as a percentage of the budgeted establishment (excluding band and agency budgeted establishment).
4. Consultant appraisal process allows 14 months before counting as non-compliant.

ACCESS STANDARDS

3.1 SUMMARY

The following section provides a summary of the Trust's performance against key national access standards at the **end of April 2015**. It shows those standards not being achieved either in the current ***quarter (i.e. quarter 1)***, and/or the ***month***. The standards include those used in Monitor's Compliance Framework, as well as key standards included within the NHS operating framework and NHS Constitution.

Achieving (10)	**Underachieving (2)**
- 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 - Delayed Discharges - Reperfusion times (door to balloon time of 90 minutes)	- 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)**
- A&E Maximum waiting time (4-hours) - 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 - 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 April and May 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

		Thresholds		Previous YTD	Year to date (YTD)	Month												Quarter				
	Target	Green	Red			May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16
Cancer	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	96.8%	95.5%	97.0%	96.0%	97.0%	93.2%	94.8%	94.7%	96.3%	97.5%	94.3%	95.8%	93.1%	Cancer standards report two months in arrears	96.7%	95.0%	96.1%	94.3%	
	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.2%	96.9%	97.9%	96.2%	96.8%	96.2%	96.2%	95.7%	94.0%	98.5%	97.9%	98.4%	97.0%		97.2%	96.4%	96.2%	97.7%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.8%	99.6%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	99.0%	98.1%	100.0%		99.7%	100.0%	99.6%	99.0%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	94.9%	93.2%	93.5%	94.0%	97.8%	91.7%	96.4%	92.3%	95.0%	95.6%	94.4%	95.9%		94.9%	94.6%	94.8%	95.4%	
	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.4%	97.6%	98.9%	95.1%	97.6%	98.4%	97.4%	98.2%	99.5%	97.2%	96.5%	97.7%	97.2%		97.2%	97.8%	98.3%	97.1%	
	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.1%	79.3%	81.1%	85.1%	79.4%	77.6%	74.3%	78.8%	81.4%	84.6%	80.8%	75.2%	79.4%		80.4%	76.8%	81.6%	78.5%	
	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	93.3%	89.0%	90.2%	90.9%	90.2%	94.3%	83.3%	73.3%	100.0%	90.9%	71.4%	60.0%	100.0%		90.4%	90.8%	84.4%	80.6%	
	Cancer 62 Day Referral To Treatment (Upgrades)	Not published	Not published	90.1%	90.1%	86.1%	100.0%	86.7%	70.0%	89.3%	85.7%	100.0%	90.5%	84.4%	94.4%	87.2%		95.3%	83.1%	90.4%	88.8%	
Referral to Treatment	Referral To Treatment Admitted Under 18 Weeks	90%	90%	91.9%	79.9%	91.8%	90.1%	87.2%	84.4%	82.4%	85.2%	83.1%	84.3%	80.5%	80.4%	80.5%	79.9%	91.2%	84.7%	84.3%	80.5%	79.9%
	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	93.6%	90.2%	94.0%	92.8%	89.7%	90.0%	89.0%	89.2%	88.8%	89.9%	88.9%	89.3%	90.0%	90.2%	93.4%	89.5%	89.3%	89.4%	90.2%
	Referral To Treatment Incomplete pathways Under 18 Weeks	92%	92%	92.7%	90.5%	92.5%	92.1%	92.0%	91.1%	90.0%	89.4%	88.7%	87.5%	88.9%	89.4%	89.7%	90.5%	92.4%	91.0%	88.5%	89.3%	90.5%
A&E Clinical Quality Indicators	A&E Total time in A&E 4 hours - without Walk in Centre attendances	95%	95%	94.5%	94.8%	94.3%	95.2%	92.4%	93.7%	92.4%	93.8%	88.6%	86.3%	90.9%	89.5%	95.0%	94.8%	94.7%	92.8%	89.6%	91.9%	94.8%
	A&E Time to initial assessment (95th percentile) - in minutes	15	15	14	30	12	11	13	12	11	12	12	36	14	14	29	30	12	12	15	15	30
	A&E Time to treatment decision (median) - in minutes	60	60	53	51	57	55	59	47	55	51	59	57	48	50	53	51	55	54	55	50	51
	A&E Unplanned reattendance rate (within 7 days)	5%	5%	2.7%	2.7%	2.2%	2.4%	0.2%	2.5%	2.6%	2.5%	2.6%	2.4%	2.7%	2.5%	2.5%	2.7%	2.4%	1.7%	2.5%	2.6%	2.7%
	A&E Left without being seen	5%	5%	1.5%	1.9%	1.9%	1.4%	2.2%	2.0%	2.0%	1.5%	2.3%	1.6%	1.6%	1.5%	1.6%	1.9%	1.6%	2.1%	1.8%	1.6%	1.9%
Other key access standards	Last Minute Cancelled Operations	0.80%	1.50%	0.98%	1.20%	0.96%	1.10%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1.00%	0.85%	1.03%	1.20%	1.02%	1.16%	1.16%	0.97%	1.20%
	28 Day Readmissions	95%	85%	94.2%	84.8%	85.2%	94.4%	95.3%	90.5%	85.2%	85.3%	90.4%	87.0%	82.9%	94.8%	93.5%	84.8%	91.3%	90.6%	87.3%	91.0%	84.8%
	6-week wait for key diagnostics	99%	99%	98.3%	98.3%	96.6%	97.3%	97.7%	97.0%	98.1%	99.1%	98.3%	95.8%	95.5%	97.9%	97.9%	98.3%	97.4%	97.6%	97.8%	97.1%	98.3%
	Primary PCI - 150 Minutes Call To Balloon Time (direct admissions only)	90%	70%	81.8%	79.7%	78.3%	82.1%	80.6%	76.9%	81.8%	79.4%	73.8%	80.0%	78.3%	87.1%	83.9%		79.4%	79.6%	77.2%	82.4%	
	Primary PCI - 90 Minutes Door To Balloon Time (direct admissions only)	90%	90%	92.7%	92.4%	93.5%	96.4%	88.9%	94.9%	90.9%	94.1%	81.0%	92.0%	95.7%	96.8%	90.3%		95.1%	91.7%	88.1%	94.4%	
	Delayed discharges (Green to Go List)	30	41	56.0	40.0	51	58	50	53	57	44	55	42	59	49	46	40	55.0	53.7	47.0	52.0	40.0
	Ambulance hand-over delays (over 30 minutes) - 10% reduction on 14/15	0	96.5	96.0	46.0	100	79	139	144	100	77	131	168	119	78	49	46	91.7	127.7	125.3	82.0	46.0

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 62-day Screening referral to treatment ↑ (up from 60.0% in February to 100% in March);
- A&E 4-hour maximum wait ↓ (down from 95.0% in March to 94.8% in April); *however, recovery trajectory achieved in the month, so not reported as a exception;*
- 28-day readmissions following a last-minute cancelled operation ↓ (down from 93.5% in March to 84.8% in April);
- Delayed discharges (Green to Go) ↓ (down from 46 in March to 40 in April);

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 nine 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
9) A&E 4-hour maximum wait
10) Time to Initial Assessment

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 April (1.20% of operations) which is above the national standard of 0.8%. The main reasons for cancellations in April were as follows:

- 20% (13 cancellations) were due to an emergency patient being prioritised;
- 20% (13 cancellations) were due to a surgeon being ill/unavailable;
- 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;
- 14% (9 cancellations) were due to no high dependency/intensive care beds being available;
- 14% (9 cancellations) were due to no ward beds being available;
- 18% (12 cancellations) were due to a range of reasons, with no consistent themes or patterns emerging.

Of the 66 cancellations, 22 were day-cases and 44 were inpatients (33% 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 the main causes of cancellation being emergency patients taking priority, clinically complex patients in theatre and 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 emergency patients needing to be treated, or cases running over because they were more complicated than expected.

In April 84.8% of patients cancelled in the previous month were readmitted within 28 days of the cancellation, against a national standard of 95%. There were ten breaches of 28-day readmission standard in the month, of which six patients were due for readmission for procedures within the Bristol Heart Institute (BHI), three within the Bristol Royal Infirmary and one within the Bristol Children's Hospital. The number of failures to re-book with 28 days of a cancellation was unusually high in the BHI. This was due to a number of the Cardiac Intensive Care Unit beds being occupied for an extended period by high acuity patients. This is preventing the usual volume of cardiac surgery operations taking place, and has limited the

ability to re-book cancelled patients promptly. In all other cases, patients could not be re-admitted within 28-days due to more clinically urgent patients requiring admission and/or clinician availability.

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) has provided greater flexibility to manage a higher proportion of patients needing higher levels of clinical input; however the nurse staffing model is being changed to try to ensure the maximum number of beds are kept open at any point in time;
- 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 April, with performance between March and April showing a small deterioration relating to an increase in elective bed pressures. Performance against the 28-day readmission standard also deteriorated in April, for the same reason.

ACCESS STANDARDS

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 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 March was 79.4% against the 85% standard. This was below the recovery trajectory for the month of 87.0%. There were 6.4 more breaches in the month than 'expected' in the plan. Late referrals remained the leading cause of breaches in the period. The other main variances were in the number of breaches due to delayed admitted diagnostic procedures and a range of 'other' causes of breaches, with no common themes arising.

Performance for internally managed pathways was 90.2% against the 85% standard. Performance for shared pathways was 61.9%. 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 86.8%, and above the 85% standard.

Breach reasons - March	Trajectory (expected number)	Actual number	Variance	Percentage of breaches (actual)
Late referral	4.7	7.0	2.4	41%
Medical deferral/Clinical complexity	2.7	2.5	-0.2	15%
Patient choice to delay	0.9	1.0	0.1	6%
Histology delay	0.2	0.0	-0.2	0%
Delayed outpatient appointment	0.3	1.0	0.7	6%
Delayed admitted diagnostic	0.3	2.0	1.7	12%
Administrative delay/pathway management	0.3	0.5	0.3	3%
Delays at other provider	1.0	0.5	-0.5	3%
Elective cancellation	0.1	0.0	-0.1	0%
Elective capacity	0.2	0.0	-0.2	0%
Other	0.0	2.5	2.5	15%
	10.6	**17.0**	**6.4**	**100%**

65% of breaches were due to primarily unavoidable reasons, including late referral, medical deferral, clinical complexity and patient choice.

There were 5 breaches (29%) relating to internally managed pathways and 12 breaches (24 pathways x 0.5 accountability) relating to shared pathways.

ACCESS STANDARDS

The transfer of breast and urology services to North Bristol Trust has left the Trust with a challenging group of pathways to meet the 62-day GP standard. This is because breast cancers are relatively easy to treat within 62-day of referral because the diagnostic pathways are simple and patients are usually fit enough to proceed to treatment without further intervention. In March 2015, the 85.0% standard was only achieved for breast and skin cancers at a national level, with all other tumour sites performing at or below 80.8%. The national average performance across all tumour sites was 82.1%. 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 typically equates to a 3.5% reduction in expected performance. This figure is without any adjustment for the tertiary nature of our services.

62-day GP Screening

Performance in March was 100% against the 90% standard. 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 over the last two quarters. 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 69.5% against the 90% standard in quarter 4, with the Trust performing at 73.9%. Breaches of the 62-day screening standard for quarter 4 as a whole were due to patient choice and delays at other providers, and therefore outside of the control of the Trust.

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 Steering Group and Service Delivery Group. The action plan is updated with new actions on an ongoing basis as these are identified, with current increased emphasis on proactively identifying key 'underpinning' actions as well as 'fixing' actions for specific issues. 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:

- Four new work-streams identified, targeting broad areas that underpin many pathways, with the aim of achieving greater impact. These areas are: radiology timescales, outpatient timescales, managing weekdays of tests (day of week a test is performed is often more relevant than number of days taken to perform it, due to MDT dates), and identifying patients with poor fitness earlier;
- 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 includes introduction of GP straight-to-test endoscopy;
- 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) have been developed. Mapping of actual against ideal pathways has been completed for OG, this shows CT scans and PET scans particularly at other providers are main areas to improve against. Up to 70% of OG 62 day breaches could be avoided by all providers following the timescales. These have been shared with other providers. Work to map lung actual against ideal is close to completion. Both pathway timescales have been shared with providers across the region. Hepato-Pancreato Biliary is the next area to have pathway timescales developed;
- 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. This could lead to a change in clinical practice, so is currently undergoing clinical audit;
- Trust participating in working group led by commissioners to manage impact of changing NICE guidance for cancer referrals, which could result in 40% more referrals and changes to routes of referral. This presents both a risk and an opportunity for cancer performance. Commissioner support of direct booking via Choose & Book of cancer first outpatient appointments is an important part of this.

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 January to March are confirmed following the completion of quarter 4 reporting.

	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%	80.8%	75.2%	79.4%	78.5%

62-day screening

The 90% standard was achieved in March, with no breaches (i.e. 100% achieved).

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.

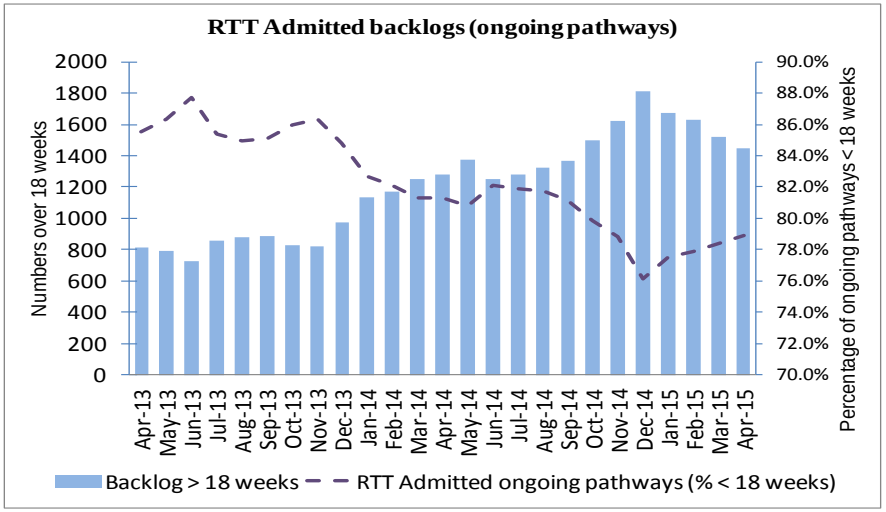
Performance during the period, including reasons for exceptions:

The Trust continued to under-perform against the three RTT pathways standards in April 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 additional capacity put in place to treat more long waiters, in combination with the impact of the validation work of the appointed team of validators, continued to be felt in April. 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 April improved by 0.8%, from 89.7% to 90.5%.

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.

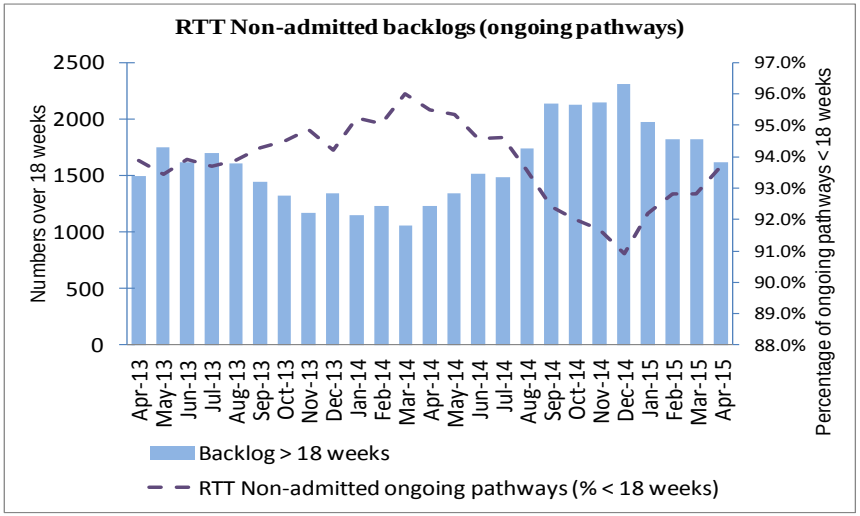


Table 1: Performance against the RTT Admitted standard at a national RTT specialty level in April.

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	118	85	203	58.1%
Cardiothoracic Surgery	24	23	47	51.1%
Dermatology	141	46	187	75.4%
E.N.T.	175	11	186	94.1%
Gastroenterology	72	4	76	94.7%
General Medicine	9	3	12	75.0%
Gynaecology	141	50	191	73.8%
Ophthalmology	598	88	688	87.2%
Oral Surgery	191	21	212	90.1%
OTHER	723	249	972	74.4%
Rheumatology	79	0	80	100.0%
Thoracic Medicine	11	0	11	100.0%
Trauma & Orthopaedics	54	8	62	87.1%
Urology	1	0	1	100.0%
TOTAL	**2337**	**588**	**2928**	**79.9%**

ACCESS STANDARDS

In April, six of the fourteen specialties achieved the 95% standard, as in March. As in March, 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 – 61.2%
- Paediatric Ear Nose Throat – 41.5%
- Paediatric T&O – 59.0%
- Clinical Oncology - 100%
- Paediatric surgery – 57.3%

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

RTT Specialty	Under 18 Weeks	18+ Weeks	Total Clock Stops	Percentage Under 18 Weeks
Cardiology	109	48	157	69.4%
Cardiothoracic Surgery	24	6	30	80.0%
Dermatology	461	18	479	96.2%
E.N.T.	758	25	783	96.8%
Gastroenterology	38	29	67	56.7%
General Medicine	151	0	151	100.0%
Geriatric Medicine	38	0	38	100.0%
Gynaecology	358	25	383	93.5%
Neurology	66	6	72	91.7%
Ophthalmology	894	59	953	93.8%
Oral Surgery	173	37	210	82.4%
OTHER	2845	417	3262	87.2%
Rheumatology	86	3	89	96.6%
Thoracic Medicine	262	1	263	99.6%
Trauma & Orthopaedics	123	17	140	87.9%
TOTAL	**6386**	**691**	**7077**	**90.2%**

In April, six out of the fifteen specialties achieved the 95% non-admitted standard, as in March. 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 – 48.8%
- Maxillo facial surgery – 92.9%
- Radiotherapy treatments – 99.4%
- Paediatric ENT – 98.0%
- Paediatric ophthalmology – 94.5%

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

RTT Specialty	**Under 18 Weeks**	**18 + Weeks**	**Total Ongoing**	**Percentage Under 18 Weeks**
Cardiology	1734	421	2155	80.5%
Dermatology	1859	85	1944	95.6%
E.N.T.	2520	66	2586	97.4%
Gastroenterology	458	34	492	93.1%
General Medicine	84	4	88	95.5%
Gynaecology	1066	62	1128	94.5%
Neurology	267	116	383	69.7%
Ophthalmology	4033	233	4266	94.5%
Oral Surgery	2289	121	2410	95.0%
OTHER	12737	1852	14589	87.3%
Rheumatology	367	1	368	99.7%
Thoracic Medicine	590	12	602	98.0%
Trauma & Orthopaedics	903	27	930	97.1%
Cardiothoracic Surgery	251	34	285	88.1%
Geriatric Medicine	152	1	153	99.3%
TOTAL	**29310**	**3069**	**32379**	**90.5%**

In April, eleven of the fifteen specialties achieved the 92% ongoing standard, compared with ten in March.

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 – 75.7%
- Paediatric ENT –67.7%
- Clinical Genetics – 85.4%
- Paediatric T&O – 85.0%
- Paediatric dentistry – 89.7%

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The number of patients waiting over 40-weeks from referral to treatment decreased from 119 at the end of March to 116 at the end of April, and was significantly below the trajectory limit of 150. There were 4 over 52-week RTT waiters were reported at April month-end, consistent with the trajectory. There are not expected to be any 52-week waiters at the end of May, although this position continues to be at risk due to bed pressures within the Children's Hospital and patients potentially choosing not to be treated in the period.

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;
- 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; a significant number of ongoing pathways are being closed down as a result of this validation work;
- 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.

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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. An amber RAG rating indicates where the performance trajectory was not achieved, due to over-performance against a backlog reduction trajectory

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	1619											
Admitted (plan)	1857	1819	1772	1711	1533	1348	1179	1070	941	820	768	661	590	521	465
Admitted (actual)	1677	1627	1519	1450											
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%	90.5%											
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%	79.9%											
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%	90.2%											

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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 April was 98.3% against the 99% national standard for 6-week diagnostic wait. This is above the recovery trajectory of 98.0%. There were 114 breaches of the 6-week standard at month-end, of which 66 were waiting for echocardiography scans (down from 89 in March), 17 were for MRI scans (down from 20), 22 were for paediatric gastrointestinal endoscopies (down from 30), and 9 were for sleep studies (no long waiters at the end of March).

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;

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- 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;
- A change has been implemented to the monitoring process to ensure there are no avoidable sleep studies long waiters from the end of May onwards;
- A consultant paediatric gastroenterologist post has been recruited to; the successful applicant is now in post and the backlog is starting to be cleared.

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	114					
Actual performance	**97.9%**	**97.9%**	**98.3%**					
Trajectory achieved	**Yes**	**Yes**	**Yes**					

Risks remain for achievement of the end of May trajectory target, due to previous 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.

ACCESS STANDARDS

A9-A10. EXCEPTION REPORT: A&E maximum wait 4 hours + Time to Initial Assessment	RESPONSIBLE DIRECTOR: Chief Operating Officer

Description of how the target is measured:

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

Time to Initial Assessment is measured from the patient's arrival in the Emergency Department to their initial assessment, and applies only to ambulance arrivals. The target is for 95% of patients to be assessed within 15 minutes of arrival.

Monitor measurement period: Quarterly

Performance during the period, including reasons for exceptions:

At a Trust level performance against the 4-hour standard declined from 95.0% in March to 94.8% in April. However, the best case recovery trajectory of 94.7% was met.

For further information on activity and performance levels by site, please see the tables below.

Table 1 – The number of BRI Emergency Department (ED) attendances, admissions and ambulance arrivals in the current and the previous months, and the same period last year.

	Mar-15	Apr-15	Apr -14
Attendances	5380	**5167**	5411
Emergency admissions via the ED	1777	**1771**	1886
Ambulance arrivals	2163	**2039**	2190
Performance against 4-hour standard	94.0%	**92.9%**	92.4%
Numbers of patients waiting less than 4 hours	5055	**4800**	5000

Table 2 – The number of BCH Emergency Department (ED) attendances, admissions and ambulance arrivals in the current and the previous months, and the same period last year.

	Mar-15	Apr-15	Apr -14
Attendances	3139	**3055**	2516
Emergency admissions via the ED	705	**692**	525
Ambulance arrivals	704	**636**	540
Performance against 4-hour standard	94.3%	**95.4%**	95.6%

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Numbers of patients waiting less than 4 hours	2961	**2915**	2406

There was a further reduction in over 30 minute ambulance hand-over delays in the BRI ED in the period, reflecting a decrease in ambulance arrivals. Performance against a number of the other measures of patient flow also improved, such as the number of delayed discharges, bed-days spent by patients outlying from their specialty ward, and out of hours discharges. Length of Stay increased in the period, reflecting a higher level of long stay patients being discharged in the month, which in turn resulted in fewer long stay patients being in hospital at month-end.

Table 1 – Number of Delayed Discharges on the Green to Go list at the end of April 2015 compared with the previous month-ends

Month	Total number of Green to Go (Delayed Discharge) patients at month-end
April 2014	56
May 2014	51
June 2014	58
July 2014	50
August 2014	53
September 2014	57
October 2014	44
November 2014	55
December 2014	42
January 2015	59
February 2015	49
March 2015	46
April 2015	**40**

Performance against Time to Initial Assessment was 87.9% against the 95% standard in April. This was due to a data quality issues following the inclusion of the wait for initial assessment at the Bristol Children's Hospital (at 43.0% against the 95% standard) from data sourced from the Medway Patient Administration System (PAS). All children are assessed at the point of an ambulance arriving at the BCH, which is before the patient has been registered as having arrived in the Department. However, it is not currently possible to automate the capture of this data pre-arrival. As a consequence there is a heavy reliance on manual data capture and entry, and consequent validation. Local information continues to confirm all assessments are carried-out at the point of ambulance arrival (i.e. a zero wait). Performance against the Time to Initial Assessment standard at the BRI was over 99%. The capture of accurate data for the BCH times to initial assessment remain under review.

Recovery plan, including expected date performance will be restored:

A whole system operational resilience plan has been developed with partner organisations, for improving emergency access and delivering the 4-hour

target. The core elements of this plan are as shown below:

A) Front Door – including the 'protection' of the clinical management of minor injury/illness patients to deliver high levels of performance for this stream of patients; Care of the Elderly consultant-led rapid assessment of patients in the Emergency Department and Older Persons Assessment Unit; extension of the South Bristol Urgent Care Centre opening hours; BrisDoc out of hours service supporting the ED minors pathway; GP working in the Bristol Children's Hospital Emergency Department;

B) Admission avoidance – including establishment of a virtual multi-disciplinary team and a rapid assessment clinic at South Bristol Community Hospital, for frail elderly patients in the community; nursing and residential homes having access to dietetics and speech and language therapy input;

C) Flow – Enhanced recovery pathways for elderly patients; increased therapist cover across weekends; increased consultant physician cover across weekends; improved general surgical and trauma theatre access at weekends; increased liaison psychiatry cover across winter months;

D) Discharge – pathways for non weight-bearing patients, pathways for patients needing percutaneous endoscopic gastrostomy (PEG) management; additional interim community bed capacity for patients needing long-term care placements or patients with dementia; additional community rehabilitation bed capacity, increased cardiac diagnostics at weekends; paediatric home intravenous (IV) services; additional ward rounds at the Children's Hospital at weekends;

E) System governance – improved robustness of breach analysis; improved clarity of the reasons for delayed discharges to support system planning/resilience; community services inclusion criteria in which all patients are accepted to assess for appropriate need.

In addition, the Trust takes part in the daily sector teleconference calls managed through ALAMAC. A full review of the previous day's 4 hour performance, key performance indicators, (included in the ALAMAC "kitbag"), and actions to improve performance are discussed and further actions agreed. The key areas for action have included reduction in the Trust's "Green to Go" list and addressing other operational constraints which impact on flow, which when addressed will help to improve performance.

Additional actions are being taken in response to the issues highlighted in the Care Quality Commission (CQC) report. An internal action for the Trust is the development of an electronic CM7 form for health needs assessment, which is the means through which a referral is made to the local authority for social work assessment. The current paper-based system can result in a number of days delay to the referral and assessment process being commenced.

Progress against the recovery plan:

The expected impact of both the internal and partner organisations actions' in reducing 4-hour breaches of standard has been assessed. This has been used to create an A&E 4-hour performance trajectory using the last 12 month's activity and performance as a baseline, with best case and realistic scenarios. Using historical performance and activity as a baseline has allowed seasonal pressures to be factored-in. The trajectory, as shown below, reflects changes in the assessment of the impact of the actions in the plan, and is informed by the continued decline in national performance.

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Key Performance Indicators (KPIs) have been established to enable the delivery against the individual elements of the above plan to be monitored, and to enable analysis of which actions are not delivering the expected outcomes to be undertaken. A sub-set of the KPIs, together with the last six week's performance, is shown below:

	Indicator	Threshold	30/3/15	6/415	13/415	20/4/15	27/4/15	4/5/15
Front door	Minors performance (ESC 1 and 2)	>=98.0%	98.6	98.2	98.4	96.4	96.7	98.5
	Time to Treatment (60 minutes)	>=50.0%	47.2	49.9	50.0	46.9	47.3	44.1
	Number of emergency admissions (BRI)	<= 463	560	560	528	542	541	550
Admission avoidance	Bed occupancy (BRI)	< = 91.5%	90.2	93.8	91.1	90.6	87.7	87.8
	BRI ED conversion rate %	TBC	35.0%	35.0%	35.0%	34.0%	35.0%	32.0%
	Increase 0 to 1 day stays > 75 year olds	>=250	229	240	238	257	287	249
Flow	Weekly average Length of Stay emergency patients (Medicine)	<=4.9	4.9	4.7	5.1	4.8	5.0	4.4
	Number patients > 14 days Length of Stay BRI	<=99	134	130	124	124	119	116
	Total number of weekend discharges	TBC	125	160	130	205	171	161
Discharges	Green to Go Delayed Discharges (Medicine)	30	35	39	39	44	30	39
	Number of discharges by 10:00	>=15	3	4	8	2	3	5
	Percentage discharges by 14:00	>=75%	33.2	33.9	34.1	32.9	32.7	34.2

The patterns of emergency admissions following the Frenchay Emergency Department closure are still emerging, in particular increases in ambulance arrivals at the weekend and earlier in the day. In conjunction with the changing age-profile of patients admitted to the Trust, this poses risks to achievement of the 95% standard over the winter, which may be difficult to mitigate fully, as reflected in the Realistic scenario.

Scenario	Jan-15	Feb-15	Mar-15	Q4	Apr-15	May-15	Jun-15	Q1	Jul-15	Aug-15	Sep-15	Q2
Best case	91.9%	91.5%	94.0%	**92.5%**	94.7%	94.5%	96.4%	**95.2%**	97.3%	95.8%	94.2%	**95.8%**
Realistic	91.5%	90.6%	92.8%	**91.7%**	94.4%	94.2%	95.8%	**94.8%**	96.0%	95.1%	93.9%	**95.0%**
Actual	90.9%	89.5%	95.0%	**91.9%**	94.8%							

Performance in April was above trajectory and consistent with the trajectory for the quarter as a whole, of between 94.8% and 95.2%.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting to be held in public on Wednesday, 27 May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
8. 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**
26/5/15					

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	01/06/2016

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	Major	Complete review
18/05/2015	9	Trust Secretary	Minor	Incorporation of comments from Quality and Outcomes Committee held 30/04/15

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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 and insight on quality of care and workforce;

2.1.3 To support the Trust to actively engage on quality of care with patients, staff and other relevant stakeholders and take 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 To support the Trust's objective to strive for continuous quality improvement and outcomes; and

2.1.6 To support the objective 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 and the workforce agenda which supports this;

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, workforce 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 will:

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 following officers are expected to attend meetings of the Committee at the invitation of the Chair:

4.4.1 Associate Director of Performance

4.4.2 Head of Quality (Patient Experience and Clinical Effectiveness)

4.4.3 Head of Quality (Patient Safety)

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 compliance with Care Quality Commission's Fundamental Standards of Care and Quality Objectives as set out in the Annual Plan; and

6.2.2 Review the Trust's Annual Quality Report prior to submission to the Trust's 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 at divisional and sub-divisional level 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 CQC Fundamental Standards of Care 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; and

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 assessing 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: Trust-wide learning; actions have been completed; and ensure divisional intelligence and oversight;

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;

6.5.7 Receive and review the annual report on Safeguarding;

6.5.8 Receive and review the annual report on Children's Services;

6.5.9 Receive and review the Equality and Diversity Annual Report;

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

6.5.11 Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, patient safety and staff. The definition of significant will be determined by the Chief Nurse and Medical Director; and

6.5.12 Receive assurance regarding data quality assessment against the six national domains of data quality outlined in the Audit Commission's National Framework.

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 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.

7.4 Outside of the formal reporting procedures, the Governors' Quality Focus Group shall be informed by the Quality and Outcomes Committee via the Chair and Executive Leads, supported by the Trust Secretariat.

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 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 27 May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
9. Quarterly Workforce Report January to March 2015
Sponsor and Author(s)
Sponsor: Sue Donaldson Author: Heather Toyne
Intended Audience

Board members	√	Regulators		Governors		Staff		Public	

Executive Summary
Purpose The Quarterly Workforce Report is intended to provide a more detailed and wide ranging update on our Workforce and Organisational Development agenda than is currently provided in the monthly performance reports. The report is based on the Key Performance Indicators (KPI's) which were agreed in May 2015 and includes a description of the current position for each indicator, progress on actions to improve performance, and the agreed KPIs for 2015/16. Key issues to note As in last quarter, the focus continues to be on staff turnover, sickness absence and bank and agency usage, and whilst vacancies have reduced significantly, they continue to be over target.
Recommendations
Trust Board are asked to: • Note the contents of this report; • Discuss any issues arising in relation to the areas reported.
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
None

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)**
26 May 2015				20 May 2015	WF&D Group 13 May 2015

University Hospitals Bristol NHS
NHS Foundation Trust

QUARTERLY WORKFORCE REPORT – JANUARY – MARCH 2015

Executive Summary

1. Introduction

The Quarterly Workforce Report is intended to provide a more detailed and wide ranging update on our Workforce and Organisational Development agenda than is currently provided in the monthly performance reports. The report is based on the Key Performance Indicators (KPI's) which were agreed in May 2015 and includes a description of the current position for each indicator, progress on actions to improve performance, and the agreed KPIs for 2015/16.

2. Overview

The table below provides an overview of each indicator agreed for 2014/15. As this quarter represents the year end, the out turn for March 2015, and the new KPI for 2015/16 is included. An explanation of how the new KPIs have been determined is set out in Section 7. We are working with the Association for United Kingdom University Hospitals to develop a more rounded set of benchmarks, as these are currently limited, but where available they have been included in this table.

Domain	Measure	KPI Description	2014/15 KPI Threshold	Q4 Performance	Q3 Performance	Out turn Mar 2015	2015/16 KPI	Benchmark
Workforce costs /FTE	**Workforce expenditure (£)**	Workforce expenditure within 1% of budget	> 1%	0.6% above	1.7% above	1.2% above	> 1%	
	Workforce numbers (FTE)	Staffing numbers within 1% of establishment including bank and agency	> 1%	1.8% above	1.3% above	1.4% above	> 1%	
	Bank (FTE)	Percentage of total staffing (within 10% of target)	3.2%	5.0%	5.4%	5.0%	3.5%	
	Agency (FTE)	Percentage of total staffing (within 10% of target)	0.5%	1.9%	1.8%	1.5%	1%	4.4% (Feb 2015 based on 6 Trusts - board reports)
	Overtime	Percentage of total staffing (within 10% of target)	0.6%	0.9%	0.9%	<1%	0.7%	
	Sickness absence rate*(%)	Within 0.5% points of target	3.5%	4.6%	4.5%	4.1%	3.7%	4.3% (Quarter 3 based on 33 University Hospitals - *Iview* data).

Domain	Measure	KPI Description	2014/15 KPI Threshold	Q4 Performance	Q3 Performance	Out turn Mar 2015	2015/16 KPI	Benchmark
Staff Experience	**Vacancies**	Difference between budgeted establishment and in post	> 5%	5.3%	6.0%	5.3%	> 5%	7.1% (Feb 2015 based on 6 Trusts - board reports)
	Turnover	Trajectory to achieve target by March	10%	13.8%	13.5%	13.8%	11.5%	13% (February 2015 based on 10 Trusts – board reports)
	Friends and Family Test	Percentage returns	18%			18%	18%	
Staff Development	**All staff Appraisal (exc. medics)**	Appraisal of eligible staff on a rolling 12 month cycle	85%	85.6%	85.1%	85.6%	85%	
	Medical Staff Appraisal	Appraisal of eligible staff on a 15 month cycle – 5 within 5 years	85%	90%*	93%*	95%	85%	
	Essential Training	All staff completed relevant essential training topics (trajectory to achieve target by March)	90%	88%	84%	88%	90%	
Compliance Requirements	**Manual Handling Risk Assessment**	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed or reviewed in last 12 months in +80% of cases	98%	97%	98%	97%	
	Stress Risk Assessment	Risk assessments completed or reviewed within 12 month timeframe	Risk assessment completed or reviewed in last 12 months in + 80% of cases	95%	91%	95%	83%	
	Junior Doctor New Deal compliance	Junior doctor rotas compliant with New Deal requirements	90% or more of rotas compliant		82%		90%	

*provided from the revalidation database

As in last quarter, the focus continues to be on staff turnover, sickness absence and bank and agency usage, and whilst vacancies have reduced significantly, they continue to be over target.

The key points in relation to each of these key areas of focus are as follows.

3. Recruitment

The recruitment effort has continued, with 494 starters, including 84 registered nurses, taking up employment in the last quarter. The high levels of turnover continue with 378 staff leaving the Trust, of which 78 were registered nurses.

Vacancies this quarter have reduced slightly to 5.3% compared to 6.0% in the previous quarter, and continue to exceed the KPI threshold of 5%. UH Bristol vacancies compare favourably with available benchmarks, with an average vacancy rate of 7.1% amongst Trusts who publish their data.

Benchmarking work indicates that UH Bristol is already implementing best practice in relation to increasing the speed of recruitment, particularly once the new recruitment tracking system is implemented in May. Overseas recruitment is being explored as part of a range of solutions, particularly for nurse recruitment – the approach has already been successful for some key posts in Diagnostic and Therapies Division.

4. Retention

Turnover at the end of March 2015 was 13.8% compared with 13.5% at the end of quarter 3. The turnover figure includes staff leaving for all reasons. If only voluntary turnover is considered, (excluding, for example, dismissals, end of fixed term contracts, redundancy, etc), the Trust turnover rate would be 11.2%, compared with 10.9% in quarter 3.

Information produced by Health Education South West shows that the upward trend over the last year at UH Bristol is mirrored by the NHS organisations across the South West, with an average turnover rate (for all reasons except employee transfers) of 13% last December.

As agreed with Senior Leadership Team, in addition to the ongoing retention and engagement work, work has been focused in the following areas:

- *Nursing/Midwifery Assistants*: Building on existing programmes, the work includes improved communication, pre and post-induction support and clearer career pathways and supporting development opportunities. The new nursing assistant recruitment and training pathway has received positive feedback, with less new starters leaving when recruited in this way.
- *Incentives*: The Trust has been promoting the considerable range of benefits it provides staff, producing a staff benefits booklet for display in ward/department areas as well as a revised staff benefits page on the Trust Intranet.
- *Career Progression* – Corporate nursing leads are ensuring there are clear competences and training for each nursing role. It is planned that by July, all core job descriptions will have been revised to ensure consistency. A website will then be developed which will display all nursing-related information covering training, development and career progression at UH Bristol.

Staff Engagement/Experience

An extensive Staff Experience Programme continues across the Trust. A key priority of the programme is the improvement of two-way communication. Actions include focus on recognition events; focus groups and listening events; team building; review of appraisal process; training programmes for managers/supervisors, targeted action to address harassment and bullying; and support for staff forums and reverse mentoring. Activity during this quarter includes:

- A survey regarding inpatient nursing staff views on shift patterns was rolled out during December and early January.
- The Speaking Out Policy and practice review process has taken place. Full consultation on the policy will now take place, with the relaunch of the full policy and procedures in June and July 2015.
- Aston Organisational Development training for team coaches commenced in March 2015.
- The 2014 Staff Survey results have been presented to Executive Team, Board, Senior Leadership Team and Quality and Outcomes Committee and shared with staff side during March.
- Recruitment and training of new Harassment and Bullying Advisors to provide further support for staff will take place in May and June 2015.

In addition to the corporate activities, specific Divisional engagement schemes include divisional newsletters, staff champion schemes and the pilot of "thank you" cards.

5. Bank and agency usage

Bank and agency spend has increased by 9.7% compared with last quarter, but 24% of this spend was covered by operational resilience funding, which has been provided since October, in recognition of the additional capacity pressures the NHS is facing on a national level.

During January – March 2015 the proportion of temporary staffing provided by agency as opposed to bank or overtime at UH Bristol has increased slightly from 22.2% to 24.6% compared with the previous quarter. Progress on actions to reduce bank and agency this quarter includes:

- Further improving and extended coverage of management information on staffing to provide feedback to ward sisters.
- Incentives such as payment at the end of the month for substantive staff working bank hours and agreement of intensity bonus for bank only staff from April 1st.
- Training for all HR Business Partners in workforce planning to improve alignment of future service changes and workforce solutions.
- Improved texting service to allow two-way communication to be implemented from April 1st.

6. Sickness Absence

Sickness absence has increased to 4.6% this quarter, compared to 4.4% last quarter (updated figures). The most recently available benchmark data shows that UH Bristol absence rates for Q3 were broadly in line with comparable Trusts. In quarter 3 the figure of 4.4% for UH Bristol compared with 4.8% nationally for 40 other large acute Trusts and 4.3% for 33

University Hospitals (I*view* data).

Progress on action plans, focused on stress management, colds and flu, and musculoskeletal includes the following:

- 67 staff attended the two extended "Lighten Up" (resilience building) modules.
- 4168 staff have been vaccinated against influenza, representing 60% of clinical staff.
- Actions to prevent and address musculoskeletal sickness absence include campaigns and targeted support from Physio Direct and the Manual Handing team.

In addition Divisions continue collaborating on areas for improvement with regard to the managing of sickness absence.

7. KPIs for 2015/16

New workforce KPIs for 2015/2016 have been established through the aggregation of the values agreed at Divisional level as part of the annual workforce planning process. The Divisional KPIs form an integrated part of the workforce plans, taking account of changes in demand resulting from service changes and changes in supply, through an assessment of the plans in place for recruitment, sickness reduction, and agency reduction, in the light of relevant benchmarking data. The KPIs have been set in the context of performance in the previous year, benchmarking with similar organisations and an iterative dialogue with Divisions. It is clear that there is a strong desire to achieve a step change in key areas of staff turnover, sickness absence and use of agency staff. However, lessons have been learnt from last year, and the result is a balance between KPIs which are both challenging and realistic.
We have also been refining certain aspects of workforce reporting to improve the way we measure our KPIs, and this will impact on future monthly and quarterly reports. Changes include the following.

- Improved reporting of consultant time to include Additional Programmed Activities which are worked in addition to full time hours. This will enable more detailed assessment of consultant time in future quarterly reports.
- Future vacancy reporting against our 5% KPI will exclude the component of the funding and FTE which is being reserved for temporary staffing to cover sickness, maternity, annual and study leave. The result will be an apparent reduction in vacancies, because the future measure will only include posts which are intended to be filled by recruitment, and not simply the gap between budgeted establishment and staff in post. This aligns with the way our Finance Department assess vacancies.
- As in 2014/15, there has been a re-basing of the turnover trajectory. This means that the straight line trajectory starts from the out turn of March 2015 of 13.8%, and assumes the cumulative target of 11.5% is reached by March 2016.

KPIs were agreed as part of the Divisional Operating Planning process, and the aggregated Trust-wide KPIs were reviewed and endorsed at the Workforce and Organisational development Group.

8. Recommendation

Quality and Outcomes Committee are asked to:

- Note the contents of this report;
- Discuss any issues arising in relation to the areas reported.

QUARTERLY WORKFORCE REPORT – JANUARY – MARCH 2015

1. INTRODUCTION

The Executive Summary has provided an overview of the KPI performance for both quarter 4 and 2014/15, the planned KPIs for 2015/16 and an update on programmes of work in relation to key areas. The report which follows provides detailed information in respect of each KPI. A summary dashboard of the KPIs is included in Appendix 1, and detail of performance at a Divisional level is in Appendix 2. A breakdown is provided by staff group in Appendix 3.

2. WORKFORCE COSTS/FULL TIME EQUIVALENT (FTE) STAFF

Workforce costs/FTE has three, interlinked components: workforce expenditure; workforce numbers; and temporary staffing (bank and agency) usage. The position for each is set out below. The overall position described shows an increase in pay expenditure variance, but little change in workforce numbers variance compared with the last quarter. There has been an increase in bank and agency as a proportion of total staffing costs and numbers of staff attributable to use of bank and agency staff, however this is partially offset by additional external funding to support Operational Resilience.

WORKFORCE EXPENDITURE

The pay expenditure for the quarter was £88.72m against a budget of £88.17m. The cumulative over-spend for 2014/15was £3.97m (representing 1.2% more than budget), with cumulative overspend of £0.55m for Q4, (which is 0.6% over budget). The gap between pay budget and expenditure has increased compared with the position at the end of quarter 3 when variance was 1.7% above budget. This change is largely due to year-end adjustments.

The pay budget and expenditure graphs are included as Appendix 2. Only three Divisions were above the red rated threshold for both the quarter and the year: Medicine, Specialised Services and Surgery Head and Neck.

A. WORKFORCE NUMBERS

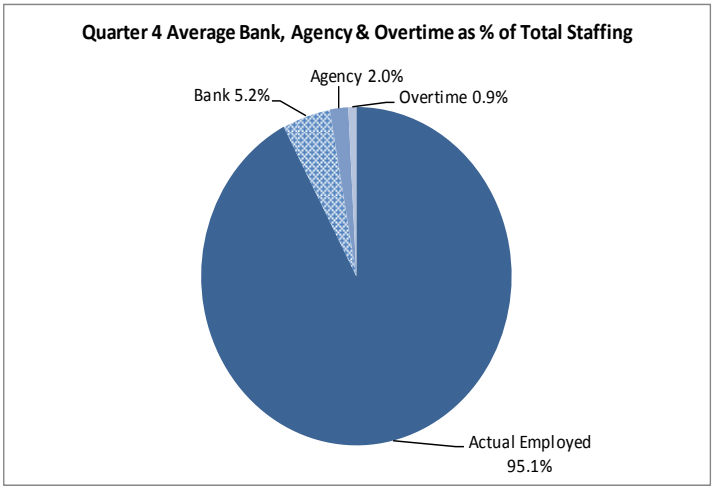
The average total FTE, including substantive, bank and agency staff, over the quarter was 8074.4 and was at the highest at the end of March when it reached 8130.6. The variance has reduced slightly to 1.8% above budgeted establishment, compared with 1.9% last quarter. As at 31 March 2015, 7544.1 staff were substantively employed, approximately 155 FTE more than at 31 December 2014. Staffing levels in relation to budgeted establishment are shown graphically in Appendix 1.

B. TEMPORARY WORKERS – BANK AND AGENCY STAFF AND OVERTIME WORKING (FTE)

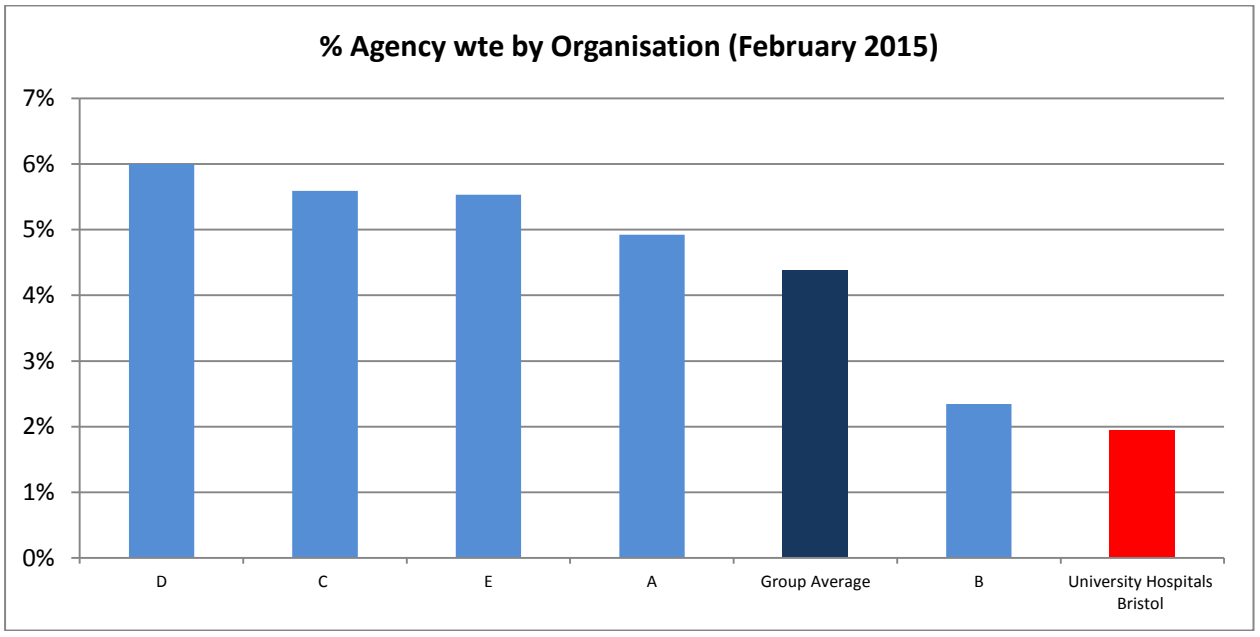
The proportion bank and agency usage of pay costs and total staffing compared with last quarter is as follows:

- 3% of costs (compared with 3.7% last quarter) and 5.2% of FTE (compared with 5.4% last quarter) were provided by bank (see pie chart below);

- 4.7% of costs (compared with 3.6% last quarter) and 2.0% of FTE (compared with 1.8% last quarter) were provided by agency.



Few Trusts publish data in the board reports on agency as a percentage of total staffing. UH Bristol compares favourably with the 5 Trusts which were found to publish this data, with 1.9% for the month of February, compared with an average of 4.4%, as shown in the diagram below.



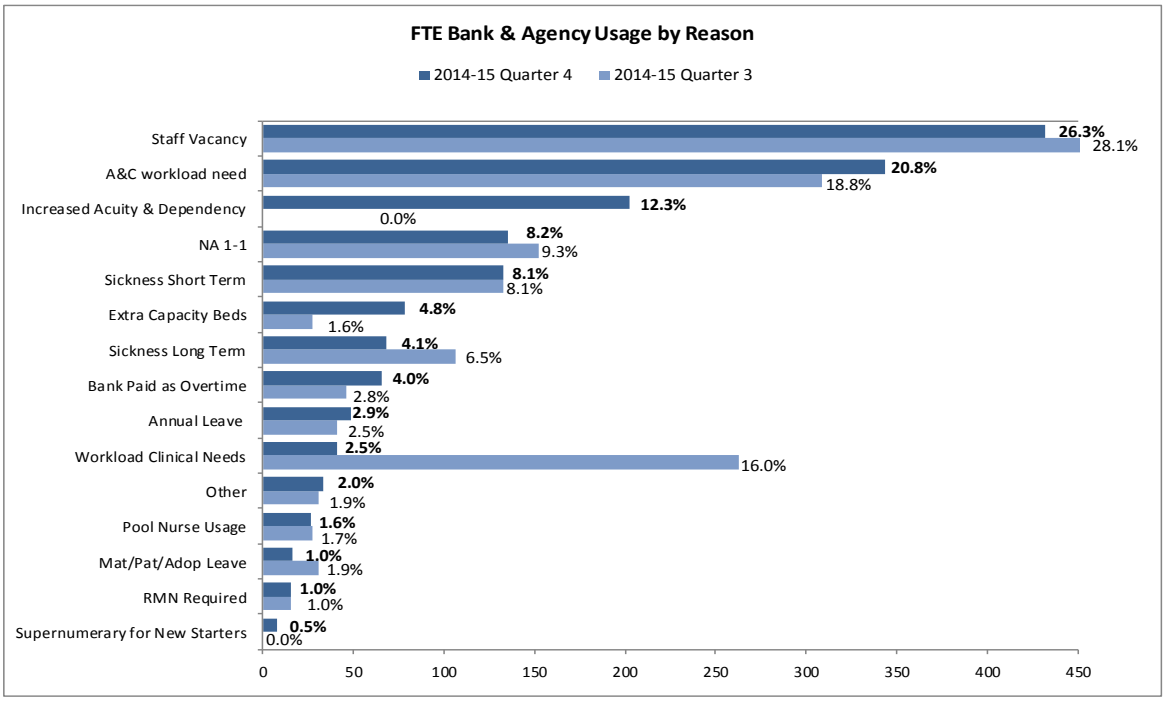
Between October and April 2015, UH Bristol has been granted £3.8 million Operational Resilience funding. When Operational Resilience funded bank and agency usage is excluded, as the table below shows, the underlying position shows a reduction in bank and agency FTE, which varies by Division.

Bank and agency usage (FTE)

Bank and agency actual (FTE)		UH Bristol	Diagnostics & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Women's & Children's	Trust Services	Facilities & Estates
Q3	All Bank & Agency	1652.0	57.5	546.7	193.6	292.9	245.2	122.7	193.3
	Excluding B&A funded by op. resilience	1529.4	51.0	465.8	181.3	289.3	225.9	122.7	193.3
Q4	All Bank & Agency	1688.7	48.1	580.1	192.6	276.9	248.3	137.8	204.9
	Excluding B&A funded by op. resilience	1358.0	34.2	313.9	171.9	267.1	228.2	137.8	204.9

A further 68.1 average FTE or 0.9% of staffing was provided through overtime working, which is a slight reduction on last quarter (73.3 average FTE), although the proportion of staffing remains static at 0.9%. Facilities and Estates Division continues to be the highest user of overtime, accounting for nearly 60% of all usage.

Reasons for using bank and agency are summarised in the table below, which shows that vacancies continue to be the main reason.



The Bank and Agency Action Plan continues to be reviewed regularly at the Recruitment and Retention Group. Progress this quarter is set out below:

Enhanced Rostering, Operational and Workforce Planning:

- There are further Key Performance Indicators covering more areas which were put in place in February and March. All adult ward areas now receive a monthly review of the funded establishment vs actual usage and indicative staffing based on acuity and dependency returns. These will also be displayed in the ward performance data to support the evaluation of staffing levels in the context of quality indicators, staffing used and the resource envelope. Planned timeframe is currently May 2015. The additional KPI's are now being reported and monitored in the Safe staffing paper submitted to QOC.
- KPIs for bank and agency have been reviewed as part of the operating plan process, with more realistic levels set for 2015/16 particularly in respect of bank, which is recognised to be a cost effective way of supplying temporary staff to meet peaks and troughs in demand.
- The programme of work to improve workforce planning capability is now underway, with all HR Business Partners attending a three day training programme. A framework to extend capability to key managers across Divisions will be developed and initiated by the Strategic Workforce Planning Group during the next quarter.

Reducing requests due to clinical need and enhanced observation:

- The Standard Operating Procedure continues to ensure all agency requests are appropriately approved, with controls in place to monitor this.
- The Temporary Staffing Bureau issued a reminder to Heads of Nursing and Matrons in January with regards to the Standard Operating Procedure for approval of escalating to agency. This process ensures all agency requests are appropriately approved, with controls in place to monitor this. The Temporary Staffing Bureau only approach agencies when the process for escalation is followed and the appropriate Divisional management approval given.
- The Temporary Staffing Bureau continues to offer flexibility of shifts wherever possible and this was widely communicated in March to all Bank registered staff and Senior Nurses.

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

- Senior Leadership team and Trust Pay Assurance Group agreed that the intensity bonus for staff with bank-only contracts would be increased and will come into effect from April 1st.
- Shifts can now be paid at the end of the month they are worked, encouraging substantive staff to undertake additional hours.
- Newsletters were sent to staff in March 2015 as part of the revamped and improved communications from the Temporary Staffing Bureau. The newsletter updated staff on new developments such as the new texting service, reminding staff about essential training requirements and reinforcing the benefits of working on the bank to increase bank working.
- In response to the withdrawal of the nhs.net text service at the end of March 2015, the Temporary Staffing Bureau has introduced a replacement texting service which the Trust uses for outpatient services communications. This has already proved to be successful. One of the key benefits of the service is that it allows a two-way communication between bank staff and the Temporary Staffing Bureau.

- The Domestic Assistant Bank has increased from 20 to over 150 bank staff in the last 18 months. In addition to this, 8 porters have been recruited and trained to create a Porters Bank.

KPI for 2015/16

The out turn figure for 2014/15 was 5% of bank as a proportion of total staffing, and 1.5% for agency, compared with a target of 3.2% for bank and 0.5% for agency. The KPI for 2015/16 is 3.5% for bank usage, and 1% for agency. These KPIs have undergone rigorous review to test alignment with recruitment planning and financial assumptions. The KPI for 2015/16 reflects the anticipated use of flexible staffing to support peaks and troughs of demand, for example, in relation to additional bed capacity.

3. SICKNESS ABSENCE

Sickness absence has increased to 4.6% this quarter (against a target of 3.6%), compared to 4.4% last quarter (target of 3.7%). The most recently available benchmark data shows that UH Bristol absence rates for Q3 were broadly in line with comparable Trusts. In quarter 3 the figure of 4.4% for UH Bristol compared with 4.8% nationally for 40 other large acute Trusts and 4.3% for 33 University Hospitals (I*view* data).

The highest levels of Divisional absence during quarter 4 were recorded in Facilities and Estates (6.7%), and the lowest in Specialised Services (3.1%) (Appendix 2). Highest rates by staff group continue to be unregistered nursing at 8.0% and estates and ancillary at 6.9% (Appendix 3). Long-term absence (those of 29 calendar days or more) accounted for 45.4% of the total calendar days lost during the quarter, compared with 48.8% last quarter.

The top five reasons are shown in the table below. Overall, the number of days lost has increased since last quarter by 2.6% (926) to 36,127. Colds and flu related absence are always high during Q4, but this quarter was particularly high, being 43% higher than the same period a year ago. Chest & respiratory problems also increased significantly during this quarter, and were 103.4% higher than in Q3.

Reason	2014-15 Quarter 4		2014-15 Quarter 3	
	Days Lost	% Total Days Lost	Days Lost	% Total Days Lost
Cold, Cough, Flu - Influenza	7162	20%	6166	18%
Anxiety/stress/depression/other psychiatric illnesses	5972	17%	6320	18%
Other musculoskeletal problems	5185	14%	5031	14%
Gastrointestinal problems	4001	11%	4164	12%
Chest & respiratory problems	2213	6%	1088	3%

Stress, Anxiety and Depression

Given that psychological reasons are one of the top reasons for absence, there are significant programmes of work to target this cause of absence. Progress on each is described below.

- There are two extended 'Lighten Up' (resilience building) modules for up to 300 participants being delivered up until April 2015. The modules are 'Making change' and 'Identifying and managing work related stress`. To date, only 67 staff have

attended the 10 modules, due to difficulties in releasing staff, but those that have attended have evaluated both modules positively. A full evaluation report will be available later in May 2015.

- Team building sessions have been delivered by the Occupational Health Counselling team with a department that was experiencing particular internal relationship issues. A more robust approach to stress risk assessments has been implemented for areas where stress is an issue. Trust wide, there is 95% coverage of assessments.

Flu – Influenza

- The 2014/15 flu vaccination campaign has continued this quarter. 4,168 staff have been vaccinated up to February 2015, of which 3444 (59.7%) are patient facing. This benchmarks favourably with NHS Trusts in the South West. The target was to increase coverage to 75%, which was not attained by any trust in the south west region but for UH Bristol there has been a 9% increase on 2013/14 and represents a positive achievement. The flu vaccine is still available via a mobile vaccination service which goes to sites trust wide.

Musculoskeletal

Actions to prevent and address musculoskeletal sickness absence include the following:

- 218 Physio Direct contacts were completed for UH Bristol staff in Quarter 4.
- A Workshop and programme of exercise sessions have been delivered by the Occupational Health Physiotherapy team to a Trust team that was experiencing specific work related musculoskeletal issues.
- All advice for staff through referrals to Occupational health for musculoskeletal conditions is now provided by the Occupational Musculoskeletal Specialist Physiotherapists which is helping to keep waiting times to a minimum.
- The Manual Handling Team provides quarterly campaigns on technique, issues awareness and training (e.g. hoisting) based on risk and incident activity and is progressing a programme of targeted training which analyses working practice and environment, and tailors training to address identified risks.
- Training of a new musculoskeletal specialist to increase capacity for clinic referrals and on site advisory visits.
- The manual handling team provided more than 200 individual in-loco staff follow-up visits to advise and assess on best practice, musculo and skeletal wellbeing and patient safety, and provided 15 individual Workstation / advisory visits related to wellbeing in quarter 4.

Divisions continue to collaborate on areas for improvement with regard to the managing of sickness absence, including drop-in sessions, and focus sessions for managers, using a standard presentation, working in collaboration with Employee Services and Teaching and Learning.

In addition, regular monthly meetings with a network of HR Business Partners, Employee Services and corporate team members in Workforce Planning and Health, Safety and Wellbeing have been established to ensure a coordinated approach to managing sickness absence across the Trust. Some Divisions have other specific schemes, for example, Division

of Women's & Children's Services has a Divisional based wellbeing group which held its inaugural meeting in March 2015.

KPI for 2015/16

The out turn figure for 2014/15 was 4.1%, compared with 4% the previous year, and a KPI of 3.5%.

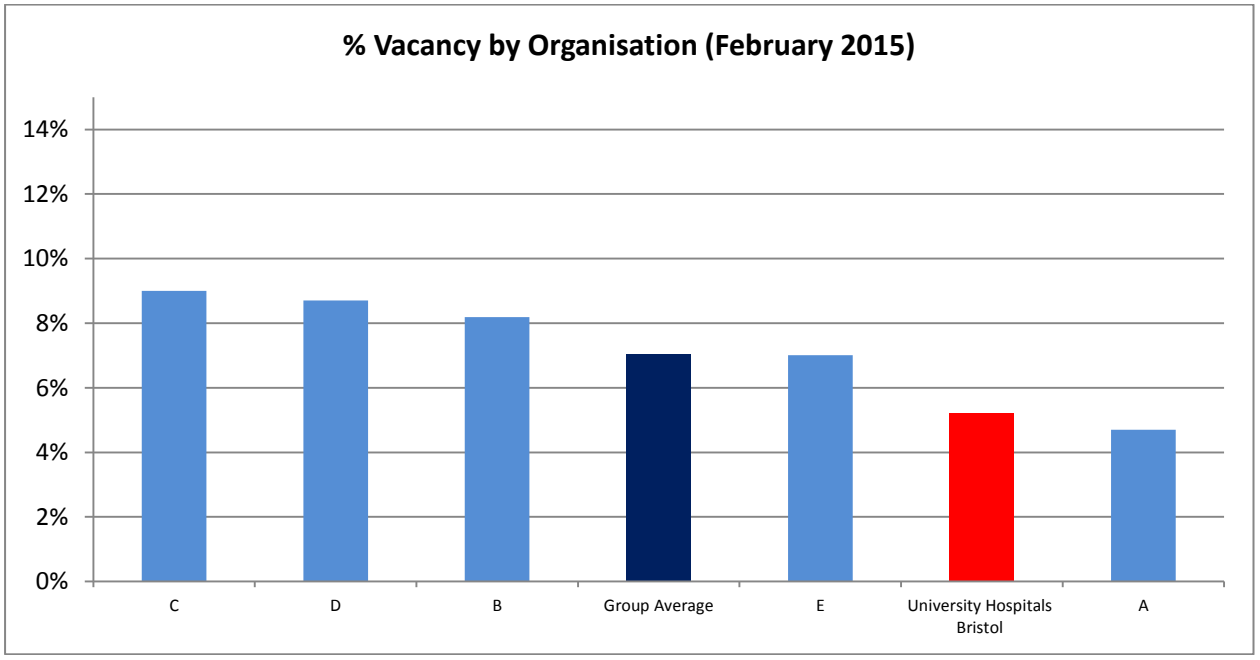
The most recently available benchmark data shows that UH Bristol absence rates were broadly in line with comparable Trusts. In quarter 3 the figure of 4.5% for UH Bristol compared with 4.8% nationally for 40 other large acute Trusts and 4.3% for 33 University Hospitals (I*view* data). Divisions have set challenging but realistic targets for sickness for 2015/16, recognising that they are below benchmarks for similar trusts. The Divisional targets are aggregated to provide a Trust wide KPI for 2015/16 of 3.7%.

4. STAFF EXPERIENCE

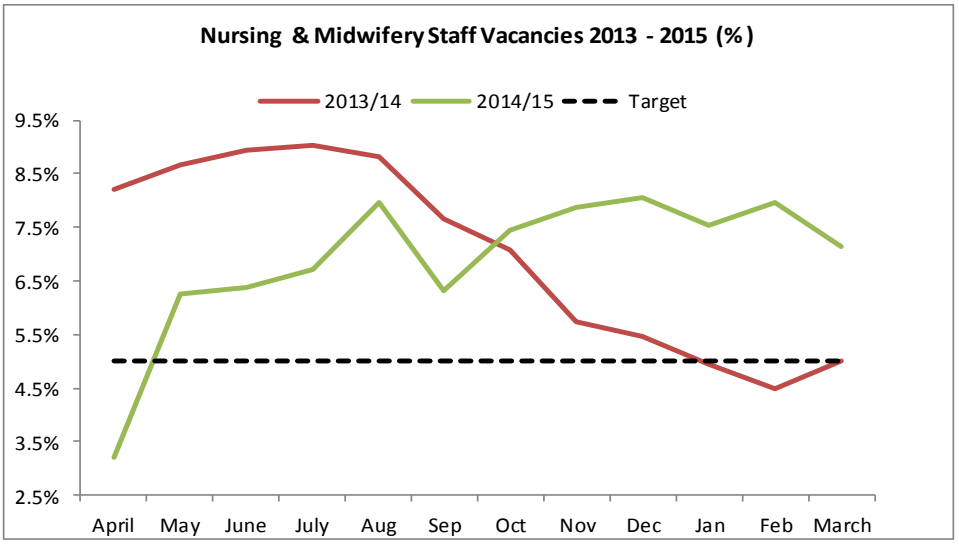
A. VACANCIES

Vacancies this quarter have reduced to 5.3% (421.3 average FTE) compared with 6.0% (469.6 average FTE) last quarter.

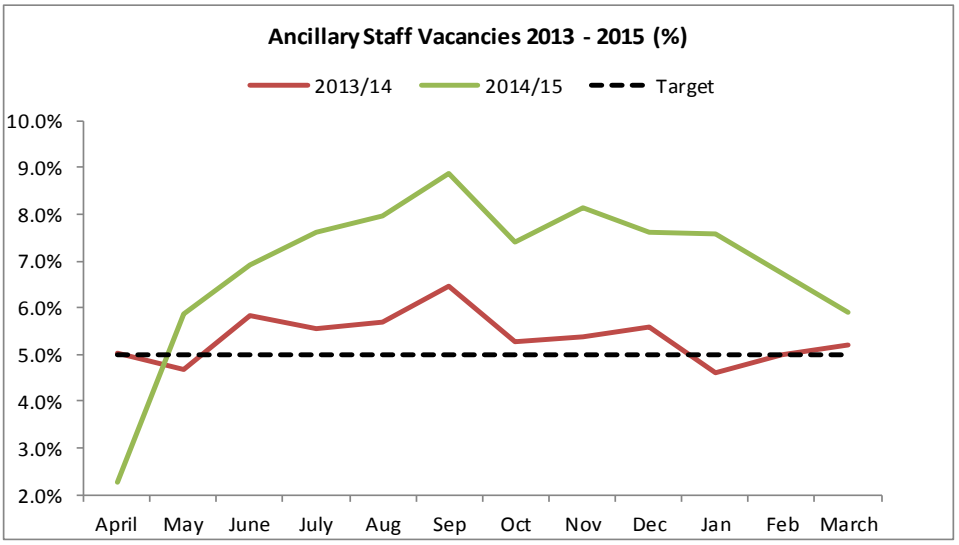
The high NHS vacancy levels nationally have been well publicised in the national media. However, it is difficult to gather specific benchmark data on vacancies as few Trusts publish this data on their Trust websites. Of those that do, UH Bristol compares favourably with the group of Trusts (including UH Bristol), having an average of 7.1%, (see graph below).



Nursing and Midwifery The average vacancy this quarter was 7.5% compared with an average of 7.8% last quarter, as shown in the graph below.



Ancillary vacancies have reduced compared to the previous quarter. The average vacancy FTE for this quarter was 52.8 compared with an average of 60.3 FTE in Quarter 3, as a result of the successful recruitment activities.



Progress against the recruitment plan agreed with Senior Leadership Team is described below.

Increased speed of recruitment - Conversion to hire

- 9 Trusts have responded to a request to benchmark good recruitment practice. The greatest improvements were in two trusts which have introduced the same recruitment system being implemented at UH Bristol, with benefits including reduced conversion to hire time, improved communication with appointing managers, online health assessment forms, cover between the recruitment coordinators and real time management information on vacancy progress. Improvements in other Trusts include the introduction of electronic Disclosure and Barring (e-DBS), streamlined internal recruitment processes and employment checks being undertaken at open days. These improvements have already been adopted for some time at UH Bristol.

- A review has been undertaken to improve the way the Resourcing and Occupational Health Departments communicate to focus on expediting the clearance process. Open days between Medical HR and Occupational Health have been arranged to ensure all rotational doctors starting in August are cleared prior to their start date. There have been several workshops to develop the online Occupational Health portal which will go live in June 2015 with an initial pilot roll out of the system to a chosen Division in May.
- The RAG rating status reports of all recruitment in the pipeline is now reported to the management team within the Recruitment Service 3 times a week to monitor throughput. 98 files have been escalated through this process, resulting in a final offer letter and contract issued within 24 hours of escalation or the file being given time specific actions to enable the final offer and contract to be expedited. It is anticipated that upon implementation of the Recruitment Management System, daily RAG ratings will be available giving, access to extensive real-time management information to demonstrate specific areas of improvement which will support the speed and delivery of the recruitment process.
- The Temporary Staffing Bureau has worked closely with the Recruitment team in Resourcing to identify ways to eradicate unnecessary administration and introduce a more efficient and effective process. This has ensured that if the member of staff is already working for the Trust, only necessary employment checks are undertaken and the process to register with the Bank has been simplified.
- A further 12 months funding has been identified to support the pivotal role of Nurse Recruitment Manager.

IT infrastructure within the end-to-end recruitment process

- A full procurement exercise has been concluded for a fit-for-purpose recruitment management system. Approval was sought by the IM&T Board in February 2015 to proceed with the successful supplier. A formal project plan has been compiled for the implementation of the new recruitment management system in partnership with IM&T. A soft 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 with the team which will further inform the implementation programme and wider training schedule. Baseline measurements will be used to inform ongoing reviews post implementation for benefit realisation.

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

- The Resourcing team structure remains agile with its existing resources to ensure that recruitment challenges are faced effectively.

Recruitment campaigns to target the national UK market for nurses

- For general registered and non-registered nurse recruitment, 88 final offers were made to external applicants in the last quarter and 91 final offers to external Nurse Assistants. 57 final offers were issued to internal registered nurses moving within the Trust and 6 internal Nurse Assistants.
- A wide ranging marketing schedule covering adult theatres, general nursing, Registered Nurse Bank, open day promotion, website updates, resource design and recruitment fairs in Dublin and Belfast in April 2015 have been implemented.

- A third Return to Practice cohort was advertised in February 2015, resulting in only one offer in the Children's Hospital.
- Women's and Children's Division held a further open day in March. 30 attended, all having tours and being interviewed on the day. 29 were successful on the day, which included 5 new offers for theatres.

Overseas Nurse Recruitment

- The newly established Recruitment and Retention sub-group will be overseeing the development of a business case for an international recruitment campaign for registered nurses. Requirements are currently being compiled by Heads of Nursing and HR Business Partners. Procurement has been asked to undertake a tendering exercise to identify an appropriate recruitment agency to work with the Trust. The invitation to tender specification will be issued in April 2015.

Facilities Recruitment

- 44 Domestic Assistants have joined the Trust in the last quarter and 29 Bank Domestics. In addition, 5 Porters and 4 Team Leaders have taken up post.
- At the end of March there were 48 vacancies for Domestic Assistants across the Trust, however 35 offers have been made to successful candidates. The remaining 13 vacancies that have not been recruited to will be sourced through a further open day.

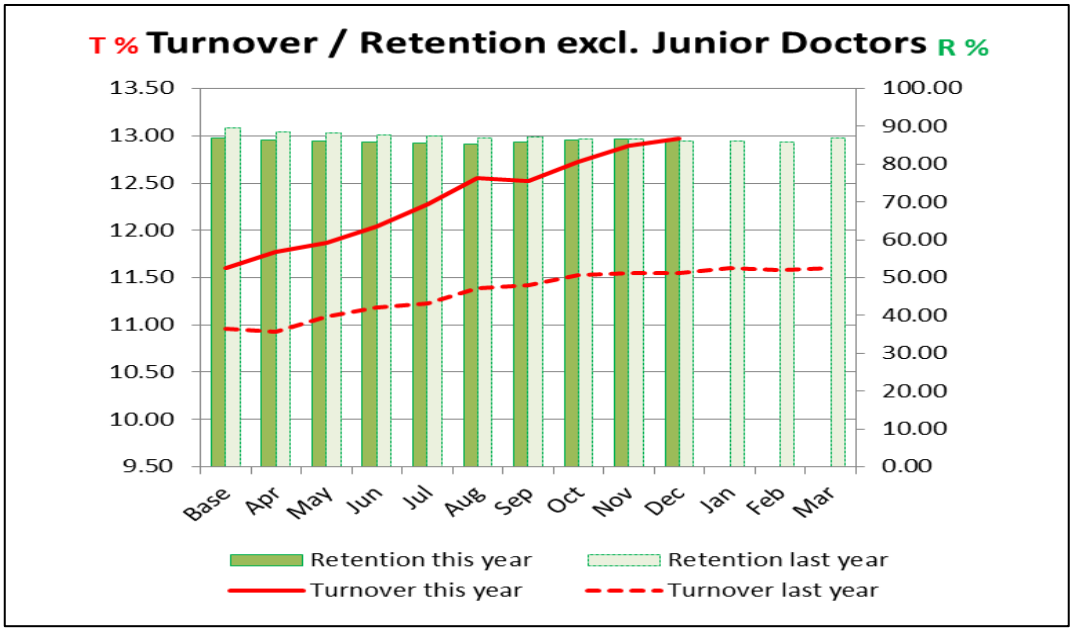
All Domestic Assistant vacancies associated with the new Ward Block at the Bristol Royal Infirmary have been filled, with 36 Domestic Assistants already in post, and 8 undergoing the recruitment process.

KPI for 2015/16

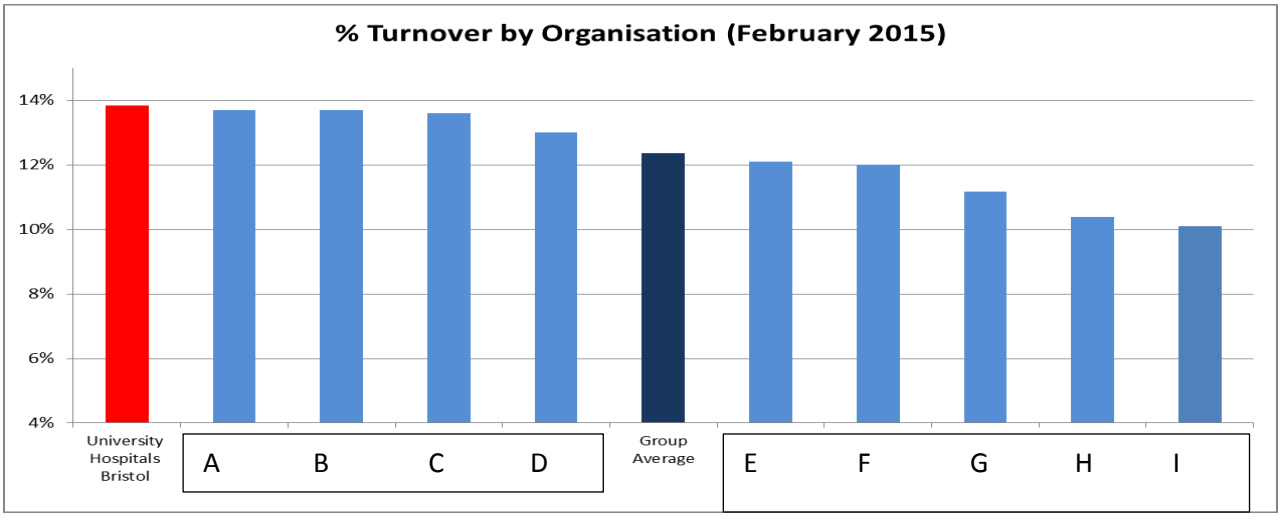
The out turn figure for 2014/15 was 5.2% compared with a KPI of 5%. The KPI for 2015/16 continues to be 5%, although the measurement will change so that the gap between budgeted establishment and in post will now exclude posts which are intended to be filled by bank and agency. This is a more accurate way of measuring vacancies, as it only includes those posts which will be recruited to.

B. TURNOVER

Turnover at the end of Quarter Four was 13.8%, against a target of 10.0% for the period. Turnover rates between Divisions continue to vary, as the table in Appendix 2 shows. This quarter there has been an increase in one of the adult bed holding divisions, but reductions in the other two. The highest rate continues to be seen in Specialised Services at 16.6%, although there has been consistent reduction across the quarter. Turnover continues to be lowest in Diagnostic and Therapies with a rate of 11.4%. Turnover within Estates and Ancillary staff remains high at 13.5%, but rates have reduced across the period.
Health Education South West, now produce average turnover and retention data for all the Trusts in the South West in the form of a chart (see below). The turnover calculation is slightly different to the ESR calculation, but it clearly shows an upward trend from 11.8% in April 2014 to 13% in December 2014, which mirrors the pattern at UH Bristol, and shows levels in 2014 considerably above 2013.



In addition, turnover rates of the 9 Trusts which have been identified which publish data on their websites is shown in the graph below, with the UH Bristol rate of 13.8% compared with an average for the group of 12.4%.



Data on reasons for leaving is available from the electronic termination forms completed by managers. Changes since last quarter are summarized below.

- There have been 119 more staff leaving due to Work Life Balance / Child Dependents / Adult Dependents this quarter than a year ago, and 24 more relocations.
- 26% of all leavers have been employed in the Trust for one year or less; this is a slight reduction on the same period last year, when it was 29.1%.
- The greatest change in 'destination' is in staff going to "no employment", (where no future employment has been lined up), which has risen to 173 from 56, now accounting for just over 47% of leavers in the period.
- There continues to be an increase in the percentage of staff moving to neighbouring trusts, from 6.1% of leavers to 7.1%. However when compared with starters, UH

Bristol is gaining more starters than losing leavers to neighbouring Trusts, across all staff groups, with 59.6 FTE starters coming from neighbouring Trusts and 43.6 FTE leaving to go to a neighbouring Trust.

In addition to the data from the termination forms, staff specific data is derived from the exit questionnaires and interviews in relation to the areas that leavers feel the trust could improve. The return rate this quarter was 31%.

An overview for the key staff groups where turnover has increased is provided below:

Registered Nurses

- The data in respect of "reasons for leaving" does not identify a single driver, but continues to reflect the combination of "promotion/better reward package/work life balance/relocation", which combined, account for nearly three quarters of leavers within the period; this is a slight increase on the same period last year, when they accounted for 67% of leavers.
- 15.7% of leavers have been in post for less than one year, a reduction compared with this quarter in 2013/14, when nearly a quarter left before completing a year's service.
- Around 31% of registered nurses are moving to other NHS organisations, which has reduced slightly since last year, when it accounted for 32.7% of registered nurse leavers. We have a significant net gain between starters and leavers, with 12.5 FTE more nurses joining from other NHS Trusts than leaving.

Feedback from the exit questionnaires from registered nurses identified the following areas in which the Trust could improve:

- Parking issues
- Better communication
- Involve more junior staff in decision making
- Staffing levels, particularly nursing assistants
- Better equipment
- Induction/ mentoring of new staff

Nursing Assistants

- There was a significant increase in nursing assistants leaving for "Work Life Balance / Child Dependents / Adult Dependents" compared with a year ago (increased from 5 to 55).
- Of unregistered nursing leavers, the biggest increases compared with the previous year are seen in those going to no employment.
- 34.7% of leavers have been in post for less than a year, which is an increase compared with last year, when only 29.4% left within a year.
- There is a small net loss between starters and leavers going to other NHS Trusts, with 11.9 FTE leaving, and 10 FTE joining the Trust from other NHS Trusts.

Areas, in which the Trust could improve, identified in the exit questionnaires included:

- Staffing levels
- Higher pay
- More funding for training/career progression

Estates and ancillary staff

- "Work Life Balance / Child Dependents / Adult Dependents" continues to show the biggest increase in reasons for leaving (19 compared with 4 in the same quarter last year), as well as accounting for the largest proportion of leavers (57.6%);
- There is a slight increase in the proportion of leavers who have been in post a year or less (27.3% compared with 26.3% last year);
- Slightly more left to go to other NHS Trusts (4.9 FTE) than joined from other NHS Trusts (2.7 FTE).

Areas for improvement identified in the exit questionnaires included the following:

- To have a "real" difference in pay between Band 1 and Band 2
- Invest more in the department
- Lack of proper induction
- Clearer roles and responsibilities

Feedback from the exit questionnaires is provided for HR Business Partners to share with divisional colleagues and address appropriately.

Exit Management Process

To increase the numbers of employees having an exit interview, from May 1st 2015, employees resigning from their employment will be contacted directly by the Employee Services team when a termination form is received, inviting the employee to attend an exit interview to capture all employee reasons for leaving their employment, as part of the Trust's retention strategy.

Due to the large numbers of termination forms being completed with "no employment" as a destination, the Employee Services team will, for an initial three month period starting on May 1st 2015, be contacting managers to confirm the detailed reason for the employee's resignation - pending a review of the termination form definitions.

C. **RETENTION**

Turnover is being addressed through a number of programmes which will now be described.

Nursing/Midwifery Assistants

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

<u>Nursing/Midwifery Assistants</u>

- *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* – The Trust has already undertaken transformation work to ensure Nursing/Midwifery Assistant recruitment processes

and pathways are consistent and robust to reduce turnover. New nursing assistants are recruited through a values-based assessment centre, given contracts according to their level of experience and qualifications and are provided with appropriate training to reflect their level of competence and experience. A nursing pathways review meeting took place in 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. An initial review of leaver numbers during the first six months of the assessment process showed that 8% of starters left, compared with 11.3% of those starting in the same period in the previous year.

- *Career Progression* – Corporate nursing leads are ensuring there are clear competences 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 has been 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 for staff groups. Having secured funding from Above and Beyond, the Trust is taking the opportunity to promote the considerable range of benefits it provides staff, producing a staff benefits booklet for display in ward/department areas as well as 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/Experience

An extensive Staff Experience Programme continues across the Trust. This work is being directed both centrally by the Senior Leadership Team and locally by Divisional Management Teams. A key priority of the programme is the improvement of two-way communication. Actions include focus on recognition events; focus groups and listening events; team building; review of the appraisal process; training programmes for managers/supervisors, a wide range of health and wellbeing initiatives – including specific work on stress related illness and a piloted Employee Assistance Programme; targeted action to address harassment and bullying; a revision and re-launch of the 'Speaking Out' process; and support for staff forums and reverse mentoring. Activity during this quarter includes:

- A survey regarding inpatient nursing staff views on shift patterns was rolled out during December and early January. The survey closed on 9th January and was followed by focus groups throughout February. Initial results have been shared with the Chief Nurse, and the information from the survey and focus groups triangulated with sickness and turnover data and information from the national staff survey and Friends and Family Test. A report will be presented to the Executive Team in May 2015 for full consideration.
- The Speaking Out Policy and practice review process has taken place. The revised policy, FAQ and extensive management and staff guidance was shared with the Executive Team in March 2015, together with details of the *Freedom to Speak Up* recommendations on

Speaking Up. Full consultation on the policy will now take place, with the re-launch of the full policy and procedures in June and July 2015.

- 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. The Team coach profile has been developed, opportunities to train as a coach will be advertised during January/February and teams for the new coaches to work with will be identified. Training with Aston is due to commence in March and complete in May 2015.
- The 2014 Staff Survey results have been received and fully analysed. Findings have been presented to Executive Team, Board, Senior Leadership Team and QOC 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.
- Recruitment and training of new harassment and bullying Advisors to provide further support for staff, will take place in May and June 2015.

In addition to the corporate activities, specific Divisional engagement schemes include the following:

- Divisional newsletters to communicate key issues/events within the Division.
- Listening events which often include the Head of Nursing/Divisional Director visiting wards/departments.
- Staff Champion schemes, for example, within Coronary Intensive Care Unit and Ward D703.
- Division of Surgery, Head and Neck will be piloting the use of 'thank-you' cards next quarter.

KPI for 2015/16

The out turn figure for 2014/15 was 13.8% compared with a target of 10%. The KPI for 2015/16 is 11.5%. This continues to be a challenging target from the current levels of turnover, which is unlikely to be achieved until the end of 2015/16, given the rolling 12 month nature of the measure.

5. STAFF DEVELOPMENT

A. APPRAISAL

Appraisal compliance has remained above target in quarter three, with a rate of 85.6% at 31 March 2015, which is similar to the same point in the previous year, when compliance was at 85.9%.

All Divisions were compliant with the 85% target for their non-medical staff groups except Medicine, Surgery Head and Neck, and Women's and Children's, where a recovery plans are in place.

Work continues to ensure that the quality of appraisal is improved. Scoping work and consultation has been completed, and a clear plan of action will be considered at the Workforce and Organisational Development Group during the next quarter.

Consultant Appraisal and Revalidation

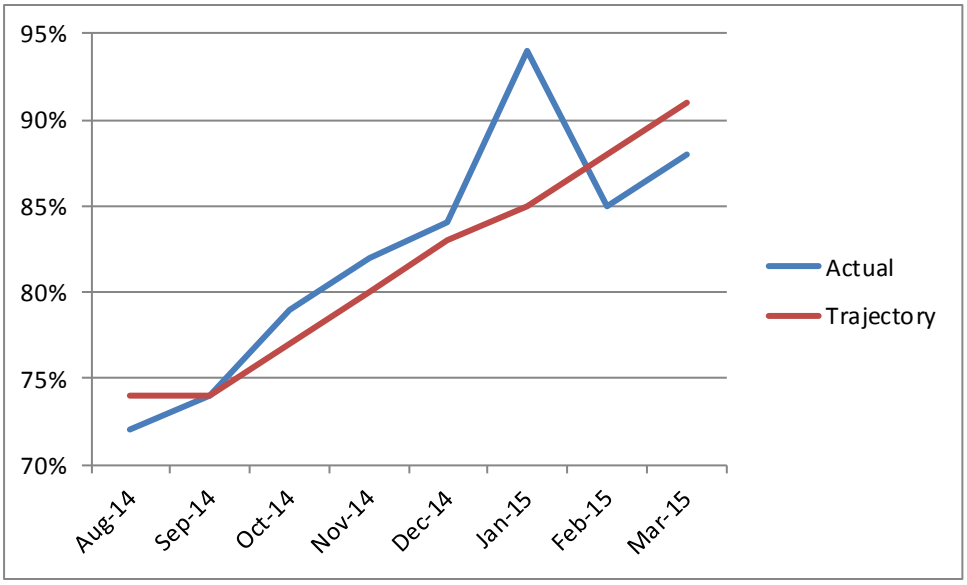
Consultant appraisal data is derived from the consultant revalidation database. Different parameters apply to medical staff, as revalidation requires five appraisals to take place in five years, rather than a strict annual requirement. For this reason, they are not considered overdue until 15 months have elapsed since the last appraisal, in contrast with other staff, for whom an annual appraisal is required. In quarter 4, 95% of consultants had been appraised within the required timeframe.

Revalidation of doctors' General Medical Council licence to practice has now been operational for two years. Revalidation is based on annual appraisal and with evidence consistent with good medical practice. During 2014/15, there were 194 positive recommendations for revalidation and 24 deferments. Of the 24 deferments, 11 were the result of unavoidable factors, and 13 were due to lack of sufficient evidence. During quarter 4, there were 32 consultants recommended for revalidation, and only one referral due to lack of evidence. Full information on revalidation at UH Bristol will be included in the annual report on appraisal and revalidation which will be reviewed by Quality and Outcomes Committee in June.

B. ESSENTIAL TRAINING

Trust compliance with core Essential Training, which excludes Safeguarding and Resuscitation, at the end of March 2015 was 88% against a trajectory of 90%.

Individual topics vary in terms of compliance; with 6 topics exceeding 90% and 4 reaching over 85% (see Appendix 1). There are plans in place to improve compliance for topics with the lowest rates which include Safeguarding and Resuscitation. Separate Trust trajectories are in place for Safeguarding Adults, Safeguarding Children and Resuscitation; all of these areas have improved their position in the last quarter. Divisions are working with local trajectory recovery plans to ensure the compliance gap is closed; additional training places continue to be available; and are reflective of divisional demand; we have seen a real month on month increase in the uptake of E-Learning which was launched in October which further supports staff to access learning through a blended approach.



All divisions have robust trajectories and plans in place to continue to work towards the target of 90% for all Essential Training. The Trust position continues to improve month on month.

C. LEADERSHIP DEVELOPMENT

Whilst not linked to a specific KPI, leadership development is included in this report in order to provide an update on the training and development being offered to line managers, which will support the achievement of most other KPIs.

During quarter 4, 222 front-line managers and leaders received training on one of the Leadership and Management development modules. These modules are based on the Healthcare Leadership Model which focuses on Leadership behaviours and covers topics from dealing with difficult conversations to managing and improving performance.

During this time we have also launched our 'Learning and Leading Together' monthly leadership masterclasses where 70 multi-professional leaders listened and engaged with the debate on Collective Leadership and how this links with 'Leading with Care' one of the core behavioural dimensions in the Healthcare Leadership Model. These masterclasses will run throughout the year and encourage leaders and front line managers to learn, network and explore their leadership behaviours in an action learning set environment. The next session in April focuses on sharing the vision and encourages leaders to consider the importance of team engagement when shaping change.

6. COMPLIANCE REQUIREMENTS

A. HEALTH AND SAFETY

Mar-15	Diagnostic & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's	Trust wide
Manual Handling Risk	100%	100%	100%	96%	96%	93%	100%	98%

Assessments								
Stress Risk Assessments	100%	100%	94%	86%	90%	100%	94%	95%

The quarterly KPI for reporting within the timeframes required for reportable incidents under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, continues not to be achieved as a trust. This is due in part to very small numbers divided by 6 divisions and then trust services being sub divided into Facilities & Estates and the rest of Trust Services. We have therefore requested a review and would advise to reset the KPI to 75% from April onwards whilst aspiring to 100%. This has been agreed at Workforce and Organisational Development Group and also discussed at Risk Management Group.

KPI's for risk assessment have exceeded the trajectory of 93% for both topics by year end as shown in the table above. For 2015/16, it is intended that we sustain these levels.

B. JUNIOR DOCTOR NEW DEAL COMPLIANCE

The 'New Deal' refers to the Junior Doctors Terms and Conditions of Service. This includes rest and hours targets which must be met in order for a rota to be 'compliant'. At the end of March, there were 65 compliant and 8 non-compliant rotas. The divisional position is provided below:

	Number Non-Compliant	Number Compliant	Compliance	Anticipated Date for 100% Compliance
Diagnostics & Therapies	0	6	100%	
Medicine	0	12	100%	
Specialised Services	1	10	91%	June 2015
Surgery Head & Neck	2	23	92%	June 2015
Women's & Children's	5	14	74%	July 2015

Each Division has a robust action plan, with dates to achieve compliance where necessary. Divisions are required to report progress against action plans at their Performance and Operations quarterly review meetings.

7. CONCLUSION

Quarter 4 has seen progress in some areas. Vacancies have reduced significantly, but continue to be marginally above target, and Essential Training rates have improved considerably at 88%, whilst still slightly below the KPI of 90%. Turnover and bank and agency usage, in line with other Trusts, continue to be above plan, together with sickness absence levels. Divisions have developed their annual workforce plans, and this has included establishing new workforce KPIs for 2015/2016, which will form the basis of future reporting. New KPIs have

been set in line with available benchmarks for similar Trusts.

There has been significant progress in progressing workforce governance structures, with operational sub-groups being established which report into the Workforce and Organisational Development Group developing their terms of reference, action plans and ensuring clear accountability arrangements for managing workforce risks.

Quality and Outcomes Committee is asked to:

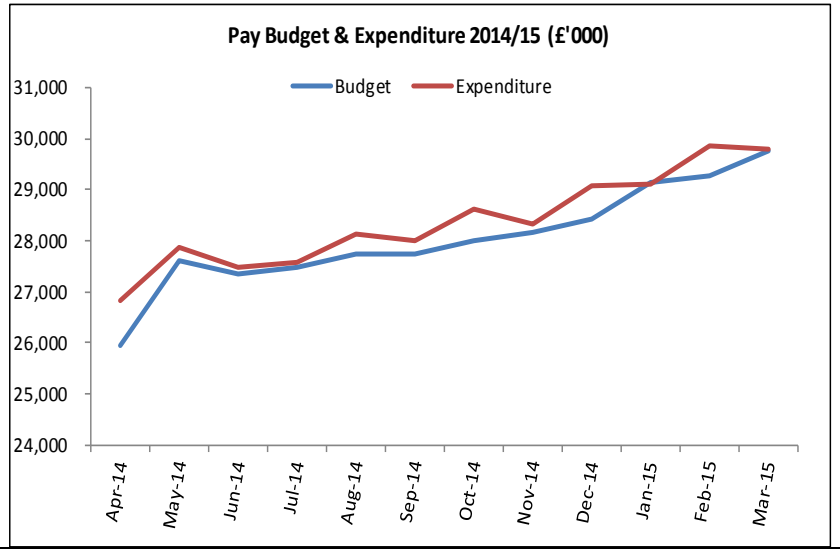
1. Note the contents of this report;
2. Discuss any issues arising in relation to the areas reported.

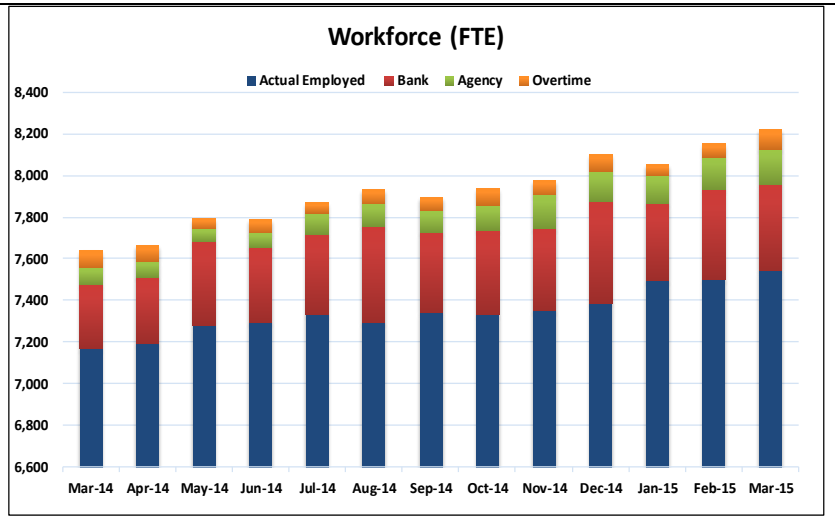
APPENDICES

Appendix 1 – Workforce Performance Dashboard
Appendix 2 – Divisional KPIs – Quarterly Comparisons
Appendix 3 – Staff Group KPIs – Quarterly Comparisons

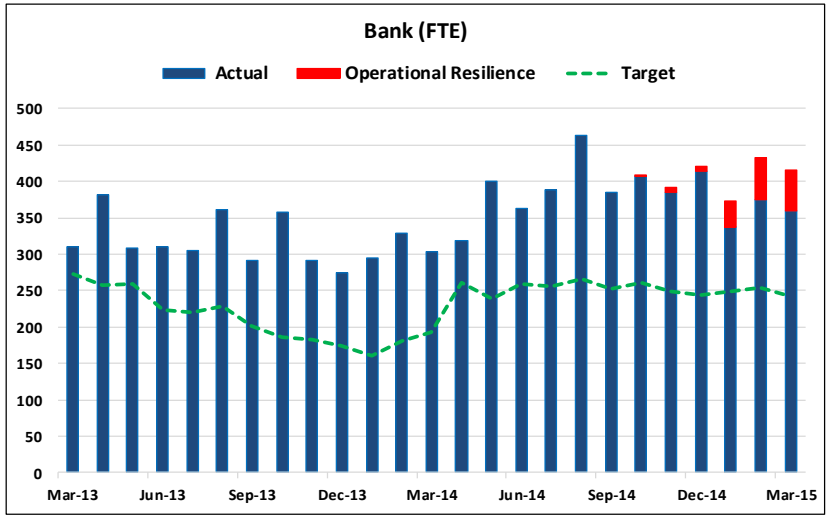
Appendix 1 – Workforce Performance Dashboard

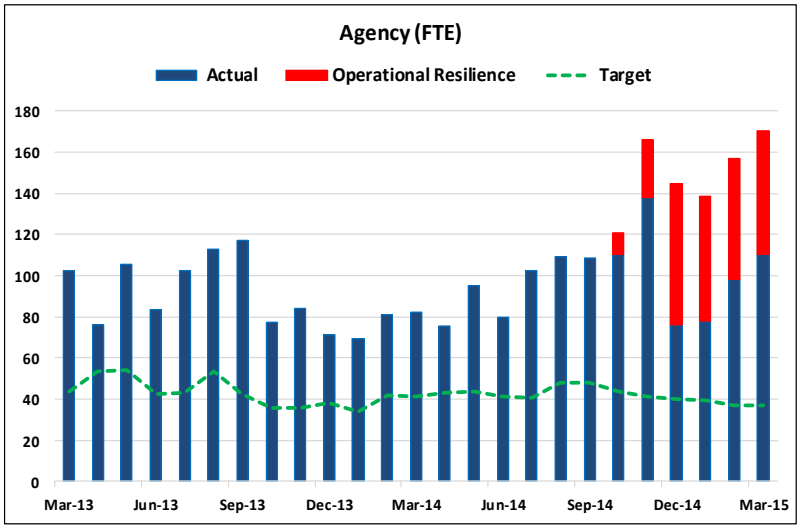
Workforce Costs/FTE



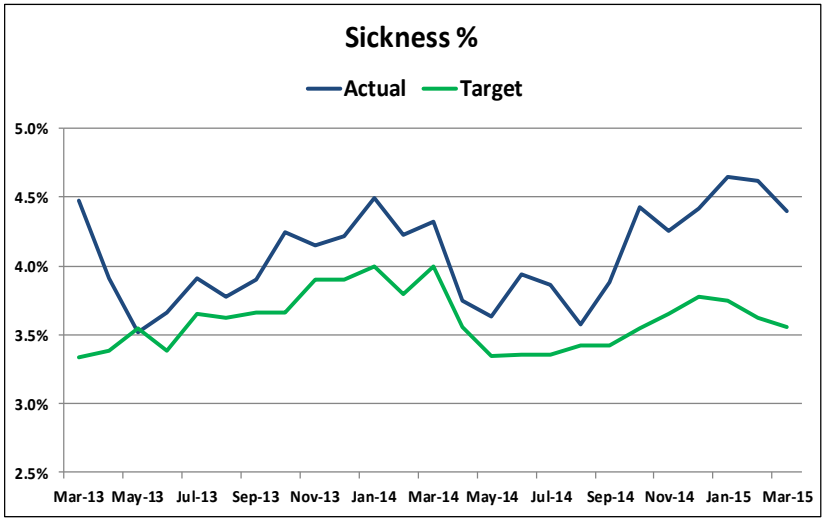


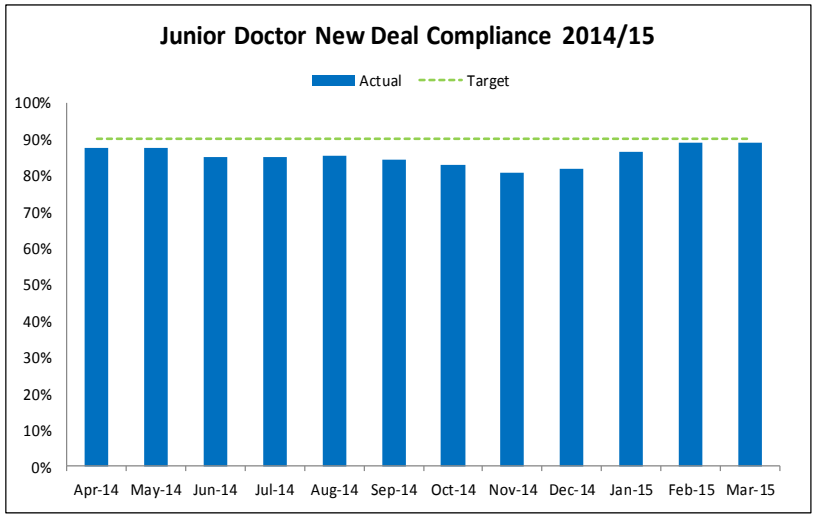
Workforce Costs/FTE



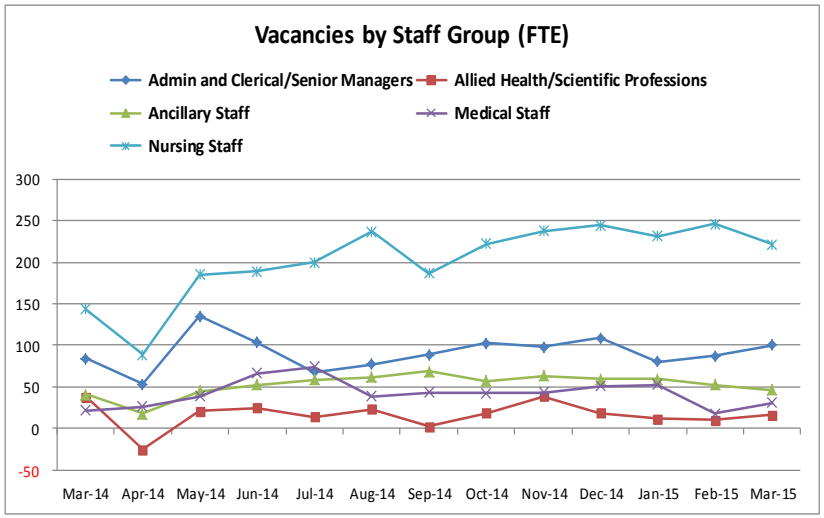


Workforce Costs/FTE

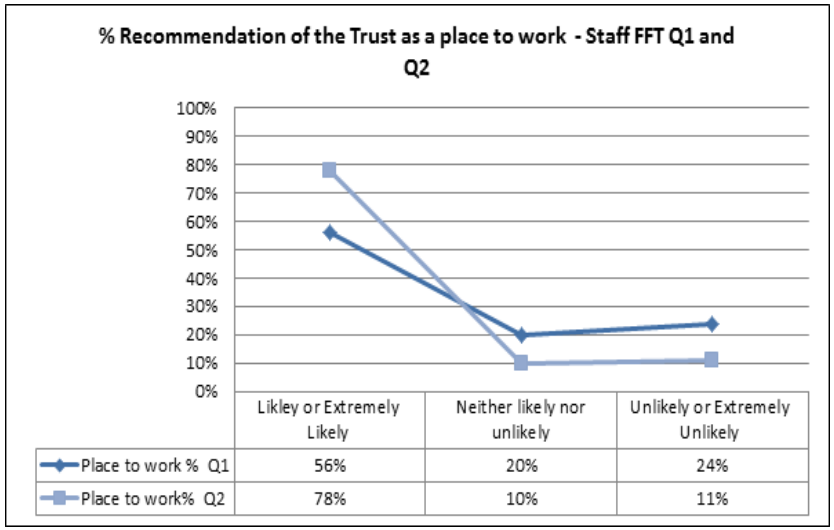


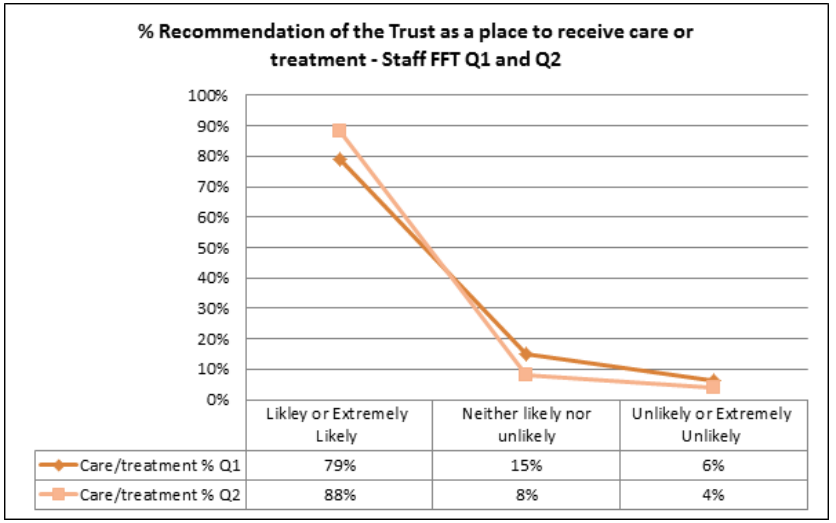


Staff Experience

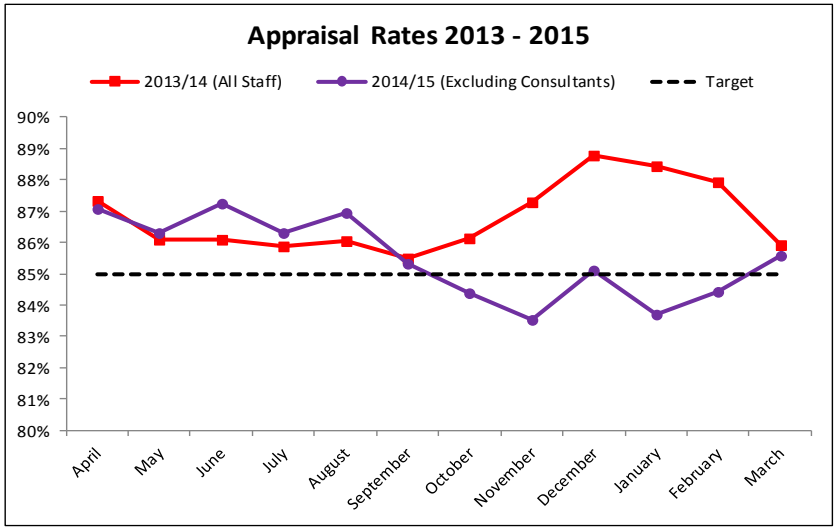


Staff Experience





Staff Development



Essential Training Compliance

Accreditation	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's	Compliance
Blood Trans	68%		81%	90%	86%	81%	85%	85%
Clinical Re	80%		81%	88%	84%	79%	82%	83%
Conflict Re	98%	99%	97%	98%	96%	97%	97%	97%
Conflict Re	86%		87%	90%	86%	78%	82%	85%
Consent	81%		79%	86%	83%	78%	81%	82%
Equality &	98%	99%	98%	97%	97%	98%	97%	98%
Fire Safety	99%	99%	98%	98%	98%	99%	97%	98%
Food Safety	98%	99%	97%	97%	97%	97%	97%	97%
Harassment	99%	99%	98%	98%	97%	98%	98%	98%
Health & S	89%	80%	86%	90%	86%	89%	81%	85%
Infection Pr	88%	79%	86%	90%	88%	89%	83%	86%
Information	98%	98%	98%	97%	98%	98%	97%	98%
Manual Har	84%	79%	84%	87%	84%	83%	80%	83%
Medical De	74%		74%	82%	79%	71%	77%	77%
Medicines M	76%		76%	84%	82%	74%	79%	79%
Nutrition	75%		79%	83%	79%	71%	77%	78%
Patient Safe	74%		74%	82%	79%	71%	77%	77%
Patient Slip	78%		77%	85%	81%	74%	78%	79%
Pressure Ul	76%		84%	86%	82%	76%	79%	81%
Venous Thr	58%		76%	87%	83%	79%	80%	81%
ALL:	89%	92%	87%	90%	88%	91%	86%	88%

Induction	90%	90%	87%	80%	84%	85%	84%	85%
Local Induc	64%	57%	39%	46%	44%	65%	53%	50%
Resuscitatio	64%		74%	78%	69%	72%	70%	71%
Safeguardi	84%	79%	86%	91%	87%	89%	84%	84%
Safeguardi	63%	48%	69%	81%	73%	61%	63%	68%
Safeguardi	87%	77%	77%	80%	80%	82%		81%
Safeguardi	83%	70%	78%	90%	83%	86%	69%	82%

Compliance Requirements

Mar-15	Manual Handling Risk Assessments	Stress Risk Assessments
Diagnostic & Therapies	100%	100%
Facilities & Estates	100%	100%
Medicine	100%	94%
Specialised Services	96%	86%
Surgery Head & Neck	96%	90%
Trust Services	93%	100%
Women's & Children's	100%	94%
Trust Wide	**98%**	**95%**

Appendix 2 Divisional KPIs – Quarterly Comparisons

Workforce Costs/FTE

EXPENDITURE (£'000)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	£10,173	£10,206	£10,324	£10,037
Facilities & Estates	£4,835	£4,936	£4,951	£4,931
Medicine	£13,489	£13,437	£12,766	£12,524
Specialised Services	£10,613	£10,232	£10,216	£9,727
Surgery, Head & Neck	£19,156	£18,190	£18,988	£18,188
Trust Services	£8,281	£8,936	£6,686	£7,240
Women's & Children's	£22,174	£22,234	£22,088	£21,945
Trust Total	**£88,719**	**£88,172**	**£86,019**	**£84,593**

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	943.1	945.0	925.1	943.3
Facilities & Estates	786.7	785.6	769.6	780.0
Medicine	1260.4	1194.6	1210.0	1133.7
Specialised Services	855.8	823.4	857.7	812.6
Surgery, Head & Neck	1741.1	1727.8	1719.7	1713.3
Trust Services	701.9	697.7	685.1	693.2
Women's & Children's	1785.6	1758.7	1764.0	1751.2
Trust Total	**8074.4**	**7932.8**	**7931.2**	**7827.3**

Workforce Costs/FTE

BANK (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	9.5	11.5	10.5	11.2
Facilities & Estates	50.2	13.0	50.9	13.0
Medicine	135.1	79.7	138.9	80.7
Specialised Services	43.4	19.8	45.7	22.0
Surgery, Head & Neck	71.0	53.3	83.8	54.4
Trust Services	35.7	26.4	32.4	26.0
Women's & Children's	62.5	44.9	67.8	44.3
Trust Total	**407.4**	**248.5**	**429.8**	**251.5**

AGENCY (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	6.6	1.9	9.2	1.4
Facilities & Estates	18.1	4.1	14.3	4.9
Medicine	58.3	8.4	50.4	9.7
Specialised Services	20.8	3.4	22.5	3.7
Surgery, Head & Neck	21.3	6.9	19.9	8.0
Trust Services	10.2	4.8	9.8	5.6
Women's & Children's	20.2	8.4	17.7	8.5
Trust Total	**155.5**	**38.0**	**143.7**	**41.8**

Workforce Costs/FTE

OVERTIME (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	9.9	8.4	11.4	8.8
Facilities & Estates	35.3	19.1	41.7	17.6
Medicine	1.8	3.4	1.1	3.2
Specialised Services	2.9	2.9	2.8	3.1
Surgery, Head & Neck	2.9	8.5	6.2	11.1
Trust Services	6.6	2.7	3.0	2.4
Women's & Children's	8.6	1.5	7.1	1.3
Trust Total	**68.1**	**46.6**	**73.3**	**47.4**

SICKNESS ABSENCE (%)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	3.6%	2.7%	3.4%	2.4%
Facilities & Estates	6.7%	5.5%	6.5%	5.7%
Medicine	5.7%	4.2%	5.3%	3.7%
Specialised Services	3.1%	4.0%	4.4%	3.9%
Surgery, Head & Neck	4.6%	3.3%	3.8%	3.4%
Trust Services	4.0%	2.9%	3.4%	3.0%
Women's & Children's	4.3%	3.4%	4.3%	3.7%
Trust Total	**4.6%**	**3.6%**	**4.4%**	**3.7%**

Staff Experience

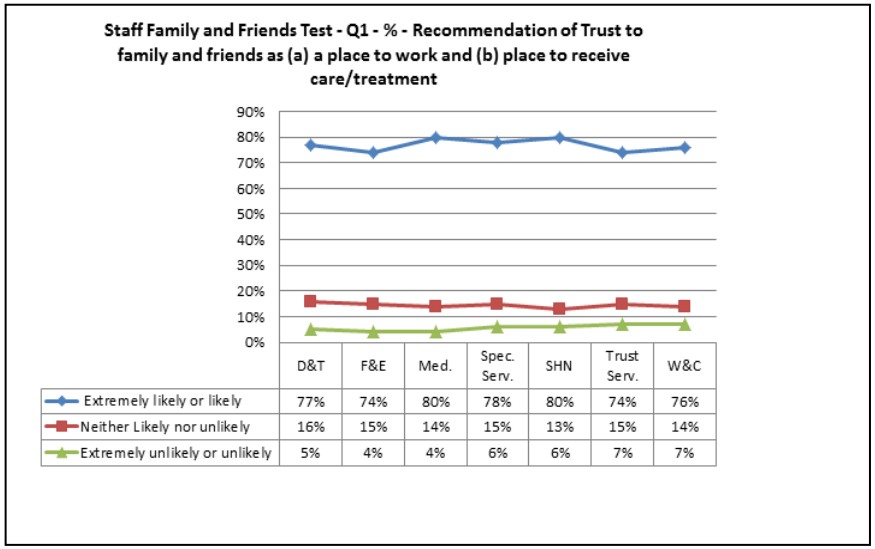
VACANCY (% FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	1.9%	5.0%	4.0%	5.0%
Facilities & Estates	8.6%	5.0%	9.7%	5.0%
Medicine	10.7%	5.0%	9.9%	5.0%
Specialised Services	3.9%	5.0%	2.8%	5.0%
Surgery, Head & Neck	4.6%	5.0%	5.7%	5.0%
Trust Services	6.0%	5.0%	7.3%	5.0%
Women's & Children's	3.2%	5.0%	4.2%	5.0%
Trust Total	**5.3%**	**5.0%**	**6.0%**	**5.0%**
Trust Total excl. bank & agency budget	**3.5%**		**4.8%**	

TURNOVER (% FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	11.4%	9.0%	10.4%	8.9%
Facilities & Estates	14.0%	10.0%	14.5%	10.5%
Medicine	13.7%	10.2%	14.7%	10.9%
Specialised Services	16.6%	9.7%	17.4%	10.5%
Surgery, Head & Neck	15.1%	10.2%	14.8%	10.3%
Trust Services	15.3%	10.3%	14.5%	10.5%
Women's & Children's	12.0%	10.1%	10.4%	9.9%
Trust Total	**13.8%**	**10.0%**	**13.5%**	**10.2%**

Staff Experience



Note, data is not yet available for Q2 or Q3.

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Diagnostics & Therapies	89.4%	85.0%	83.9%	85.0%
Facilities & Estates	85.5%	85.0%	82.4%	85.0%
Medicine	83.8%	85.0%	85.3%	85.0%
Specialised Services	89.3%	85.0%	90.8%	85.0%
Surgery, Head & Neck	83.8%	85.0%	85.2%	85.0%
Trust Services	88.7%	85.0%	90.6%	85.0%
Women's & Children's	83.4%	85.0%	82.1%	85.0%
Trust Total	**85.6%**	**85.0%**	**85.1%**	**85.0%**

Appendix 3 Staff Group KPIs – Quarterly Comparisons

Workforce Costs/FTE

EXPENDITURE (£'000)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	£12,461	£12,326	£12,314	£12,394
Scientific & Professional	£12,737	£12,967	£12,500	£12,544
Estates & Ancillary	£4,629	£4,543	£4,709	£4,621
Medical & Dental	£28,608	£28,872	£27,056	£27,295
Nursing & Midwifery	£30,296	£30,319	£29,368	£28,928
Other	-£14	-£856	£71	-£1,190
Trust Total	**£88,719**	**£88,172**	**£86,018**	**£84,593**

* 'Other' relates to financial adjustments or provisions that cannot be identified as relating to a specific staff group

WORKFORCE NUMBERS, INCL BANK & AGENCY (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	1668.6	1624.5	1652.3	1608.1
Scientific & Professional	1310.1	1313.4	1282.9	1299.6
Estates & Ancillary	800.5	783.5	785.2	780.5
Medical & Dental	1110.6	1130.6	1098.0	1130.7
Nursing & Midwifery	3184.6	3080.9	3112.7	3008.4
Trust Total	**8074.4**	**7932.8**	**7931.2**	**7827.3**

Workforce Costs/FTE

BANK (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	97.2	60.8	103.4	58.0
Scientific & Professional	8.9	14.5	7.9	7.0
Estates & Ancillary	55.3	16.6	54.4	17.9
Medical & Dental	0.0	0.0	0.0	0.0
Nursing & Midwifery	246.1	156.6	264.1	168.5
Trust Total	**407.4**	**248.5**	**429.8**	**251.5**

AGENCY (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	36.3	11.8	43.9	12.0
Scientific & Professional	1.0	0.0	1.0	0.0
Estates & Ancillary	14.5	3.9	10.6	4.7
Medical & Dental	13.9	5.1	13.3	5.3
Nursing & Midwifery	90.1	17.2	74.8	19.8
Trust Total	**155.5**	**38.0**	**143.7**	**41.8**

Workforce Costs/FTE

OVERTIME (FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	8.2	6.1	7.2	5.3
Scientific & Professional	32.3	21.1	15.3	8.4
Estates & Ancillary	0.3	0.1	42.3	20.1
Medical & Dental	10.7	10.5	0.1	0.1
Nursing & Midwifery	16.6	8.7	8.4	13.5
Trust Total	**68.1**	**46.6**	**73.3**	**47.4**

SICKNESS ABSENCE (%)

	Quarter 4 Actual	**Quarter 3 Actual**
Add Prof Scientific & Technic	4.1%	3.3%
Additional Clinical Services	5.8%	6.5%
Administrative & Clerical	4.2%	4.4%
Allied Health Professionals	3.2%	3.1%
Estates & Ancillary	6.9%	6.3%
Healthcare Scientists	2.6%	2.4%
Medical & Dental	1.1%	0.7%
Nursing & Midwifery Registered	5.0%	4.8%
Nursing & Midwifery Unregistered	8.0%	7.7%
Trust Total	**4.6%**	**4.4%**

Staff Experience

VACANCY (% FTE)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Administrative & Clerical	5.5%	5.0%	6.4%	5.0%
Scientific & Professional	1.0%	5.0%	2.0%	5.0%
Estates & Ancillary	6.7%	5.0%	7.7%	5.0%
Medical & Dental	3.0%	5.0%	4.1%	5.0%
Nursing & Midwifery	7.5%	5.0%	7.8%	5.0%
Trust Total	**5.3%**	**5.0%**	**5.4%**	**5.0%**

TURNOVER (% FTE)

	Quarter 4 Actual	**Quarter 3 Actual**
Add Prof Scientific & Technic	11.2%	10.7%
Additional Clinical Services	12.5%	14.2%
Administrative & Clerical	14.9%	13.9%
Allied Health Professionals	10.8%	10.1%
Estates & Ancillary	13.5%	13.9%
Healthcare Scientists	9.8%	9.0%
Medical & Dental	8.2%	8.9%
Nursing & Midwifery Registered	12.9%	12.6%
Nursing & Midwifery Unregistered	24.3%	24.3%
Trust Total	**13.8%**	**13.5%**

Staff Development

APPRAISAL COMPLIANCE (EXCL CONSULTANTS)

	Quarter 4		Quarter 3	
	Actual	**Target**	**Actual**	**Target**
Add Prof Scientific & Technic	75.3%	85.0%	78.6%	85.0%
Additional Clinical Services	89.8%	85.0%	90.1%	85.0%
Administrative & Clerical	86.5%	85.0%	86.6%	85.0%
Allied Health Professionals	91.5%	85.0%	82.9%	85.0%
Estates & Ancillary	83.4%	85.0%	82.2%	85.0%
Healthcare Scientists	88.5%	85.0%	80.3%	85.0%
Medical & Dental	94.7%	85.0%	95.3%	85.0%
Nursing & Midwifery Registered	83.8%	85.0%	83.6%	85.0%
Nursing & Midwifery Unregistered	84.5%	85.0%	86.1%	85.0%
Trust Total	**85.6%**	**85.0%**	**85.1%**	**85.0%**

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27 May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
10. Speaking Out 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, and supplementary documents, following a response to the recommendations from the Francis Freedom to Speak Up Review (February 2015). The Board reviewed this policy on 30th April and requested some further amendments, which have been made. 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. Attachments to Paper 1. Speaking Out – A Quick Guide for Managers 2. Speaking Out – A Quick Guide for Staff 3. Flow chart – quick quide to Speaking Out Policy 4. Managing concerns about individual clinical practice
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 Impact Assessment 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)**
26 May 2015				22 April 2015	Workforce & OD Group February and March 2015

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	
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[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

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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 that you will be disloyal to colleagues if you speak out when noticing something is in your view 'untoward'.

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 – either something that has already happened or which you think is at risk of happening – for example, any concerns about possible criminal offences being committed; healthcare matters including suspected maltreatment/ abuse of service users or staff; the health and safety of any individual; failures to comply with legal obligations; harm to the environment; or the concealment of information about any of these. It can be very difficult to know what to do. You may be worried that by reporting issues of concern, you are exposing yourself to possible victimisation, disciplinary action or putting your job at risk. The Trust understands these concerns, and this policy has been 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 when issues of concern are raised.

This policy 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:

- 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; to 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 about 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 [1],. 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 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.

[1] "In the public interest" has a number of definitions but broadly means anything affecting the . 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 - for example patient care and patient safety or suspected fraud.

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.

Both the person raising concerns and those who are potentially the focus of a concern will be treated with fairness and openness.

You have the right to be accompanied by a trade union representative, or a colleague or friend at any time during the procedure.

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 the Public Interest Disclosure Act and professional or ethical guidelines and codes of conduct /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).

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.**

NB If you believe there are strong reasons why you should not approach your Manager (informal stage) 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 (Stage 3) without following the earlier stages of the procedure. See 3.3. below.

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

Informal Process

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

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 meet with you within 5 working days, to discuss your concern. The meeting will be recorded in writing and a copy of the notes will be given to you within 3 working days. The manager will look into the matter and arrange for the concerns to be investigated. S/he will also discuss with you how you will receive feedback.

If the concern relates to fraud you may raise it with the Trust's Local Counter Fraud Specialist.

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.

We hope that this will resolve your concerns. If it does not then you should move to **the formal process** – detailed below.

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 following 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.

[2] NB If an 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 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**.

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.

3.3 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.

3.4 FURTHER OPTIONS

If, after following the formal process 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 a number of websites – including (but not restricted to) the following:

- 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.

3.5 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

The 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. http://wbhelpline.org.uk/

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

4.1 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)

Managing Concerns About Individual Clinical Practice – Guidance

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 AND MANAGERS

- 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

These will be measured through the Audit Committee.

Appendix A – CONDUCTING 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 and the Director of Finance.

- 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 immediately 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 an allegation constitutes a criminal offence then it should be referred to the police by the manager to whom it is reported. It is strongly advised that the manager should also advise her/his Divisional Director or an Executive Director that this allegation has arisen and will be referred to the police.

- 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 Further liaison with other partner agencies may be required..

- The Trust Secretary must be informed that a disclosure under this policy has been received and how it will be dealt with (e.g. informally, formally stages 1,2, or 3)

1. Investigation under the 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 must 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 taking the following steps:

  (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. This should take place within five working days of receipt of the concern. NB if the person who raises the concern has chosen to remain anonymous, then this will not be possible and step(d) – carrying out an informal investigation – will need to commence.

  (b) 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

  (c) Keeping clear notes of the discussion with the member of staff and passing the typed notes of the discussion to her/him (where possible – i.e.unless the person has chosen to remain anonymous) for agreement that this is a correct record. This should happen within three working days of the meeting/discussion.

  (d) 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. This informal investigation should take place within five working days, following the initial discussion/meeting with the member of staff raising the concern.

  (e) Communicating (where possible) with the member of staff who raised the issue, to advise on what steps have been taken and the resolution. This should take place within three working days of the completion of the informal investigation.

  (f) 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.

  (g) 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. [See Step One of the formal stages below]

  (h) 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.

  (i) It is vital, throughout, 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.

2. 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.

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. NB if the person who raises the concern has chosen to remain anonymous, and does not wish to meet, then this will not be possible and step (f) –considering whether a formal investigation is required – will need to commence.

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) The Director/Clinical Chair/Executive Director/Chief Executive will need to communicate (where possible – i.e. unless the person has chosen to remain anonymous) with the member of staff who raised the issue, to advise on what steps have been taken and the resolution.

o) 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.

p) 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 does 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

It will 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. NB if the person who raises the concern has chosen to remain anonymous and does not wish to meet, then this will not be possible and steps (e) and (f) – reviewing steps taken and considering whether a further formal investigation is required – will need to commence

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) The Chairman/Senior Independent Non-Executive Director will need to communicate (where possible i.e unless the person has chosen to remain anonymous) 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.

o) 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

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 a number of websites - including:

- 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, including

- 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.

This is a non-exhaustive list – check your own professional body's website for specific guidance.

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 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 with 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:

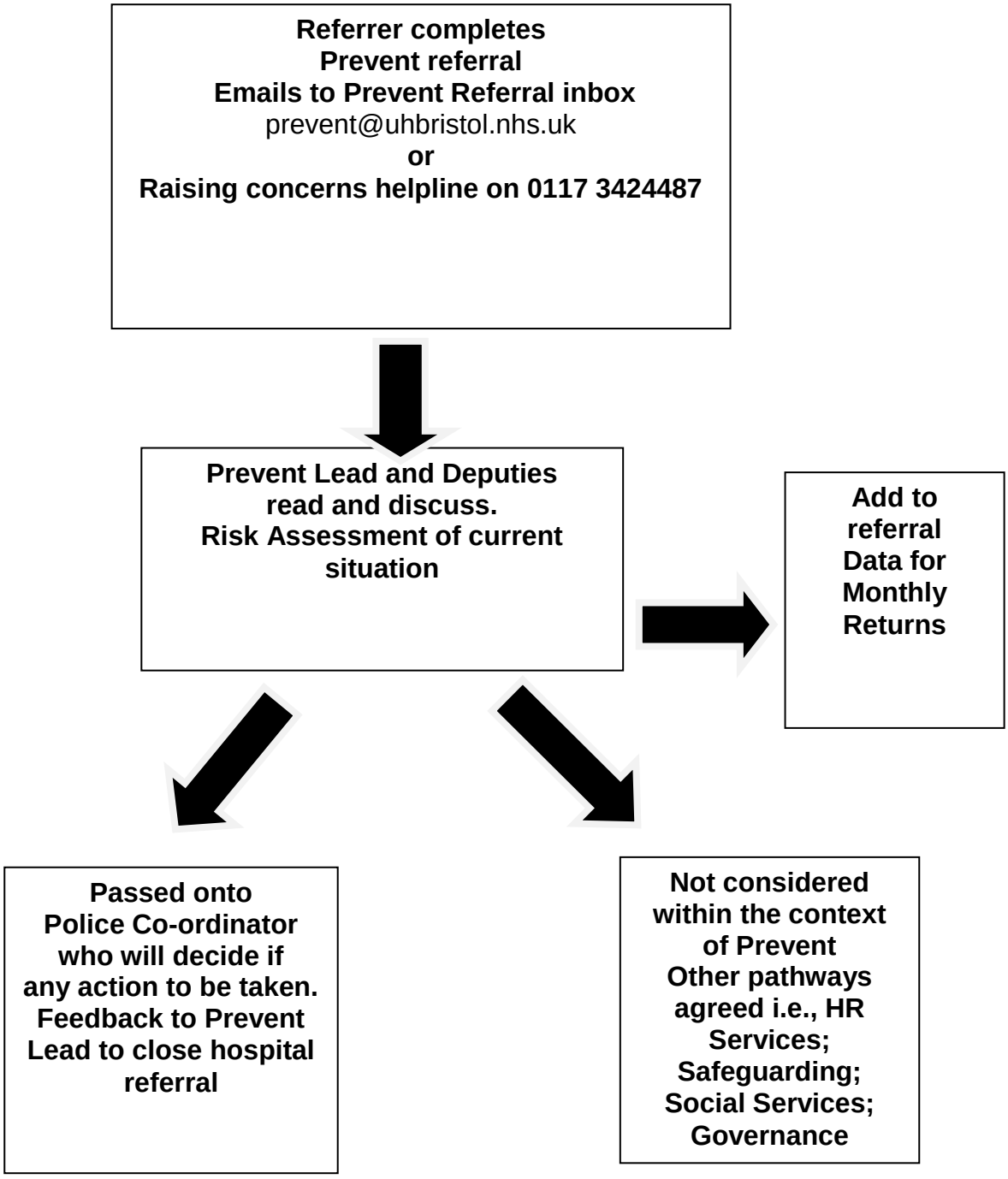
Emailing prevent@uhbristol.nhs.uk
Phoning the Raising Concerns helpline 0117 342 4487 (calls can be made anonymously)

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

3.3 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

3.4 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; Trust Board; Quality Outcomes Committee; Safeguarding Team; Local Security Management Leads; Local Counter Fraud Specialists; Caldicott Guardian; Senior Independent Non-Executive Director; a representative of Staff Governers.

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
	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
	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:		

University Hospitals Bristol NHS
NHS Foundation Trust

SPEAKING OUT - A Quick Guide for managers when a concern is raised

This quick guide explains the steps you will need to take, when a person raises a concern to you under the Trust's Speaking Out Policy.

The Trust Board actively encourages people to raise genuine concerns, for the benefit of our patients, our staff and the community we serve.

The Trust has a Speaking Out (Whistleblowing) Policy, which sets out the informal and formal speaking out process. Appendix C of the policy has full guidance for managers when a concern is raised to them, and Appendix A of the same policy gives guidance on conducting investigations.

If a person raises a concern with you informally, you will need to:

- 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
- respect the person's confidentiality – don't disclose their name without their permission – and check whether they want to remain anonymous (if this is how they have raised the issue).
- meet with the person (or phone them, if they prefer) to discuss their concerns within 5 working days.
- listen to the complaint, keeping an open mind
- ensure that you understand what you are being told, by clarifying facts.
- consider whether the concerns being raised to you fall under the Speaking Out policy – or whether you should be directing the person to the Grievance or Tackling Harassment and Bullying Policy . If you are unsure, seek advice from another senior manager or a member of the HR team
- explain that feedback will be given on any investigation and that if the concern is raised confidentially their identity will not be disclosed without their consent.
- make sure that the person understands the Speaking Out: (Whistle-blowing) Policy and Procedure and has a copy.
- keep a written and dated record of the initial conversation and agree the accuracy with the individual within three working days – by asking them to sign the written record.
- consider discussing the concern with your Divisional Director/Clinical Chair/other member of your Divisional board and/or another appropriate manager or executive in the organisation, in strictest confidence. Remember not to disclose the identity of the person who has spoken out, without their permission. You should advise the person who has raised the concern that you will be doing this.
- once you have met with the person and are clear that s/he 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"*
- this means that you will need to carry out (or ask another manager to carry 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. This informal investigation should take place within five working days, following the initial discussion/meeting with the member of staff raising the concern. The outcome of the investigation will need to be shared with the person who raised the concern within 3 working days of the completion of the investigation.
- know when to ask for help. 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;.
- If the informal steps which are taken don't resolve the person's concern, they should be directed to the formal stages of the Speaking Out Policy.

Important things to remember:

If the matter relates to alleged fraud, you should seek advice from the Local Counter Fraud Specialist and the Director of Finance.

If the concern raised relates to the care and treatment of children or vulnerable adults the Safeguarding Children / Adults Leads) must be informed immediately

If there are concerns that an individual may be susceptible to violent extremism or engaged in terrorist activity the Safeguarding Adults Lead must be informed.

The Trust Secretary must be informed that a disclosure under this policy has been received.

University Hospitals Bristol NHS
NHS Foundation Trust

SPEAKING OUT - A Quick Guide

This quick guide explains the Trust's various formal and informal processes for speaking out and raising concerns. We all have a responsibility and a duty to speak out when we believe something at work is not right. Where you highlight something that you honestly believe is a concern, you will be supported by the Trust Board.

Many things can be dealt with by having an informal discussion with your line manager.. This guidance and the Trust's Speaking Out Policy, explains the options available to you, where you need a more formal route for raising concerns in the public interest. If the concern you have relates to employment related matters, it may be more appropriate to deal with it through the Trust's Grievance or Harassment and Bullying procedures. Your manager or the HR Team can help advise you if you are not sure.

Speaking Out (also known as whistleblowing) and the processes that support it, have undergone a great deal of scrutiny following the Francis Inquiry and other recent reports.

In addition to this brief guide, the Trust also has a Speaking Out Policy, which sets out the informal and formal speaking out process. The Trust Board actively encourages you to raise genuine concerns, for the benefit of our patients, our staff and the community we serve.

However, in addition to the Trust's ***formal*** policy and process for raising concerns, our Board is clear that the Trust wants to hear about concerns that staff may have, before it is necessary to use the formal process.

The Trust Board is committed to staff feeling able to raise concerns promptly and without fear of retribution. **There are various ways** that this can be done: -

- Speak to your line manager or another appropriate manager in the Trust.
- Raise concerns through your departmental team meetings;
- We have regular Executive walkabouts, use these opportunities;
- Seek advice from your Trade Union Representative
- Raise concerns through the Chief Executive's briefing sessions;
- Call the Raising Concerns telephone number x2 4487 or 0117 342 4487.
- Email raisingconcerns@uhbristol.nhs.uk
- Report concerns through our incident reporting system;
- Raise concerns with the Safeguarding team

or

- Use the more formal stages of the Trust Speaking Out Policy, which gives avenues to senior manager, including the Trust Chairman and to the Senior Independent Non-Executive Director.

The policy also lists internal and external sources of support which you can access at any time.

The Trust Board encourages you to raise any genuine concerns you have.. We will investigate, and we will provide feedback.

What type of issues should be raised under the "Speaking Out" process?

These should be concerns that relate to "**making a disclosure in the public interest".** For other more personal employment related concerns, it will usually be more appropriate to follow the Trust's Grievance or Harassment and Bullying Process.

You are encouraged to report all concerns you have that something is not right, illegal, or anything that may be considered to be against '***public interest***'. Examples of these are, when you think that: -

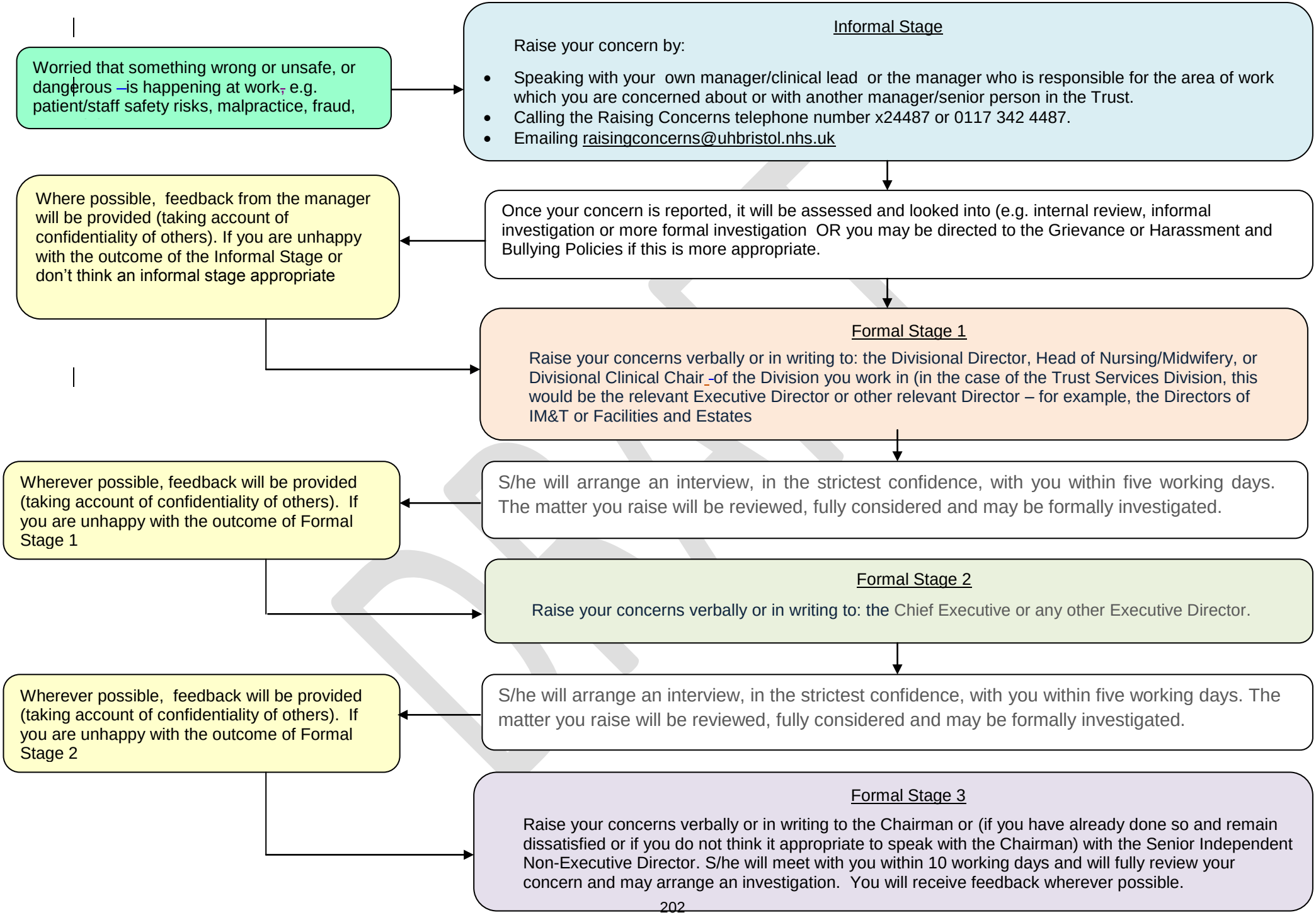
- there is malpractice, or ill treatment of a patient/client;.
- the health or safety of any person has been, is being or is likely to be at risk;
- fraud or corruption has occurred or is likely to occur;
- a criminal offence has been committed, is being committed or is likely to be committed ;
- someone has failed or is likely to fail to comply with a legal obligation ;
- the environment has been, or is likely to be damaged;
- information relating to any of the above has been or is likely to be deliberately concealed

These are called '***qualifying disclosures***', and there are three elements required to ensure that employees are protected under the Speaking Out policy and national guidelines, which are: -

- It must be done in good faith;
- With the reasonable belief that the information is substantially true; and
- With a reasonable belief that the disclosure is made to the correct/an appropriate person.

For further detail, please refer to the Trust's Speaking Out Policy (available on HR web)

Be the one who makes a difference
Stand Up
Speak Out


Worried that something wrong or unsafe, or dangerous – is happening at work, e.g. patient/staff safety risks, malpractice, fraud,
Informal Stage
Raise your concern by:
Speaking with your own manager/clinical lead or the manager who is responsible for the area of work which you are concerned about or with another manager/senior person in the Trust.
Calling the Raising Concerns telephone number x24487 or 0117 342 4487.
Emailing raisingconcerns@uhbristol.nhs.uk
Once your concern is reported, it will be assessed and looked into (e.g. internal review, informal investigation or more formal investigation OR you may be directed to the Grievance or Harassment and Bullying Policies if this is more appropriate.
Where possible, feedback from the manager will be provided (taking account of confidentiality of others). If you are unhappy with the outcome of the Informal Stage or don't think an informal stage appropriate
Formal Stage 1
Raise your concerns verbally or in writing to: 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
S/he will arrange an interview, in the strictest confidence, with you within five working days. The matter you raise will be reviewed, fully considered and may be formally investigated.
Wherever possible, feedback will be provided (taking account of confidentiality of others). If you are unhappy with the outcome of Formal Stage 1
Formal Stage 2
Raise your concerns verbally or in writing to: the Chief Executive or any other Executive Director.
S/he will arrange an interview, in the strictest confidence, with you within five working days. The matter you raise will be reviewed, fully considered and may be formally investigated.
Wherever possible, feedback will be provided (taking account of confidentiality of others). If you are unhappy with the outcome of Formal Stage 2
Formal Stage 3
Raise your concerns verbally or in writing to the Chairman or (if you have already done so and remain dissatisfied or if you do not think it appropriate to speak with the Chairman) with the Senior Independent Non-Executive Director. S/he will meet with you within 10 working days and will fully review your concern and may arrange an investigation. You will receive feedback wherever possible.

Managing Concerns About Individual Clinical Practice – Guidance

This guidance has been produced to clarify how staff should deal with concerns about colleagues' clinical practice. It also covers how to handle approaches from colleagues who have concerns about our own practice.

The primary purpose of everyone working in the University Hospitals Bristol NHS Foundation Trust is to provide safe and good quality patient care. Any situation that leads to a significant compromise in this care should be corrected as soon as possible.

Although such problems are rare, from time to time it is possible that members of staff may perceive their colleagues dealing with patients in a way that appears detrimental to the patient's interests. The General Medical Council for doctors and the UK National Midwifery Council (NMC) for nurses and midwives requires concerns to be raised so that patients are not unnecessarily harmed.

What should I do if I have concerns about an individual's practice?

We each have a responsibility to those with whom we work and to our patients, to take appropriate action when we have concerns about a colleague. As a first step, ask yourself whether the concern is reasonable, and make sure that you are not motivated by other factors, such as your own feelings about the individual.

If you decide action is necessary, a discussion with the colleague involved may be all that is required – particularly if you have responsibility for their work. It is important that you define and present clearly the evidence for your concerns and check that your colleague has understood them. It is always easier to help someone recognise that there is a problem where there is a specific incident to discuss. If you remain seriously concerned, you should discuss this with your own manager and with the HR Team to consider whether more formal performance management is required.

If you are not responsible for this person's work, find out who is, and raise your concerns with them. Try to make sure that you speak to the person directly supervising the individual. If possible you should ensure that the person about whom you express concerns knows exactly what your concern is, and that it was you who raised the concern.

If, for example, you as a junior professional are concerned that a more senior professional is frequently rude to staff or patients, how might you deal with the situation?

- If possible, the simplest solution is to raise the matter with the professional colleague, giving examples.

- Alternatively, you might prefer to raise your concerns with that person's manager/clinical manager, also giving examples.

- Before doing either, you might wish to discuss the way forward in confidence with your own manager, your *Trade* Union Representative or a member of the Executive Team.

How should I approach someone with a concern?

As with all difficult discussions, there is no universal formula. Each one of us will have our own approach, which we should try to tailor to the individual situation. To be effective requires tact and a positive approach. But there are some guidelines on good practice, which will help:

- Ensure that facts are collected – impressions and subjective rumour/gossip are not the way forward. Real facts have to be collected and documented so that issues can be dealt with properly.

- Make sure that the meeting is in private, and that you will not be disturbed.

- Give the individual a chance to explain their side of the matter, and you may find that they are able to reassure you. Remember that the reason for your concern may lie elsewhere. It may be that there is a problem with a process or system rather than an action: is your colleague over-stretched, or did they find themselves in a difficult or unfamiliar situation? Remember that we can all make mistakes. If there is a problem with a process or system, discuss with the individual where support can be sourced and offer to help them to secure the help they need.

- If the individual accepts there is a problem to rectify, see your aim as helping them to understand the problem, and to help them find a way of rectifying the difficulty.

- If you are approaching someone with concerns expressed by a third party, make sure you are well briefed about the issues. It is difficult to be effective if you have been given only general concerns without an example, or if the event concerned was a long time ago. You might choose to ask the person raising the concern to come back with a specific example soon after the event occurs.

- If the person raising the concern wishes not to be identified, you will have to decide whether you can proceed further. Your actions will be determined in part by the seriousness of the concerns. In such circumstances consider discussing the situation with one of the sources of support under either the informal or formal stages of the Speaking Out Policy.

Remember: patient care is paramount – if you have concerns about patient care, these concerns must be fully addressed

What do I do if I cannot resolve my concern this way?

If the person concerned does not accept there is any problem, or does not want to discuss it, consider whether you were the most appropriate person to make the approach. In general, the person immediately supervising a member of staff is usually the most appropriate individual.

If someone else has made the approach after you raised your concern, make sure that you get feedback to allow you to judge whether things are likely to be resolved.

It may be that you feel that the problem has not been resolved satisfactorily after the efforts that you and others have made. You should then consider whether the problem is serious or recurrent enough to take it further. Remember that even after what seems an unsatisfactory airing, lessons may have been learned. If you do feel that you need to take things further, then consider who is the next person up in the ‘chain’. You might want to discuss things with someone unconnected with the area in which you work: if so, you can contact your *Trade* Union Representative, an appropriate manager or a member of the Executive Team, or with

one of the sources of support under either the informal or formal stages of the Speaking Out Policy.

What should I do if someone expresses concerns about me?

This will inevitably be stressful. Your reactions will, however, say a lot to others about your professionalism. Don't dismiss the matter out of hand, even if the concern seems trivial or unimportant. It has obviously been important to someone else, who has probably been worried about expressing their concern at all. Find out exactly what really concerned them.

Then ask yourself whether there is something in those concerns. If you realise that there was a problem and can acknowledge this to whoever has made the approach, you will impress them with your openness and honesty. They may be able to help you think about what action needs to be taken.

After time to reflect, try to think about what the concern meant, and ask yourself whether you should take any action. If possible, think about it from the other person's and the patient's perspective, ask yourself how easy you were to approach. In the right clinical atmosphere people should feel empowered to express concerns when they have them, and we should not be upset if our colleagues at work approach us in this way sometimes. Without input like this from the people we work with, would we really be confident of always knowing when things were not going right? You can obtain advice from your Trade Union/Professional Organisation or from your manager. You will also need to agree a plan of action with your Manager to address the problem(s) with realistic and achievable review dat. You may feel unhappy or even threatened by the approach made, but you should expect support from your colleagues in your attempts to put things right.

If you don't know who initiated the concern, ask yourself whether this was because they were afraid to approach you. If they were, are you helping to create the right atmosphere at work?

Finally, this advice is designed to help staff to address problems before these get too serious, and is quite separate from the *Trust's* formal disciplinary and performance management processes.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27th May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
11a Financial Resources 2015/16									
Sponsor and Author(s)									
Paul Mapson									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									

Purpose
To report to the Board on Financial Resources for 2015/16.

The 2015/16 Financial Resources Book has been prepared for consideration and approval by the Trust Board. This follows on from the Board Seminar held on 27th February 2015 and the Resources Report update produced in March and is for Trust Board approval.

The headlines for the 2015/16 Resources position include:-

- A planned deficit of £5.0m before technical items;
- A planned deficit of £6.1m after technical items (such as impairments);
- A planned cash balance at year end of £43.7m;
- A savings programme of £24.4m;
- A capital programme of £34.5m (after action to restore liquidity); and
- A Continuity of Services Risk Rating (CoSRR) of 3. (3 on liquidity and 2 for CSC – average 2.5, rounded to 3).

The Financial Resources Book is a full version of the book normally produced in March each year. It supplements the Draft Financial Resources report in the following respects:

- Additional information on Service Level Agreement analysis – including by work type, division, specialty and commissioner. In addition the quality requirements and contract terms are described in appendices.
- Cost improvement programme – analysed by division, workstream and expense type.
- Workforce plan changes
- Financial duties and financial regime along with a guide to standards and expectations for budget management. This includes guidance for budget managers on controlling and managing budgets and budget flexibility.
- The Scheme of Delegation is also included.
- A glossary of terms is included.

The financial plan is broadly in line with that previously considered by the Trust Board i.e. a planned £5m deficit but significant updates on the position re Service Level Agreements with Commissioners are included – effectively firming up the position.

Divisional Operating Plans now stand at £2m deficit which will be managed as a control total overspend for two Divisions. This is covered by a projected underspend on capital charges of £2m.

It should be noted that the Annual Plan submitted to Monitor in May 2015 is consistent with the position described in the Financial Resources Book.

Recommendation

The Board is recommended to **approve** the Financial Resources Book 2015/16, including the Capital Programme for that year.

Impact Upon Board Assurance Framework

None

Impact Upon Corporate Risk

741 – Risk that Divisions do not achieve the required level of savings;
962 – Risk that the Trust's financial plan / strategy is not delivered ;
2116 – Risk of non delivery of contracted levels of clinical activity.

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		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)**
	22 May				

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27th May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
11b 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 deficit of £0.954m (before technical items) for the first month of the new financial year.

Reporting on the first month's income and expenditure as always is subject to a health warning. In addition, the completion of the Annual Accounts and Audit, completion of the Annual Plan and preparation of the Financial Resources 2015/16 report allow only limited time to review the position for month one.

Two areas of particular concern at this early stage in the financial year are:

- The Trust's Cost Improvement Programme in which the overspending for April is £0.541m, and
- The under performance on clinical activity in April (£0.648m).

Together these two factors result in divisional budgets overspending by £0.670m in the first month of 2015/16. To this must be added 1/12th of the financial plan deficit (£5m) for the year - £0.417m for April. This is mitigated by a proportion of the forecast capital charges savings of £0.167m in April (c£2m for the year).

The results to 30 April are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 3.5).

Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
None

Impact Upon Corporate Risk
741 – Risk that Divisions do not achieve the required level of savings; 962 – Risk that the Trust's financial plan / strategy is not delivered ; 2116 – Risk of non delivery of contracted levels of clinical activity.
Implications (Regulatory/Legal)
An improvement in financial performance is required to ensure the Trust delivers its financial plan for the year.
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)**
	22 May			20 May	

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a deficit of £0.954m (before technical items) for the first month of the new financial year.

Reporting on the first month's income and expenditure as always is subject to a health warning. In addition, the completion of the Annual Accounts and Audit, completion of the Annual Plan and preparation of the Financial Resources 2015/16 report allow only limited time to review the position for month one.

However, there are two areas of particular concern at this stage, namely:

- **The Trust's Cost Improvement Programme** in which the overspending for April is £0.541m. The Programme for 2015/16 is £19.879m. This is net of the £4.476m provided non-recurringly to support the delivery of Divisional Operating Plans. Savings of £1.115m have been realised for April (68% of Plan for the month), a shortfall of £0.527m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £0.294m and a further £0.233m for scheme slippage. The 1/12th phasing adjustment adds a further £14k to the shortfall to date.

- **The under performance on clinical activity in April**. The Trust's financial plan includes a key assumption around the delivery of an increased level of clinical activity in 2015/16. An increase which is a combination of recurring and non-recurring increases to address, for example, RTT waiting times. Whilst Divisions are making progress in developing and implementing their plans to deliver a higher level of activity this has not been reflected in overall activity performance in the first month of the new financial year. Progress will be closely monitored in the forthcoming Operational and Financial review meetings by executive directors with divisional management teams.

Together these two factors result in divisional budgets overspending by £0.670m in the first month of 2015/16. To this must be added 1/12th of the financial plan deficit (£5m) for the year - £0.417m for April. This is mitigated by a proportion of the forecast capital charges savings of £0.167m in April and c£2m for the year.

Linked to the increased income targets is the allocation of additional moneys to Divisions – the contracts transfer – to provide for a corresponding increase, where required, in staffing and non-pay budgets. This is the principal reason for the significant underspending shown against non-pay budgets. It should be noted, however, that divisions will be looking to transfer moneys from their central non-pay reserve (where contract transfer funding is held and variances reported this month) to individual budgets in their respective divisions after sign-off by clinical chairs and divisional directors. This will lead to a change in the headline pay and non-pay variances in the next month's report.

The results to 30 April are reflected in the Trust's Risk Assessment Framework - Continuity of Services Risk Rating of 4 (actual 3.5). Further information on the financial risk rating is given in section 5 below and appendix 4.

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 £0.670m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 30 April
	Fav/(Adv) £'000
Pay	(389)
Non Pay	985
Operating Income	(77)
Income from Activities	(648)
Sub Totals	(129)
Savings Programme	(541)
Totals	**(670)**

Pay budgets have an overspending of £0.389m in the month. The principal areas of overspending are in Medicine, (£66k), Specialised Services (£70k), Surgery, Head and Neck (£0.178m) and Women's and Children's (£0.184m). For the Trust as a whole, bank, agency, overtime and waiting list initiative and other payments totalled £2.523m in April – this equates to 8.7% of pay expenditure in the month.

N**on-pay budgets** show a favourable variance of £0.985m in the month. The underspending relates in the main to the proportion of contract transfer funding and lower activity related expenditure.

Operating Income budgets show an adverse variance of £77k for the month.

Income from Activities shows an adverse variance of £0.648m for April. The principal areas of under achievement in April are Specialised Services (£0.169m), Surgery, Head and Neck (£0.293m) and Women's and Children's (£0.131m). In total, April clinical activity for emergency in-patients and Bone Marrow transplants were above plan with other services provided at less than plan.

The table below summarises the financial performance in April for each of the Trust's management divisions.

	Variance to 30 April
	Fav / (Adv) £'000
Diagnostic and Therapies	(17)
Medicine	(113)
Specialised Services	(60)
Surgery, Head and Neck	(376)
Women's and Children's	(135)
Estates and Facilities	6
Trust HQ	9
Trust Services	16
Totals	**(670)**

2. Savings Programme

A summary of progress against the Savings Programme for 2015/16 is summarised below. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme to 30 April 2015			1/12ths Phasing Adj Fav / (Adv)	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	159	105	(54)	(20)	(74)
Medicine	135	141	6	(50)	(44)
Specialised Services	148	144	(4)	16	12
Surgery, Head and Neck	492	206	(286)	-	(286)
Women's and Children's	422	226	(196)	66	(130)
Estates and Facilities	88	82	(6)	(3)	(9)
Trust HQ	24	35	11	(21)	(10)
Other Services	174	176	2	(2)	-
Totals	**1,642**	**1,115**	**(527)**	**(14)**	**(541)**

3. Income

Contract income was £1.09m lower than plan in April. Activity based contract performance at £33.01m for April is £1.23m less than plan. Contract rewards / penalties at a net income of £10k is £30k less than plan. Income of £5.79m for 'Pass through' payments is £0.17m higher than Plan.

Clinical Income by Worktype	**Plan**	**Actual**	**Variance**
	£'m	£'m	£'m
Activity Based			
Accident & Emergency	1.21	1.20	(0.01)
Emergency Inpatients	5.96	6.23	0.27
Day Cases	2.98	2.88	(0.10)
Elective Inpatients	4.20	3.63	(0.57)
Non-Elective Inpatients	1.29	1.05	(0.24)
Excess Bed days	0.57	0.57	-
Outpatients	6.31	5.89	(0.42)
Bone Marrow Transplants	0.75	0.92	0.17
Critical Care Bed days	3.46	3.36	(0.10)
Other	7.51	7.28	(0.23)
Sub Totals	**34.24**	**33.01**	**(1.23)**
Contract Rewards / Penalties	0.04	0.01	(0.03)
Pass through payments	5.62	5.79	0.17
Totals	**39.90**	**38.81**	**(1.09)**

4. Expenditure

In total, Divisions have overspent by £0.670m in April. The table given in section 1 (page 2) summarises the financial performance for each of the Trust's management divisions. Further analysis of the variances by pay, non-pay and income categories is given at Appendix 2.

Four divisions are red rated[1] for their financial performance for the year to date.

The **Division of Medicine** reports an adverse variance of £113k for April.

The Division has an overspending of £66k on pay this month. Whilst the Division is making further progress on the recruitment of substantive nursing staff it continues to incur high costs in the use of agency staff (£0.279m this month).

Non-pay budgets have a favourable variance of £5k in April. Reserves have been issued to budgets in accordance with the Division's Operating Plan. A further piece of work – to allocate funding associated with the 2015/16 SLA changes – will be completed for the next month's report.

The Division reports a favourable variance of £7k in the month on its Operating Income budgets. Income from Activities has a net under achievement of £15k in the month. April has seen higher than planned emergency in patient activity (£49k) partially offset lower than planned activity in, for example, A & E (£15k) and new out- patient attendances (£22k).

The **Division of Specialised Services** reports an adverse variance on its income and expenditure position of £60k for April.

Pay budgets show an overspending of £70k for the month. Nursing budgets were overspent by £59k in the month with £43k relating to staffing in the Cardiac Intensive Care Unit to meet the needs of high acuity patients.

Non pay budgets show a favourable variance of £167k for the month. The principal factors are corporate support funding and moneys yet to be allocated out to operational budgets for the changes in SLA activity with commissioners.

Income from Activities budgets show an adverse variance of £169k for April. There has been an underperformance on Cardiac Surgery (£183k) in April due to a large volume of high acuity patients who have subsequently required longer lengths of stay. This has resulted in reduced cardiac surgery throughput. Cardiology activity has also underperformed due to temporary (1.5 days) capacity reductions due to X-Ray equipment requiring repair. Bone Marrow Transplants over performed against contract – this is a continuation of good performance in 2014/15.

The Surgery, Head and Neck Division reports an adverse variance on its income and expenditure position of £0.376m for April. This is marginally better than the Division's Operating Plan trajectory for April (£0.408m adverse) but reflects the scale of the further work that is required to deliver an overspending within the control total ceiling of £1.25m.

Pay budgets have overspent by £178k in the month. The need to cover vacant clinical posts with additional sessions, bank and agency staff (with an element of premium costs) together with agency staff nursing providing 1 to 1 nursing are the principal drivers of this adverse position.

Non pay budgets are underspent by £0.292min the month and this is due to the release of $1/12^{th}$ of the corporate funding allocated to the division and a proportion of the contract transfer moneys to offset contract underperformance. Clinical supplies and drugs are underspent by £84k and £50k respectively due to lower than planned activity.

Income from Activities shows a deficit variance of £0.293m. This is due to net under performance against target in Upper GI, Ophthalmology and Oral Surgery together with private patient income and the adverse impact on the division of cardiac surgery under performance. ENT and ITU income was higher than plan in the month.

[1] Division has an annualised cumulative overspending greater than 1% of approved budget.

Operating Income budgets show a favourable variance of £89k. This is primarily due to training income in the Dental School.

The Division of Women's and Children's Services reports an adverse variance on its income and expenditure position of £135k for April.

Pay budgets are overspent by £184k in the month as a result of overspendings in medical / dental (£107k) including £49k for NICU consultant agency cover and £41k of waiting list initiatives together with nursing / midwifery staff overspending by £57k of which £35k was for 1 to 1 mental health agency nursing support.

Non-pay budgets show an underspending of £0.349m in the month this includes unallocated funding linked to the contract transfer which will be issued to operational budgets in month 2.

Income from Activities shows an adverse variance of £131k for the month. This is a reflection of the volatile nature of certain services e.g. paediatric surgery (£127k less than plan.

Income from Operations shows an adverse variance of £39k. This will be corrected in the may report with a transfer from the non pay budget.

The remaining three divisions are green rated.

The **Diagnostic and Therapies Division** reports an overspending for the month of £17k. This includes a £20k adverse phasing adjustment to bring the Division's savings programme on to a 1/12ths basis. Overall the financial performance for April is marginally better than the operating plan projection.

The Facilities and Estates Division reports an underspending for April of £6k.

Trust Headquarters Services reports an underspending of £9k for April.

5. Continuity of Service Risk Rating

The Trust's overall financial risk rating, based on results for the month ending 30 April is 4. The actual financial risk rating is 3.5 which is then rounded to 4 (March 4.0). Further information showing performance to date is given at Appendix 5.

	March	April	Annual Plan 2015/16
Liquidity			
Metric Performance	5.61	6.32	(3.48)
Rating	4	4	3
Capital Service Capacity			
Metric Performance	2.86	1.78	1.55
Rating	4	3	2
Overall Rating	**4**	**4**	**3**

6. Capital Programme

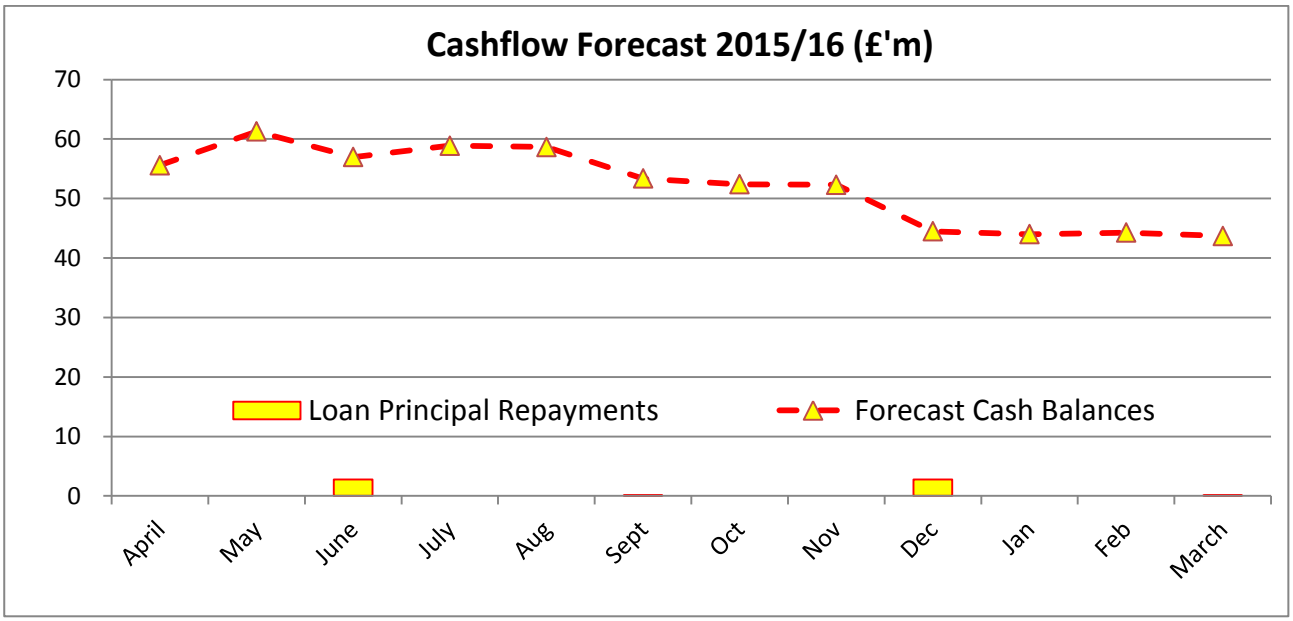
A summary of income and expenditure for the month ending 30 April is given in the table below. Expenditure for the period of £1.024m equates to 60% of the capital expenditure plan to date.

	Annual Plan	Month Ending 30 April		
		Plan	Actual	Variance Favourable / (Adverse)
	£'000	£'000	£'000	£'000
Sources of Funding				
Donations	4,558	-	-	-
Retained Depreciation	20,814	1,704	1,715	11
Sale of Property	1,100	-	-	-
Recovery of VAT	954	-	-	-
Cash balances	7,043	12	(691)	(703)
Total Funding	**34,469**	**1,716**	**1,024**	**(692)**
Expenditure				
Strategic Schemes	(15,862)	(618)	(382)	236
Medical Equipment	(4,257)	(286)	(129)	157
Information Technology	(3,171)	(240)	(173)	67
Estates Replacement	(2,207)	(200)	(190)	10
Operational Capital	(8,972)	(372)	(150)	222
Total Expenditure	**(34,469)**	**(1,716)**	**(1,024)**	**692**

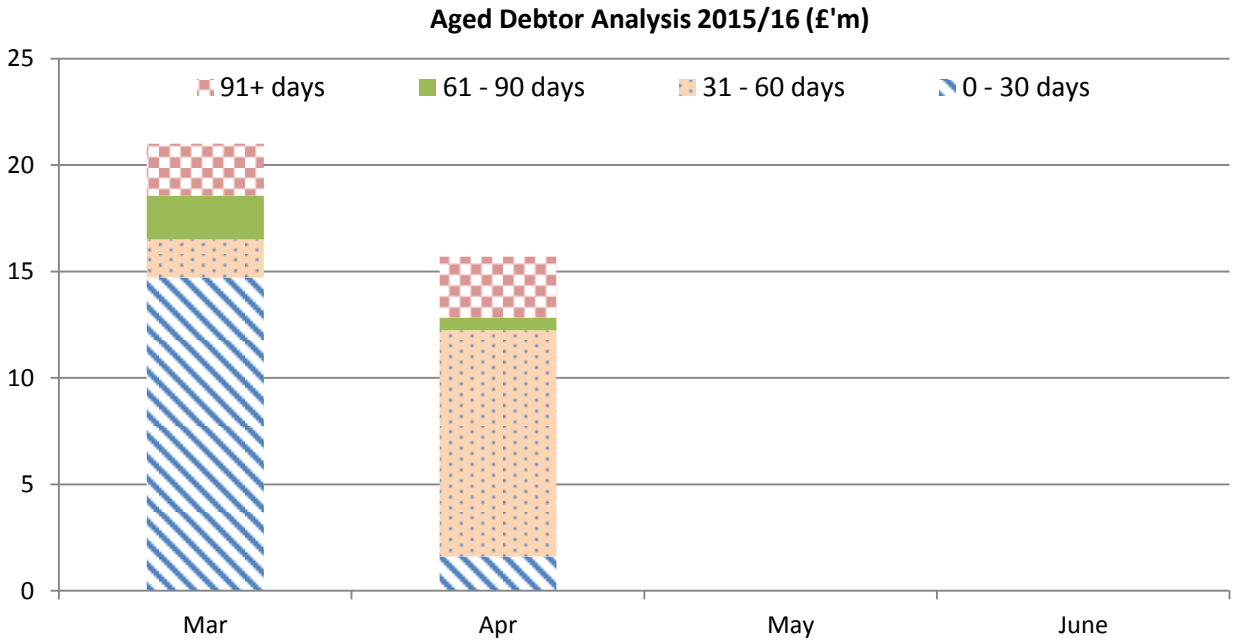
The Finance Committee is provided with further information on this under agenda item 6.

7. Statement of Financial Position (Balance Sheet) and Cashflow

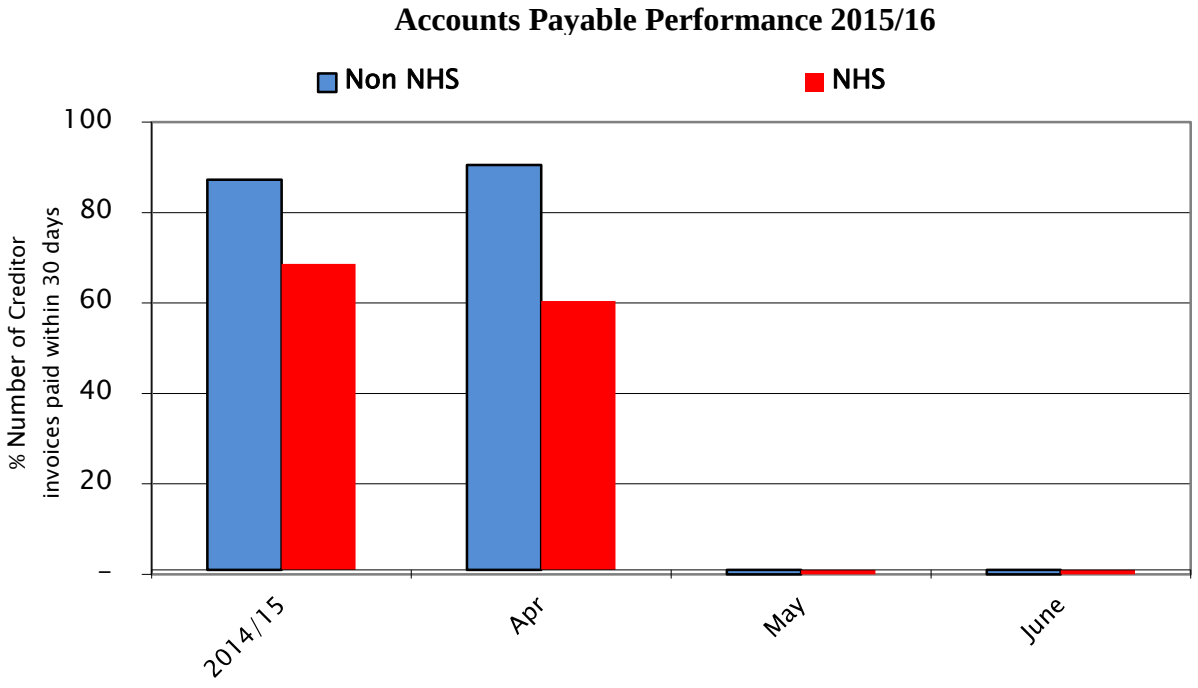
Cash - The Trust held a cash balance of £70.075m as at 30 April. A Cashflow forecast for 2015/16 is shown below.



Debtors - The total value of invoiced debtors has decreased by £5.315m during April to a closing balance of £15.701m. The total amount owing is equivalent to 9.7 debtor days.



Accounts Payable Payments - The Trust aims to pay at least 90% of undisputed invoices within 30 days. In April the Trust achieved 60% and 91% compliance against the Better Payment Practice Code for invoices paid for NHS and Non NHS creditors.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Executive Summary
Appendix 4 – Continuity of Services Risk Rating
Appendix 5 – Key Financial Risks
Appendix 6 – Financial Risk Matrix

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report April 2015 – Summary Income & Expenditure Statement

Approved Budget / Plan 2015/16	Heading	Position as at 30th April		
		Plan	Actual	Variance Fav / (Adv)
£'000		£'000	£'000	£'000
	Income (as per Table I and E 2)			
500,584	From Activities	40,683	39,850	(833)
87,057	Other Operating Income	7,490	7,418	(72)
587,641	**Sub totals income**	**48,173**	**47,268**	**(905)**
	Expenditure			
(331,743)	Staffing	(28,593)	(29,048)	(455)
(203,712)	Supplies and Services	(17,167)	(16,509)	658
(535,455)	**Sub totals expenditure**	**(45,760)**	**(45,557)**	**203**
(24,898)	Reserves	(167)	–	167
27,288	**EBITDA**	**2,246**	**1,711**	**(535)**
	Financing			
(19,680)	Depreciation & Amortisation – Owned	(1,715)	(1,715)	–
244	Interest Receivable	20	20	–
(291)	Interest Payable on Leases	(24)	(27)	(3)
(3,192)	Interest Payable on Loans	(262)	(261)	1
(9,369)	PDC Dividend	(682)	(682)	–
(32,288)	**Sub totals financing**	**(2,663)**	**(2,665)**	**(2)**
(5,000)	**NET SURPLUS / (DEFICIT) before Technical Items**	**(417)**	**(954)**	**(537)**
	Technical Items			
4,558	Donations & Grants (PPE/Intangible Assets)	–	28	28
(4,219)	Impairments	–	–	–
–	Reversal of Impairments	–	–	–
(1,472)	Depreciation & Amortisation – Donated	(123)	(123)	–
(6,133)	**SURPLUS / (DEFICIT) after Technical Items**	**(540)**	**(1,049)**	**(509)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report April 2015 - Divisional Income & Expenditure Statement

Approved Budget / Plan 2015/16	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date
			Pay	Non Pay	Operating Income	Income from Activities	CRES	
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Service Agreements							
490,014	Service Agreements	39,898	-	-	2	(2)	-	-
-	Overheads	(485)	-	-	-	(32)	-	(32)
38,491	NHSE Income	3,208	-	-	-	-	-	-
528,505	**Sub Total Service Agreements**	**42,621**	**-**	**-**	**2**	**(34)**	**-**	**(32)**
	Clinical Divisions							
(50,507)	Diagnostic & Therapies	(4,305)	10	134	(48)	(39)	(74)	(17)
(69,190)	Medicine	(6,141)	(66)	5	7	(15)	(44)	(113)
(83,294)	Specialised Services	(6,831)	(70)	167	-	(169)	12	(60)
(98,969)	Surgery Head & Neck	(8,621)	(178)	292	89	(293)	(286)	(376)
(113,590)	Women's & Children's	(9,776)	(184)	349	(39)	(131)	(130)	(135)
(415,550)	**Sub Total - Clinical Divisions**	**(35,674)**	**(488)**	**947**	**9**	**(647)**	**(522)**	**(701)**
	Corporate Services							
(35,200)	Facilities And Estates	(3,175)	31	(15)	(14)	13	(9)	6
(23,697)	Trust Services	(2,041)	104	(78)	(13)	6	(10)	9
(1,872)	Other	(20)	(36)	131	(59)	(20)	-	16
(60,769)	**Sub Totals - Corporate Services**	**(5,236)**	**99**	**38**	**(86)**	**(1)**	**(19)**	**31**
(476,319)	**Sub Total (Clinical Divisions & Corporate Services)**	**(40,910)**	**(389)**	**985**	**(77)**	**(648)**	**(541)**	**(670)**
(24,898)	Reserves	-	-	167	-	-	-	167
(24,898)	**Sub Total Reserves**	**-**	**-**	**167**	**-**	**-**	**-**	**167**
27,288	**Trust Totals Unprofiled**	**1,711**	**(389)**	**1,152**	**(75)**	**(682**	**(541)**	**(535)**
	Financing							
(19,680)	Depreciation & Amortisation - Owned	(1,715)	-	-	-	-	-	-
244	Interest Receivable	20	-	-	-	-	-	-
(291)	Interest Payable on Leases	(27)	-	(3)	-	-	-	(3)
(3,192)	Interest Payable on Loans	(261)	-	1	-	-	-	1
(9,369)	PDC Dividend	(682)	-	-	-	-	-	-
(32,288)	**Sub Total Financing**	**(2,665)**	**-**	**(2)**	**-**	**-**	**-**	**(2)**
(5,000)	**NET SURPLUS / (DEFICIT) before Technical Items**	**(954)**	**(389)**	**1,150**	**(75)**	**(682)**	**(541)**	**(537)**
	Technical Items							
4,558	Donations & Grants (PPE/Intangible Assets)	28	-	-	28	-	-	28
(4,219)	Impairments	-	-	-	-	-	-	-
(1,472)	Depreciation & Amortisation - Donated	(123)	-	-	-	-	-	-
(1,133)	**Sub Total Technical Items**	**(95)**	**-**	**-**	**28**	**-**	**-**	**28**
(6,133)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**(1,049)**	**(389)**	**1,150**	**(47)**	**(682)**	**(541)**	**(509)**

Appendix 3

<table>
<tr><th>Key Issue</th><th>RAG</th><th>Executive Summary</th><th>Table</th></tr>
<tr><td>Financial Risk Rating</td><td>A</td><td>The deficit before technical items for the month ended 30 April 2015 is £0.954m. The Trust's overall Continuity of Services financial risk rating for the month is 4 (actual score 3.5, March = 4.0).

An Amber RAG rating has been applied because the Trust is adverse to Plan at this, albeit early, stage and capital debt service requirements are likely to be a significant feature of the Trust's CoSRR for the reporting of the first quarter's results.</td><td>Agenda Item 5.1</td></tr>
<tr><td>Service Level Agreement Income and Activity</td><td>A</td><td>Contract income was £1.09m lower than plan in April. Activity based contract performance at £33.01m for April is £1.23m less than plan. Contract rewards / penalties at a net income of £10k is £30k less than plan. Income of £5.79m for 'Pass through' payments is £0.17m higher than Plan.
<table>
<tr><th rowspan="2">Clinical Service</th><th rowspan="2">Activity to 30 April</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>9,799</td><td></td><td></td><td>129</td><td>1.3</td></tr>
<tr><td>Emergency
Non Elective</td><td>3,291
206</td><td>70</td><td>2.2</td><td>
7</td><td>
3.3</td></tr>
<tr><td>Elective
Day Cases</td><td>1,102
4,266</td><td></td><td></td><td>127
290</td><td>10.3
6.4</td></tr>
<tr><td>Outpatient Procedures
New Outpatients
Follow up Outpatients</td><td>6,712
11,849
24,045</td><td></td><td></td><td>201
1,461
1,251</td><td>2.9
11.0
4.9</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</td></tr>
<tr><td>Savings Programme</td><td>R</td><td>The 2015/16 Savings Programme totals £19.879m. Actual savings achieved for April total £1.154m (68% of Plan), a shortfall of £0.527m. The 1/12th Phasing adjustment adds a further £14k to the shortfall to date. The full year effect of 2015/16 schemes is estimated at £16.276m.</td><td>Agenda Item 5.4</td></tr>
<tr><td>Capital</td><td>A</td><td>The capital programme expenditure for 2015/16 is £34.5m. Actual expenditure of £1.024m is £0.692m less than forecast for April.</td><td>Agenda Item 6</td></tr>
</table>

Key Issue	RAG	Executive Summary	Table
Diagnostic & Therapies	G	The Division reports an overspending of £17k for April. This is in line with the Operating Plan shortfall to date of £18k. Further work will be completed for the month 2 reporting round on the allocation of moneys to operational budgets for service developments, cost pressures and increases in SLA activity.	Agenda Item 5.3
Medicine	R	The overspending for April at £113k is marginally better than the projection made in the Division's Operating Plan. The principal areas of overspending are on pay (£66k) and savings (£44k). The Division reports continued progress on nursing staff recruitment. Operational budgets will be updated for the May report to reflect OPP changes.	
Specialised Services	R	The overspending for April is £60k. Pay budgets overspent by £70k/ This was mainly on nursing staff services to maintain staffing levels on the Cardiac ICU. Income from Activities is £169k adverse of which £183k relates to lower than planned cardiac surgery in patient work with capacity limited by a number of high acuity patients requiring longer lengths of stay.	
Surgery, Head & Neck	R	The overspending for April is £0.375m. This is marginally better than the Division's trajectory for April and reflects the scale of the further work required to deliver a position within the proposed control total ceiling of £1.25m for the year. The principal cause of this position is slippage and unidentified schemes on the savings programme (£0.286m) and income from activities being significantly lower than plan (£0.293m). The underspending on the non pay heading includes corporate support and moneys issued to fund additional clinical activity. Work is progressing to allocate funding to operational budgets for next month's report.	
Women's & Children's	R	The overspending for April is £135k. The principal factors are the overspending on pay budgets (£184k), the under performance on income from activities (£131k) and non achievement of savings programme (£130k). The under spending on non pay budgets includes moneys for service developments and SLA changes. A significant proportion of this funding will be allocated to operational budgets for the May report.	
Facitities & Estates	G	The underspending for April is £6k, this is marginally better than the Operating Plan projection to date.	
THQ	G	The underspending for April is £9k, this is marginally better than the Operating Plan projection to date.	
Statement of Financial Position	G	The cash balance on 30 April was £70.1m. The balance on Invoiced Debtors has decreased by £5.315m in the month to £15.701m. The invoiced debtor balance equates to 9.7 debtor days. Creditors and accrual account balances total £80.7m. Invoiced Creditors - payment performance for the month for Non NHS invoices and NHS invoices within 30 days was 91% and 60% respectively. Payment performance by value is 89% for Non NHS and 72% for NHS invoices.	Agenda Item 7

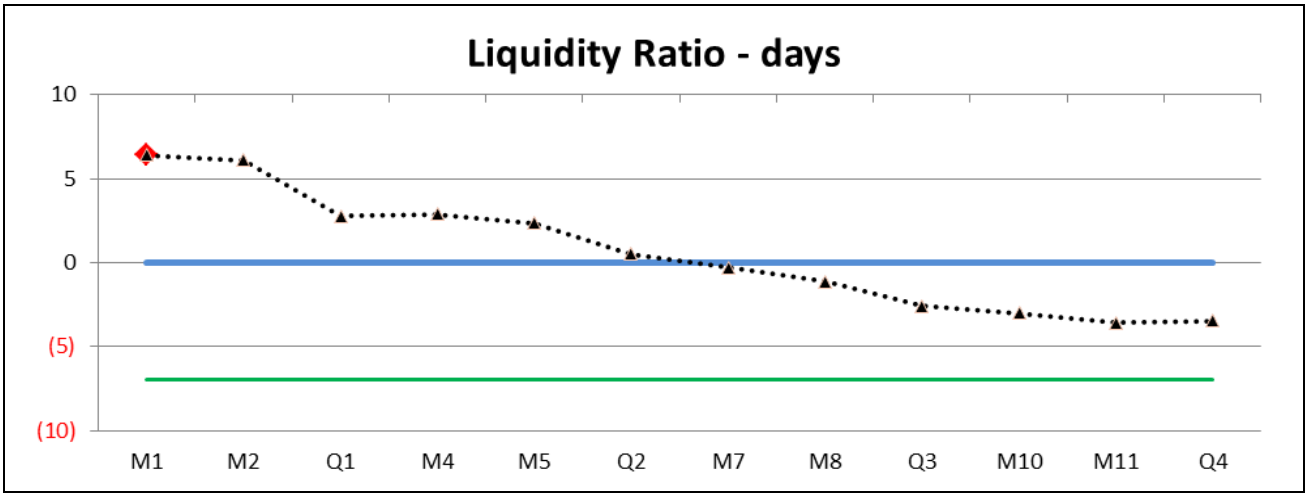
University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 4

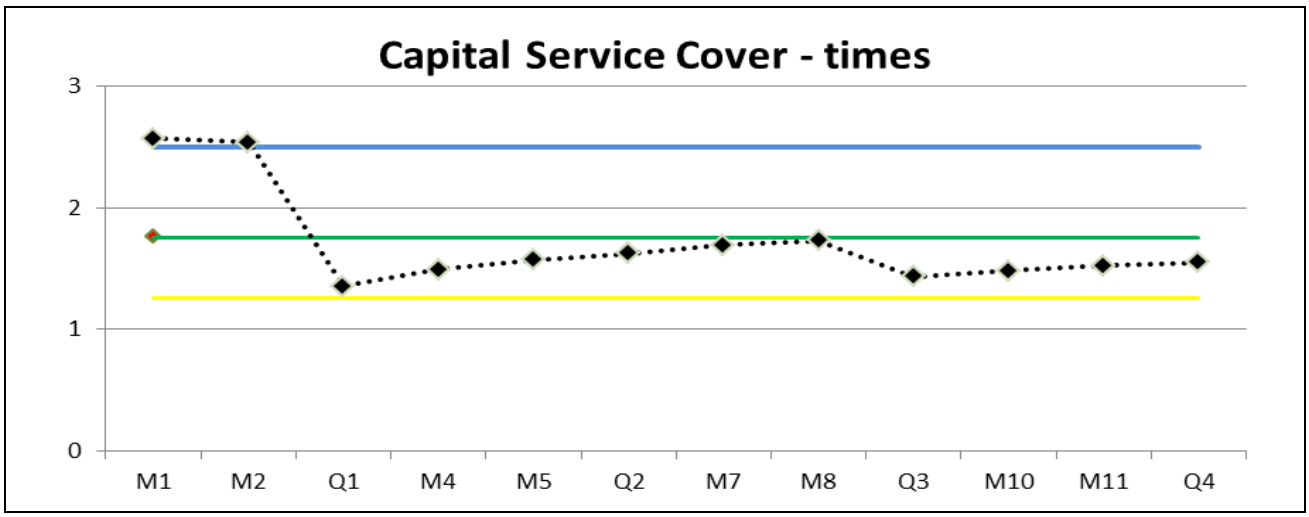
Continuity of Services Risk Rating – April 2015 Performance

The following graphs show performance against the 2 Financial Risk Rating metrics. The 2015/16 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 2015	Plan March 2016	April
Liquidity			
Metric Performance	5.61	(3.48)	6.32
Rating	4	3	4
Capital Service Cover			
Metric Performance	2.86	1.55	1.78
Rating	4	2	3
Overall Rating	**4**	**3**	**4**

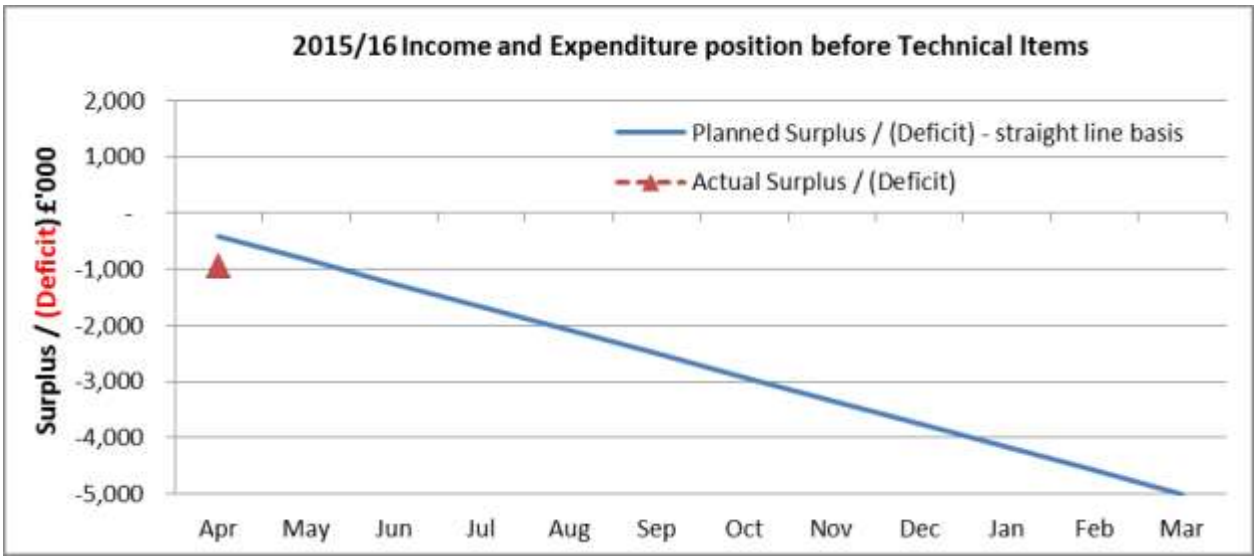


	Plan for Year £'000	April 2015 £'000
Annual Operating Expenses	**555,561**	**546,684**
Current Assets	81,245	102,115
Less Inventories	(10,087)	(11,769)
Less Assets held for Sale	-	-
Current Liabilities	(76,530)	(80,749)
Totals	**(5,372)**	**9,597**
Metric Performance - days	**(3.48)**	**5.56**



	Plan for Year £'000	April 2015 £'000
Revenue available for debt service		
Surplus / (Deficit) after technical items and tax	(6,133)	(1,049)
Impairments	4,219	-
PDC Expense	8,184	682
Depreciation	22,286	1,838
Interest payable on loans and leases	3,396	288
Gain / loss on asset disposals	-	-
Donations / Grants	(4,558)	(28)
Totals	**27,394**	**1,731**
Capital servicing costs		
PDC Dividend	8,184	682
Interest on Borrowings	3,088	261
Interest on Finance Leases	308	27
Loan Principal Repayments	5,834	-
Finance Lease Capital Repayments	269	-
Totals	**17,683**	**970**
Metric Performance - cover	**1.55**	**1.78**

Income and Expenditure Surplus / (Deficit) (before Technical Items)



Key Financial Risks **Appendix 5**

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income from Activities - Clinical Activity									
Current Month									
Plan	(3,034)	(3,967)	(4,332)	(6,175)	(8,145)	(313)	-	(8,279)	(34,245)
Actual	(2,993)	(3,967)	(4,176)	(5,901)	(7,865)	(306)	-	(7,811)	(33,019)
Variance Fav / (Adv)	(41)	-	(156)	(274)	(280)	(7)	-	(468)	(1,226)
Year to date									
Plan	(3,034)	(3,967)	(4,332)	(6,175)	(8,145)	(313)	-	(8,279)	(34,245)
Actual	(2,993)	(3,967)	(4,176)	(5,901)	(7,865)	(306)	-	(7,811)	(33,019)
Variance Fav / (Adv)	(41)	-	(156)	(274)	(280)	(7)	-	(468)	(1,226)

The information shown in this section relates to performance against the assumed level of activity for April for service level agreements with commissioners. SLAs, at the time of writing, had not yet been agreed. Divisional management budgets may have small differences in their planning assumptions to reflect their plans to earn extra income from other sources eg private patients. More detailed information on performance within divisions is provided in divisional reports included under item 5.3 of the Finance Committee agenda.

Income from Activities - Contract Rewards / Penalties									
Current Month									
Plan	-	(28)	(4)	(11)	(3)	-	-	83	37
Actual	-	(35)	(5)	(16)	(4)	-	-	65	5
Variance Fav / (Adv)	-	7	1	5	1	-	-	18	32
Year to date									
Plan	-	(28)	(4)	(11)	(3)	-	-	83	37
Actual	-	(35)	(5)	(16)	(4)	-	-	65	5
Variance Fav / (Adv)	-	7	1	5	1	-	-	18	32

Contract Rewards is included in total under the 'Corporate' heading with Actual matched to Plan at £0.659m. Other information included within the section including 'Corporate' relates to Contract Penalties.

Income / Savings shown as credit values. Expenditure shown as debit values.

Key Financial Risks **Appendix 5**

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost Improvement Programme									
Current Month									
Plan	(179)	(185)	(132)	(492)	(356)	(91)	(45)	(176)	(1,656)
Actual	(105)	(141)	(144)	(206)	(226)	(82)	(35)	(176)	(1,115)
Variance Fav / (Adv)	(74)	(44)	12	(286)	(130)	(9)	(10)	-	(541)
Year to date									
Plan	(179)	(185)	(132)	(492)	(356)	(91)	(45)	(176)	(1,656)
Actual	(105)	(141)	(144)	(206)	(226)	(82)	(35)	(176)	(1,115)
Variance Fav / (Adv)	(74)	(44)	12	(286)	(130)	(9)	(10)	-	(541)

The Trust's Savings Programme for 2015/16 is £19.879m. This is net of the £4.476m provided non-recurringly to support the delivery of Divisional Operating Plans. Savings of £1.115m have been realised for April (68% of Plan for the month), a shortfall of £0.527m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £0.294m and a further £0.233m for scheme slippage. The 1/12th Phasing adjustment adds a further £14k to the adverse position to date.

Agency Staffing Costs

Current Month									
Plan	124	386	239	164	56	41	21	19	1,050
Actual	106	324	205	172	189	47	(3)	-	1,040
Variance Fav / (Adv)	18	62	34	(8)	(133)	(6)	24	19	10
Year to date									
Plan	124	386	239	164	56	41	21	19	1,050
Actual	106	324	205	172	189	47	(3)	-	1,040
Variance Fav / (Adv)	18	62	34	(8)	(133)	(6)	24	19	10

Planned expenditure on agency staff of £8.209m in 2015/16 is £3.337m or 29% lower than expenditure in 2014/15 of £11.546m. In total, agency staff usage was broadly in line with Plan although it can be seen that a significant amount of higher than planned usage in the Women's and Children's Division is offset by lower than plan spend in other areas.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report April 2015 - Risk Matrix

Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk	
		Risk Score	Value			Risk Score	Value
			£'m				£'m
741	Risk that Divisons do not achieve the required level of cost efficiency savings.	High	10.0	Programme Steering Group established. Monthly Divisional reviews to ensure targets are met. Benefits tracked and all schemes risk assessed.	DL	High	10.0
962	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	High	-	Long term financial model and in year monitoring of financial performance by Finance Committee and Trust Board.	PM	High	-
2116	Risk of non delivery of contracted levels of clinical activity.	High	10.0	Robust approach to capacity planning - demand assessment and supply.	DL	High	10.0
1240	Risk of national contract mandates financial penalties on under-performance.	High	3.0	Regular review of performance. RTT fines increasing during the year.	DL	High	2.0
	Risk of Commissioner Income challenges	Medium	3.0	Maintain reviews of data, minmise risk of bad debts	PM	Medium	2.0
1623	Risk to UH Bristol of fraudulent activity.	Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	Low	-

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27th May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
13 Policy Review - Capital Investment Policy									
Sponsor and Author(s)									
Paul Mapson									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To present the Capital Investment Policy to the Board, for ratification, following approval by the Finance Committee.

Key issues to note

The Capital Investment Policy requires annual review and as such it has now been reviewed by the Capital Programme Steering Group (CPSG), Senior Leadership Team (SLT) and the Finance Committee and received approval. The following minor changes were approved:

1. Absolute decision thresholds updated to reflect the Trust's 2015/16 planned turnover of £587m;
2. The removal of the reference to Monitor's "Risk Evaluation for Investment Decisions" document; and
3. An updated Annex 2 to reflect the 2015/16 capital prioritisation process.

Recommendations
The Board is recommended to receive the report for **approval.**
Impact Upon Board Assurance Framework
None.
Impact Upon Corporate Risk
None.
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		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)**
	22 May 2015			20 May 2015	11 May 2015 CPSG

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board
27 May 2015
Item 14

CAPITAL INVESTMENT POLICY

Owner	James Rimmer, Director of Strategy & Transformation	
Version 9	11 May 2015	Submitted to Capital Programme Steering Group – 11 May 2015 Submitted to Senior Leadership Team – 20 May 2015 Submitted to Finance Committee – 22 May 2015 Submitted to Trust Board – 27 May 2015
Version 8	12 May 2014	Submitted to Capital Programme Steering Group – 12 May 2014 Submitted to Senior Leadership Team – 21 May 2014 Submitted to Finance Committee – 23 May 2014 Submitted to Trust Board – 28 May 2014
Version 7	25 March 2013	Submitted to Capital Programme Steering Group – 11 February 2013 Submitted to Finance Committee – 25 March 2013
Version 6	03 February 2012	Submitted to and considered by the Trust Management Executive meeting on 15th February. Submitted to and considered by the Finance Committee meeting on 22nd March. To Trust Board for ratification 27 March.
Version 5	04 February 2011	To be submitted to Trust Executive Group 16 February 2011. To be submitted to Finance Committee to be approved for ratification by Trust Board 23 February 2011. To Trust Board for ratification 28 February 2011.
Version 4	15 October 2010	Submitted to Capital Prioritisation Group 19 October 2010. Submitted to Trust Executive Group 15 December 2010 for consideration.
Version 3	7 December 2009	Submitted to Trust Board for approval 22 December 2009
Version 2	18 July 2008	Submitted to Capital Prioritisation Group 16 July to note. Submitted to Trust Executive Group 23 July 2008 to support. Submitted to Trust Board for approval 29 July 2008
Version 1	24 June 2008	Draft considered at Trust Board 1 July 2008

1. PURPOSE

This policy sets out the governance arrangements for capital investments undertaken by the University Hospitals Bristol NHS Foundation Trust (UH Bristol).

The policy takes into account Monitor's Risk Assessment Framework published 26th March 2015
This policy will be subject to annual review by the Board of Directors.

2. SCOPE

The policy applies to capital investments by UH Bristol regardless of the source of funding. Charitably funded projects must be prepared and managed therefore in accordance with the policy.

Particular consideration is given to capital investments which impact on the Trust's Continuity of Services Risk Rating and are classed as major and / or high-risk accordingly.

The full definition of a major or high-risk investment is given in section 4.2.

3. INVESTMENT PHILOSOPHY AND OBJECTIVES

The Trust will invest in opportunities that are consistent with its purpose, vision and objectives.

The statutory and principal purpose of the Trust is the provision of goods and services for the health service in England.

In fulfilling its core purpose, the Trust's mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. When appropriate, the Trust will make investment decisions in line with the Trust's business and service intent as set out in the Trust's Clinical Strategy, as summarised below:

- Our strategic intent is to provide excellent local, regional and tertiary services, and maximising the mutual benefit to our patients that comes from providing this range of services;
- Our focus for development remains our specialist portfolio and we aim to expand this portfolio where we have the potential to deliver exceptional, affordable healthcare;
- As a University teaching hospital, delivering the benefits that flow from combining teaching, research and care delivery will remain our key advantage. In order to retain this advantage, it is essential that we recruit, develop and retain exceptionally talented and engaged people;
- We will do whatever it takes to deliver exceptional healthcare to the people we serve and this includes working in partnership where it supports delivery of our goals, divesting or our sourcing services that others are better placed to provide and delivering new services where patients will be better served;
- The Trust's role in community service provision will be focused upon supporting our partners to meet the needs of our patients in a timely way, however, where our patients' needs are not being met, the Trust will provide or directly commission such services;
- Our patients – past, present and future - their families, 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.

The investment policy sets out the criteria which will be used by the Trust to evaluate potential major and / or high risk capital investment decisions (defined in section 7).

The Trust will also take into account the financial, strategic, quality, operational, regulatory and reputational risk and benefit when evaluating potential investment decisions.

The Trust will not enter into any project that would result in a breach of the terms of its NHS Provider Licence.

4. CAPITAL BUDGET-SETTING

4.1 THE MEDIUM TERM CAPITAL PROGRAMME

The Board of Directors will approve both the size of the Medium Term Capital Programme, taking account of the approved long term financial plan, and the budget allocation between classes of investment in the programme, which will include at a minimum:

- Major strategic projects;
- Operational capital;
- Medical equipment;
- Other equipment;
- Information Technology; and
- Works replacement.

A capital planning process will be integrated into the annual business planning round which will determine the approval route for each class of investment.

The Trust will move towards establishing a rolling replacement programme for key assets.

Guidance will be made available about the process to be followed for each class of capital investment. The guidance will also make specific reference to the process for rapid preparation and approval of spend-to-save schemes.

4.2 IDENTIFICATION OF MAJOR OR HIGH RISK INVESTMENTS

A proposal will be classed as a major investment if its estimated capital cost including VAT exceeds 1% of Trust's turnover or £5.87million based on the 2015/16 plan of £587million.

High risk investments are defined as:

- Transactions which trigger the requirement to inform Monitor. The criteria for reportable transactions are described in Annex 1; and
- Transactions that may have any one or more of the following characteristics:
    - Significant reputational risk;
    - The potential to destabilise the core business;
    - The creation of material contingent liabilities; and
    - An equity component involving shares.

4.3 BUSINESS CASE REQUIREMENTS

All investment proposals will be supported by relevant business case documentation according to the value of the proposed investment as shown in Table 1 below:

Scheme cost as % of Trust turnover	Documentation required
Up to 0.25%	Short-form business case
Between 0.25% and 1%	Comprehensive business case
More than 1%	Outline Business Case (OBC) and (subject to OBC approval) a Full Business Case (FBC)

Table 1: Thresholds for business case requirement

Any project requiring financial support for production of the appropriate business case prior to scheme approval must have an approved Project Initiation Document.

Detailed templates and guidance for each form of business case is available from the Director of Strategic Development.

4.4 PROJECT SPONSOR

Each capital investment proposal will require Executive Director support who will be the Project Sponsor.

The Project Sponsor is responsible for ensuring that the terms of the Capital Investment Policy and other Trust policies are followed and that business cases follow the appropriate approval route (see section 6).

5. FINANCE COMMITTEE

The Finance Committee will take the role of **capital investment committee** for the purposes of this policy. It will have delegated authority from the Trust Board for:

- Approving the investment and borrowing strategy and associated policies;
- Setting performance benchmarks and monitoring investment performance;
- Reviewing and revising the Capital Investment Policy on an annual basis for Board approval;
- Obtaining assurance that there is compliance throughout the Trust with the Capital Investment Policy;
- Approving capital investments according to the thresholds outlined in section 6.5 including ensuring that the Trust has the legal authority to enter into a particular investment; and
- Approving Project Initiation Documents for all schemes.

6. APPROVAL ROUTE

6.1 BOARD OF DIRECTORS

The Board will provide oversight of the Finance Committee. It will have the final decision over all major schemes (greater than 1% of the Trust's turnover) and high risk investments as defined in this policy.

The Board will approve the Capital Investment Policy on an annual basis.

6.2 FINANCE COMMITTEE

The Finance Committee will have delegated authority to approve business cases with a value greater than 0.5% and up to and including 1% of Trust turnover, which do not qualify as high risk investments.

It will report its approvals to the Trust Board including an account of the cumulative value of schemes approved in-year.

It will also consider all business cases classed as major and / or high risk and make recommendations for approval or rejection to the Board.

6.3 SENIOR LEADERSHIP TEAM

The Senior Leadership Team will have delegated authority to approve investments greater than 0.25% and up to and including 0.5% of turnover, which do not qualify as high risk investments.

It will report its approvals to the Finance Committee, including an account of the cumulative value of schemes approved in-year.

It will also consider schemes between 0.25% and 1.0% of Trust turnover and which do not qualify as high risk investments. It will make recommendations about these proposals to the Finance Committee.

The Senior Leadership Team may choose to delegate approval of capital investments to the Capital Programme Steering Group.

6.4 CAPITAL PROGRAMME STEERING GROUP

The Capital Programme Steering Group will report to the Senior Leadership Team.

The Group will be responsible for co-ordinating the capital planning process and issuing internal guidance, ensuring that the appropriate initiation and risk assessment documentation is in place for proposed schemes. It will make recommendations about proposals to the Senior Leadership Team and the Finance Committee in line with their respective approval rights. These recommendations will cover both approval of projects and the programming of related expenditure.

The Group will approve capital investments up to and including 0.25% and will report its approvals to the Senior Leadership Team.

The Capital Programme Steering Group will report performance against the capital programme both to the Finance Committee and the Senior Leadership Team.

6.5 SUMMARY

Table 2 shows the thresholds used to determine the business case requirement for schemes which fall within the definition of high risk and / or the definition of a major scheme (see section 4.2). It should be noted that the approval route is the same with all high risk and / or major schemes:

Threshold		Business Case format	Capital Programme Steering Group	Senior Leadership Team	Finance Committee	Trust Board	Council of Governors
Percentage of turnover %	Capital expenditure including VAT* £m						
>1%	>£5.87m	OBC + FBC	✓	✓	✓	✓	✓
>0.25% <=1%	>£1.47m <= £5.87m	Comprehensive					
<=0.25%	<=£1.47m	Short-form					

Table 2: Business case requirement and approval route (high risk or major capital schemes)

For schemes that fall outside of the definition of high risk and / or involve capital expenditure totalling 1% or less than the Trust's turnover of £587million, table 3 shows the thresholds, business case requirement and approval route:

Threshold		Business Case form	Capital Programme Steering Group	Senior Leadership Team	Finance Committee	Trust Board
Percentage of turnover	Capital expenditure including VAT* £m					
>0.5% <=1%	>£2.94m <= £5.87m	Comprehensive	✓	✓	✓	
>0.25% <=0.5%	>£1.47m <= £2.94m	Comprehensive	✓	✓		
<=0.25%	<=£1.47m	Short-form	✓			

Table 3: Business case requirement and approval route (all other)

7. EVALUATION

Business cases will be evaluated against explicit financial and non-financial criteria outlined below.

7.1 FINANCIAL CRITERIA

Proposals which are not classed as a major investment decision will be assessed for scheme affordability.

Business cases for major capital investment (over 1% of turnover) will be expected to demonstrate as a minimum a neutral recurring revenue position including financing costs as follows:

- 3.5% if internally funded or financed through Public Dividend Capital; or
- at the opportunity cost to the Trust of interest, if financed through borrowing.

The Board may choose to waive the requirement to deliver a neutral recurring revenue position where it deems that exceptional circumstances apply. Such circumstances may include mitigation against significant strategic, statutory, regulatory, operational or reputation risks or a desired investment in a quality improvement.

In this case, the Board will make the final investment decision itself, including explicit approval of the cross-subsidy arrangements which should apply to the capital investment in question.

7.2 NON-FINANCIAL CRITERIA

The following non-financial criteria will be used to evaluate all capital investment proposals.

Strategic Fit – the extent to which the proposed investment is consistent with the Trust's Strategy and strategic objectives.

Magnitude / Scope – the scale of the proposed investment and the scope of the potential benefit.

Improving Quality – the extent to which the proposed investment delivers UH Bristol's annual quality objectives and improves patient care.

Risk Mitigation - the extent to which the proposed investment addresses existing or anticipated strategic, financial, operational, regulatory and reputational risks.

Weightings will be applied to the scoring of investments against these criteria. The weightings will be formally agreed by the Trust Board as part of the annual review of the Capital Investment Policy. The weightings are shown in Table 4 below:

Criterion	Weighting
Strategic fit	25%
Magnitude / Scope of Benefit	25%
Improving Quality	25%
Risk mitigation	25%

Table 4: Thresholds for business case requirement

A scoring template for the non-financial appraisal of an investment is attached at Annex 2.

8. RISK MANAGEMENT

The non-financial evaluation criteria include risk mitigation and therefore take into account the risk of not entering into a proposed investment.

The Trust will also take into account the risk and return (both financial and non-financial) of making a proposed capital investment. The risks will be fully identified and assessed according to the Trust's standard risk assessment tool. A sample due diligence checklist is attached at Annex 3.

The Trust will seek to quantify the risks of a proposed investment in financial terms wherever possible. Business cases for major capital investment will include a quantified risk and mitigation assessment.

The Trust will actively monitor the performance of its investments and ensure that adequate risk mitigation is in place.

9. APPENDICES

Annex 1 – Thresholds for reporting investments to Monitor.
Annex 2 – Scoring Matrix for non-financial evaluation for an investment.
Annex 3 – Simple due diligence checklist to inform risk assessment.

THRESHOLDS FOR REPORTING INVESTMENTS OR DIVESTMENTS TO MONITOR

Source: *Risk Assessment Framework*, Monitor, March 2015

If a transaction meets any one of the criteria below, it must be reported to Monitor.

Ratio	Description	UK Healthcare	Non Healthcare
Assets	The gross assets* subject to the transaction divided by the gross assets of the foundation trust	> 10 %	> 5 %
Income	The income attributable to: • the assets; or • the contract associated with the transaction divided by the income of the foundation trust	> 10 %	> 5 %
Consideration to total NHS FT capital	The gross capital** or consideration associated with the transaction divided by the total capital*** of the foundation trust following completion.	> 10 %	> 5 %

* Gross assets are the total of fixed assets and current assets.
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets.
*** Total capital of the Foundation Trust equals tax payers equity.

Small, Material or Significant Transaction

Transactions which do not meet the reporting requirements set out above are classified as "small" transactions. All reportable transactions will be classified as either "material" or "significant" by Monitor. Monitor will classify a transaction as significant, and subject to a detailed review, if the transaction meets one of the following criteria:

- A relative size of greater than 40% in any of the tests set out above;
- A relative size of between 25% and 40% of the tests set out above and an additional risk factor has been identified by Monitor and is considered relevant;
- A relative size of between 10% and 25% of the tests set out above and in Monitor's view, one or more major risk or more than one other risk has been identified by Monitor and is considered re relevant.

A non-exhaustive list of examples of risk factors are set out below to provide an indication of what Monitor may consider to be a major risk or otherwise.

Risk factor	Example of major risk	Example of other risk
Leverage	Capital servicing capacity of the enlarged organisation is <1.75 (as defined in the *Risk Assessment Framework*)	Capital servicing capacity of the enlarged organisation is <2.5 (as defined in the *Risk Assessment Framework*)
Acquirer's experience of services provided by target	A significant change in scope of activity of acquirer	A minor change in scope of activity of acquirer
Acquirer quality	Governance at the acquirer is rated "red" or subject to narrative with a "formal investigation" underway	Governance at the acquirer is subject to narrative description of some concerns
Acquirer financial	Continuity of services risk rating of ≤2 in the acquirer	Continuity of services risk rating of 2*/3 in the acquirer
Target quality	Target is rated "inadequate" by CQC	Target is rated "requires improvement" by CQC
Target financial	Target has significant current and/or historical deficits	Target has minor current and/or historical deficits

Annex 2

SCORING MATRIX FOR NON-FINANCIAL EVALUATION OF MAJOR MEDICAL AND OPERATIONAL CAPITAL INVESTMENTS

SCORE	STRATEGY FIT		IMPROVING QUALITY	RISK MITIGATION
	Strategic Fit	**Magnitude / Scope of Benefit**	**Delivery of UH Bristol's Quality Priorities**	
5	Clear evidence that the case **delivers a specific & tangible** element of the Trust's Strategy benefit and provides a specific and tangible benefit across the Bristol / South West Health economy and delivers an income	Impacts on > 10,000	Clear evidence that the case **delivers a specific & tangible** Trust wide safety priority	**Extreme** risk score (15 to 25) as per Trust's Risk Assessment Matrix
4	Clear evidence that the case **delivers a specific & tangible** element of the Trust's Strategy and delivers an income benefit	impacts >5000 < 10,000	Clear evidence that the case **delivers a specific & tangible** Divisional safety priority	**High** risk score (8-12) as per Trust's Risk Assessment Matrix
3	Clear evidence that the case **delivers** a **specific & tangible** element of the Trust's Strategy	Impacts >1,000 < 5,000	Clear evidence that the case **delivers a specific & tangible** Trust wide quality priority	
2	Does not fit directly with strategic intentions, but can **demonstrate an income and patient benefit** not previously captured in the Trust Strategy	Impacts on > 250 < 1,000	Clear evidence that the case **delivers a specific & tangible** Divisional quality priority	**Moderate** risk score (4 to 6) as per Trust's Risk Assessment Matrix
1	Evidence that the scheme **supports delivery** of the Trust Mission and Vision	Impacts on less than 250 patients	Clear evidence that the case influences the Strategy on improving patient care	**Low** risk score (1 to 3) as per Trust's Risk Assessment Matrix
0	**No impact** on delivering the Trust's Strategy & Mission or any benefit to income	**No impact** on patients	**No impact** on patient care improvements	**No risk**, score 0
Scores				
Weighting	*x 25*	*X 25*	*x 25*	*x 25*
Weighted scores				
Total score				

IT SHOULD BE NOTED THAT SOME INVESTMENTS WILL BE FUNDED WITHOUT RECOURSE TO THIS MATRIX. THESE WILL BE UNAVOIDABLE INVESTMENTS AND EXCEPTIONAL IN THEIR NATURE.

ANNEX 3

DUE DILIGENCE CHECKLIST TO INFORM RISK ASSESSMENT

Typical due diligence items

Type of process	Area	Example Items
Financial and commercial due diligence	▪ Strategy	▪ Rationale for how proposed investment will deliver value ▪ Strategic and business plans ▪ Business strengths and weaknesses ▪ Competitive dynamics
	▪ Finance	▪ Historical normalised earnings ▪ Most recent 5-year projection ▪ Key assumptions and sensitivity analysis ▪ Working capital strategy
	▪ Operations and manufacturing	▪ Business economics ▪ Customer and supplier relationships/contracts
	▪ Organisation and Management	▪ Management capabilities ▪ Organisation structure ▪ Systems integration ▪ Corporate culture and style
	▪ Research and development	▪ Key research efforts ▪ Research relationships and contracts
Tax and accounting due diligence	▪ Information technology	▪ Security and contingency plans ▪ Types of systems ▪ Outsourced services
	▪ Accounting	▪ Financial reporting systems ▪ Contribution margin ▪ Depreciation schedules
	▪ Finance	▪ Capital structure ▪ Covenants triggered by deal
	▪ Tax	▪ Tax liabilities from non-paid taxes ▪ Tax reserve
	▪ Insurance	▪ Claims history and policy status ▪ Contingent liabilities
Legal due diligence	▪ Corporate structure	▪ Shares outstanding and shareholder interests (if relevant) ▪ Legal entities
	▪ Legal	▪ Indemnification provisions ▪ Outstanding and pending limitation ▪ Licences, patents and trademarks
	▪ Labour	▪ Employment contracts and agreements ▪ Pension provisions and funding levels ▪ Non-paid benefits
	▪ Anti-competitive	▪ Potential anti-trust liabilities ▪ Potential remedies/outcomes
	▪ Environment	▪ Existing and future liabilities ▪ Successor liability ▪ Remediation plans

This is not an exhaustive list of areas to be covered within due diligence. The scope of due diligence will vary depending on the proposed transaction and should be discussed and agreed with the NHS foundation trust's professional advisers.

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University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 27th May 2015 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
Treasury Management Policy									
Sponsor and Author(s)									
Paul Mapson									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff	**x**	Public	

Executive Summary

The Trust's Treasury Management Policy provides the framework for the Trust's treasury management activities and defines its objectives, attitude to risk, responsibilities, and policies. The policy is required to be regularly reviewed and formally approved by the Trust Board.

The policy was last reviewed and amended in February 2014. A review of the policy a year later has resulted in no required changes.

It is proposed that the Treasury Management Policy is kept under review over the next twelve months and any amendments required will be identified and reported to the Finance Committee for approval at Trust Board.

A copy of the Treasury Management Policy is not attached in order to reduce printing resources but is available on FinWeb* and will be sent to Board members on request.

Recommendations

The Board is recommended to note that the Treasury Management Policy remains unchanged and approve the ongoing review by the Finance department.

Impact Upon Board Assurance Framework
None
Impact Upon Corporate Risk
None
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		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**
	23 February				

* *FinWeb is the Trust's intranet based central source of financial information.*

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									
16. 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

21 May 2015

ID Governor Name

120 Sue Milestone **Title: Inpatient Facilities**

Query **01/05/2015**

Please can more detail be provided about access to communications and entertainment devices available to inpatient's across the Trust; what is the standard set up and what types of items have been provided with charitable funding to enhance patient experience?

Response **01/05/2015**

Pending reponse from Executive Lead.

Status: *Assigned to Executive Lead* ***Executive Lead:*** *Director of Finance*

119 Graham Briscoe **Title: Agency Rates**

Query **24/04/2015**

Recent media reports (Sunday Times 5/4/15) note NHS reliance upon Agency Staff for surgeons, doctors and nurses, with very high rates being reported, especially over weekends. For example: £3,681 for a 24 hour shift by a surgeon, £2,700 for an anaesthetist to be on duty 24 hours and £2,200 for a single shift for an agency nurse . Please can the Trust provide the cost of the highest shift, or 24 hour, agency rates paid and what staff group these rates applied to?

Response **24/04/2015**

Sent to Exec, pending response.

Status: *Assigned to Executive Lead* ***Executive Lead:*** *Director of Human Resources and Organisational Development*

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**

We have a number of systems in place to ensure that we have sufficient numbers of serviceable equipment available and in use by trained staff:

•Currently the common infusion pumps are provided by a manufacturer free of charge and maintained by them. We pay for the giving sets. There are sufficient numbers and wards can ask for more as required.
•Clinical staff are trained on induction and when introduced to new equipment on the ward or in the theatre. They keep comprehensive records of training. The training matrices are regularly audited.
•High risk equipment such as infusion pumps have defined competencies for staff which they must pass before being allowed to use the pumps.
•All medical devices are on an asset register and assigned to wards as required. We have a number of different infusion pumps for different purposes.
•Other specialist pumps are serviced by MEMO Clinical Engineering and we control & monitor the required services through our asset management software
•Both the suppliers and MEMO Clinical Engineering are regularly assessed for quality of service by BSI or other registered assessors
•Finally, incidents where a medical device is not available is logged onto our risk management system and these are monitored for trends.

The CQC visit in September checked on all these areas and were satisfied with our service.

Status: *Awaiting Governor Response* ***Executive Lead:*** *Medical Director*

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* ***Executive Lead:*** *Chief Operating Officer*

ID	Governor Name		
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 **28/04/2015**

The definition of a serious incident and a never event are nationally defined.

A serious incident is defined as an incident (whether by commission or omission) which occurred in relation to care resulting in:
1.An unexpected or avoidable death or severe harm to one or more patients, staff, visitors, members of the public.
2.Severe harm is, for example, where the outcome requires lifesaving intervention or major medical/surgical intervention or will shorten life expectancy or result in prolonged pain or psychological harm; including falls resulting in major fractures and grade 3 and 4 pressure ulcers, hospital acquired venous thrombo- embolism when the outcome is life threatening
3.“Never events” are, by definition, serious patient safety incidents that should never happen. The list of designated never events is reviewed on an annual basis and can be found here Never Event Never events are automatically designated as serious incidents.
4.A scenario that prevents or threatens to prevent the Trust’s ability to continue to deliver healthcare services e.g. actual or potential loss or damage to property, reputation or the environment, or a serious IT systems failure. This includes incidents where there is compromised capacity to continue to deliver services across the Local Health Economy.
5.Allegations, or incidents, of physical abuse and or sexual assault or abuse
6.Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation
7.An Information Governance Incident that is graded according to DH criteria at Level 2 or above Checklist for reporting, managing and investigating information governance serious untoward incidents : Department of Health - Publications
8.Serious outbreaks of communicable diseases
9.A reportable serious incident that occurred in relation to English NHS national screening programmes
10.A reportable serious incident as defined in the Human Tissue Authority’s guidance
11.Further guidance is available in the Information resource to support the reporting of Serious Incidents
12.Suspension of maternity services in accordance with guidance agreed with commissioners in Appendix F. See also Maternity Services Risk and Assurance Strategy for additional information regarding maternity services incident trigger list
13.This list is not exhaustive and staff can refer any incident they think may be a serious incident for consideration as a serious incident

A new National Serious Incident Framework for 2015 has just been published which contains some clarification and changes from the previous versions, but the definitions remain largely the same. We will update our local policy accordingly.

Never events are defined in NHS England’s Never Event policy framework and list. A new policy framework 2015 and list for 2015/16 have just been issued by NHS England which contain some clarification and changes from the previous versions.

Until April 2015 the response timeframe for a serious investigation was 45 days, 60 days or 6 months depending on the level of serious incident.

From April 2015 it is 60 days but a longer time frame can be negotiated with commissioners for externally independent and complex investigations.

Status: *Awaiting Governor Response* ***Executive Lead:*** *Chief Nurse*