University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for the Meeting of the Trust Board of Directors held in Public to be held on 30 July 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 June 2015	Chairman	3
4. Matters Arising (Action log) To review the status of actions agreed	Chairman	14
5. Chief Executive's Report To receive the report to note	Chief Executive	15
Delivering Best Care and Improving Patient Flow		
6. Patient Experience Story To receive the Patient Experience Story for review	Chief Nurse	19
7. Quality and Outcomes Committee Chair's report To receive the report for assurance	Quality & Outcomes Committee Chair	To follow
8. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer/Deputy CEO	24
9. Transforming Care Report To receive the report for assurance	Chief Executive	68
10. Complaints Annual Report 2014/15 To receive the reports for assurance	Chief Nurse	74
11. National In-Patient Survey Results 2014 To receive the report for assurance	Chief Nurse	100
12. Speaking Out Policy To approve the policy	Director of Workforce & OD	138
Building Capability		
13. Annual Revalidation Report 2014/15 To receive the report for assurance	Medical Director	152
Delivering Best Value		
14. Finance Committee Chair's Report To receive the report for assurance	Finance Committee Chair	To follow

15. Finance Report To receive the report for assurance	Director of Finance & Information	162
Renewing our Hospitals		
16. Quarterly Capital Projects Status Report To receive the report for assurance	Chief Operating Officer/Deputy CEO	183
Leading in Partnership		
17. Clinical Research Network Annual Plan 2015/16 To approve the Annual Plan 2015/16	Medical Director	187
Compliance, Regulation and Governance		
18. Q1 Risk Assessment Framework Declaration Report To approve the report prior to Monitor submission	Chief Executive	217
19. Board Assurance Framework To receive the Board Assurance Framework for assurance	Chief Executive	240
20. Corporate Risk Register To receive the Corporate Risk Register for assurance	Chief Executive	248
21. Board of Directors Register of Interests To receive the report for assurance	Trust Secretary	254
Information		
22. Register of Seals To receive the register for information	Trust Secretary	259
23. West of England Academic Health Science Network Board report June 2015 To receive the report for information	Chief Executive	263
24. Governors' Log of Communications To receive the Governors' log to note	Chairman	268
25. 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 September 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 June 2015 at 11:00am, Conference Room, Trust Head Quarters, Marlborough Street, BS1 3NU

Board members present:
Emma Woollett – Vice Chair and meeting chair
Robert Woolley – Chief Executive
Deborah Lee – Chief Operating Officer/Deputy Chief Executive
Paul Mapson – Director of Finance & Information
James Rimmer – Director of Strategy and Transformation
Carolyn Mills – Chief Nurse
Sue Donaldson – Director of Workforce and Organisational Development
Sean O'Kelly – Medical Director
David Armstrong – Non-executive Director
Julian Dennis – Non-executive Director
John Moore – Non-executive Director
Guy Orpen – Non-executive Director
Lisa Gardner – Non-executive Director
Jill Youds – Non-executive Director

Present or in attendance:
Debbie Henderson – Trust Secretary
David Wynick – Joint Director of Research UH Bristol and NBT
Diana Benton – Head of Research and Innovation
Fiona Reid – Head of Communications
Amanda Saunders – Head of Membership and Governance
Kay Collings – Head of Education
Sarah Murch – Membership & Governance Administrator (Minutes)
Clive Hamilton – Public Governor
Florene Jordan – Staff Governor
Ray Phipps – Patient Governor
John Steeds – Patient Governor
Benjamin Trumper – Lead Governor/ Staff Governor
Pam Yabsley – Patient Governor
Anne Skinner – Patient Governor
Bob Skinner – Foundation Trust Member
Amanda Callard – Above and Beyond
Nerys Beynon – Member of the public

40/06/15 Chairman's Introduction and Apologies
Emma Woollett, Vice Chair, chaired the meeting in the absence of John Savage, Chairman. Apologies for absence were received from John Savage (Chairman) and Alison Ryan (Non-executive Director).

41/06/15 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. Guy Orpen noted that there were two items (Items 9 and 16) which involved interactions between the Trust and the

University of Bristol. Guy therefore, declared an interest as an executive of the University of Bristol. No further declarations of interest were received.

42/06/15 Minutes and Actions from Previous Meeting
The Board considered the minutes of the meeting held in public on 27th May 2015. It was agreed to add to the list of attendees Clive Hamilton (Public Governor), Ray Phipps (Patient Governor), Sean O'Kelly (Medical Director) and John Steeds (Patient Governor), and to change the word 'a' to 'of' in the first line of Item 32/05/15. Subject to these amendments, it was:

RESOLVED:
- **That the minutes of the meeting held 27th May 2015 be agreed as an accurate record of proceedings**

43/06/15 Matters Arising
Matters arising and actions completed were noted by the Board. It was noted that Actions 5 and 6 would be reported to the Trust Board meeting in July. Action 4 was noted as complete and would be reported under Item 16 (Estates Strategy).

44/06/15 Chief Executive Report
The Board had received a written report of the main business conducted by the Senior Leadership Team in June 2015. Robert Woolley provided a verbal update on the following recent developments affecting UH Bristol.

There had been several recent national announcements in relation to controlling spend in the health service, particularly around efficiencies in procurement and agency staff. There had also been interest from the Department of Health in the level of pay of very senior managers, in response to which, the Trust Board's Remuneration and Nomination Committee would reviewing its own policies.

Monitor had restored the Trust's Governance Risk Rating to Green following a significant period in which the Trust had been under review. Monitor confirmed that they had received a sufficient level of assurance in line with the Trust's recovery trajectories.

NHS England had announced changes to the Referral to Treatment Time (RTT) targets that Trusts were expected to achieve, effectively withdrawing both the admitted and the non-admitted RTT target. The aim would be to focus attention on a patient's right within the NHS Constitution to receive treatment within 18 weeks from referral, as it had been judged that other targets had distorted the focus. In response to a query from Clive Hamilton, Robert advised that while Monitor would no longer hold the Trust to account in relation to the targets, there would be little change in practice, as the Trust would still maintain its focus on achieving both the admitted and non-admitted targets as stages in the 18-week pathway.

NHS England had invited organisations and partnerships to apply to become 'vanguard' sites under the 5-Year Forward View programme. Vanguard sites would lead the development of new care delivery models at a local level. Commissioners had been seeking to express an interest in a vanguard proposition for urgent and emergency care services for Bristol, North Somerset, Somerset and South Gloucestershire. The Trust has also considered submission of an expression of interest jointly with North Bristol Trust in July in a further Vanguard programme to sustain and improve local acute care. This would consider how local services could be aligned and explore the potential for sharing of support functions, or joint working

around specialist services. Reports of the progress of these initiatives would be received at a future meeting.

Robert brought to the Board's attention the positive news that UH Bristol had won a CHKS top hospital award. The redevelopment of the Bristol Royal Infirmary and the Bristol Haematology and Oncology Centre (BHOC) had won a major award from the Chartered Institute of Building and Construction Excellence South West as building project of the year. Also, BHOC had been designated one of 17 centres to take forward a new radiotherapy programme by NHS England.

The Independent Review of Congenital Children's Heart Services in Bristol had entered a new phase. Clinical experts had been recruited, clinical reviews had taken place, and the Care Quality Commission had implemented a case note review in parallel. Evidence sessions had commenced, following which the Review would also gather the views of families and children who had used the service.

Jill Youds referred to the Senior Leadership Team's consideration of the revised policy for the managements of external visits, inspections and accreditations and its new policy for the management and co-ordination of responses to national reviews and reports. Debbie Henderson clarified that these policies related primarily to processes and that the Trust Board would receive a register of corporate action plans on a bi-annual basis. It was:

RESOLVED:

- **That the Board receive the report from the Chief Executive**

45/06/15 Patient Experience Story

Carolyn Mills introduced the Patient Story which focussed on the personal experience of a member of Trust staff who had been admitted to the Bristol Royal Infirmary for elective surgery. The experience had generally been a positive one, though the patient had stayed overnight in the recovery room as there had been no surgical ward beds available. This had not resulted in excellent experience in relation to noise levels at night. Trust Board members welcomed the news that the Division had since changed their escalation procedures, and the recovery room was no longer used in this way.

A further point of interest in the story was that the patient had received information about the surgery in a way that was appropriate for her. While recognising that patients all required a different level of detail, Robert Woolley emphasised the importance of giving patients appropriate information to ensure that the consent process was as effective as possible.

James Rimmer was heartened by the patient's assertion that she trusted Trust staff and would not have considered seeking treatment elsewhere. It was:

RESOLVED:

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

46/06/15 Quality and Performance Report

Overall Performance

Deborah Lee introduced the monthly report which reviewed the Trust's performance in relation to Quality, Workforce and Access standards. Three indicators had improved over the period in question: theatre productivity; savings plan achievement; and staff sickness.

Challenges remained in a number of areas, including Emergency Department waits, the 62-day GP and screening cancer standards, and referral-to-treatment times. In relation to the latter, the Trust had continued to make good progress and was expected to achieve the recovery trajectory agreed with commissioners and regulators. There was some concern about dental specialties, which had not delivered all activity, resulting in heightened oversight to deliver a recovery plan. Deborah assured the Board that this would not compromise the Trust's plan to return to compliance in respect of residual RTT standards from October.

Quality and Outcomes Committee Chair's Report

In the absence of Alison Ryan (Committee Chair), Julian Dennis presented the report for members of the Board on the business of the Quality and Outcomes Committee meeting held on 26 June. He summarised the key issues that the Committee had discussed, and noted that the Committee had in particular wished to bring the following issues to the attention of the Trust Board:

- The risk to delivery of the 4-hour A&E standard due to current re-tendering of domiciliary care services by Bristol City Council.

- The risk that the current organisational Board and substructure did not support the level of detailed discussion on workforce required to ensure an appropriate level of assurance to the Board.

Lisa Gardner referred to the re-tendering of domiciliary care services by Bristol City Council and enquired as to the measures in place to mitigate the risk to delivery of the 4-hour A&E standard. James Rimmer, Director of Strategy and Transformation, explained that as a result of the re-tendering, new contracts were due to start with a number of providers. The key risk related to the transition period, but James provided assurance to the Board that mitigation steps were in place. The Strategic Resilience Group would oversee development and Bristol City Council had been made aware of the risk.

Jill Youds requested further information about the increase in the Trust's Green-to-go list. Deborah Lee explained that activity had been volatile due to social work capacity, staff sickness, and waits for assessment. The position had been recovered quickly, but it had highlighted a need to reinvigorate the approach to the discharge lounge internally.

Sue Donaldson referred to the Committee's concern that sufficient time could be dedicated to the workforce agenda and advised that more detailed reporting should include updates on the operating plan and an improved level of granularity in relation to progress against in-year key performance indicators and the impact of action plans.

Jill Youds referred to staff turnover and requested assurance on the apparently high levels of Nursing and Midwifery vacancies. Sue Donaldson advised that the figures included both registered and unregistered nursing vacancies. Some of the unregistered vacancies had been anticipated as they related to fixed-term contracts, and there was also some degree of seasonality to the figures.

Carolyn Mills drew the Board's attention to the Friends and Family Test performance in the Emergency Department, which had seen a downturn in performance over recent months, and offered assurance that measures had been put in place to improve it.

Clive Hamilton requested further detail with regard to the increase in the outpatient hospital cancellation rate in April and May 2015. Deborah Lee responded that there was no specific

explanation, but that part of the increase had been due to cancellations in order to bring patients forward. Deborah added that the Trust had launched a new outpatients' improvement plan dedicated to driving through a series of improvements and efficiencies in outpatient areas. It was:

RESOLVED:

- **That the Board receive the Quality and Performance Report for assurance**

47/06/15 Quarterly Complaints and Patient Experience Reports

Carolyn Mills introduced the Patient Experience report presenting quality assurance data from the Trust patient experience programme, principally the Friends and Family Test survey, the monthly inpatient/parent and maternity postal surveys and the national patient surveys. Carolyn highlighted that the Trust's performance was generally strong, but noted the need to improve Friends and Family Emergency Department performance.

The Complaints report included detailed performance data regarding the handling of complaints and an analysis of the themes. Two areas of concern had been identified: complaints had increased significantly in relation to outpatient services at the Bristol Heart Institute and in relation to various issues at Bristol Eye Hospital, particularly telephone responses and appointment times. Deborah Lee provided detail and offered the Board assurance that processes had been reviewed and appropriate action was being taken. At Bristol Eye Hospital, significant work was ongoing in improving validation of patient records, improvements to the Choose and Book system, and the replacement of the telephone system. It was:

RESOLVED:

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

48/06/15 Education, Learning and Development Strategy 2015-20

Sue Donaldson introduced the strategy which described the Trust's mission, vision and ambitions as a teaching Trust for the current and future workforce. The strategy recognised the Trust's responsibilities for learning and development of its entire workforce and the benefits of working with partners (University of Bristol, University of the West of England, Health Education South West and others).

The strategy was welcomed as a tool for improved staff engagement and as a means of ensuring the Trust's continuing reputation as a centre for teaching excellence. Jill Youds emphasised the importance of visibility of opportunity and communication and asked for clarification on governance. Robert Woolley confirmed that he would have oversight of the strategy's objectives, with the support of the Executive team and divisional leadership teams. Sue added that the Surgery Head and Neck Division had already put in place an education and research group as part of their divisional board sub-group structure, a model that it was hoped could be shared with other divisions.

Guy Orpen noted his conflict of interest with this item as a University of Bristol employee, and welcomed its clear language around how the Trust developed its workforce and provided education. Guy suggested that opportunities be explored to work with the University of Bristol system of annual student surveys and to discuss with the University, the Trust's position in its ratings of its partner academies.

Guy requested further information about the implementation of the Equality and Diversity of Opportunity measures. Sue Donaldson referred him to the findings of the Equality and Diversity Annual Report which highlighted that there was more work to do in this area.

John Moore welcomed the close working partnership with the universities but also asked that the strategy take into consideration the range of people that it needed to develop in terms of other local higher education establishments, such as technical colleges.

Clive Hamilton enquired when the Board would receive an update on the appraisal process, and Sue Donaldson confirmed that this was a key priority and would feature in the next quarterly workforce report. It was:

RESOLVED:

- **That the Board approve the Education, Learning and Development Strategy 2015-2020**

49/06/15 Annual Education, Learning and Development Report 2014/15

Sue Donaldson, Director of Workforce and Organisational Development, introduced this report, which described how UH Bristol had delivered against its education and teaching priorities during 2014/15.

The report demonstrated the breadth of the Trust's education, learning and development plan. Among the key achievements in-year, Sue highlighted the excellent work of the recently-developed Faculty of Children's Nurse Education, and the simulation work.

David Armstrong asked whether the Board would receive a fully-resourced and timetabled plan, in order to assess whether the Trust's strategic workforce priorities would be achievable. Sue advised that work was ongoing and further detail would be reported to the Trust Board later in the summer. John Moore asked that the plan include mitigation of the challenge of a potential national shortage of nurses and changes to doctors' numbers in coming years.

In relation to leadership and management development, Jill Youds noted that 800 managers had attended courses in 2014, and enquired what steps had been implemented to assess the value of this training. Sue noted that this would be assessed as part of the appraisal process; however, further work was ongoing to ensure that courses had been appropriately targeted to need and evaluated effectively.

RESOLVED:

- **That the Board receive the Annual Education, Learning and Development Report 2014/15 for assurance**
- **That the Board receive a further report at a future meeting on the detailed action plan arising from the Education, Learning and Development strategic priorities**

50/06/15 Equality and Diversity Annual Report 2014/15

Sue Donaldson introduced this report and provided an update on progress in 2014/15 in relation to the Trust's objectives in the area of Equality and Diversity and compliance with the Equality Act 2010.

Sue highlighted areas progress in the areas of reverse mentoring, education to target specific groups of staff, and staff-led focus groups. Training was in place focusing on disability and dementia and improved support to carers. The report identified improvements in relation to staff experience, embedding the equality agenda into the mainstream work of the Trust, and self-assessing and publication of results.

Guy Orpen welcomed the report as an important area of governance and enquired as to the extent to which the Trust had been effective in tracking retention and development of specific staff groups through to the senior levels of the organisation. Sue acknowledged that representation of some groups had been lower and noted that training included 'unconscious bias', to ensure senior managers had not unconsciously acted in a way that would reinforce negative behaviours.

In response to a further question by Deborah Lee as to whether the priorities in the report had been ambitious enough, it was suggested inviting an independent third party to review the annual report to test the priorities.

Florene Jordan welcomed the report, adding that it was inspiring to hear the positive steps taken in this area. Debbie Henderson further added that governors would be invited to discuss ways in which the Trust could promote Patient and Public Foundation Trust membership among underrepresented groups in the city. It was:

RESOLVED:

- **That the Board receive the Equality and Diversity Annual Report 2014/15 for assurance**

51/06/15 Report on Staffing Levels

Carolyn Mills introduced this report and provided assurance that the position had not changed significantly since the previous report in November. Carolyn confirmed that safe nursing and midwifery staffing levels continued to be in place. The report detailed the Trust's actions in response to the recommendations following the Care Quality Commission inspection which included: a review of red flags and implementation of the new Datix reporting system; undertake 15/16 annual staffing reviews for all Divisions; review of nurse staffing in the Children's Emergency Department; and a review of the roles and responsibilities of Band 4 Assistant Practitioners in inpatient areas across the Trust. It was:

RESOLVED:

- **That the Board receive the report on staffing levels for assurance**

52/06/15 Research and Innovation Strategy Update

David Wynick and Diana Benton presented the objectives supporting delivery of the Research and Innovation Strategy and an update on performance including examples of successful trials and their impact.

The Trust had achieved the highest levels of recruitment of patients during 2014, and as a result, research capability funding had been at the highest level to date, comparing favourably with other Trusts. David also reported the Trust's most successful year in terms of commercial income. David noted the high level of commitment to research generally in divisions, and the research workforce in Women and Children's Division had been

reconfigured and centralised to ensure maximum effectiveness. The Trust had also been the first in the country to achieve in full, a direct research CQUIN.

David noted significant operational challenges for 2015/16. A recent inspection by the Medicines and Healthcare Research Authority had recommended improvements in relation to oversight of trials. David assured the Board that work had commenced and would be reported to the Senior Leadership Team.

Areas of focus for the coming six months included ensuring that the research workforce in the Medicine Division was fully optimised and fit for purpose, improving financial transparency in all research aspects of Pharmacy, and closer partnership working with University of Bristol colleagues. This included reviewing renewals of units and consideration of a bid for a biomedical research centre as well as working as part of Bristol Health Partners to focus on system leadership development.

In response to a query from David Armstrong regarding the implications of a bid for a biomedical research centre, David Wynick advised that consideration should be given to the effect on credibility if the bid exceeded their current capability. In response to a further question regarding decision-making, David Wynick explained that discussions would first take place between all senior Trust and University teams before a formal recommendation would be made to the senior university Board and the Senior Leadership Team. It was:

RESOLVED:
- **That the Board receive the Research and Innovation Strategy Update for assurance**

David Wynick and Diana Benton left the meeting.

53/06/15 Finance Report
Paul Mapson presented the report on the Trust's current financial position and reported that the summary income and expenditure statement showed a deficit of £0.901m (before technical items) at the end of month 2. Paul advised that this was marginally adverse to the phased plans, and has been primarily driven by lower than planned clinical activity. Paul provided assurance to the Board that this did not represent a major concern at the current time. The Trust had commenced preparation for approving the service-level agreement with commissioners and had made significant improvements to the terms of those contracts. Paul also highlighted slippage with regard to the Capital Programme, and noted the key risks remained activity delivery, achievement of CQUINs and payment of fines. It was:

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

54/06/15 Finance Committee Chair's Report
Lisa Gardner presented the report which highlighted the business discussed at the meeting of the Finance Committee on 23 June. Lisa reported the key issues for the attention of the Board as challenge regarding the ability of plans to recover the position in respect of the divisional deficit. The primary driver was the delivery of activity in Surgery, Head and Neck and Specialised Services.

Other issues currently being monitored by the Committee were the Trust's savings programme, slippage on the capital programme, and effective reporting of pay expenditure

linking finance with workforce, as a result of which the Director of Workforce & Organisational Development would attend the Committee meetings to report quarterly. It was:

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

55/06/15 Estates Strategy Update
Deborah Lee introduced the report and provided an update on progress against implementation of the Trust's Estates strategy. Deborah drew the Board's attention to the recommendations around the redevelopment of Trust Headquarters and the land around Marlborough Hill. One of the Trust's priorities had been the improvement of the offer to patients in respect of car parking and as a result, planning discussions had commenced and were ongoing regarding a multi-storey car park solution in the area. Two design options had been developed and compilation of an outline business case and delivery models had commenced. Discussions with the planners had been positive, though it appeared that the Trust may not get as many spaces as it had anticipated. Further details would be discussed at the Trust's Capital Planning Group in September and a report would be presented at a Trust Board meeting thereafter. It was:

RESOLVED:
- **That the Board receive the Estates Strategy Update for assurance**
- **That a further report regarding car parking be presented to the Trust Board in September**

56/06/15 Partnership Programme Board report
Robert Woolley introduced this report which provided an update on the key issues considered at the May 2015 meeting of the UH Bristol and North Bristol Trust Partnership Programme Board. It was:

RESOLVED:
- **That the Board receive the Partnership Programme Board report for assurance**

57/06/15 Corporate Governance Statement – Board self-certification of compliance
Robert Woolley, Chief Executive, explained that the Board was required to submit the self-certification on 30th June 2015 as part of its Annual Plan submission to Monitor. The Board considered the risks and mitigating actions outlined in the report. It was:

RESOLVED:
- **That the Board approve the Corporate Governance Statement – Board self-certification of compliance**

58/06/15 Audit Committee Chair's report
John Moore introduced the report which advised Board members on the business transacted at the meeting of the Audit Committee on 9th June 2015. John highlighted the key issues as: clarity regarding the validity of Single Tender Actions above the threshold of £100,000; key milestones to embed segregation of duties relating to non-purchase order procurement; governance processes relating to hosted organisations.

John also brought to the attention of the Board the findings of a benchmarking exercise on the function of the Trust's clinical audit remit and commended the positive work which highlighted that UH Bristol was well-regarded in terms of ensuring a strong clinical audit service, aligned with the objectives of the organisation and the ongoing development of outstanding patient care. It was:

RESOLVED:
- **That the Board receive the Audit Committee Chair's report for assurance**

59/06/15 Board of Directors Register of Interests
Emma Woollett introduced the report and requested clarification as to whether Directors should declare all interests or only those which could be perceived to present a conflict. Debbie Henderson, Trust Secretary advised that best practice would require Directors to report all interests to the Board so that a considered view could be taken about what should be publicly declared. The report was received, but it was noted that all interests would be collated on an ongoing basis and the Board would take a view as to whether the public declaration would require amendment. It was:

RESOLVED:
- **That the Board receive the Board of Directors Register of Interests**

60/06/15 Monitor Governance Risk Rating Decision and Feedback on Quarter 4, Risk Assessment Framework submission
Robert Woolley introduced the report which included Monitor's analysis of the Trust's Quarter 4 submission (Continuity of Services Risk Rating – 4; Governance Risk Rating – Green). The report also outlined the rationale for the decision to return the Trust to a Governance Risk Rating of Green and the conditions attached. It was:

RESOLVED:
- **That the Board receive the Monitor Governance Risk Rating Decision to note**

61/06/15 Governors' Log of Communications
The purpose of this report was to provide the Trust Board with an update on governors' questions and responses from Executive Directors on the Governors' Log of Communications. Emma Woollett noted the value for non-executive members of the Board of the real-time email updates. Clive Hamilton noted that his question (Log item no. 118) could be closed and confirmed his satisfaction with the response. It was:

RESOLVED:
- **That the Board receive the Governors Log of Communications to note**

62/06/15 Any Other Business
There were 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 13:10.

The next meeting of the Trust Board of Directors will take place on Thursday 30 July 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 June 2015
Action tracker

Outstanding actions following meeting held 30th June 2015					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
	55/06/15	A report on car parking proposals to be submitted to the Board	Chief Operating Officer/ Deputy CEO	September 2015	N/A
	49/06/15	A report to be provided on the detailed action plan arising from the Education, Learning and Development Strategic priorities	Director of Workforce & OD	September 2015	N/A
1	**31/05/15**	Explore options to include number of staff leavers, those who have completed exit interviews and at what stage of the process in future quarterly workforce reporting	Director of Workforce & OD	August 2015	N/A
2	**30/05/15**	Consideration to be given to outcomes for measuring success of Board committees in future Terms of Reference reviews	Trust Secretary	2015/16 reviews	To be incorporated into Well Led Review action planning
Completed actions following meeting held 30th June 2015					
3	**32/05/15**	Revised Speaking Out Policy to be submitted to July meeting for approval	Director of Workforce & OD	July 2015	Complete – agenda item 12
5	**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	Complete – included in revised Q&P report – agenda item 8
6	**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	Complete – agenda item 8

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
05. Chief Executive's Report
Sponsor and Author(s)
Author - Robert Woolley, Chief Executive Sponsor – Robert Woolley, Chief Executive
Intended Audience

Board members	√	Regulators		Governors		Staff		Public	

Executive Summary
<u>Purpose</u> To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. <u>Key issues to note</u> 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 – JULY 2015

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **supported** the recommendation to declare the standards failed in Quarter 1 to be the Referral to Treatment Non-Admitted, Admitted and Ongoing pathways standards, the Accident and Emergency 4-hour standard, the 62-day GP and 62-day Screening cancer standards. The planned ongoing failure of the Referral to Treatment standards as part of the agreed trajectory should be flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-day GP standards and the Accident and Emergency 4-hour standard, as part of the narrative accompanying the declaration.

As part of its regular review, the group **approved** revised terms of reference for the Senior Leadership Team and Service Delivery Group. Terms of reference for the Clinical Quality Group were **considered** and a request made for the addition of an annex describing more clearly where responsibility sat for particular issues.

The group **received** an update on the financial position for month three of 2015/2016 and **approved** a recommendation to the Trust Board that the Annual Plan be revised and re-submitted to Monitor.

The group received the 2014 National Inpatient Survey and National Neonatal Intensive Care Survey results and **approved** the reports for onward submission to the Quality and Outcomes Committee and Trust Board.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** the renaming of the Medical Assessment Unit to Acute Medical Unit noting the recommendation by the Royal College of Physicians that this term be adopted as a standard name for these units.

The group **noted** the 2015/2016 Commissioning for Quality and Innovation (CQUINs) programme and **approved** the proposed Senior Leadership Team sponsor for each indicator.

The group **received** the Board Assurance Framework 2015/2016 Quarter 1 update prior to onward submission to the Trust Board.

The group **noted** the Quarter 1 update on Corporate Quality Objectives.

The group **approved** recommendations to assist implementation of the Trusts Smoke Free Policy.

4. RISK, FINANCE AND GOVERNANCE

The group **received** an update on the status of the transfer of Cellular Pathology to North Bristol Trust, including the proposed timetable and related risks.

The group **approved** the Corporate Risk Register report prior to onward submission to the Trust Board.

The group **noted** progress on completion of accepted corporate actions for the Utley Report.

The group **noted** the outcome of the Major Trauma Peer Reviews for the Trusts major trauma centre for Children's Services and its major trauma unit for Adult Services and the actions being taken to address highlighted areas of concern.

The group **noted** the Quarter 1 Serious Incident Report.

The group **noted** two low impact Internal Audit Reports in relation to Management of Commissioning Contracts and Payroll and a medium impact Internal Audit report in relation to the Operation of World Health Organisation Check Lists. Changes to the Internal Audit Plan 2015/2016 were **approved in principle**, subject to a final discussion on detail with Internal Audit.

The group **received** Annual Reports 2014/2015 relating to Complaints, Spiritual and Pastoral Services and Voluntary Services.

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

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

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

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
July 2015

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
06. Patient Experience Story
Sponsor and Author(s)
Sponsor: Carolyn Mills – Chief Nurse Author: Tony Watkin –Patient Experience Lead (Engagement and Involvement)

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

Executive Summary

Purpose

Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality. The patient agreed to share his story with the Trust Board, furthering the ambition to move towards the Board receiving first-hand accounts of patient's experience of our services.

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 for this patient and for Board. members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

Key issues to note

Positive:

- The actions of a porter and helpfulness of the receptionist in trying to support the patient and resolve the situation.
- The actions of a nurse in the BRI Emergency Department to ensure the patient arrived at the correct location.
- The quality of the individuals providing the clinical and nursing care.
- The six week follow up appointment was on time.

Negative:

- The manner in which the patient was turned away from the surgical assessment unit (STAU)
- The failure of the usual process which ensures that direct GP referrals to the STAU are managed smoothly.
- The increased anxiety experienced by the patient as a result of being turned away from the STAU.

Recommendations

To receive and reflect on the story

Impact Upon Board Assurance Framework

Implementation of the learning associated with this story supports achievement of the Trust's corporate quality objective to improve communication with patients.

Impact Upon Corporate Risk
No links to corporate risks.
Implications (Regulatory/Legal)
Learning from feedback supports compliance with CQC's fundamental standards – regulation 9, person centred care; regulation 10, dignity and respect; regulation 12, safe and appropriate treatment; regulation 17, good governance.
Equality & Patient Impact
None
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Story
Trust Board – 30th July 2015

My experience of hospital care

Summary
This patient story outlines the personal experience of a patient who was referred directly to the Bristol Royal Infirmary Surgical Assessment Unit (SAU) by their GP. The narrative has been written by the patient and is presented here by way of an introduction to ensure that the Board is able to gain insight into the overall patient journey, whilst enabling the discussion at Board to focus on the key impact areas.

The patient wrote:
"In the week prior to Easter 2015 I had not felt well. I woke early on Thursday 2 April 2015 with severe lower abdominal pains. As soon as our GP opened my wife telephoned and encouraged the receptionist to give me an appointment that day at 10am. I saw a Locum Doctor who diagnosed that I had chronic diverticulitis. He printed a number of pages from my patient records, and wrote some handwritten notes on them. He put them into an envelope and marked them SAU. He told me to go directly to the BRI SAU department and not to A&E as he wanted me treating promptly.

I returned home and my wife drove me to hospital, I arrived around 10.45am. I was greeted upon arrival by a welcome who asked if I knew where to go. I was told to go to level 6. All was well up to then. I pressed the bell on the outside of SAU and after a fairly long wait was told over the intercom that they were not expecting me. I said I had a referral from my GP but that did not help.

I was in considerable pain and now getting anxious. I spoke to a porter who suggested I might go to level 2. He thought there was another SAU relating to ambulant care! I struggled to find anything relevant and asked a receptionist. She phoned SAU on level six who gave her a similar story that they were not expecting me and that I should phone my GP to ensure I had gone to the right hospital. I opened the referral letter to check and gave it to the amazingly helpful receptionist, who then phoned my GP surgery, who confirmed that I should be there and could not understand the problem. She again phoned level 6 who said they then knew about me, but had no bed space and that I should go to A&E. I was in considerable pain but got to A&E who checked me in at 12.30. I was quickly processed and booked in. A male staff nurse then came with a wheel chair, saying I am taking you directly to level 6, to avoid any further problems.

From then on all was well, the diagnosis was confirmed and I spent the next 48 hours on an antibiotic drip. My Consultant Mr Longman and his team, together with all the nursing and care staff were excellent. My six week follow up appointment has arrived as promised.
In summary, I am glad that I am a strong personality, many others could have been in real trouble, having to wait one and three quarter hours to get in the system. Thanks to the

wonderful receptionist, who went well past her normal responsibility and did not let a drama turn into a crisis."

The positive and negative aspects of this patient's experience at UH Bristol

Positive:

- The actions of a porter and helpfulness of the receptionist in trying to support the patient and resolve the situation.
- The actions of a nurse in the Bristol Royal Infirmary Emergency Department to ensure the patient arrived at the correct location.
- The quality of the individuals providing the clinical and nursing care.
- The six week follow up appointment was on time.

Negative:

- The manner in which the patient was turned away from the Surgical Assessment Unit (SAU).
- The failure of the usual process which ensures that direct GP referrals to the SAU are managed smoothly.
- The increased anxiety experienced by the patient as a result of being turned away from the SAU.

Divisional response

- This patient story has had a powerful impact on the Division and we are determined to take learning from it and change behavioural practices to ensure this type of incident does not occur again.
- As a Division, we are extremely sorry that these events occurred as this is not the level of care we want for any of our patients. This experience must have been very difficult for this patient; to be turned away from the SAU without someone coming to talk to them face to face is unacceptable.
- When a GP phones in a patient referral to the hospital they speak to either the on-call doctor or the Clinical Site Manager (CSM) who takes the patient details. The doctor or CSM will then inform the nurse in charge on SAU to let them know the patient is expected. This does sometimes cause a delay in the information being relayed to SAU, however this incident should never have occurred.
- The staff should have welcomed the patient into the unit and asked the patient to take a seat in the "chairs area" and contacted the CSM for information about the patient. They should have also asked the patient for any correspondence from his GP which is normal practice for patients to have with them who are directly admitted into SAU. This information would have informed the staff of the patient's surgical condition. They would have then contacted the on call team for the patient to be reviewed.
- Even if the staff on SAU were not expecting the patient, the response from the staff in SAU was well below the standard we strive for in the Division. The fact that the patient had to be signposted to the Emergency Department to then be admitted into SAU must have been frustrating and potentially frightening for the patient especially as he was experiencing pain at the time.

- The Ward sister and Matron will be feeding back to the nursing staff and ward clerks the personal impact on the patient resulting from this event. All staff will be asked to reflect and learn from this feedback and look closely at their personal behaviours in the work place and how they are perceived. The Ward Sister and Matron will monitor this closely to ensure no further incidents like this occur again.
- Training needs for the ward clerks will be addressed: they will be undertaking a customer care course. They will be instructed to discuss all telephone queries with the allocated nurse in charge of the unit.
- The Division is pleased to see that once this patient was on the unit, his experience was a positive one.

Jane Palmer
Head of Nursing
Division of Surgery, Head and Neck

July 2015

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
08. Quality and Performance Report
Sponsor and Author(s)
Report sponsors: • Overview & Access – 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) Report authors: • Xanthe Whittaker (Associate Director of Performance) • 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.
Recommendations
The Board is recommended to receive the report for **assurance.**
Impact Upon Board Assurance Framework
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Impact Upon Corporate Risk
As detailed in the individual exception reports.
Implications (Regulatory/Legal)
Links to achievement of the standards in Monitor's Risk Assessment Framework.
Equality & Patient Impact
As detailed in the individual exception reports.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
28/07/15					

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

July 2015

Executive Summary

Progress continued to be made in recovering performance against the access standards this month, with achievement of the 95% standard for the A&E 4-hour wait, delivery of the 6-week diagnostic 99% national standard for the first time since October 2014, and further reductions in both the total number of patients waiting over 18 weeks Referral to Treatment (RTT) and the longest waiting patients. Further successes for the month are detailed on the Over-view page of this report, alongside the priorities, risks and threats for the coming months.

However, there is evidence that the current position may be a fragile one, given a number of system risks at play. These include the recommissioning of domiciliary care package provision and planned closures of beds in neighbour acute providers, which could result in an increase in delayed discharges and additional emergency demand respectively. The Trust has also seen a recent growth in outpatient referrals, which the rising waiting list indicates is outstripping the additional capacity put in place to reduce the over 18-week RTT backlogs. The higher acuity of patients needing to be treated in the Trust's intensive therapy units (ITU) is also impacting on access standards, by reducing the availability of beds to admit patients for elective cancer and cardiac surgery. This is having a knock-on impact on a number of access standards, not least the provision of surgical capacity to continue to meet cancer waiting times standards, but also last-minute cancellations of operations and readmission within 28 days of cancellation. These changes in patient acuity have required an increase in nurse staffing levels in these areas. Challenges with staff recruitment, in combination with this additional need, has fuelled the demand for agency staffing, which can be seen playing-out in the workforce metrics.

Despite the challenges posed by the higher acuity of patients coming through the Trust's doors, the quality metrics paint a strong picture of the health of the organisation, from safety through to patient experience. The results of our inpatient Friends & Family Test, accord well with the findings from our internally designed surveys of inpatient patient experience and provide good assurance of the positive experience most patients undertaking inpatient stays have of our services. Similarly, there is a consistent story painted by the monthly audit results from the Safety Thermometer and our reporting of pressure ulcers and inpatient falls, which are GREEN rated against their respective thresholds and have been sustained at such a level for several months. Finally, SHMI (Summary, Hospital Mortality Indicator), as perhaps the most important measure of clinical effectiveness, provides an objective, independent measure of the likelihood of patients dying in our hospitals given the specific risk factors inherent in our patient cases-mix, has now been GREEN rated for the fourth consecutive month.

In summary, progress continues to be made in improving access to services, although system pressures pose risks to further reductions in waiting times and sustaining current good A&E performance. These same system risks are also playing-out in the workforce metrics. Our response to this changing demand will be helped by the current significant focus on improvements to recruitment process and ways to support staff retention. The quality metrics provide assurance over the quality of our services in this climate of increasing demand and acuity. Working in partnership with other organisations within the community to mitigate these system risks, remains a core part of the Trust's strategy for improving the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

This section provides details of the ratings and scores published by the Care Quality Commission (CQC), NHS Choices website and Monitor. A breakdown of the currently published score is provided, along with details of the scoring system and any changes to the published scores from the previous reported period.

Care Quality Commission

Intelligence Monitoring Report

This is a tool used by the CQC to assess risk within care services. It was developed to support the CQC's regulatory function. The scoring uses a set of indicators, 93 of which are applicable to the Trust, against which tests are run to determine the level of risk for each indicator. From this analysis trusts are assigned to one of six risk bands based upon a weighted sum of the number of 'risks' or 'elevated risks', with 'elevated risks' scoring double the value of 'risks'.

Band 6 represents the lowest risk band.

Overall risk score = 5 points (2.69%) – **band 5** (not published as recently inspected)

Previous risk score = 10 points (5.43%) – band 3 (not published as recently inspected)

Current scoring

<u>Risks</u>

Safe:	Never Event Incidence
Effective:	SSNAP Domain (Stroke) team-centred rating score
Responsive:	Referral to Treatment Time (composite indicator) Ratio of days delayed in transfer from hospital to total occupied beds (delayed discharges)
Well-led:	Monitor Governance Risk Rating(see next page)

<u>Elevated risks:</u>

None

NHS Choices

Website

The NHS Choices website has a 'Services Near You' page, which lists the nearest hospitals for a location you enter. This page has ratings for hospitals (rather than trusts) based upon a range of data sources.

Site	User ratings	Recommended by staff	Open and honest	Infection control	Mortality	Food choice & Quality
BCH	4 stars	OK	✓	Not avail	OK	OK
STH	3.5 stars	OK	✓	✓	OK	OK
BRI	4.5 stars	OK	✓	OK	OK	OK
BDH	4 stars	OK	✓	Not avail	OK	Not avail
BEH	3.5 stars	OK	✓	✓	OK	!

Stars – maximum 5
OK = Within expected range
✓ = Among the best
! = Among the worst
Please refer to appendix 1 for our site abbreviations.

Monitor's Risk Assessment Framework

During quarter 1 the Trust failed to meet six of the standards in Monitor's 2015/16 Risk Assessment Framework, as shown in the table below. Overall this gives the Trust a Service Performance Score of 4.0[1] against Monitor's Risk Assessment Framework. However, positively Monitor has recently restored the Trust to a GREEN risk following its review of actions being taken to recover performance against the above standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

	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 actual*	Notes	Q1 Draft Risk Assessment Risk rating
Monitor Risk Assessment Framework	1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	TBC**	✓	✓	✓	✓	TBC**	✓	Limit 11 avoidable, with 10 total cases reported in Q1.	Achieved
	2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	98.9%	✓	✓	✓	✓	99.3%	✓		Achieved
	2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	95.3%	✓	✓	✓	✓	94.1%	✓		
	2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.8%	✓	✓	✓	✓	96.7%	✓		
	3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	76.9%	✗	✗	✗	✗	76.8%	✗	62-day screening standard breaches outside of the control of theTrust.	Not achieved
	3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	84.2%	✓	✓	✗	✗	78.6%	✗		
	4	Referral to treatment time for admitted patients < 18 weeks	1.0	90%	80.4%	Achieved each month	Not achieved	Not achieved	Not achieved	80.4%	✗		Not achieved
	5	Referral to treatment time for non-admitted patients < 18 weeks	1.0	95%	90.8%	Not achieved	Not achieved	Not achieved	Not achieved	90.8%	✗		Not achieved
	6	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.6%	Achieved each month	Not achieved	Not achieved	Not achieved	90.6%	✗	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%	98.0%	✓	✓	✓	✓	96.8%	✓		Achieved
	8a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	94.5%	✓	✓	✓	✓	94.8%	✓		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%	94.5%	✗	✗	✗	✗	94.5%	✗	Achieved 95% standard in June.	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	GREEN	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.

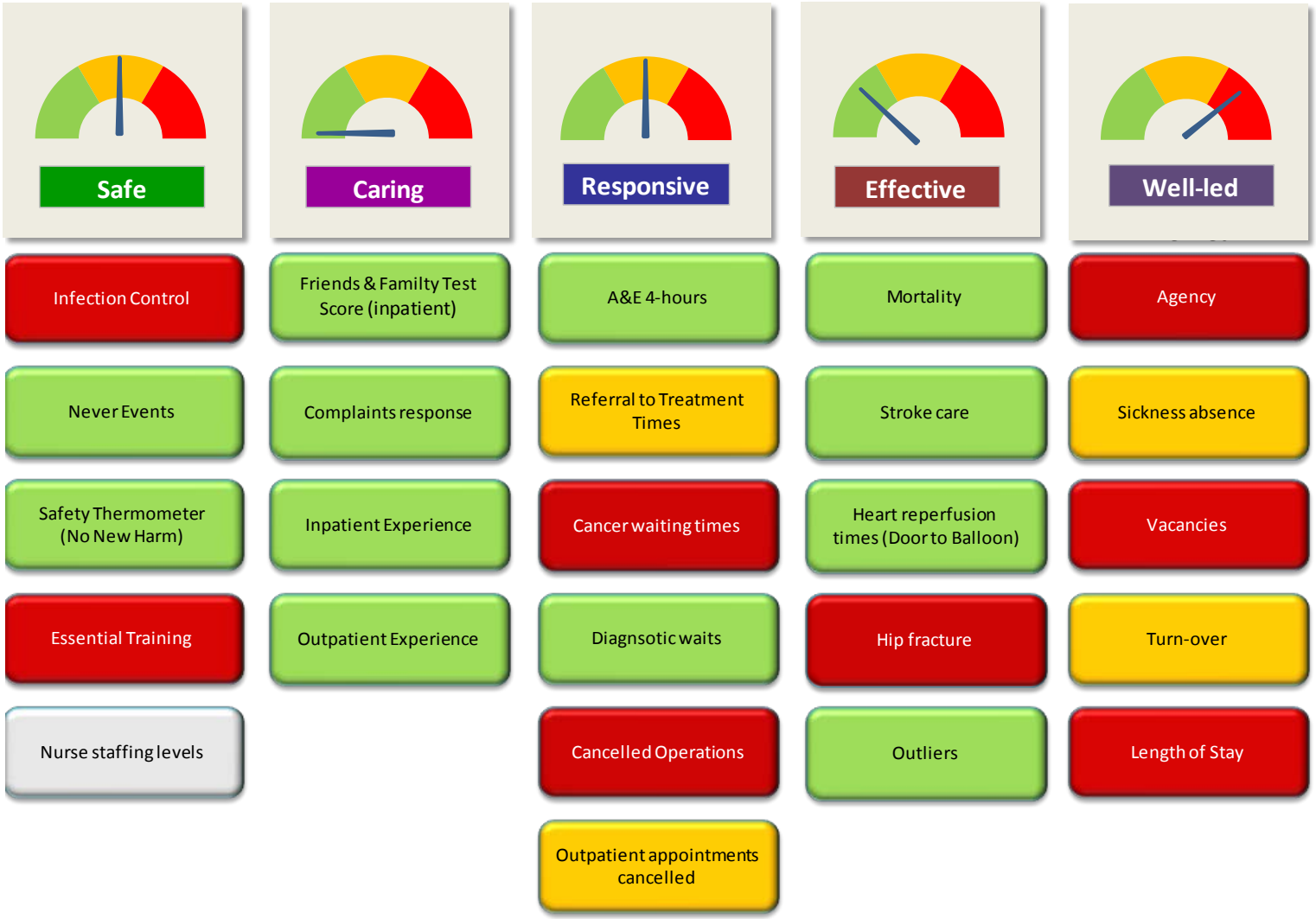
***Q1 Cancer figures based upon confirmed figures for the April and May, and draft for June.**
**** C. diff cases from June still subject to commissioner review.**

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

[1] **Please note** that in the Q1 reporting template that Monitor has recently issued (see Annex B), failure of the admitted and non-admitted RTT standards are no longer scored, meaning that the Trust is holding a Service Score of 3 rather than 4. We are seeking further clarity from Monitor regarding this, as this potentially conflicts with other information received from NHS England.

Summary Scorecard

The following table shows the Trust's current performance against the chosen headline indicators within the Trust Summary Scorecard. The number of indicators changing RAG ratings from the previously reported period is also shown in the box to the right. Following on from this is a summary of key successes and challenges, and reports on the latest position for each of these headline indicators.



Key changes in indicators in the period:

RED to GREEN (2 indicators):
- A&E 4-hours
- 6-week diagnostics

RED to AMBER (1 indicator):
- Outpatient appointments cancelled

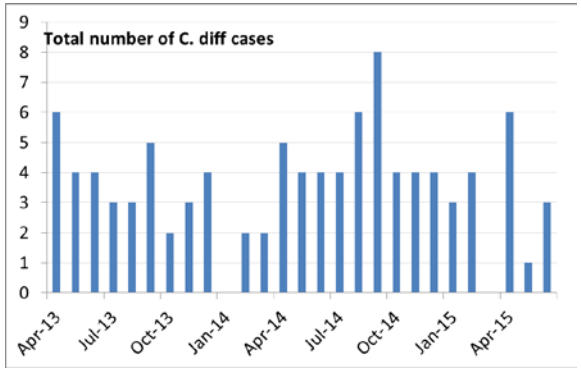
AMBER to GREEN (1 indicator)
- Safety Thermometer

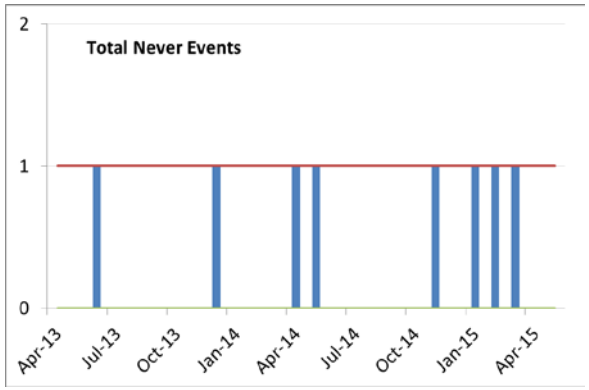
GREEN to RED (2 indicators)
- Infection Control (MRSA)
- Vacancies

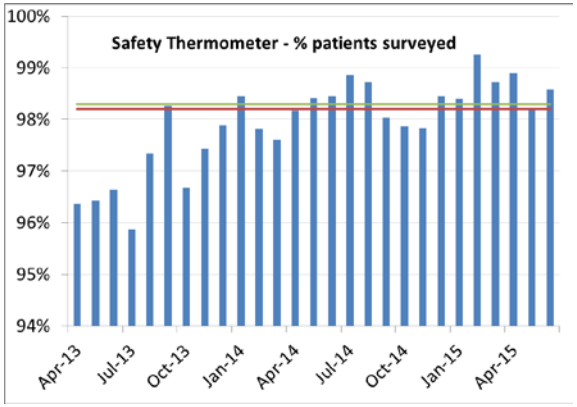
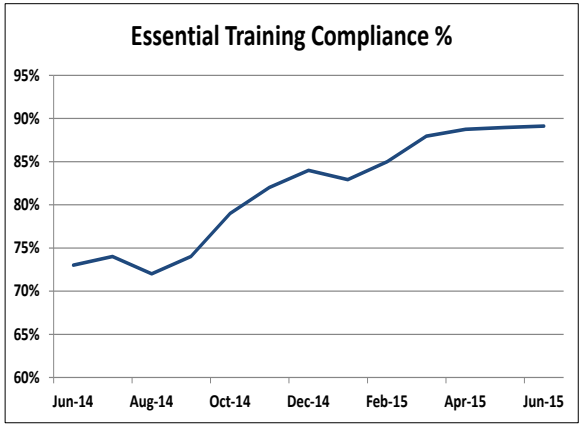
Overview

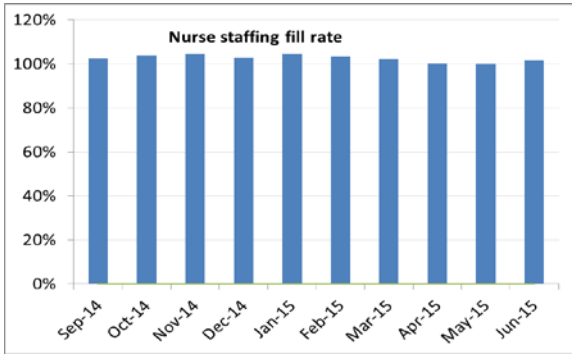
The following summarises the key successes in June 2015, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2015/16.

Successes	Priorities
• Achievement of the national 95% 4-hour A&E maximum waiting times standard, and the 99% standard for 6-week diagnostic waits • Achievement of the Referral to Treatment (RTT) Incomplete pathways recovery target • Sustained high levels of cleanliness and hand hygiene compliance • Reduction in the incidence of inpatient falls • Sustained venous-thrombo embolism risk assessments above 99% • Summary Hospital Mortality Indicator below 65 for four consecutive months • Reduction in ward outlier bed-days following bed reconfiguration • The new UH Bristol recruitment management system, TRAC, went live in June 2015	• Maintaining recent high activity levels in order to sustain target reductions in numbers of patients waiting over 18 weeks RTT • Identifying and implementing options for improving access to high dependency unit (HDU) beds • Improving staff experience and staff retention • National recruitment campaigns for nursing and theatres staff • Improvement in serious incident reporting and investigation time scales. • Improvement in time to theatre for fractured neck of femur patients • Improvement in Friends and Family Test coverage, emergency department and in-patients
Opportunities	**Risks & Threats**
• A number of workshops will be held during July and August with staff to look at practical solutions to enhance communications and improve staff engagement.	• High levels of cancellations of surgery due to high patient acuity within the intensive therapy units, impacting on cancer and cardiac surgical capacity and achievement of target reduction in cancellations • Increase in outpatient referrals in excess of the capacity being delivered to reduce the number of patients waiting over 18 weeks RTT • Reduced diagnostic capacity in July and August, putting sustained achievement of the 6-week standard at risk • Re-commissioning of domiciliary care package providers and closure of beds in local acute providers, which may impact on achievement of the 4-hour standard • Risk of not achieving target annual reduction in staff turnover, agreed during Operating Planning Process

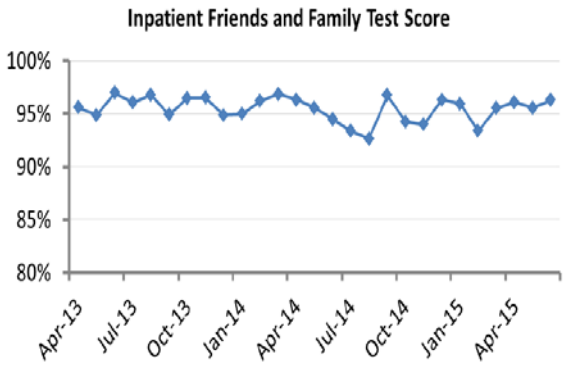
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections and the number of MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias.
The Trust limit for 2015/16 is 45 avoidable cases of clostridium difficile and zero cases of MRSA.</td>
<td>Three cases of clostridium difficile (C. diff) were reported in June and have been assessed as unavoidable by the Trust. However this still needs to be agreed with the Clinical Commissioning Group (CCG). This is against a limit of 3 for the period.
There was one MRSA reported in the period, and for this reason this overall indicator is RED rated.
<table>
<tr><th></th><th>C. diff</th><th>MRSA</th></tr>
<tr><td>Medicine</td><td>1</td><td>0</td></tr>
<tr><td>Surgery</td><td>0</td><td>0</td></tr>
<tr><td>Specialised Services</td><td>2</td><td>1</td></tr>
<tr><td>Women’s & Children’s</td><td>0</td><td>0</td></tr>
</table>
</td>
<td> 

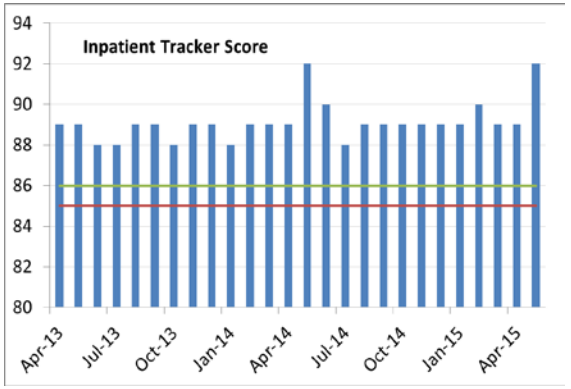
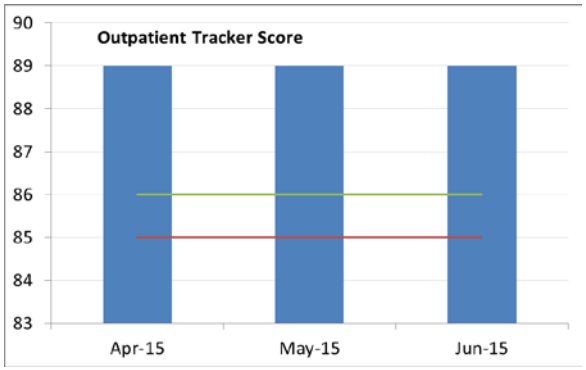
A total of 10 cases (unavoidable + avoidable) were reported in quarter 1, against a limit of 11 for unavoidable cases.</td>
<td>The multidisciplinary Post Infection Review meeting with commissioners for the single case of MRSA which occurred in June is to be held on the 28th July. This meeting will identify any learning and preventative actions to be in place if required.</td>
</tr>
<tr>
<td>Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. There are currently 14 different categories of Never Events listed by NHS England.</td>
<td>There were no Never Events reported in June 2015, or quarter 1 as a whole. The last Never Event was reported in March 2015.</td>
<td>Number of never events
 
</td>
<td>Proactive risk assessment and mitigation of the new never events list continues by the Never Events Risk Assessment Group.
Reducing the risk of perioperative never events is part of our ‘Sign up to Safety’ Patient Safety Improvement Programme 2015-2018.</td>
</tr>
</table>

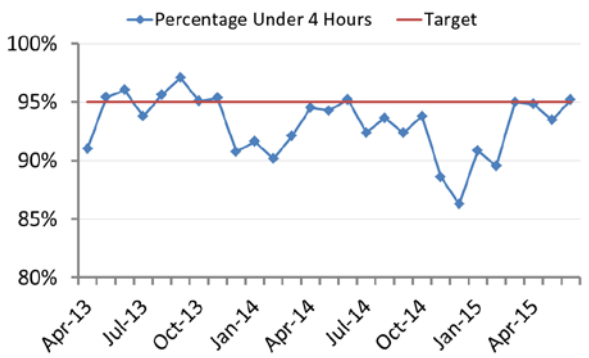
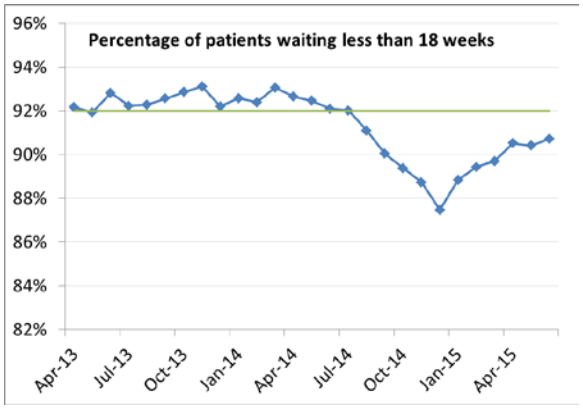
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.</td>
<td>In June 2015, the percentage of patients with no new harms was 98.6%, against an upper quartile target of 98.26% (GREEN threshold) of the NRLS (National Learning & Reporting System) Patient Safety peer group of trusts. This is an improvement from May, when the indicator was AMBER rated.</td>
<td>The percentage of patients surveyed showing No New Harm each month.
 
</td>
<td>Ongoing improvement work to reduce falls, pressure ulcers, venous-thromboembolism and catheter associated urinary tract infections continues to contribute to the achievement of this metric.</td>
</tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Compliance at the end of June was 89% against the 90% threshold for core Essential Training.
<table>
<tr><th>June 2015</th><th>Compliance Rate</th></tr>
<tr><td>UH Bristol</td><td>89%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>89%</td></tr>
<tr><td>Medicine</td><td>89%</td></tr>
<tr><td>Specialised Services</td><td>91%</td></tr>
<tr><td>Surgery Head & Neck</td><td>89%</td></tr>
<tr><td>Women's & Children's</td><td>86%</td></tr>
<tr><td>Trust Services</td><td>92%</td></tr>
<tr><td>Facilities And Estates</td><td>93%</td></tr>
</table>
Please see Appendix 2 for detailed of compliance against other training.</td>
<td> 
</td>
<td>The Trust has maintained 89% over several months. However, evidence shows that release of staff to attend training is a key factor in achieving 90% compliance on a recurrent basis, and this is reflected in the action plan (Action 1A and 1B).
There has been a month on month improvement in the Safeguarding Adults/Children and Resuscitation compliance levels and there is a plan to reach 90% compliance by the end of August this year (Action 2).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in June the Trust had rostered 208,051 expected nursing hours, with the number of actual hours worked of 211,788, giving an overall fill rate of 102%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>62,997</td><td>60,122</td><td>2875</td></tr>
<tr><td>Specialised Services</td><td>39,871</td><td>38,883</td><td>988</td></tr>
<tr><td>Surgery Head & Neck</td><td>43,525</td><td>41,258</td><td>2267</td></tr>
<tr><td>Women’s & Children’s</td><td>65,393</td><td>67,788</td><td>-2393</td></tr>
<tr><td>Trust - overall</td><td>211,788</td><td>208,051</td><td>3736</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month is shown below:


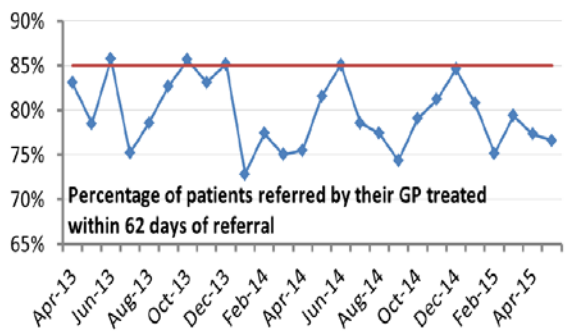
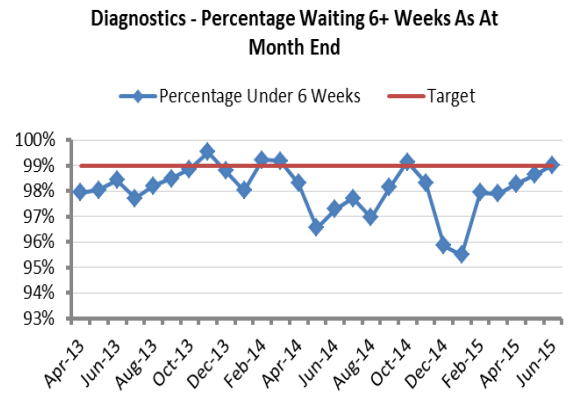
</td>
<td>There was an overall deficit of hours within Women’s and Children’s Division. This is due to vacancies in some wards in the Children’s Hospital and St Michael’s. Recruitment progress is described in the actions section of this report (Action 3). Robust plans have been developed to mitigate the current shortfall, which is assessed on a daily basis by the senior nurse team.
Further detail can be found in the detailed monthly report presented to Quality and Outcomes Committee and Trust Board.</td>
</tr>
</table>

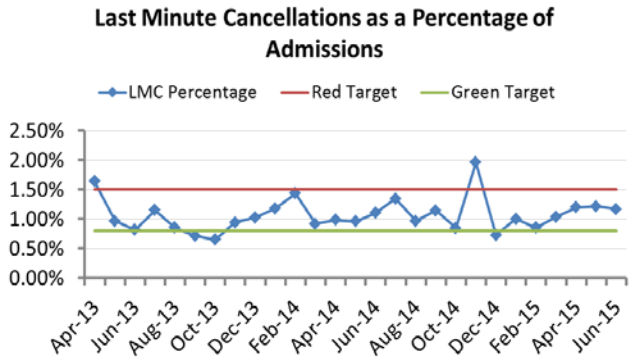
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Friends & Family Test inpatient score is a measure of how many patients said they were ‘very likely’ to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.</td>
<td>Performance for June 2015 was 96.3%, and Quarter 1 as a whole was 96.0%. This metric combines Friends and Family Test scores from inpatient and day case areas of the Trust, for both adult and paediatric services. A breakdown of the scores by site shown below:
<table>
<tr><th>Site</th><th>Inpatient FFT score</th></tr>
<tr><td>Bristol Children’s Hospital</td><td>92.4%</td></tr>
<tr><td>Bristol Dental Hospital</td><td>98.6%</td></tr>
<tr><td>Bristol Eye Hospital</td><td>99.2%</td></tr>
<tr><td>Bristol Haem. & Oncology Centre</td><td>100%</td></tr>
<tr><td>Bristol Royal Infirmary</td><td>95.4%</td></tr>
<tr><td>South Bristol Community Hospital</td><td>97.9%</td></tr>
<tr><td>St Michael’s Hospital</td><td>98.3%</td></tr>
</table>
</td>
<td> 
</td>
<td>The scores for UH Bristol are in line with national norms, and a very high proportion of the Trust’s patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards.</td>
</tr>
<tr>
<td>Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.</td>
<td>For the month of May 2015, performance was 3.2%. The first milestone is to achieve 10% in the first six months of 2015/16.
In May, we sent out 63 responses to complaints. By the 14th July we had received two responses back from complainants indicating they were dissatisfied with the Trust’s response = 3.2%.</td>
<td>There is a new and more valid method of calculating dissatisfied responses compared to previous years. It will be applied retrospectively to historic data to enable a trend graph to be produced for future reports.</td>
<td>Improving the quality written complaint responses is one of our quality objectives for 2015/16.
Actions being taken to achieve this are described in the actions section of this report (Action 4).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of May 2015, the score was 92 out of a possible score of 100. Divisions’ scores for Quarter 1 to date are broken down as follows.
<table>
<tr><th></th><th>Quarter 1 to date</th></tr>
<tr><td>Trust</td><td>90</td></tr>
<tr><td>Division of Medicine</td><td>86</td></tr>
<tr><td>Division of Surgery, Head & Neck</td><td>91</td></tr>
<tr><td>Division of Specialised Services</td><td>90</td></tr>
<tr><td>Women's & Children's Division (BCH)</td><td>93</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>89</td></tr>
</table>
</td>
<td> 
</td>
<td>The Trust’s performance is in line with national norms in terms of patient-reported experience. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report. This analysis consistently shows lower survey scores in maternity services and the Division of Medicine. However, these differences in patient-reported experience are mirrored at a national level and reflect demographic / health factors over and above the quality of care delivered.</td>
</tr>
<tr>
<td>Outpatient experience tracker comprises four scores from the Trust’s monthly survey of outpatients (or parents of 0-11 year olds):
1) Cleanliness
2) Being seen within 15 minutes of appointment time
3) Being treated with respect and dignity
4) Receiving understandable answers to questions.</td>
<td>This metric is derived from a new survey that the Trust introduced in April 2015. For the month of June 2015, the score was 89 out of a possible score of 100. Divisions’ scores for Quarter 1 are broken down as follows.
<table>
<tr><th></th><th>Quarter 1 to date</th></tr>
<tr><td>Trust</td><td>89</td></tr>
<tr><td>Division of Medicine</td><td>89</td></tr>
<tr><td>Division of Surgery, Head & Neck</td><td>88</td></tr>
<tr><td>Division of Specialised Services</td><td>88</td></tr>
<tr><td>Women's & Children's Division (BCH)</td><td>83</td></tr>
<tr><td>Diagnostic and Therapies</td><td>92</td></tr>
</table>
</td>
<td> 
</td>
<td>This metric is derived from a new survey. Caution is needed in applying the Trust-level thresholds at a Divisional-level, given the small sample sizes. However, Bristol Royal Hospital for Children received a relatively low score in Quarter 1. It is not clear if this will become a consistent trend from the survey, but this result will be analysed in detail and an update provided in routine Patient Experience reports to the Board (Action 5).</td>
</tr>
</table>

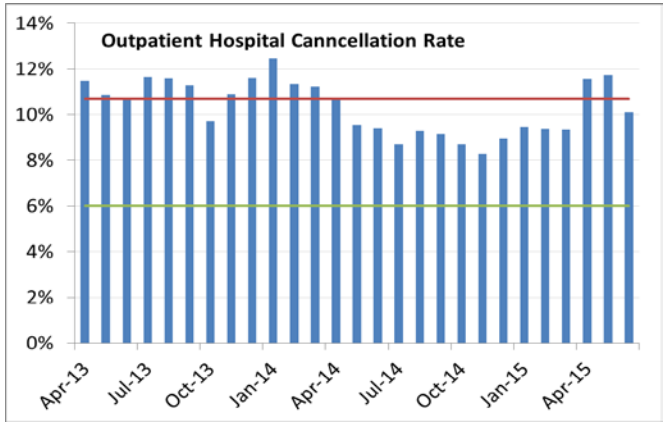
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% standard was achieved in the month of June, with performance for the Trust as a whole reported at 95.2%. Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>June 2014</th><th>May 2015</th><th>June 2015</th></tr>
<tr><td>Attendances</td><td>5605</td><td>5508</td><td>5424</td></tr>
<tr><td>Emergency Admissions</td><td>1788</td><td>1791</td><td>1743</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5180
92.4%</td><td>5101
92.6%</td><td>5107
94.2%</td></tr>
<tr><th>BCH</th><th>June 2014</th><th>May 2015</th><th>Jun e 2015</th></tr>
<tr><td>Attendances</td><td>3157</td><td>3354</td><td>3199</td></tr>
<tr><td>Emergency Admissions</td><td>682</td><td>803</td><td>711</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3083
97.7%</td><td>3073
91.6%</td><td>3037
94.9%</td></tr>
</table>
</td>
<td> 
</td>
<td>The Q1 trajectory of 94.8% was narrowly missed, with performance of 94.5%. This was due to performance in May being lower than expected, following an 18% rise in emergency admissions into the Bristol Children's Hospital (BCH) above same period last year (Action 6A). Recovery of performance continues to be supported by the community-wide resilience plan and internal transformation efforts focusing on Bristol Royal Infirmary and BCH patient flow (Actions 6B and 6C).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>The backlog reduction trajectory for non-admitted pathways was achieved at the end of June, with 1612 patients waiting over 18 weeks against a trajectory of 1616. The incomplete pathway trajectory target of 90.5% was also achieved, with 90.7% of patients waiting less than 18 weeks. This was despite the admitted backlog reduction trajectory not being met.
There was a continued reduction in the number of patients waiting over 40 weeks RTT at month-end against trajectory (in brackets)
<table>
<tr><th></th><th>April</th><th>May</th><th>Jun</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>116
(150)</td><td>89
(106)</td><td>38
(72)</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>4
(4)</td><td>1
(0)</td><td>0
(0)</td></tr>
</table>
</td>
<td> 

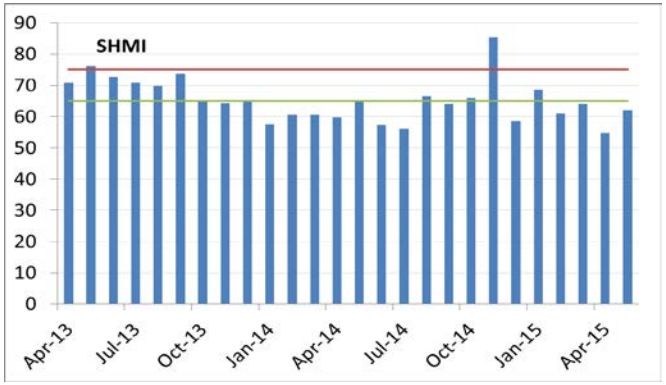
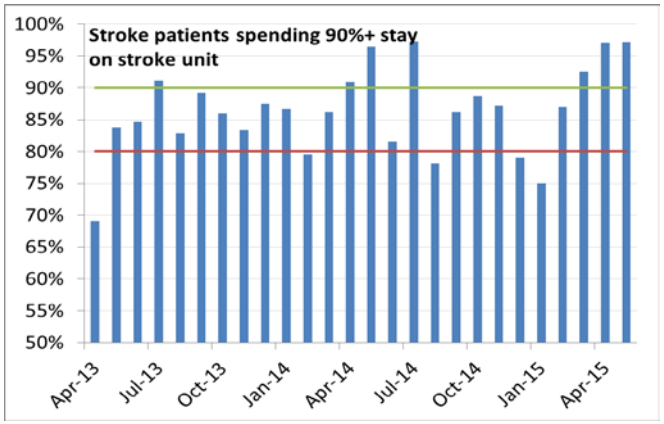
Although the Admitted trajectory target was not achieved (1398 against target of 1348), this was the lowest reported backlog admitted backlog since September 2014.</td>
<td>Divisions continue to implement their activity plans to deliver target reductions in first outpatient and elective waiting times. Backlog reductions are monitored on a weekly basis (Action 7A). The weekly RTT Operations Group reviews the longest waiting patients, to ensure these patients continue to be prioritised (Action 7B).
Inability to recruit as planned, and unexpected losses in capacity continue to pose risks to delivery, as does the recent rise in outpatient referrals.</td>
</tr>
</table>

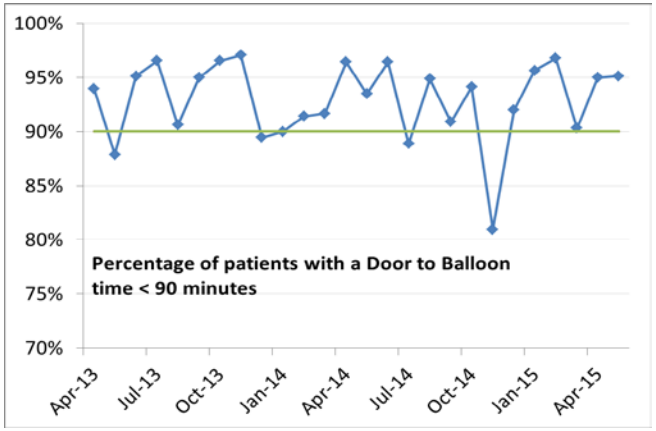
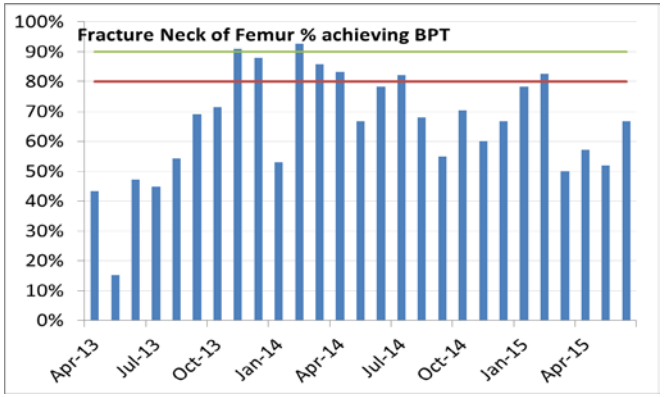
Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	Performance against the 85% 62-day GP standard was 76.6% in May. Performance against the 90% 62-day screening standard was 80%. The other six cancer standards were achieved for the quarter as a whole. The main reasons for failure to achieve the 85% national 62-day GP standard in May were: **Breach reason** / **May** Late referral by other provider: 7 Medical deferral/clinical complexity: 7 Administrative issues: 3 Delayed diagnostic test: 3.5 Other (no significant themes): 3.0 **TOTAL**: **23.5**	 The 62-day screening pathway breaches in the period were due to patient choice or medical deferral, and therefore continued to be outside of the control of the Trust.	The priorities for improving the Trust's performance against the 62-day GP cancer standard continue to be the implementation of a 7-day wait for the first step in the pathway, and implementation of ideal timescale pathways both within the Trust and by referring providers (Action 8). Late referral from other providers remains the highest cause of breaches, and along with case-mix poses and ongoing risk to achievement.
Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.	The national 99% standard was achieved at the end of June, consistent with the Trust's recovery trajectory. The number and percentage of over 6-week waiters at month-end, is shown in the table below: **Diagnostic test** / **Apr** / **May** / **Jun** Echo: 66 / 58 / 34 Audiology: 0 / 14 / 8 MRI: 17 / 5 / 0 Endoscopies: 22 / 17 / 26 Other: 9 / 1 / 2 **TOTAL**: **114** / **95** / **70** Percentage: **98.3%** / **98.6%** / **99.0%** Trajectory: 98.0% / 98.4% / 99.0%		Although the 99% standard was achieved at the end of June, there are risks that this position will not be sustained, due to recent resignations within the echocardiography team. Additional focus is also being placed on reducing the number of routine patients waiting over 6 weeks for paediatric gastro-intestinal endoscopies. These are the two areas of focus of the ongoing action plan (Actions 9A and 9B).

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In June, the Trust cancelled 1.17% of operations at last-minute for non-clinical reasons. There were 70 last minute cancellations, the reasons for which are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number/ percentage</th></tr>
<tr><td>No intensive therapy unit (ITU) or high dependency unit (HDU) bed, or staff</td><td>35 (50%)</td></tr>
<tr><td>Surgeon taken ill / unavailable</td><td>9 (13%)</td></tr>
<tr><td>No ward bed</td><td>8 (11%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>6 (9%)</td></tr>
<tr><td>Other causes (no themes)</td><td>12 (17%)</td></tr>
</table>
</td>
<td> 

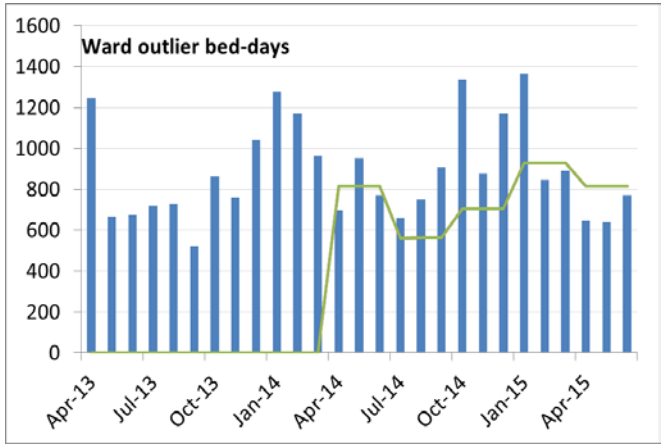
81% of patients cancelled in May were readmitted in June, within the required 28 days. Twelve were not readmitted within 28 days, half of which were impacted by Cardiac Intensive Care Unit bed availability.</td>
<td>The level of last-minute cancellations due to a lack of ITU or HDU beds in June was more than three times higher than the average for the previous twelve months. Cancellations for this reasons were also high in April/May, and combined with other ‘exceptional’ causes of cancellation resulted in the Trust’s quality objective not being met for the quarter. Options for reducing HDU related cancellations are under review (Actions 10A and 10B).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In June 10.1% of outpatient appointments were cancelled by the hospital. This is a reduction on May’s performance of 11.7%, when the indicator was RED rated.

Further analysis is being undertaken as to the cause of the higher cancellation rate than last year, but it is believed to be due to the increased capacity established to maintain lower first outpatient waiting times, which may have resulted in a higher proportion of patients’ appointments being brought forward.</td>
<td> 
</td>
<td>Whilst it’s positive for patients to be offered earlier appointments, if the right capacity is established in the first place, patient’s appointments do not need to be moved, both reducing administrative workload and improving patient experience. Ensuring outpatient capacity is effectively managed is a core part of the work to improve the efficiency of the Trust’s outpatient services as being overseen by the Outpatients Steering Group (Action 11).</td>
</tr>
</table>

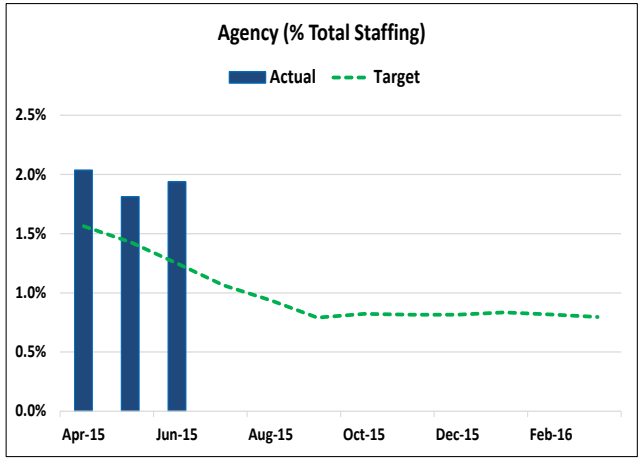
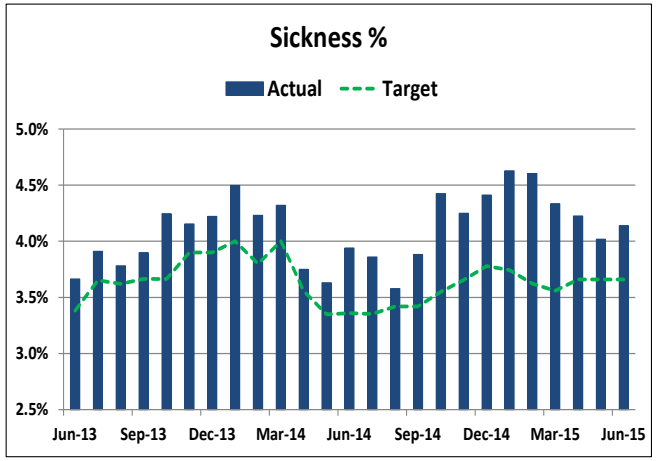
Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator (in hospital deaths) is the ratio of the actual number of patients who died in hospital and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other factors.	Summary Hospital Mortality Indicator for May 2015 was 62.1 against an internally set target of 80.	Summary Hospital Mortality Indicator (SHMI) for in hospital deaths. 	This is a high level indicator of the effectiveness of the care and treatment we provide. May's performance indicates that fewer patients died in our hospitals than would have been expected given their specific risk factors.
Stroke care. This indicator is a measure of what percentage of a stroke patient's stay was spent on a designated stroke unit. The target is for 90% of patients to spend at least 90% of their stay in hospital on a stroke unit, so that they receive the most appropriate care for their condition	Performance in May 2015 was 97.2% (latest data) against a target of 90%. There were 36 patients discharged in May, of which 35 had spent at least 90% of their stay on the stroke unit. The additional bed numbers dedicated to stroke following the move from B501 (19 beds) to A522 (25 beds) in January 2015 has had a positive impact on performance related to 90% stay, which evidence tells us, gives us the best outcome for patients.		The Standard Operating Procedure (SOP) to ensure a Stroke bed remains empty at all times to facilitate a direct admission, has also been embedded into practice and is a focus of the daily Patient Flow meetings too.

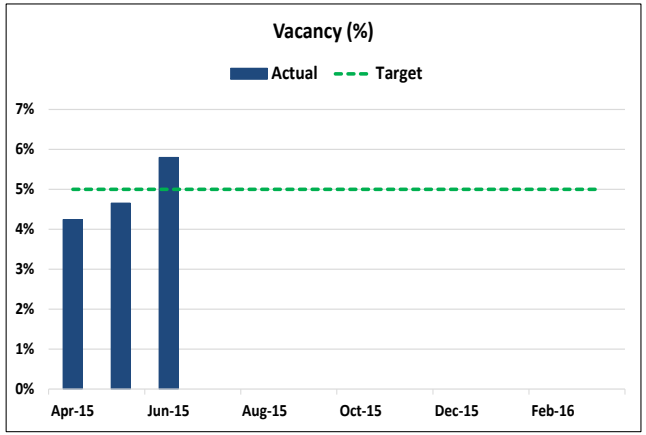
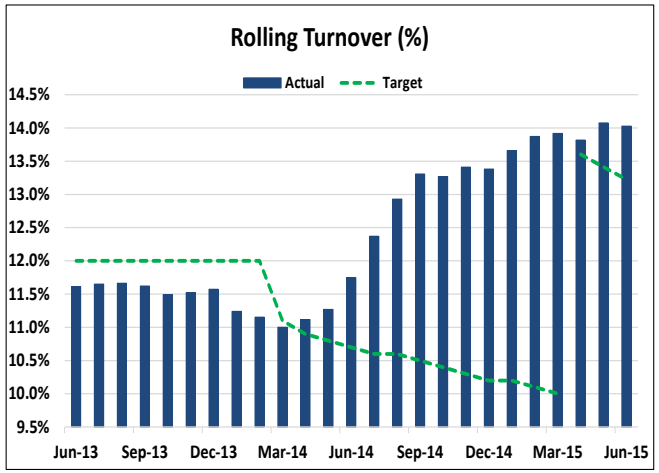
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.</td>
<td>In May (latest data), 39 out of 41 patients (95.1%) were treated within 90 minutes of arrival in the hospital, meeting the 90% standard.</td>
<td> 
</td>
<td>Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. No main themes arising for the year to date, and the 90% standard continues to be met for the quarter as a whole.</td>
</tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In June we achieved 66.7% overall performance in Best Practice Tariff. There were 24 patients eligible for Best Practice Tariff in the period, 8 of which were not operated on within 36 hours. Two of these patients were also not reviewed by an Ortho-geriatrician within 72 hours due to sickness and planned leave.
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Not diagnosed on admission</td><td>1</td></tr>
<tr><td>Waiting for a MRI scan</td><td>1</td></tr>
<tr><td>Waiting to be medically optimised</td><td>2</td></tr>
<tr><td>Not well enough for theatre</td><td>1</td></tr>
<tr><td>Lack of theatre capacity</td><td>3</td></tr>
</table></td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.

</td>
<td>All of the three patients who breached due to lack of theatre capacity were delayed due to another Fractured Hip (NOF) patient being prioritised.

Actions being taken to improve performance reflect the two main issues affecting best practice tariff achievement, which are consistent access to theatre and Ortho-geriatrician review, are described in the actions section of this report (Actions 12A to 12F).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.	In June there were 769 outlier bed-days against a Q1 monthly target of 814.		Ward changes as a result of bed-modelling have seen an increase in the bed base for Medicine and the number of medical outliers has reduced significantly in Q1 2015/16. Work is in progress to map surgical patient pathways to decrease the length of stay and achieve “Right patient, Right bed’. Work continues to reduce the number of delayed transfers of care patients within the Trust which will release acute beds further.

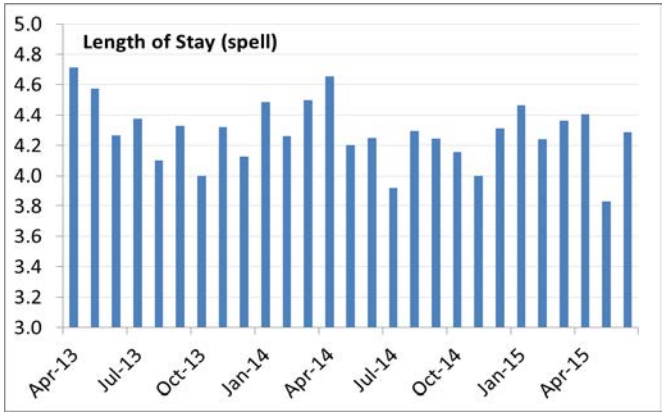
Outlier bed-days	June 2015
Division of Medicine	302
Division of Surgery, Head & Neck	348
Division of Specialised Services	106
Women's & Children's Division	13
Total	769

Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency KPIs were established by Divisions within the Operating Plan Process. **June 2015 / FTE / % / KPI** **UH Bristol: 157.3 / 1.9% / 1.2%** Diagnostics & Therapies: 5.8 / 0.6% / 1.0% Medicine: 34.1 / 2.7% / 2.4% Specialised Services: 26.1 / 3.0% / 2.1% Surgery, Head & Neck: 32.2 / 1.8% / 1.1% Women's & Children's: 36.8 / 2.0% / 0.5% Trust Services: 12.3 / 1.8% / 0.7% Facilities & Estates: 10.1 / 1.3% / 1.2%		There was a 6% increase in agency FTE this month, most of which was nursing, with increased usage due to vacancy cover, sickness absence, and increased patient acuity The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 13).
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence targets were established by Divisions within the Operating Plan Process. Current performance is variable resulting in a Trust position of 4.1% against a month 3 target of 3.7% **June 2015 / Actual / KPI** **UH Bristol: 4.1% / 3.7%** Diagnostics & Therapies: 3.0% / 3.0% Medicine: 6.0% / 4.2% Specialised Services: 3.7% / 3.7% Surgery, Head & Neck: 3.9% / 3.5% Women's & Children's: 3.6% / 3.6% Trust Services: 3.1% / 2.6% Facilities & Estates: 5.9% / 5.2%		There are programmes of work in place to tackle anxiety, stress and depression (Action 14) which continues to be the top reason for absence, although there was a 12% reduction in absence due to these reasons in June. Unusually this month, gastro-intestinal related absence is second highest with a 17% increase. This will be monitored during the coming months, as there was no corresponding increase in outbreaks reported by wards.

Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Vacancies have increased from 4.7% (368.5 FTE) to 5.8%, (463.6 FTE) against a target of 5%, mainly due to higher funded establishment (78 FTE) associated with contract changes. In addition there has been a reduction in staff in post (Trust wide: 17 FTE).		Recruitment trajectories have been produced to provide assurance that there is alignment between workforce demand and planned supply, and these will be updated during July and August. Ongoing recruitment plans are described in improvement plan section (Action 15).
Turn-over is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory**.**	Turnover has remained at about 14%. Facilities & Estates reduced by 7.7% to 13.2% in June. The highest increases were in Trust Services, followed by Diagnostics & Therapies and Surgery Head & Neck.		Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 16). However, at the end of the first quarter achievement of the annual target appears at risk. This will be closely examined during quarterly reviews.

June 2015	Rate
UH Bristol	**5.8%**
Diagnostics & Therapies	5.7%
Medicine	6.7%
Specialised Services	6.2%
Surgery, Head & Neck	4.5%
Women's & Children's	4.3%
Trust Services	7.3%
Facilities & Estates	9.2%

June 2015	Actual	Target
UH Bristol	**14.0%**	**13.2%**
Diagnostics & Therap.	12.1%	11.3%
Medicine	13.5%	13.4%
Specialised Services	16.4%	15.6%
Surgery, Head & Neck	16.0%	14.5%
Women's & Children's	12.1%	11.5%
Trust Services	16.4%	14.0%
Facilities & Estates	13.2%	13.6%

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In June the average length of stay for inpatients was 4.28 days. This is an increase on the previous month, when patients stayed an average of 3.83 days. The average LOS for patients discharged in the month is often a reflection of the number of long stay patients discharged in the period. Consistent with the increase in LOS for patients discharged in June, there was a decrease in the number of patients that had stayed 14 days or more in hospital at the end of the month.		The number of surgical outliers has increased in recent weeks, with LOS being above plan for particular specialties (Action 17). Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan.

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Essential Training	1A	Continue to drive compliance of core topics, including increasing e-learning	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	Trajectory linked to action plans to achieve compliance by August 2015
	1B	From July, all managers will receive an electronic notification of when compliance for their staff members expires	July 2015	Oversight by Workforce and OD Group via the Essential Training Steering Group	Trajectory linked to action plans to achieve compliance by August 2015
	2	Detailed plans to improve compliance of Safeguarding and Resuscitation	August 2015	Oversight of safeguarding training compliance by Safeguarding Board	
Monthly Staffing levels	3	Posts have been recruited to, with start dates of September.	September 2015	Future staffing reports.	N/A
Caring					
Dissatisfied Complainants	4	Training is being delivered to all Divisions in relation to the quality objective to improve the quality of written complaint responses.	Completion by October 2015	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	10% by October 2015, then 5% by March 2016.
Outpatient Experience	5	Analysis of Divisional-level outpatient survey data.	August 2015	To Trust Board in August 2015	Individual improvement actions will be identified if necessary.
Responsive					
A&E 4-hours	6A	Analysis of the causes of the unexpected rise in emergency admissions into the BCH; work with commissioners to mitigate expected winter rise in admissions.	August	Urgent Care Board	Achievement of recovery trajectory over winter, when emergency admissions increase as a result of respiratory viruses.
	6B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of 95% for Q2, as per the recovery trajectory

	6C	Working with partners to mitigate any impact of planned recommissioning of domiciliary care packages providers and bed closures in other acute trusts	Ongoing	Urgent Care Board	Achievement of 95% for quarter 2, as per the recovery trajectory
Referral to Treatment Time (RTT)	7A	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory.	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of the RTT Incomplete/Ongoing pathways standard from Q2 2015/16.
	7B	Continued weekly review of management of longest waiting patients through RTT Operations Group	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of the RTT Incomplete/Ongoing pathways standard from Q2 2015/16.
Cancer waiting times	8	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments.	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with escalation to Cancer Steering Group.	Restore internal pathway performance to above 85% for quarter 3.
Diagnostic waits	9	Weekly monitoring of waiting list to inform capacity planning, with particular focus on cardiac stress echo and paediatric gastrointestinal endoscopy long waiters.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Ongoing achievement of 99% standard, now achieved in June.
Last minute cancelled operations	10A	Review of options to reduce HDU/ITU bed-related cancellations.	July	Monthly Divisional Review Meetings; improvement to be evidenced by a reduction in cancellations for this reason.	Timescale for improvement dependent upon options identified
	10B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan by Associate Director of Operations.	Achievement of national standard of 0.8% in quarter 4 2015/16.
Outpatient appointments	11	Improvements to be realised through improvements in booking	To be confirmed	Oversight of programme of work, which this is a core part,	To be confirmed.

cancelled by hospital		practices and appointment slot management		by the Outpatients Steering Group.	
Effective					
Fractured Neck of Femur Best Practice Tariff	12A.	Trauma theatre to start on time to maximise available theatre time.	Ongoing	100% performance in the past 4 weeks	80% by August 2015.
	12B	Weekend trauma lists	Ongoing	All day trauma in place all day Saturday and Sunday	In place
	12C	Escalation of each NOF patient admitted	End July 2015	All fractured NOF patients over 24 hours escalated by trauma co-ordinator to AGM for T&O. Any without plan to be escalated to Divisional Director/Clinical Chair/Deputy Divisional Director.	
	12D	Senior management attendance at the daily Trauma meeting	July 2015	Management team presence now in place for all daily trauma meetings. Escalation from meetings to Assistant General Manager if patients not dated within 36 hours.	
	12E	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	September 2015	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured NOF patients waiting and all fractured NOF patients over 24 hours. Operational triggers agreed against amber and red thresholds. Updates currently being completed and Training to be undertaken in August 2015.	
	12F	Confirm cover arrangements for current 1 Whole Time Equivalent (WTE) gap in Ortho-geriatric establishment due to sickness.	September	Locum post recruited to, to start in September 2015.	Improve Ortho-geriatrician review to 100%

Well led					
Agency Usage	13	As with all workforce KPIs, improvement plans are being driven divisionally, by staff group (where appropriate) and corporately. Key actions driven corporately for Agency are: <u>Nursing and midwifery</u> • Introduction of weekly divisional meetings to undertake a proactive review of bank/agency activity to ensure appropriate controls are being monitored, informed by benchmarking • Disseminate a guide for managers and staff on bank pay arrangements to give clarity for staff wishing to work additional hours, and managers • Close work with wards continues in order to maximise the functionality of Rosterpro to support booking and payment processes for bank staff. A trial for direct booking based at ward level is being scoped and is planned to commence in September 2015 <u>Admin & Clerical</u> • Re-engineering of the recruitment process to the bank to ensure speed and	July 2015 July 2015 September 2015 August 2015	Oversight by Savings Board (Nursing Agency) and Medical Efficiencies Group (Medical Agency)	The full achievement of agency reduction trajectories are dependent on vacancy levels being below the 5% KPI. Trajectories will be reviewed during imminent quarterly Divisional reviews

		efficiency <u>Ancillary</u> • Further recruitment and skills training to continue to develop a fit for purpose Porters Bank <u>Medical agency usage</u> • Reduce costs by agreed locum rates and procurement of a Master Vend supplier for locums	August 2015 August 2015		
Sickness Absence	14	The Workforce and OD Group have commissioned a review of divisional and corporate sickness absence management plans to ensure focus is on highest impact actions. Continued implementation of the Staff Health and Well Being action plan: *Stress, Anxiety and Depression* The Resilience Building Programme (previously "Lighten-up") consists of 5 modules providing tools and techniques to build resilience and prevent absence for psychological reasons. Work during July will include gathering feedback from previous participants on whether the impact of the programme has been sustained. *Musculo-skeletal* Targeted intervention by: • Occupational Health Musculo-	August Commencing August 2015 to April 2016	Oversight by Workforce and OD Group via the Staff Health and Well Being Sub Group	The Trust is currently amber rated. However, still anticipate hitting 2015/2016 target of 3.7%. This will be rigorously assessed at quarterly reviews with Divisions

		skeletal services • Physio direct • Support from Manual Handling Team	Ongoing		
Vacancies	15	Recruitment action plan includes the following ongoing activities: • Following a decision not to undertake overseas recruitment during 2015/2016, the focus is on an advertising programme to target the national market for hard to fill posts including nursing and midwifery. This will be underpinned by a schedule of targeted recruitment campaigns including dates for in house open days between now and March 2016 • Full implementation and handover to the Trust from the suppliers of TRAC at the end of July will enable conversion to hire rates to improve and benefits realised	Commencing September 2015 to March 2016 September 2015	Oversight by Workforce and OD Group via the Recruitment Sub Group.	Improvement is focussed on staff groups where vacancy levels are above target including nursing and midwifery. Specific trajectories will be set for these areas as part of the ongoing action plan
Turnover	16	As there is no single driver for turnover, there is a wide ranging programme of work on retention. Key corporate actions next quarter include: • As part of the Staff Experience Programme a number of workshops for staff will take place to agree how we improve communications between our	July – September 2015	Oversight by Workforce and Organisational Development Group	At the end of the first quarter, turnover rates have not started to reduce in line with Operating Plan assumptions. These will be reviewed during quarterly performance discussions and a trajectory produced to show anticipated position to March 2016

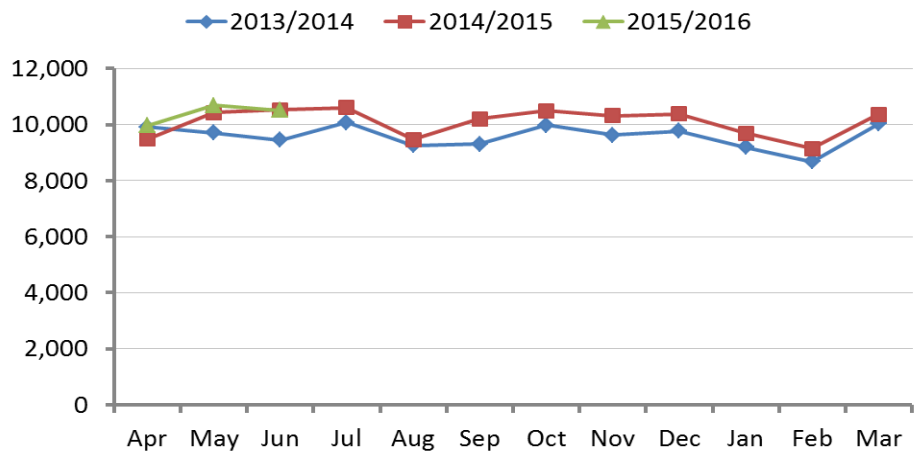
		managers and teams with an outcome of improving staff experience.
		• Programme to reduce nurse turnover, including:
		  o Preceptorship for Newly Qualified nurses and midwives;
		  o New recruitment and training pathway for nursing assistants.
		• Consideration of innovative training and development for theatres and critical care staff			

Length of stay	17	Further benchmarking of surgical Length of Stay to be undertaken, as recent increase in surgical outliers within the medical bed base; actions to be developed from this, and information on where specialty LOS resulting in patients outlying from their specialty wards.	To be confirmed	Followed-up through monthly Divisional Review meetings.	Improvements to be evidenced through a reduction in outliers. Timescales to be confirmed.

Operational context

This section of the report provides a high level view of the level of demand for the Trust's services during the reporting period, relative to that of previous months and years.

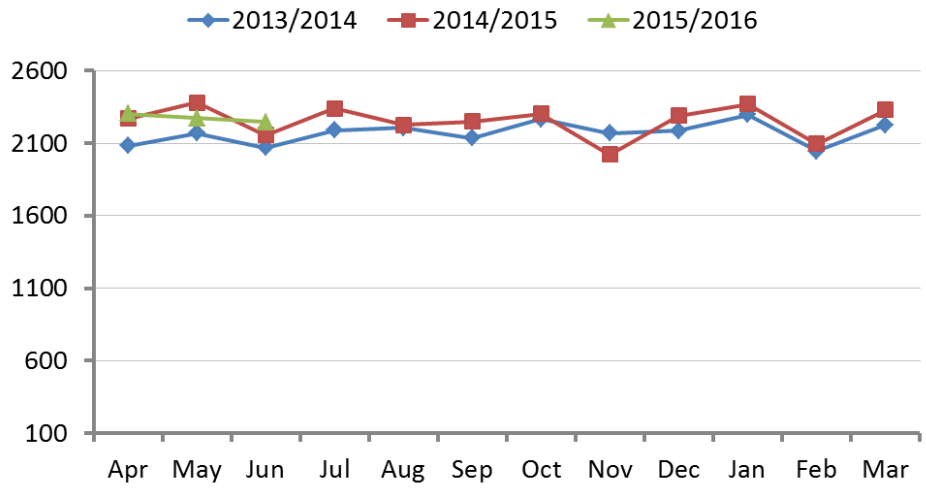
A&E attendances



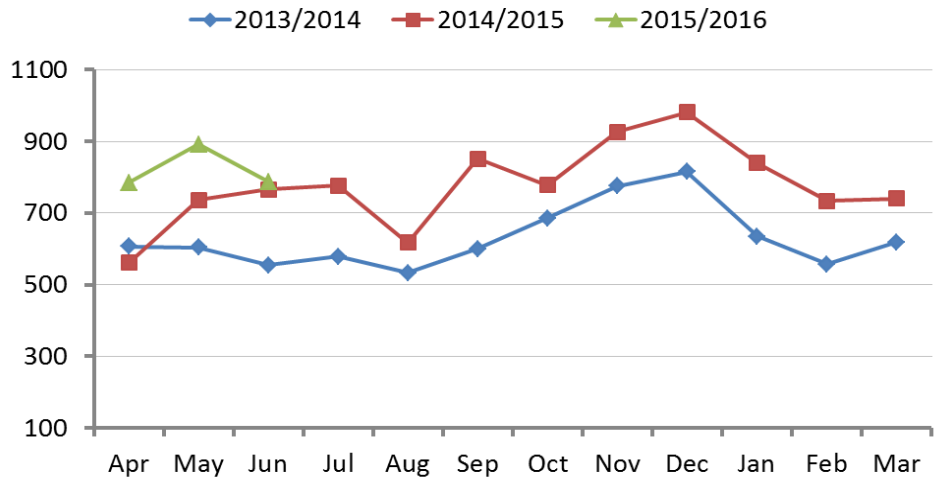
Summary points:

- The level of emergency admissions into the BRI remains consistent with the seasonal norms; levels of emergency admissions into the BCH have reduced from the winter-type levels seen in May, which impacted in 4-hour performance;
- Consistent with the increased level of activity planned to deliver reductions in numbers of patients waiting over 18 weeks from Referral to Treatment, there has been an increase in elective admissions and outpatient attendances in June;
- However, as will be seen in the Assurance and Leading Indicators summary, this additional activity has not off-set the growth in the outpatient waiting list, resulting from a sharp rise in outpatient referrals in June.

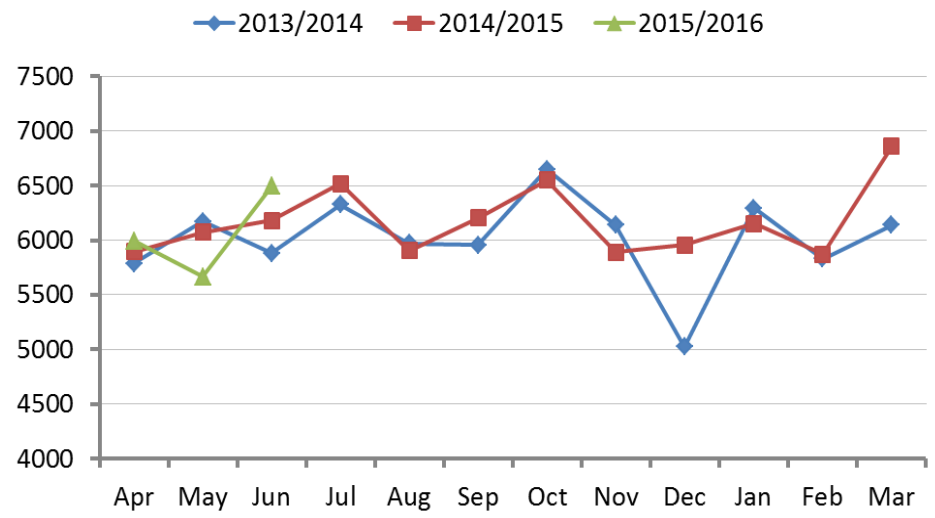
Emergency admissions (BRI)



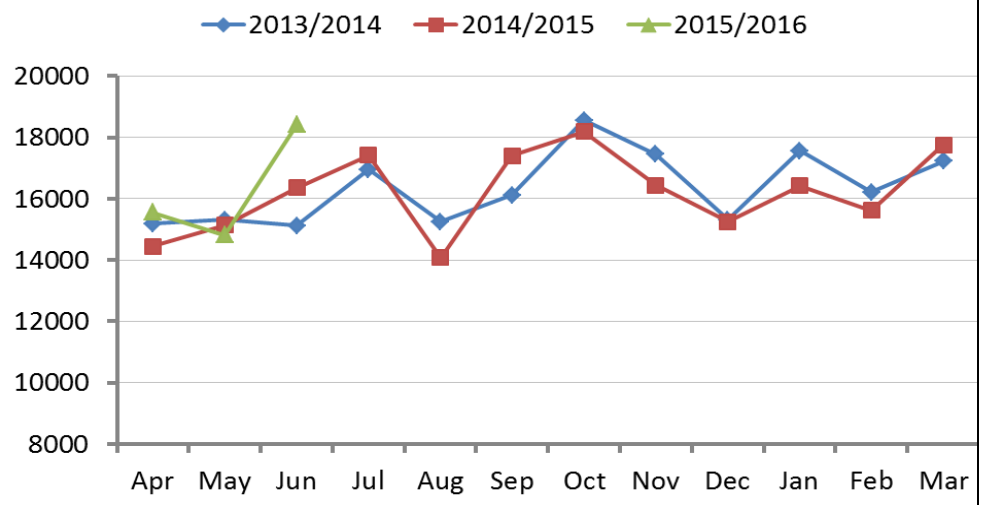
Emergency admissions (BCH)



Elective admissions



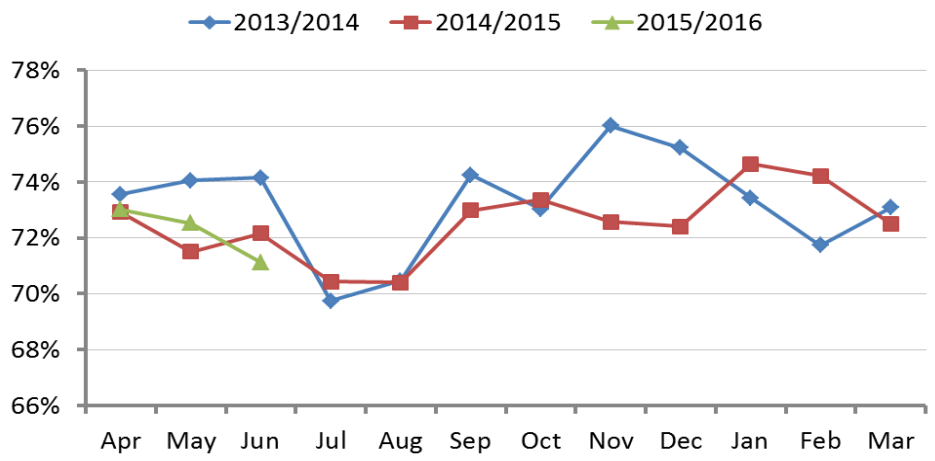
New outpatient attendances



Assurance and Leading Indicators

This section of the report looks at set of assurance and 'leading' indicators, which help to identify future risks and threats to achievement of standards. This indicator set will be added-to in future months.

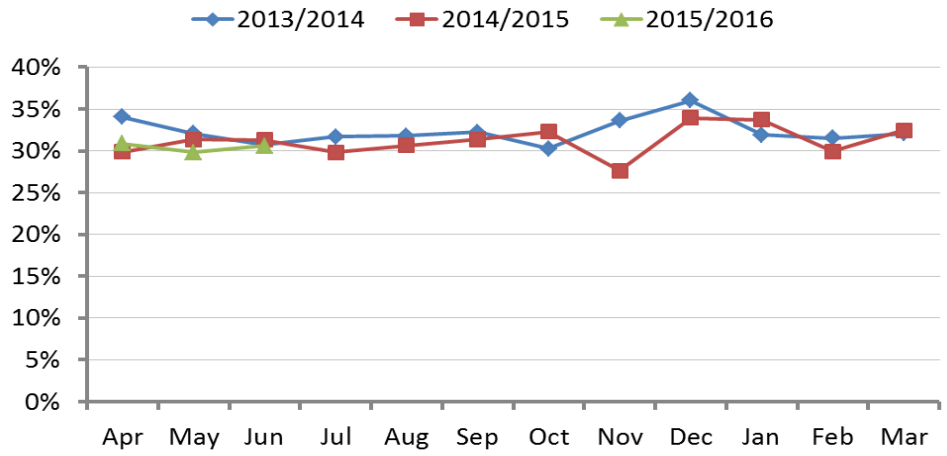
Percentage ED attendances resulting in admission



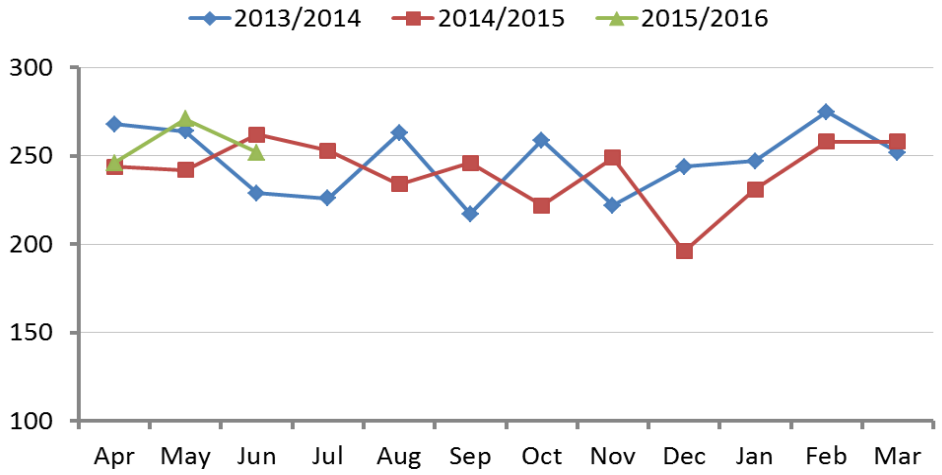
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission, and the percentage of patients admitted aged 75 years and over, remains within the seasonal norm;
- Over 14 day stays reduced in June, which was heavily contributed to by the number of delayed discharges returning to 2014/15 levels; delayed discharges, however, remain higher than the end of April;
- Numbers of patients on the elective waiting list have started to reduce; this is consistent with additional work undertaken to reduce the number of patients waiting over 18 weeks from Referral to Treatment (RTT);
- Numbers of patients awaiting a new outpatient appointment is rising, following an increase in referrals in June 2015; this suggest a future risk to continued achievement of RTT backlog reductions.

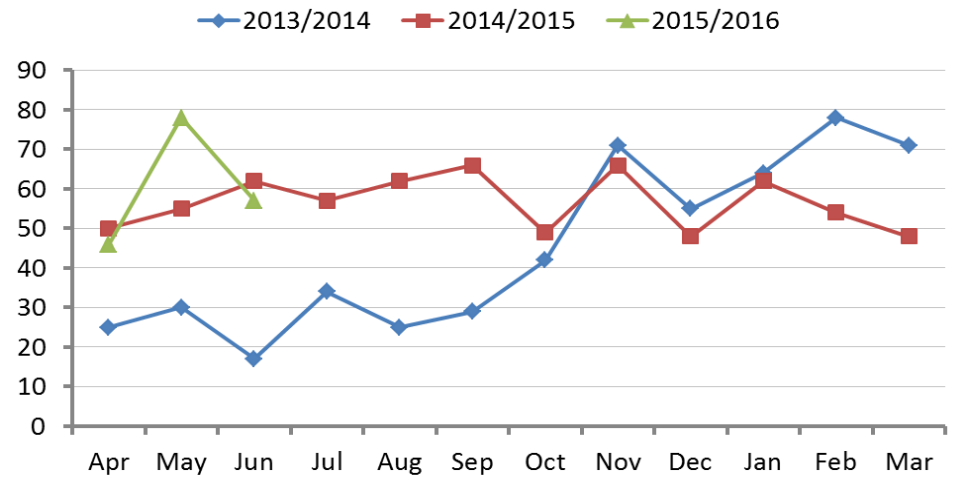
Percentage of Emergency BRI spells patients aged 75 years and over



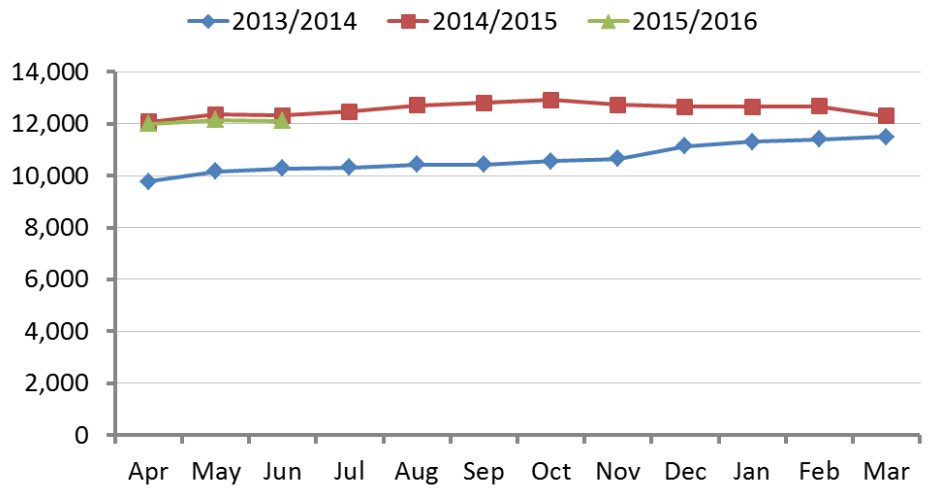
Over 14 day stays



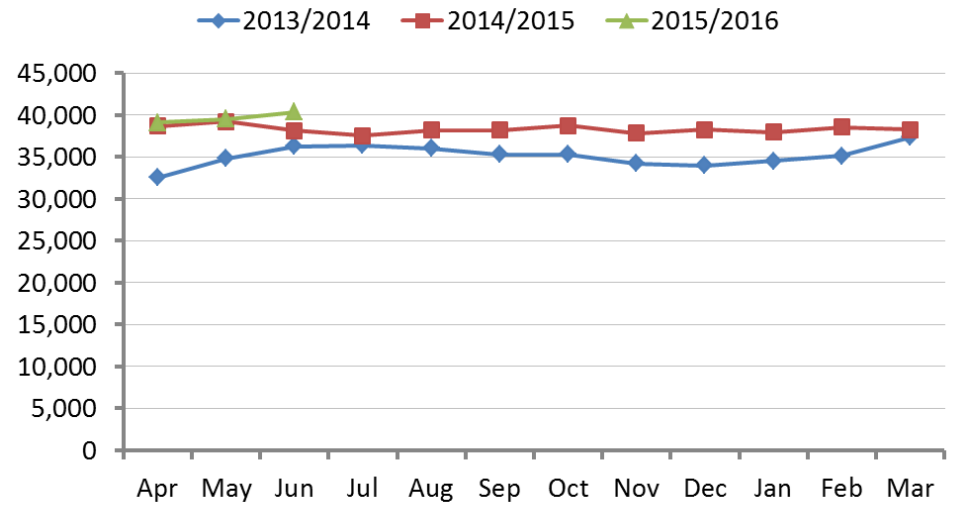
Delayed discharges



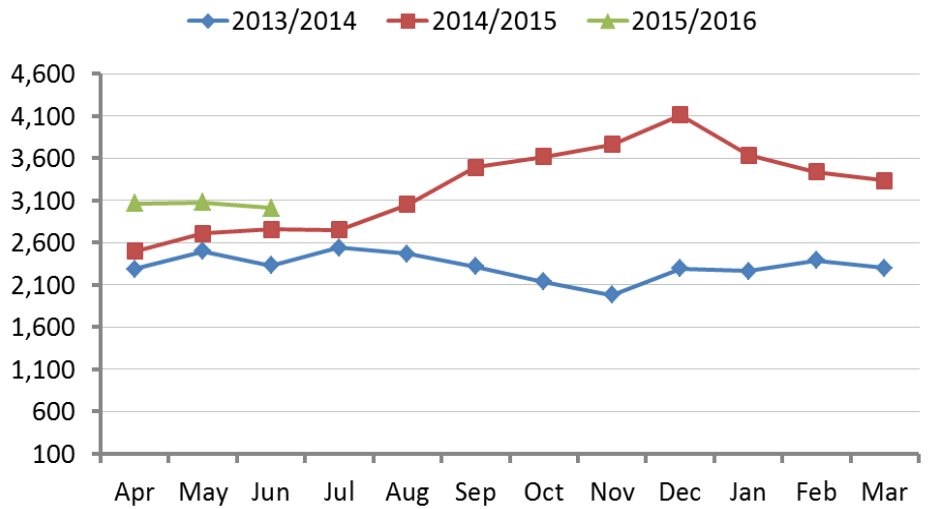
Elective waiting list size



Outpatient waiting list size



Number of RTT pathways over 18 weeks



Trust Scorecards

QUALITY

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-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	2	3	3	3	3	3	4	4	5	5	1	1	2	3	4	5	2
	DA03	C.Diff Cases - Monthly Totals	50	10	4	6	8	4	4	4	3	4	0	6	1	3	18	12	7	10
	DA02	MSSA Cases - Monthly Totals	33	9	7	1	4	1	3	4	3	2	4	4	1	4	12	8	9	9
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	8	-	2	3	5	6	6	6	7	8	8	-	-	-	5	6	8	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.2%	97.2%	96.8%	96.9%	97.1%	96.3%	97.2%	97.6%	97.1%	97.4%	97.6%	97%	96.9%	97.6%	97%	97%	97.4%	97.2%
	DB02	Antibiotic Compliance	89.3%	90.1%	89.6%	86.2%	88.5%	90.3%	91.2%	89.1%	90.6%	88.8%	88.8%	90.7%	90.9%	88.9%	88.2%	90.3%	89.4%	90.1%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	95%	-	93%	96%	96%	95%	95%	94%	95%	96%	96%	96%	95%	95%	95%	95%	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	96%	-	96%	97%	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	97%	97%	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	95%	-	91%	96%	95%	95%	96%	95%	95%	96%	96%	97%	97%	95%	94%	95%	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	78	16	10	3	7	10	6	8	7	4	6	6	6	4	20	24	17	16
	S02a	Number of Confirmed Serious Incidents	69	4	8	3	6	8	5	7	5	4	6	3	1	-	17	20	15	4
	S02b	Number of Serious Incidents Still Open	4	11	-	-	-	1	0	1	2	0	0	2	5	4	-	2	2	11
	S03	Serious Incidents Reported Within 48 Hours	88.5%	81.3%	100%	100%	100%	80%	83.3%	100%	100%	100%	83.3%	100%	100%	25%	100%	87.5%	94.1%	81.3%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	73.3%	78.6%	70%	85.7%	100%	50%	66.7%	37.5%	80%	66.7%	100%	75%	85.7%	66.7%	81.8%	46.7%	76.2%	78.6%
Never Events	S01	Total Never Events	6	0	0	0	0	0	1	0	1	1	1	0	0	0	0	1	3	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	12712	2226	1104	1038	1258	1151	1028	1073	1017	1022	1124	1087	1139	-	3400	3252	3163	2226
	S06b	Patient Safety Incidents Per 1000 Beddays	41.32	43.05	42.88	41.09	49.62	44.91	40.6	41.66	37.64	41.85	43.14	42.65	43.43	-	44.53	42.4	40.81	43.05
	S07	Number of Patient Safety Incidents - Severe Harm	89	12	5	4	16	3	12	6	12	7	6	7	5	-	25	21	25	12
Patient Falls	AB01	Falls Per 1,000 Beddays	4.8	3.97	4.51	4.59	4.26	5.23	4.5	5.59	4.89	4.91	4.53	3.61	4.46	3.81	4.45	5.11	4.77	3.97
	AB06a	Total Number of Patient Falls Resulting in Harm	28	4	0	3	5	2	4	1	2	1	2	2	2	0	8	7	5	4
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.387	0.31	0.427	0.396	0.394	0.312	0.553	0.388	0.37	0.45	0.269	0.353	0.267	0.311	0.406	0.417	0.361	0.31
	DE02	Pressure Ulcers - Grade 2	110	23	10	10	10	8	13	8	9	10	5	9	7	7	30	29	24	23
	DE03	Pressure Ulcers - Grade 3	9	1	1	0	0	0	1	2	1	1	2	0	0	1	1	3	4	1
	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%	99.2%	98.4%	98.6%	98.9%	98.7%	99%	99%	99.1%	99.4%	99.2%	99.1%	99.3%	99.1%	98.7%	98.9%	99.2%	99.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.4%	93.8%	95.3%	96.6%	93.2%	92.6%	92.3%	96.7%	92.4%	92.9%	96%	93.9%	93%	94.3%	95.1%	93.8%	93.8%	93.8%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	88.9%	90.9%	89%	89.3%	93.1%	88.3%	87.2%	87.8%	87.4%	88.4%	87.9%	86.8%	93%	92.3%	90.4%	87.8%	87.9%	90.9%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.9%	99.5%	99.7%	99.6%	99.7%	99.6%	99.4%	100%	100%	100%	100%	99.7%	100%	99.6%	99.6%	100%	99.9%

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Quarterly Totals 14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Patient Safety																				
Medicines	WA01	Medication Errors Resulting in Harm	0.45%	0.29%	1.09%	0.52%	0.56%	0%	0.57%	0%	0%	0%	0.54%	0%	0.56%	-	0.72%	0.2%	0.21%	0.29%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.01%	0.96%	1.41%	1.42%	0.69%	1.21%	0.86%	0.37%	1.55%	1.54%	0.52%	0.63%	1.43%	0.96%	1.19%	0.84%	1.23%	0.96%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	96.6%	97.6%	96.7%	96.9%	96.5%	96.1%	96.7%	97%	96.7%	97.9%	96.5%	97.5%	97.1%	98.2%	96.7%	96.6%	97%	97.6%
	AK04	Safety Thermometer - No New Harms	98.4%	98.6%	98.9%	98.7%	98%	97.9%	97.8%	98.5%	98.4%	99.3%	98.7%	98.9%	98.2%	98.6%	98.5%	98.1%	98.8%	98.6%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	89%	92%	91%	96%	88%	88%	86%	83%	92%	96%	88%	90%	96%	91%	92%	85%	91%	92%
Out of Hours	TD05	Out of Hours Departures	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	19.5%	19.1%	18.9%	16.9%	18.4%	18.9%	16.9%	19%	18.5%	22.3%	20.6%	20.4%	19%	18.1%	18.1%	18.3%	20.4%	19.1%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9862	2547	827	681	791	829	726	800	809	877	873	845	838	864	2299	2355	2559	2547
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	97.9%	100%	-	90%	100%	85.7%	100%	100%	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	0	0
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.4%	101%	-	-	102.5%	103.8%	104.5%	102.9%	104.4%	103.3%	102.2%	100.2%	100.1%	101.7%	103.6%	103.7%	103.3%	101%
Clinical Effectiveness																				
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deat	64.1	58.4	56.1	66.5	64.1	65.9	85.4	58.5	68.7	60.9	64.1	54.8	62.1	-	62.2	68.7	64.9	58.4
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	95.8	-	-	-	95.8	-	-	-	-	-	-	-	-	-	95.8	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	68.4	64	58.1	74.7	73.9	70.4	89.7	63.3	71.1	57.6	69	57	71.9	-	69	73.1	66.5	64
Readmissions	C01	Emergency Readmissions Percentage	2.82%	3.32%	2.51%	2.95%	2.96%	2.45%	2.39%	2.99%	3.06%	2.83%	2.96%	2.89%	3.76%	-	2.8%	2.61%	2.95%	3.32%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	61.5%	62.8%	64.7%	61.4%	63.8%	58.9%	65.5%	59.6%	60%	59.8%	57.9%	60.9%	63.4%	64.1%	63.4%	61.3%	59.3%	62.8%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	76%	70.2%	82.1%	71.4%	61.3%	77.8%	73.3%	70%	78.3%	89.7%	72.7%	71.4%	72%	66.7%	71.3%	73.6%	81.1%	70.2%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	93.4%	78.6%	100%	96.4%	93.5%	88.9%	86.7%	93.3%	95.7%	93.1%	86.4%	77.1%	68%	91.7%	96.6%	90.3%	91.9%	78.6%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.1%	58.3%	82.1%	67.9%	54.8%	70.4%	60%	66.7%	78.3%	82.8%	50%	57.1%	52%	66.7%	67.8%	66.7%	71.6%	58.3%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	40.7	57.3	54.1	41.5	41.3	57.5	45.5	47.2	47.6	45.5	57.4	56.8	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	56.5%	67.1%	48.6%	53.7%	61.1%	62.8%	59%	62.8%	55%	66.7%	60%	68.6%	65.7%	-	54.4%	61.6%	61.2%	67.1%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	86.4%	97.2%	97.3%	78%	86.1%	88.6%	87.2%	79.1%	75%	87%	92.5%	97.1%	97.2%	-	86.8%	84.9%	85.1%	97.2%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.2%	60.5%	25%	72.2%	66.7%	58.8%	73.3%	64.7%	50%	57.1%	50%	69.2%	83.3%	30.8%	61.4%	65.3%	52.8%	60.5%
Dementia	AC01	Dementia - Find, Assess, Investigate and Refer Q1	65%	84.9%	62.1%	67.5%	66.6%	61.4%	63.7%	62.9%	78.3%	77.3%	81.6%	83.9%	88.4%	82.7%	65.4%	62.6%	79.3%	84.9%
	AC02	Dementia - Find, Assess, Investigate and Refer Q2	84.1%	97%	84.7%	81.7%	87.3%	87.1%	92.2%	82.2%	90.7%	88.5%	94.2%	98.6%	100%	92.8%	84.7%	86.3%	91.7%	97%
	AC03	Dementia - Find, Assess, Investigate and Refer Q3	58.5%	91.5%	55.2%	50%	35.9%	78.3%	73.3%	68%	82.4%	81.3%	90.5%	90%	92.3%	92.9%	44.8%	74.3%	85.2%	91.5%
	AC04	Percentage of Dementia Carers Feeling Supported	75.2%	94.6%	-	-	70%	80%	88.9%	64.3%	87.5%	81.8%	-	90.9%	100%	93.3%	57.1%	78.7%	85.2%	94.6%
Outliers	J05	Ward Outliers - Beddays	11216	2054	659	749	908	1338	876	1169	1364	847	889	647	638	769	2316	3383	3100	2054

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-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	-	-	88	89	89	89	89	89	89	90	89	89	92	-	89	89	89	90
	P01g	Patient Survey - Kindness and Understanding	-	-	92	93	94	93	93	94	93	93	93	94	96	-	93	93	93	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	-	-	-	-	-	-	-	-	-	89	89	89	-	-	-	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	38.7%	17.7%	35.5%	32.9%	33.1%	36.1%	41.3%	29.5%	37.9%	33.9%	59.3%	17.4%	19.7%	16.2%	33.8%	35.5%	44%	17.7%
	P03b	Friends and Family Test ED Coverage	20.8%	6.7%	16.1%	22.7%	26.2%	20.2%	14.9%	16%	17.3%	22.5%	37.1%	6.6%	6.7%	7%	21.6%	17.1%	26.1%	6.7%
	P03c	Friends and Family Test MAT Coverage	28.9%	26.1%	19.7%	47.5%	32.4%	18.9%	54.3%	29.2%	26.9%	22.5%	35%	23.9%	33.7%	20.1%	33.1%	33.7%	28.2%	26.1%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	94.9	96	93.4	92.6	96.7	94.3	94	96.3	95.9	93.3	95.5	96.1	95.5	96.3	94.3	94.7	95.1	96
	P04b	Friends and Family Test Score - ED	92.7	72.2	93.8	91.1	91.2	90.5	92.4	92.1	93.4	89.9	93.5	80.7	66.3	70.4	91.8	91.5	92.5	72.2
	P04c	Friends and Family Test Score - Maternity	94.2	95.6	95.7	92.2	93	97.1	95.8	92	97.1	97.1	91.5	97.3	93.3	97.8	93.1	95	94.9	95.6
Patient Complaints	T01	Number of Patient Complaints	1883	459	178	170	170	148	140	133	165	171	181	158	147	154	518	421	517	459
	T01a	Patient Complaints as a Proportion of Activity	0.261%	0.249%	0.282%	0.321%	0.266%	0.224%	0.251%	0.224%	0.267%	0.291%	0.273%	0.266%	0.25%	0.231%	0.288%	0.232%	0.277%	0.249%
	T03a	Complaints Responded To Within Trust Timeframe	85.9%	84.9%	91.5%	88.3%	88.1%	84.4%	82.9%	82.9%	84.8%	83.7%	85.3%	89.5%	83.9%	82.1%	89.5%	83.4%	84.7%	84.9%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	93%	76.1%	83.3%	81.4%	77.9%	78.6%	87.1%	87.9%	81.4%	92.6%	93%	91.9%	94%	80%	81.1%	88.1%	93%
	T04b	Percentage of Complainants Disatisfied with Response	-	2.5%	-	-	-	-	-	-	-	-	-	1.8%	3.2%	-	-	-	-	2.5%
Ward Moves	J06	Average Number of Ward Stays	2.32	2.22	2.34	2.38	2.42	2.32	2.37	2.25	2.24	2.28	2.24	2.31	2.18	2.19	2.38	2.31	2.25	2.22
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.08%	1.19%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.16%	1.16%	0.97%	1.19%
	F01a	Number of Last Minute Cancelled Operations	749	199	84	54	68	52	108	41	58	46	66	66	63	70	206	201	170	199

ACCESS

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	14/15	15/16 YTD	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Referral to Treatment (RTT)	A01	Referral To Treatment Admitted Under 18 Weeks	90%	90%	84.9%	80.4%	87.2%	84.4%	82.4%	85.2%	83.1%	84.3%	80.5%	80.4%	80.5%	79.9%	81%	80.4%	84.7%	84.3%	80.5%	80.4%
	A02	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	90.3%	90.8%	89.7%	90%	89%	89.2%	88.8%	89.9%	88.9%	89.3%	90%	90.2%	91.4%	90.7%	89.5%	89.3%	89.4%	90.8%
	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	90.4%	90.6%	92%	91.1%	90%	89.4%	88.7%	87.5%	88.8%	89.4%	89.7%	90.5%	90.4%	90.7%	91%	88.5%	89.3%	90.6%
		d																				
Referral to Treatment (RTT) Ongoing Volumes	A03A	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2754	3055	3497	3622	3766	4117	3641	3440	3339	3069	3078	3010	-	-	-	-
	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	59	5	4	0	1	6	8	13	9	11	4	4	1	0	5	27	24	5
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	1842	243	189	153	170	140	117	177	160	161	119	116	89	38	512	434	440	243
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.5%	94.5%	97%	93.2%	94.8%	94.7%	96.3%	97.5%	94.3%	95.8%	93.1%	94.1%	94.9%	-	95%	96.1%	94.3%	94.5%
	E01b	Cancer - Breast Symptom Referrals Seen In Under 2 Weeks	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	96.9%	98%	96.8%	96.2%	96.2%	95.7%	94%	98.5%	97.9%	98.4%	97%	96.3%	99.5%	-	96.4%	96.2%	97.7%	98%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.6%	98.9%	100%	100%	100%	100%	98.9%	100%	99%	98.1%	100%	100%	97.8%	-	100%	99.6%	99%	98.9%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	95.3%	94.5%	97.8%	91.7%	96.4%	92.3%	95%	95.6%	94.4%	95.9%	94.1%	97.1%	-	94.6%	94.8%	95.4%	95.3%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.6%	97.8%	97.7%	98.4%	97.4%	98.2%	99.5%	97.2%	96.5%	97.7%	97.2%	97.5%	98.1%	-	97.8%	98.3%	97.1%	97.8%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	76.9%	78.6%	77.4%	74.3%	79%	81.2%	84.6%	80.8%	75.2%	79.4%	77.3%	76.6%	-	76.8%	81.6%	78.5%	76.9%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	89%	84.2%	92%	94.3%	83.3%	73.3%	100%	90.9%	71.4%	60%	100%	100%	80%	-	90.8%	84.4%	80.6%	84.2%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	90.1%	89.5%	86.7%	68.4%	89.3%	85.7%	100%	90.5%	84.4%	94.4%	87.2%	100%	83.3%	-	83.1%	90.4%	88.8%	89.5%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.08%	1.19%	1.35%	0.97%	1.14%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.16%	1.16%	0.97%	1.19%
	F02B	Number of LMCs Re-admitted Within 28 Days	699	699	660	161	61	76	46	58	47	94	34	55	43	56	54	51	183	199	132	161
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	79.7%	79%	80.6%	76.9%	81.8%	79.4%	73.8%	80%	78.3%	87.1%	83.9%	77.5%	80.5%	-	79.6%	77.2%	82.4%	79%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	92.4%	95.1%	88.9%	94.9%	90.9%	94.1%	81%	92%	95.7%	96.8%	90.3%	95%	95.1%	-	91.7%	88.1%	94.4%	95.1%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.47%	98.64%	97.71%	96.96%	98.13%	99.14%	98.32%	95.85%	95.48%	97.92%	97.9%	98.27%	98.63%	99%	97.6%	97.8%	97.11%	98.64%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	9.2%	11%	8.7%	9.3%	9.1%	8.7%	8.3%	8.9%	9.4%	9.4%	9.4%	11.6%	11.7%	10.1%	9%	8.6%	9.4%	11%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	40	50	54	44	59	43	49	43	39	30	58	51	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	17	12	12	5	7	5	13	11	9	16	20	6	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.7	3.7	4.26	4.17	3.92	4.29	4.25	4.16	4	4.31	4.46	4.24	4.36	4.41	3.83	4.28	4.15	4.16	4.36	4.17

ACCESS (continued)

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 14/15	Annual 15/16 YTD	Monthly Totals Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Quarterly Totals 14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Emergency Department Indicators																						
Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	92.23%	94.48%	92.4%	93.65%	92.37%	93.81%	88.62%	86.27%	90.87%	89.53%	95.01%	94.81%	93.47%	95.2%	92.78%	89.59%	91.92%	94.48%
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	10	0	0	0	0	0	0	0	10	0	0	0	0	0	0	0	10	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95%	95%	97.2%	88.5%	97.1%	100%	100%	100%	99%	87.8%	99.7%	99.8%	87.9%	87.9%	88.3%	89.3%	99%	95.6%	95.1%	88.5%
	B02a	ED Time to Initial Assessment - 95th Percentile	15	15	14	30	13	19	11	12	12	35.8	14	14	29	30	30.4	28	12	15	15	30
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	55.4%	54.8%	51.1%	60.9%	54.3%	58.1%	50.9%	53%	60.6%	59.6%	56.3%	57.2%	53.5%	53.9%	55.2%	54%	58.8%	54.8%
	B03a	ED Time to Start of Treatment - Median	60	60	54	54	59	47	55	51	59	57	48	50	53	51	56	56	54	55	50	54
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.3%	2.8%	0.2%	2.5%	2.6%	2.5%	2.6%	2.4%	2.7%	2.5%	2.5%	2.7%	3%	2.6%	1.7%	2.5%	2.6%	2.8%
	B05	ED Left Without Being Seen Rate	5%	5%	1.8%	2.4%	2.2%	2%	2%	1.5%	2.3%	1.6%	1.6%	1.5%	1.6%	1.9%	2.4%	2.9%	2.1%	1.8%	1.6%	2.4%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	1032	1032	1287	121	139	144	100	77	131	168	119	78	49	46	46	29	383	376	246	121

WORKFORCE

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	14/15	15/16 YTD	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1
Sickness	AF02	Sickness Rate	4.2%	4.1%	3.9%	3.6%	3.9%	4.5%	4.4%	4.5%	4.7%	4.6%	4.3%	4.2%	4%	4.1%	3.8%	4.5%	4.5%	4.1%
Staffing Numbers	AF08	Funded Establishment FTE	93285.2	24076.6	7744.9	7729.1	7733.4	7775.8	7833.6	7872.4	7927.2	7912.4	7958.8	7976.8	8011.6	8088.3	23207.4	23481.8	23798.4	24076.6
	AF09A	Actual Staff FTE (Including Bank & Agency)	94601.3	24432.8	7819.9	7863.2	7835.5	7859.9	7910.8	8022.7	8004.1	8088.6	8130.6	8137.8	8180.7	8114.4	23518.6	23793.5	24223.3	24432.8
	AF13	Percentage Over Funded Establishment	1.4%	1.5%	1%	1.7%	1.3%	1.1%	1%	1.9%	1%	2.2%	2.2%	2%	2.1%	0.3%	1.3%	1.3%	1.8%	1.5%
Bank Usage	AF04	Workforce Bank Usage	4831.4	1331.2	389.3	463.1	384.9	407.1	392.6	489.6	373.9	432.2	416.2	426	481.7	423.5	1237.3	1289.4	1222.3	1331.2
	AF11A	Percentage Bank Usage	5.1%	5.4%	5%	5.9%	4.9%	5.2%	5%	6.1%	4.7%	5.3%	5.1%	5.2%	5.9%	5.2%	5.3%	5.4%	5%	5.4%
	Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive)																			
Agency Usage	AF05	Workforce Agency Usage	1422	471.4	100.6	107.6	108.4	120.7	165.9	144.5	138.9	157.3	170.3	165.8	148.3	157.3	316.7	431.1	466.4	471.4
	AF11B	Percentage Agency Usage	1.5%	1.9%	1.3%	1.4%	1.4%	1.5%	2.1%	1.8%	1.7%	1.9%	2.1%	2%	1.8%	1.9%	1.3%	1.8%	1.9%	1.9%
	Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive)																			
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	4937.3	1166.5	415	436.6	391.2	443.7	481.3	483.9	435.8	413.3	414.7	334.5	368.5	463.6	1242.8	1408.8	1263.8	1166.5
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	5.3%	4.9%	5.4%	5.6%	5.1%	5.7%	6.1%	6.1%	5.5%	5.2%	5.2%	4.2%	4.7%	5.8%	5.4%	6%	5.3%	4.9%
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	2415	439	241	397	275	133	154	147	162	239	199	121	174	144	913	434	600	439
	AF10	Workforce Turnover Rate			12.4%	12.9%	13.3%	13.2%	13.4%	13.5%	13.7%	13.8%	13.9%	13.8%	14.1%	14%				
	Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.																			
Training	XX	Compliance with Core Essential Training			74%	72%	74%	79%	82%	84%	83%	85%	88%	89%	89%	89%				

Appendix 1

Glossary of useful abbreviations, terms and standards

Abbreviation, term or standard	Definition
BCH	Bristol Children's Hospital – or full title, the Royal Bristol Hospital for Children
BDH	Bristol Dental Hospital
BEH	Bristol Eye Hospital
BHI	Bristol Heart Institute
BRI	Bristol Royal Infirmary
CQC	Care Quality Commission
DNA	Did Not Attend – a national term used in the NHS for a patient failing to attend for their appointment or admission
FFT	Friends & Family Test This is a national survey of whether patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. There is a similar survey for members of staff.
Fracture neck of femur Best Practice Tariff (BPT)	There are eight elements of the Fracture Neck of Femur Best Practice Tariff, which are as follows: 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 8. Abbreviated Mental Test done on admission and pre-discharge
LMC	Last-Minute Cancellation of an operation for non-clinical reasons

NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
RTT	Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times.
STM	St Michael's Hospital

Appendix 2

Other Essential Training Compliance Figures

Safeguarding Adults:

Level 1: 86%
Level 2: 74%

Safeguarding Children:

Level 1: 84%
Level 2: 84%
Level 3: (core) 74.5%
Level 3: (specialist) 69%

Resuscitation: 75%

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level in May, including national average performance for the same tumour site

Tumour Site	UH Bristol	National
Brain*	100%	91.7%
Breast*	100%	95.9%
Gynaecology	68.4%	74.8%
Haematology (excluding acute leukaemia)	71.4%	79.2%
Head and Neck	78.9%	64.9%
Lower Gastrointestinal	76.5%	68.7%
Lung	45.7%	69.3%
Other*	85.7%	79.2%
Sarcoma*	85.7%	65.2%
Skin	92.3%	95.7%
Upper Gastrointestinal	82.6%	75.9%
Urology	-	-

*= 5 or fewer patients treated in accountability terms

Appendix 3 (continued)

Access standards – further breakdown of figures

B) RTT Incomplete/Ongoing pathways standard – numbers and percentage waiting over 18 weeks by national RTT specialty

RTT Specialty	Ongoing Under 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	1,846	2,270	81.3%
Cardiothoracic Surgery	279	307	90.9%
Dermatology	1,785	1,840	97.0%
Gastroenterology	363	394	92.1%
General Medicine	111	113	98.2%
Gynaecology	1,152	1,195	96.4%
Neurology	270	375	72.0%
Ophthalmology	4,329	4,533	95.5%
Oral Surgery	2,308	2,498	92.4%
Other	12,952	14,764	87.7%
Rheumatology	357	358	99.7%
Thoracic Medicine	591	595	99.3%
Trauma & Orthopaedics	780	824	94.7%
Geriatric Medicine	143	144	99.3%
E.N.T.	2,171	2,237	97.0%
Grand Total	**29,437**	**32,447**	**90.7%**

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

Report Title									
09. Transforming Care Report									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive Author: Simon Chamberlain, Director of Transformation									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. Key issues to note The report sets out the highlights of progress over the last quarter and the next steps.									
Recommendations									
The Board is recommended to receive the report for approval.									
Impact Upon Board Assurance Framework									
To support the strategic objective to refresh our Transforming care programme, renewing the priority projects to achieve the aims of each pillar and mobilising focussed, benefits driven, rapid delivery project teams.									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance		For Approval	**X**	For Information			
Date the paper was presented to previous Committees									
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**				

Transforming Care Update to Trust Board
July 2015

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

1. Following review by SLT and Transformation Board and with strong input from Divisions, the scope of the Transforming Care programme for 2015/16 has been revised. The programmes to be taken forward are shown in appendix 1. Actions to mobilise programmes of work where required are being pursued.

2. An End of Life Car programme is being scoped to further improve the quality of care provided to patients at end of life. This will include training of staff to raise awareness and recognition of the patient at end of life, along with actions to develop the capability of the specialist end of life team. The programme will support delivery of a CQUIN in this area.

3. Within a wider programme of improving patient communications, a Patient Letters programme is being mobilised. An approach has been agreed which builds on work already in progress in the Planned Care programme, while adding a framework of Trust wide standards and content. Patient input is a strong feature of the approach and a Letter Champions week is scheduled for early August to gather further feedback from patients on existing letters. The programme supports delivery of the Trust wide quality objective on patient communications

4. An initial Outpatients workshop was held to launch the programme and hear Division views on priorities. A scope of work is being developed and will be presented to the next steering group meeting in early August. The scope will build on the previous Productive Outpatients programme, and early focus areas will include referral management and clinic outcome reporting to target improvements in these areas. The programme supports delivery of a Trust wide quality objective on Outpatients improvement.

5. The Operating Model programmes have continued to deliver improvements to the ways of working which support Improving Patient Flow across our hospitals. Increasingly we are re-applying changes that work in one area more quickly across into other areas so that we can improve the rate at which we deliver change

6. In the Unscheduled Care & Discharge programme, following the implementation of the Integrated Discharge Hub the cross-agency teams are working increasingly closely together to embed further changes including the rollout of the electronic CM7 form, new discharge pathways for patients with the most complex needs and moving patients through the new Discharge to Assess pathways.

7. The programme is also focussing on internal barriers to discharge. A package of best practice in Ward Processes has been piloted in Medicine wards where it has shown good impact in increasing discharges early in the day, and on improving length of stay. This clinically led initiative will now be

adopted across wards in other Divisions to improve day to day ways of working, and to support the Trust wide quality objective of improving discharges.

8. The Planned Care programme continues to build on the Managed Beds initiative by introducing new ways of working to improve the flow of surgical patients. New pathways have been implemented for specific surgical emergency conditions to ensure patients flow to the right bed more quickly or avoid admission where possible. The programme has delivered sustained reduction in cancellations to booking errors or no beds, but cancellations due to critical care capacity have remained a problem, so work is in hand now to improve flow through critical care areas.

9. Further work with the inpatient booking teams has taken place to build team skills and communications processes to further reduce cancellations and re-booking, and to improve the quality of communications with patients. This includes work to improve the quality of patient letters, which has informed the Trust wide approach. The initiatives developed in Surgery, Head & Neck are being reapplied in Specialised Services.

10. The Children's Surgical programme has supported the redesign of a revised theatre timetable, which is now being rolled out. The theatre scheduling tools and processes, designed with Surgery Head & Neck earlier in the year are being re-applied which will streamline the ways in which procedures are booked, take paper out of the process, and reduce changes to operating lists. Work is also in hand to improve the Pre-Operative Assessment service and how bed management supports the elective programme. The programme has supported improved levels of surgical activity which have in turn brought about reductions in patient backlogs.

11. Two strands of work have been developed under the Real time Management project led by Dr Anne Frampton. The first is further development of real time dashboards to use Medway data in real time to display pathway status and support decision making around patient flow and escalation. Dashboards are being developed for the surgical pathway, for ED and medical pathways, and the work now focusses on improving data accuracy and making best use of the information in daily routines. The second project gathers information from staff on how they are feeling and what is getting in the way of their work, in order that more issues can get fixed in "real time". This work was piloted initially in Children's ED, and the pilot has since been extended to other areas in the BRCH and in Surgery Head & Neck. Feedback to date from staff has been positive, and work on the tools which support the project is in hand to ensure the method is robust before extending further.

12. Transforming staff engagement and staff experience has been an area of considerable focus for the Senior Leadership Team in the last quarter. The SLT has identified four themes – Team briefings, Visible Leadership, Devolved Decision making and Values based behaviours – to address. A series of workshops with staff will take place over July and August to gather practical improvement ideas from staff, and to form common guidelines for managers. In parallel SLT is developing a short term plan of action to address staff engagement and communications, and a revised programme of transformational projects to support the Building Capability pillar will be mobilised.

13. Progress reporting to Transformation Board has been revised to provide a clearer view of the impact of programmes. Initially developed for the Improving Patient Flow pillar, the update summarises progress, impact and risks. This summary is based on monthly review by the relevant

programme steering group which receives a detailed dashboard of performance measures. The approach is being extended across the other pillars as detailed delivery plans are approved by Transformation Board. An example of the approach is attached at appendix 2.

14. Next steps: The priority actions for the next quarter are:

- to complete the mobilisation of the new programmes of work

- to establish short and long term plans of work to support improved staff engagement and Building Capability

- to extend the revised progress reporting arrangements across all areas of the programme.

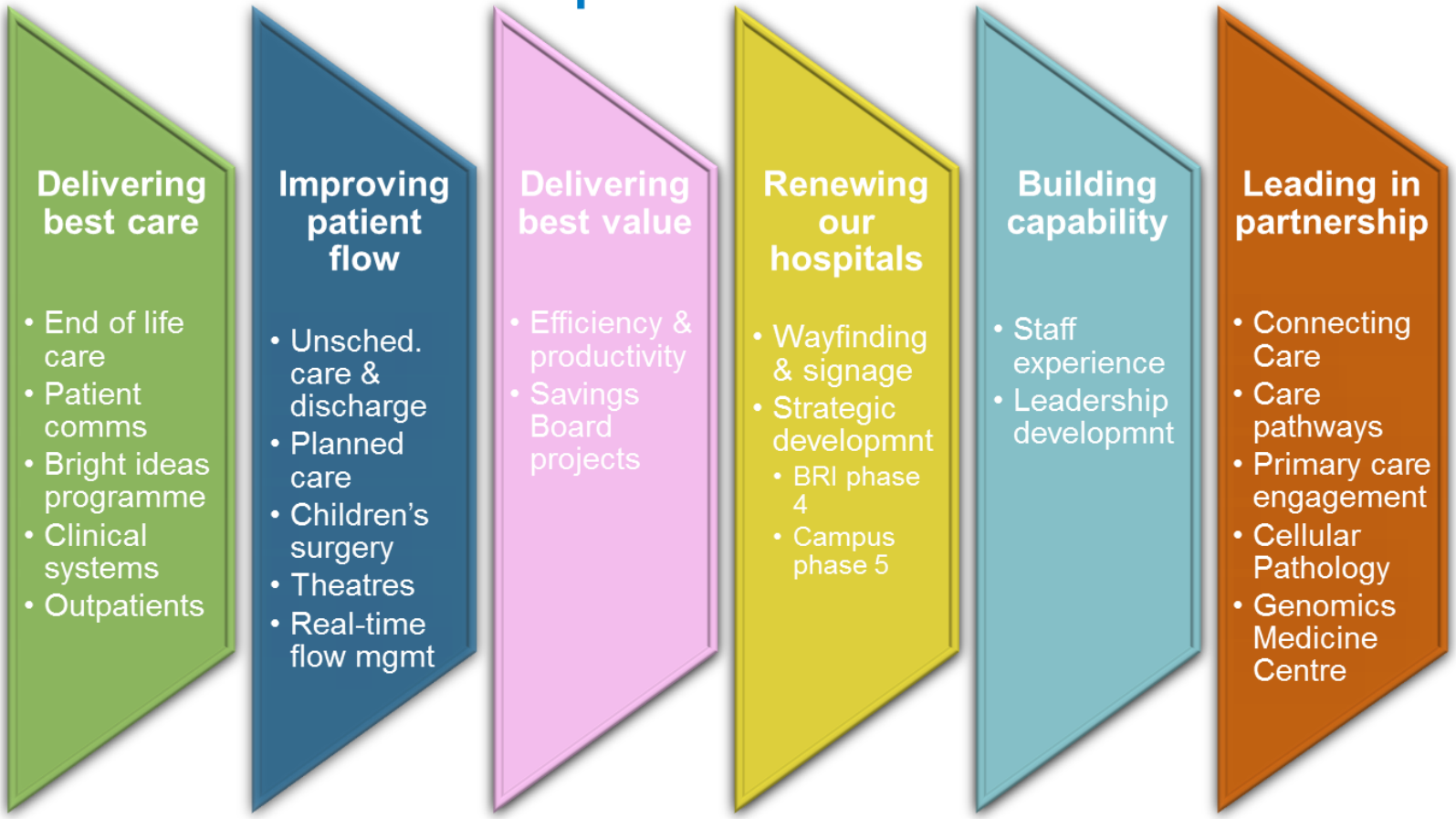
- to ensure the savings opportunities which the transformational programmes enable are quantified and captured in the relevant Division savings programmes

Simon Chamberlain

Director of Transformation

22nd July 2015

Transformation priorities 2015/16



Transforming Care

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 2

Transforming Care Programme report

Pillar	Details	Purpose	Status	Milestone review last month Jun-2015	Key deliverables	Month	Benefits / Measures	Risks
Improving patient flow	**Project:** Operating Model - Unscheduled Care & Discharge **Exec lead:** James Rimmer **Project lead:** Rowena Green IDH: Integrated Discharge Hub D2A: Discharge to assess	To establish an unscheduled care programme, supported by a fully integrated Health and Social care team which reduces occupied bed days whilst improving patient outcomes and experience.	A	•The development of a monitoring tool for the eCM7 using the existing hospital Medway system	• D2A trials evaluated	July	• Reduction in number of patients on green to go list to 30 patients • Reduction in LOS to achieve 90% bed occupancy	• Divisional ability to resource project • Lack of bed capacity and staffing resources in the community to support the projects
			G	• Go live with non weight bearing pathway	• New care providers service live	Aug		
			G	• Roles & responsibilities for IDH team members and rota to cover IDH team representation	• Medicine: ward processes workshops completed	Sep		
			G	• D2A Patient leaflets and patient stories in use	• D2A roll out to remaining wards completed	TBC		
			G	• Go live with D2A on trial wards				
			G	• Choice policy operational				
			G	• Medicine: 3 ward processes workshops held				
	Project: Paediatric Surgical Pathway Programme **Exec lead:** James Rimmer **Project lead:** Steve Sale & Charlotte Jones	To have surgical pathways which support all specialties requiring theatre access deliver high quality care in the required clinical and national target timescales.	A	• Scheduling tool configuration	• TCI reminders implemented for agreed elective Children's hospital admissions	Jul	• Achievement of Divisional RTT trajectory • Reduced last minute cancellations to less than 0.8% • To achieve Divisional income against plan for elective surgical admissions	• Management of bed capacity to enable admission of patients for all theatre sessions • Demand on Divisional resources to progress project
			A	• Backlog trajectory achieved	• BRHC scheduling standards implemented	Jul		
			G	Feedback regarding scheduling from staff and patients presented to key stakeholders	• Pre-admission services findings presented	Aug		
			G	• Gap analysis of current and required inpatient / day case beds completed	• Enhanced Recovery T&O pilot pathway delivered	Oct		
			A	• Gap analysis of pre-admission assessment currently provided completed	• Increased theatre sessions to match demand and capacity implemented	Nov		
	Project: Operating Model - Planned Care - Surgery, Head & Neck **Exec Lead:** James Rimmer **Project Lead:** Andy Hollowood & Alan Bryan	To ensure that elective and urgent tertiary activity proceeds unhindered through periods of high demand for acute medical care through our hospitals.	A	• Standardisation of Booking Co-ordinator job descriptions and completion of matching process	WLO competency based recruitment package complete	Aug	• Improved quality and consistency of patient experience within the surgical Waiting List Offices • Real-Time visibility (and operational response) to blockages in patient flow • Reduction in same day cancellations for non clinical reasons within Surgery, Head & Neck to 0.8%	• Demand on Divisional resources to progress project • The process and ownership for funding support to an Admin Teams local induction training programme is to be confirmed
			A	• Admin Teams Transformation - new SOPs approved	Electronic waiting list cards for BEH implemented	TBC		
			A	• STAU first iteration of electronic white board plan approved	Email correspondence rolled out to ENT waiting list office	Sep		
			G	• Real-Time dashboard reviewed and approved	Surgical flow dashboard used operationally within Surgery, Head & Neck	Sep		
			G	• Admin Standards Manager appointed	Booking Co-ordinator local inducation programme in place	Oct		
			G	Waiting list office staff received 'delivering bad news' training	2nd wave of Energency pathways implemented	TBC		
	Project: Operating Model - Planned Care - Specialised Services **Exec Lead:** James Rimmer **Project Lead:** Nikki Shephard	BHI Divisional staff are supported by robust processes and technology that drives efficient flow of our emergency and elective secondary and tertiary care work through the division.	A	Patient flow procedure re-written and approved by senior management team	PCI escalation pathway implemented	Jul	• Standardised pathways in place to support BHI Divisional staff in delivering emergency, non-elective and elective care • Increase in discharges before 12:00 noon • Improved theatre scheduling	• Demand on Divisional resources to progress project
			A	PCI escalation pathway implemented	Ward processess - Observations on C705. Second ward and leads identified	Jul		
			G	Action plan developed for theatre scheduling tool	Patient flow procedure document implemented	Aug		
			A	Cardiac surgery scheduling criteria finalised and approved	Cardiac surgery scheduling criteria implemented	Aug		
			G	Ward processess - Initial meeting held, identify 1st ward, timetable drafted	Communication of Cath Lab planning SOP agreed	Sep		
			G	Handling difficult telephone calls and face to face situations assertively' training completed				
	Project: Theatre Transformation Programme **Exec Lead:** Paul Mapson **Project Lead:** Jan Belcher	To provide individualised safe quality patient care with maximum efficiency in responsive operating theatres Trust wide. Which in turn will support the capacity demands for surgical intervention.	A	• Trauma and Orthopaedics Golden Case Poster complete	• SMT Team Building Event, "Amazing people doing amazing things", 15th July	Jul	• Start on time 90% achievement • Turnaround Time 85% achievement	• Theatre Staff recruitment and retention will impact capacity • Trust wide Portering plans to be aligned with local theatre initiatives
			G	• Responsible Surgeon agreement and change on Medway	• Dashboard used to inform decision making and planning	Jul		
			G	• Obstetrics audit agreed	• Phase 2 Porter Role change implemented	Jul		
			G	• Equipment efficiency programme commenced	• ENT Speciality action plan for improvement agreed and implemented	Jul		
			A	• Specific improvement trajectories progressing on plan	• Maxillofacial action plan for improvement agreed and implemented	Jul		
					• Obstetrics audit completed	Sep		
					• Obstetrics efficiency programme agreed	Oct		
								Updated: 09.07.2015

Transforming Care

University Hospitals Bristol NHS
NHS Foundation Trust

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
10. Complaints Annual Report 2014-15

Sponsor and Author(s)
Sponsor: Chief Nurse, Carolyn Mills Author: Tanya Tofts, Patient Support & Complaints Manager

Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the nature and number of complaints and contacts with the Patient Support and Complaints Team at University Hospitals Bristol NHS Foundation Trust during 2014/2015.

Key issues to note
1,883 complaints were received by the Trust in the year 2014/2015, averaging 157 per month. Of these, 844 were managed through the formal investigation process and 1,039 through the informal investigation process. This compares with a total of 1,442 complaints received in the year 2013/2014, an increase of more than 30%. During 2014/15, the volume of complaints received by the Trust as a proportion of patient activity was 0.26%: an increase on 2013/14, when 0.21% of patient episodes resulted in a complaint.

In addition, the Patient Support and Complaints Team dealt with 619 other enquiries, including compliments, requests for support and requests for information and advice: a decrease on the 723 enquiries dealt with in 2013/2014.

The Trust had 12 complaints referred to the Parliamentary and Health Service Ombudsman in 2014/15, compared with 17 in 2013/14. Five of these complaints were not upheld and one was partially upheld; the remaining six cases are still being considered by the Ombudsman (as at 12/06/2015).

84 complaints were re-opened due to complainants being dissatisfied with incomplete or factually incorrect responses. This compares with 62 in 2013/14: a 35% increase.

During the third quarter of 2014/15, the Patient Support and Complaints Team cleared a large backlog of enquiries that had been in existence for the previous 12 months. The team has maintained an up to date position since the backlog was cleared.

Throughout the year, patient stories and examples of learning from complaints have been used at the start of public meetings of the Trust Board.

The Patient Support and Complaints Team, with assistance from the Trust's Divisions, has delivered

complaints training to senior divisional staff to improve the quality of written complaint responses and give staff confidence in dealing with complaints themselves. This programme will continue into the autumn of 2015.
Recommendations
The Board is recommended to receive these reports for assurance.
Impact Upon Board Assurance Framework
The complaints report supports achievement of the corporate quality objective, "To improve the quality of written complaints responses" in 2015/16.
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
The complaints report supports compliance with the Care Quality Commission's Fundamental Standard for complaints, Regulation 16.
Equality & Patient Impact
The Complaints report includes data describing the known 'protected characteristics' of people who complaint about our services.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Finance Committee	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Quality and Outcomes Committee**
			22/7/15	28/7/15

University Hospitals Bristol NHS
NHS Foundation Trust

ANNUAL COMPLAINTS REPORT 2014/2015

Author: Tanya Tofts, Patient Support and Complaints Manager - June 2015

Contents

Executive Summary

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In summary:

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- Throughout the year, patient stories and examples of learning from complaints have been used at the start of public meetings of the Trust Board.

- The Patient Support and Complaints Team, with assistance from the Trust's Divisions, has delivered complaints training to senior divisional staff to improve the quality of written complaint responses and give staff confidence in dealing with complaints themselves. This programme will continue into the autumn of 2015.

- In last year's annual report, we described a joint project between the Trust and the Patients Association, exploring complainants' experience of the complaints process at UH Bristol. This project concluded in 2014/15 and a number of recommendations were shared with the Trust's Patient Experience Group, as described in Appendix 3 to this report.

1. Accountability for complaints management

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

The Trust's Patient Support and Complaints Manager is responsible for ensuring that:

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

The Patient Support and Complaints Manager line manages a team, which as of 31st March 2015, consisted of one full time Band 6 Deputy Manager, three full-time and one part-time complaints officers/caseworkers (Band 5) and three part-time administrators (Band 3). The total team resource, including the manager, is 7.8 WTE, compared with 4.8 WTE 12 months previously.

2. Improvements in complaints management during 2014/15

The Trust continually seeks to improve the service it offers to all patients and visitors to its hospitals and to learn from complaints. Significant developments in complaints management during 2014/15 have included:

- Clearing a backlog of enquiries that had been in existence for over 12 months and maintaining an up to date position since November 2014.
- The appointment of a new deputy manager to support the manager with the day to day operational activities of the team. The deputy manager has also taken on responsibility for coordinating all training carried out by the team.
- Training of three new members of staff who are now fully integrated into the team and carrying a full caseload of enquiries (the complaints officers) and running efficient administrative back up for the team (administrators).

In last year's annual report, we described a joint project between the Trust and the Patients Association, exploring complainants' experience of the complaints process at UH Bristol. This project concluded in 2014/15 and a number of recommendations were shared with the Trust's Patient Experience Group. For transparency, the Patients Association's 14 recommendations are listed in full in Appendix 3 to this report, accompanied by the Trust's response. The majority of the recommendations amounted to a continuation of existing good practice, however several developmental actions were added to the Trust's annual complaints work plan.

3. Complaints reporting

Each month, the Patient Support and Complaints Manager reports the following information to the Trust Board:

- Percentage of complaints per patient attendance
- Percentage of complaints responded to within the agreed timescale
- Number of cases where the complainant is dissatisfied with the original response
- Exception reports in any instances where performance deviates from target

In addition, the following information is reported to the Patient Experience Group, which meets every two months:

- Validated complaints data for the Trust as a whole and also for each clinical Division
- Quarterly Complaints Report (on occasions when this is due)
- Annual Complaints Report (which is also received by the Board)

The Quarterly Complaints Report provides an overview of the numbers and types of complaints received, including any trends or themes that may have arisen, including analysis by Division and information about how the Trust is responding. The Quarterly Complaints Report is also reported to the Trust Board and published on the Trust's web site.

A patient story is discussed at the start of the Trust's monthly public Board meetings. This is generally an anonymised example of an issue – often resulting in a complaint – where there has been learning for the department involved, for the Division, and also for the organisation as a whole. The story may be a positive or a negative one and Divisions rotate in providing the story each month. Examples of stories discussed by the Board are also shared at the Trust's bi-monthly Patient Experience Group.

4. Total complaints received in 2014/2015

In 2014/15, the Trust's target was that the volume of complaints received should not exceed 0.21% of patient activity – in other words, that no more than approximately 1 in 500 patients complain about our service. We achieved 0.26% in 2014/15, compared to 0.21% in 2013/14 (see Figure 1). The total number of complaints received during the year was 1,883, an increase of 30% on the previous year. Of these, 844 were managed through the formal investigation process and 1,039 through the informal investigation process.

The Trust's patient experience survey ratings are similar to, or better than those achieved in 2013/14, so one possible explanation is that the increase in complaints reflects the increased accessibility of the Patient Support and Complaints Team; since December 2013, the team has been located in a prominent position in the front entrance Welcome Centre of the Bristol Royal Infirmary.

Compared with 2013/14, there was an increase of 11% in the number of complaints managed through the formal investigation process and a 53% increase in the number of complaints managed through the informal investigation process.

A formal complaint is classed as one where an investigation by the Division is required in order to respond to the complaint. A senior manager is appointed to carry out the investigation and gather statements from the appropriate staff. These statements are then used as the basis for either a

written response to, or a meeting with, the complainant (or sometimes a telephone call from the manager). The method of feedback is agreed with the complainant and is their choice. This Trust's target is that this process should take no more than 30 working days in total.

An informal complaint is one where the concerns raised can usually be addressed quickly by means of an investigation by the Patient Support and Complaints Team and a telephone call to the complainant. The figures below do not include informal complaints and concerns which are dealt with directly by staff in our Divisions. We are currently investigating how systems might be put in place to record and report this information in the future.

Figure 1 - Monthly complaints as a percentage of patient activity 2012/13, 2013/14 and 2014/15

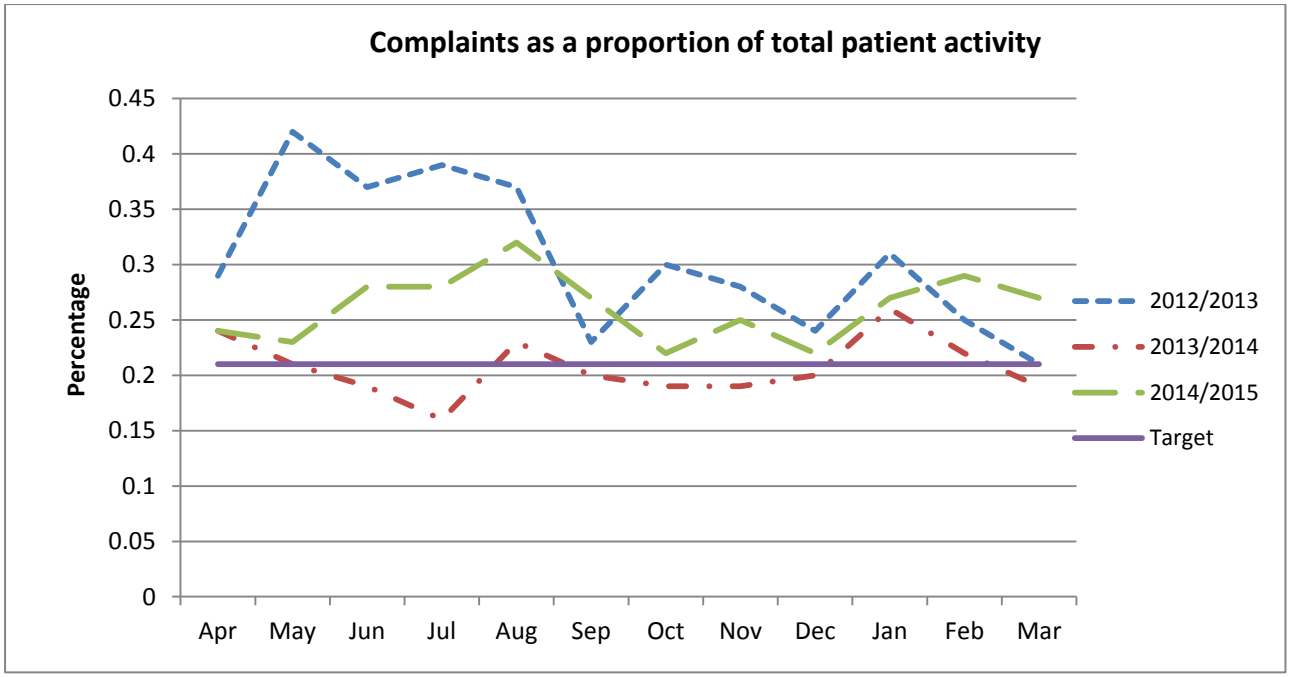


Table 1 below shows the number of complaints received by each of the Trust's clinical divisions compared with the previous year. Directional arrows indicate change compared to the previous financial year.

Table 1 - Breakdown of complaints by Division

Division	Informal Complaints 2014/2015	Formal Complaints 2014/2015	Divisional Total 2014/15	Informal Complaints 2013/2014	Formal Complaints 2013/2014	Divisional Total 2013/14
Surgery, Head and Neck	407 ↑	293 ↓	**700 ↑**	321 ↓	299 ↓	**620 ↓**
Medicine	174 ↑	176 ↑	**350 ↑**	90 ↓	171 ↓	**261 ↓**
Specialised Services	184 ↑	101 ↑	**285 ↑**	116 ↑	99 ↑	**215 ↑**
Women and Children	146 ↑	204 ↑	**350 ↑**	50 ↑	118 ↓	**168 ↓**
Diagnostics and Therapies	67 ↑	35 ↓	**102 ↑**	57 ↑	40 ↑	**97 ↑**
Facilities and Estates	27 ↑	13 ↓	**40 ↓**	22 ↑	23 ↑	**45 ↑**
Trust Services	34 ↑	22 ↑	**56 ↑**	24 =	12 ↓	**36 ↓**
TOTAL	**1039 ↑**	**844 ↑**	**1883 ↑**	**680 ↓**	**762 ↓**	**1442 ↓**

Table 1 shows a significant increase (108%) in complaints received by the Division of Women & Children. 73% of the 350 complaints received by the Division in 2014/15 were received by Bristol Royal Hospital for Children (BRHC), with 27% received by St Michael's Hospital (STMH).

For the first time, complaints data for 2014/15, includes informal complaints dealt with by the 'LIAISE'[1] team in the BRHC however this only accounted for 33 of the total 350 complaints received (9%).

The main cause for complaints about services at BRHC was cancelled or delayed appointments or operations. Significant work has been undertaken by the Division to address this, including:

- Establishing and improving new working practices following the centralisation of Specialist Paediatrics (CSP)
- Implementation of a transformation project to improve many aspects of the paediatric outpatient service, including patient experience
- Increasing capacity in outpatient departments and operating theatres, including private sector provision
- Proactive management of the recruitment of additional theatre staff, with a Senior Nurse Lead (Matron) appointed to focus solely on this issue
- Identification of physical space for outpatient clinics, with the Division exploring the option of holding extra clinics at South Bristol Community Hospital
- Maintaining regular contact with the families of those awaiting appointments and/or surgery

In addition, the Children's Emergency Department saw a significant increase in the number of complaints received. The department has undergone significant redevelopment during 2014/15, resulting in inevitable disruption to the working environment. A higher number of patients were also seen during the winter period, following the CSP project. During this challenging winter period, staff were therefore working under immense pressure. In response to these challenges:

- The Clinical Lead for the Children's Emergency Department has remained sighted on all complaints throughout the year to ensure systematic review and learning, with the aim of avoiding similar complaints occurring in future;
- The divisional management team ensured there were good governance structures in place for the department, with all complaints being investigated promptly and fully, using a multi-disciplinary approach;
- Themes from complaints were identified and discussed with teams at training days;
- Support for staff has been explored through Care First and a psychologist;
- Regular education/team days have been organised to ensure that staff possess the correct skills, and have access to appropriate education and support;
- Friends and Family Test touch-screen kiosks have been installed in the department to capture real-time feedback;
- A staff satisfaction feedback system is in place to ensure real-time feedback, with information from this informing action plans; and
- There is a robust system in place for ensuring an appropriate skill mix of doctors, emergency nurse practitioners and nursing staffon each shift.

[1] LIAISE is the equivalent of a Patient Advice and Liaison Service ('PALS') in the Children's Hospital

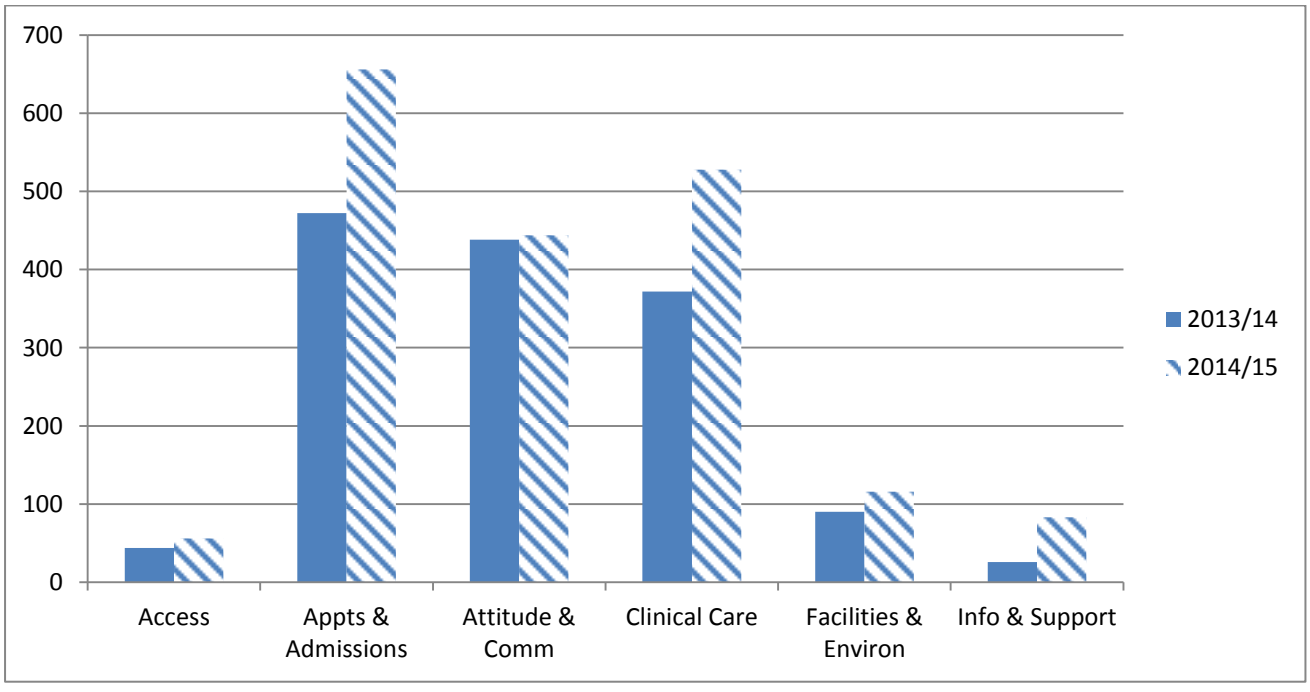
5. Complaint themes

The Trust records complaints under six main "themes" and, within each theme, by a number of specific categories. A complaint may be recorded under more than one category, depending upon the nature and complexity of the complaint. This data helps us to identify whether any trends or themes are developing when matched against hospital sites, departments, clinics and wards. Table 2 and Figure 2 show complaints received by theme, again compared to 2013/2014.

Table 2 - Complaint themes by Division

Complaint Theme	Informal Complaints 2014/2015	Formal Complaints 2014/2015	Total 2014/15	Informal Complaints 2013/2014	Formal Complaints 2013/2014	Total 2013/14
Access	41 ↑	15 ↓	**56 ↑**	24 ↑	20 ↑	**44 ↑**
Appointments and Admissions	459 ↑	197 ↑	**656 ↑**	280 ↓	192 ↓	**472 ↓**
Attitude and Communication	223 ↑	221 ↓	**444 ↑**	206 ↓	232 ↑	**438 ↓**
Clinical Care	162 ↑	366 ↑	**528 ↑**	99 ↑	273 ↓	**372 ↓**
Facilities and Environment	83 ↑	33 ↓	**116 ↑**	53 ↓	37 ↑	**90 ↓**
Information and Support	71 ↑	12 ↑	**83 ↑**	18 ↓	8 ↓	**26 ↓**
TOTAL	**1039 ↑**	**844 ↑**	**1883 ↑**	**680 ↓**	**762 ↓**	**1442 ↓**

Figure 2 - Complaints by Theme - 2013/14 and 2014/15



In 2014/15, the total number of complaints received under the theme of Information and Support, increased significantly, by 219%. This theme covers such categories of complaints as bereavement and emotional support, expenses claims, hospital and/or patient information, medical records, travel arrangements and wayfinding.

Of the 83 complaints recorded under this theme, the largest sub-category was 'Information about Patient' (29), followed by 'Expenses Claims' (12) and 'Wayfinding' (9). Some examples of the complaints categorised as 'Information about Patient' were: complaints about the patient's family not being given adequate or correct information about the patient; patients being given conflicting information by different clinicians; and patients experiencing difficulties obtaining information from their consultant to pass on to another service/organisation. There were no discernible trends in respect of this category of complaint and the cases received were spread fairly equally across the Divisions.

Of the complaints related to 'Expenses Claims', five were complaints about not being eligible to claim expenses, four were in respect of wishing to claim expenses following a cancelled appointment and three were in respect of claims for lost property during an inpatient admission. Again, there were no trends identified relating to specific wards or departments.

'Wayfinding' complaints related to patients/carers/visitors being confused about the new signage in the Trust's hospitals. This was added as a new category of complaint to coincide with Phase 1 of introduction of the new signage, from September 2014 onwards. All such complaints are notified to the Deputy Chief Operating Officer who has overall responsibility for the implementation of the new signage and the wayfinding structure across the Trust.

All complaints themes saw increases when compared with the previous year, with other significant increases being seen in complaints about Clinical Care (42%) and Appointments and Admissions (39% increase).

In respect of Clinical Care, the total number of complaints received by the Trust increased from 372 in 2013/14 to 528 in 2014/15. The largest numbers of complaints under this theme were in the following categories:

- Clinical Care (Medical/Surgical) – 234 (159 in 2013/14)
- Clinical Care (Nursing/Midwifery) – 120 (99 in 2013/14)

In respect of complaints categorised as Clinical Care (Medical Surgical), the Associate Medical Director (AMD) oversees a system to monitor complaints where individual medical staff are cited. Medical staff are interviewed by the AMD or Medical Director if patterns of repeated behaviour are identified which give cause for concern.

Elsewhere, the Division of Women and Children identified a pattern of complaints about clinical care stemming from patients not understanding what and why certain procedures were being carried out. As a result, the Head of Midwifery now personally meets with complainants, where appropriate, with the consultant present to explain and clarify procedures. Community midwives are also encouraged to ask women about their labour at the first post-natal visit and explain anything that the woman does not understand.

Following a previous decrease in Appointments and Admissions complaints in 2013/14 (largely due to the work carried out by the Trust's Productive Outpatients Team), it is disappointing to see the increase in 2014/15. The highest number of complaints received by the Trust under the theme of Appointments and Admissions were in the following categories:

- Cancelled or delayed appointments – 276 (174 in 2013/14)
- Cancelled or delayed operations or procedures – 230 (174 in 2013/14)

- Delayed treatment – 50 (30 in 2013/14)
- Delayed/incorrect/missed diagnosis – 44 (44 in 2013/14)

Issues around cancelled or delayed appointments continued to be addressed through the Trust's Transformation programme and, in the case of outpatients, through improvement activities which originated from the Productive Ward project. Here are some examples from our Divisions:

- The Ear Nose and Throat Department received a high number of complaints in this category during the first half of 2014/15. This was largely due to understaffing issues in the nurse-led clinics, due to long term sickness and difficulty in recruiting suitable candidates. The Division undertook a capacity diagnostic to understand what extra resources were needed in order to resolve this problem. Two specialty doctors started in the department in August 2014, increasing clinic capacity and enabling patient appointments to be brought forward. Waiting times reduced from 18 weeks in Quarter 1 to nine weeks in Quarter 2, with further improvement expected.

- Recruitment was also an issue at Bristol Dental Hospital; additional clinics were arranged during the undergraduate holidays to clear the backlog of patients waiting to be seen.

- Cancelled and delayed appointments at Bristol Eye Hospital were addressed through additional recruitment within glaucoma and medical retinal services. In addition, a full time Patient Support and Liaison Nurse was employed and is available to patients who have informal concerns. Two whole time equivalent Nurse Injectors were also employed during Quarter 2 of 2014/15 following positive feedback from patients about this service.

- A new locum consultant was appointed in the Dermatology Centre in September 2014 to address an increase in activity, some of which was related to the service transfer from Weston General Hospital. A capacity review was undertaken and issues around nursing vacancies were also addressed. This meant that appointments could be brought forward.

- Bristol Heart Institute carried out a large number of additional clinics in Quarter 2 of 2014/15, resulting in an additional 200 clinic appointments and allowing the service to reduce its backlog of long-waiting patients from 550 in July 2014 to 154 at the end of November 2014.

- Cardiology GUCH[2] Services at Bristol Heart Institute (BHI) appointed a fourth ACHD (Adults with Congenital Heart Defects) consultant, who started in August 2014, and focussed on addressing a backlog of follow-up appointments. The backlog was also affected by two long term sickness absences in the BHI, one was resolved during the first quarter of 2014/15, with the member of staff returning to work; recruitment took place to substantively replace the other member of staff by October 2014, with interim arrangements in place until that time.

Whilst the total number of complaints received regarding Attitude and Communication remained almost the same as the previous year, accounting for 24% of all complaints received by the Trust. The highest numbers of complaints under this theme were in the following categories:

- Communication with Patient/Relative – 126 (80 in 2013/14)
- Attitude of Medical Staff – 80 (79 in 2013/14)
- Attitude of Nursing/Midwifery Staff – 68 (41 in 2013/14)

[2] Grown-up Congenital Heart Disease

- Failure to answer telephone/respond – 65 (106 in 2013/14)
- Attitude of Admin/Clerical Staff – 30 (35 in 2013/14)

6. Annual KO41A return

Each year, NHS trusts are required to submit a 'KO41A' return to the Department of Health. This is a report which gives a detailed breakdown of formal complaints received. However, as part of its response to the Francis and Clwyd/Hart reviews 'Hard Truths', the Government has undertaken to publish complaints data from NHS providers every quarter. Some key changes have also been made to the content of the KO41a. In particular, data is to be provided at site level rather than at organisational level, and information is now being collected (where appropriate) about the age of the patient who is making the complaint. The revised KO41a was introduced in April 2015.

The KO41A return for 2014/15 is attached as Appendix 1[3].

7. Equalities data: monitoring protected characteristics

Patients' ethnicity, age, gender, religion and civil status are recorded on the Trust's patient administration system, Medway. Since 1st October 2014, where available, this information has been exported onto the Ulysses Safeguard database used by the Patient Support and Complaints Team and the data reported in the Trust's Quarterly Complaints Reports.

Information about the age, gender, ethnicity, religious beliefs and civil status of patients who have made a complaint in Quarters 3 and 4 2014/15 (or on behalf of whom a complaint was made) can be found at Appendix 2 [4]. This data shows that:

- There was a broadly even distribution of complaints between men (476) and women (462).
- 34% of patients were aged 65 years or above
- The overwhelming majority of people who complained, and whose ethnicity is recorded (78%), were White British.
- 42% of complainants list their religious affiliation as Christian.
- The civil status of the majority of complainants was Single (39%), followed by Married/Civil Partnership (29%)

Whilst this data represents the majority of complainants, a large number of cases in each category are still recorded as "unknown". The Patient Support and Complaints Team is working hard to reduce the number of "unknown" data across all protected characteristics. Improvements have already been seen in this respect, in that there were 33% fewer "unknown" entries across all protected characteristics in Quarter 4 of 2014/15 than in Q3.

[3] The KO41a shows a total of 780 formal complaints. This differs from the total of 844 formal complaints reported in this annual report; the difference is due to the timing of data extraction from the Ulysses Safeguard system. The Trust's annual figure is based on an accumulation of monthly data returns, however a small number of complaints may be reclassified after the data cut-off point each month.

[4] Data collected began in October 2014.

8. Performance in responding to complaints

In addition to monitoring the volume of complaints received, the Trust also measures its performance in responding to complainants within agreed timescales, and the number of complainants who are dissatisfied with responses.

8.1 Proportion of complaints responded to within timescale

The Trust's expectation is that all complaints will be acknowledged within two working days for telephone enquiries and within three working days for written enquiries. The complainant's concerns are confirmed and the most appropriate way in which to address their complaint is agreed. A realistic timescale in which the complaint is to be resolved is agreed, based on the complexity of the complaint whilst responding in a timely manner.

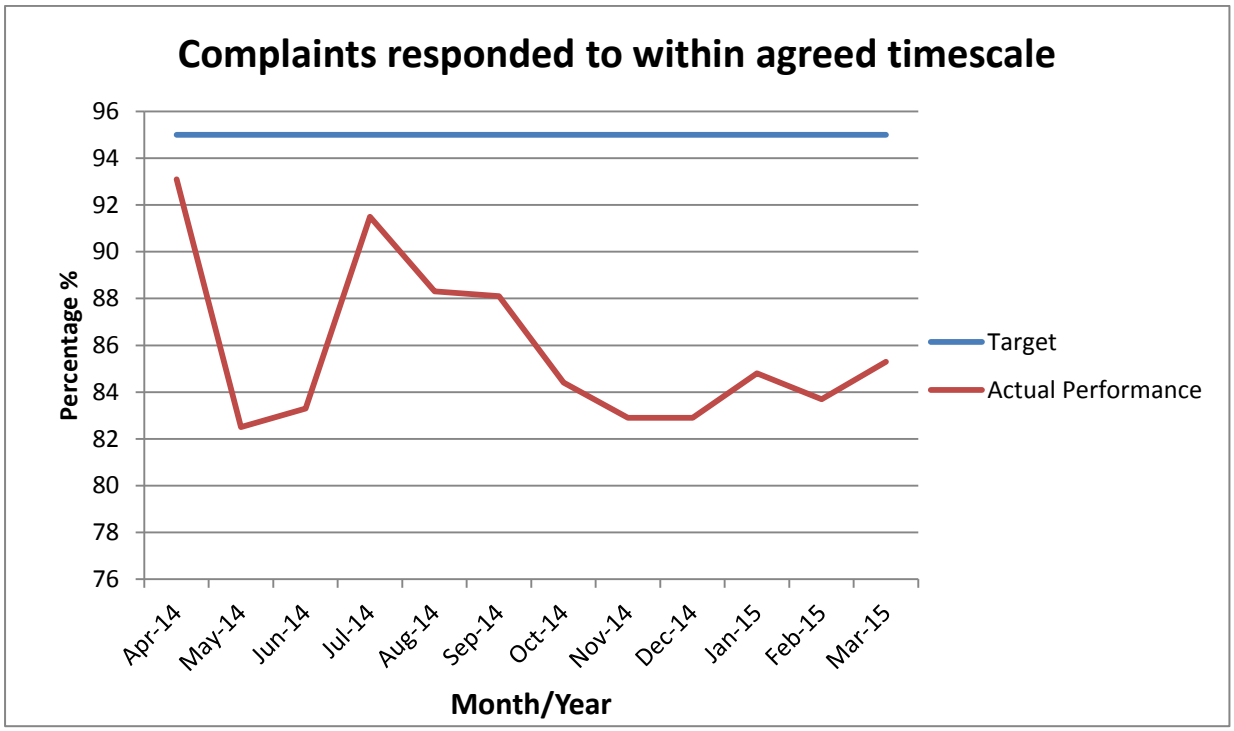
The time limit for making a complaint, as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant. These regulations and guidance from the Parliamentary and Health Service Ombudsman indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the Trust must inform the complainant of the reason for the delay and agree a new date by which the response will be sent.

The Trust captures data about the numbers of complaints responded to within the agreed timescale. The Trust's performance target for this in 2014/15 was 95% compliance. For any months when reported performance was below 85%, the Board received an exception report summarising the total number of breaches, the reasons why these breaches occurred and what steps were being taken by the Divisions and by the Patient Support and Complaints Team to improve the situation. Over the course of the year 2014/15, 85.9% of responses were responded to within the agreed timescale, a significant improvement on the 76% reported for 2013/14, but below the target of 95%.

In order to improve performance in providing timely responses to complaints, the following actions have been taken:

- Divisions have been reminded of the importance of providing the corporate Patient Support and Complaints Team with response letters at least four working days prior to the date that they are due with complainants.
- The Patient Support and Complaints Team continues to actively follow up Divisions if responses are not received on time. Divisional staff are also reminded of the need to contact the complainant to agree an extension to the deadline if necessary.
- The Patient Support and Complaints Team must ensure that the response letter is checked and sent to the Executive Directors for sign-off within 24 hours of receipt from the Division (subject to weekends and Bank Holidays). The exception to this would be if the response has been received from the Division very early, which allows additional time for the response to be checked if needed.
- Longer deadlines are agreed with all Divisions should the complainant request a meeting rather than a written response. This allows for the additional time needed to coordinate the diaries of clinical staff required to attend these meetings.
- All Divisions are now working to the same target of 30 working days.

Figure 3.



8.2 Numbers of complainants who are dissatisfied with our response

The Trust also measures performance in respect of the number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate (which we differentiate from follow-up enquiries where a complainant raises additional questions).

The total number of cases for 2014/15 where the complainant was dissatisfied with our response for this reason was 84, which represents 10% of all formal complaints received during the same period. This compares with the 62 cases reported in 2013/14 (which represented approximately 8% of formal complaints received). The number of dissatisfied cases therefore increased by 35% in 2014/15; broadly in line an overall increase in the number of complaints (up by 30%).

No theme or trend has been identified which would clearly explain the increase in dissatisfied complainants, however it is hoped that, in particular, the rolling out of detailed new training in respect of complaints investigation and the writing of response letters will help to reduce the number of complainants who are dissatisfied with the response they receive. Informal benchmarking against other NHS trusts indicates that a dissatisfaction rate of 8-10% is typical. Nonetheless our aspiration is for nobody to be unhappy with the quality of our original response.

The cases in 2014/15 were spread across the Trust's Divisions as follows:

Division of Surgery, Head and Neck – 42 cases (30 in 2013/14)
Division of Medicine – 10 cases (13 in 2013/14)
Division of Women and Children – 18 cases (8 in 2013/14)
Division of Specialised Services – 12 cases (7 in 2013/14)
Division of Diagnostics and Therapies – 2 cases (2 in 2013/14)

Division of Facilities and Estates – 0 cases (1 in 2013/14)
Division of Trust Services – 0 cases (1 in 2013/14)

In order to further improve our performance, the following procedures are in place:

- Divisions are notified of any case where the complainant is dissatisfied. Cases are reviewed by a senior manager, reinvestigated where appropriate and resolved either by way of a further written response or a meeting with the complainant.
- The Patient Support and Complaints Team monitors draft response letters to ensure that all aspects of the complaint have been fully addressed.
- Trust-level complaints metrics are replicated at Divisional level to enable Divisions to identify the specific areas for improving performance and implement appropriate actions. Divisional complaints dashboards will also be used for quarterly performance reviews.
- Training is being provided across all Divisions in respect of investigating complaints and writing response letters. This has been successfully rolled out to two Divisions (at the time of writing this report) and dates are booked for the remaining Divisions, with all training due to be completed by October 2015.
- A new response letter template, checklist and standard operating procedure have been prepared to assist with the writing of response letters and, at the time of writing this report, these were with the Executive Board for approval.

8.3 Backlog of enquiries to the Patient Support and Complaints Team

In the final quarter of 2013/14, a backlog of work developed in the Patient Support and Complaints Team, due to limited staff resources and an increasing number of enquiries. In 2014/15 this was rectified, initially by using temporary agency staff, and then by investing in three permanent posts (two caseworkers and an administrator). The backlog of enquiries was finally cleared in November 2014 and the team has remained up to date with processing complaints and enquires since that time.

9. Parliamentary and Health Service Ombudsman (PHSO)

The Trust had 12 complaints referred to the Parliamentary and Health Service Ombudsman in 2014/15, compared to 17 the previous year. Five complaints were not upheld and one was partially upheld. The remaining six cases are still being considered by the Ombudsman (as at 12/06/2015).

The one partially upheld case was in respect of a patient whose bowel was perforated during an endoscopy procedure. The PHSO found evidence of failings in some aspects of the patient's care and treatment but there was not enough evidence to say that, if these failings had not happened, the clinical outcome would have been different. They did however recognise the emotional impact on the patient and therefore partially upheld the complaint, with recommendations that the Trust write to the patient to acknowledge these failings, pay a sum of £250 in respect of the emotional impact and develop an action plan within three months to explain what had been learned from the case and what would be done differently in the future to prevent a recurrence. These recommendations were fully complied with within the timescales given by the PHSO.

10. Being customer focused

The Patient Support and Complaints Team's move to its new office in the redeveloped Welcome Centre in December 2013 has proved very successful, making the service much more accessible. The team dealt with 430 drop-in enquiries during 2014/15. Throughout the year, the team has also continued to provide support to anyone wishing to make a complaint by telephone, email and in writing.

The team ensures that people are made aware of the independent complaints advocacy service offered by SEAP (Support Empower Advocate Promote) by providing a copy of SEAP's leaflet with every complaint acknowledgement letter and on an ad hoc basis as appropriate. SEAP can provide help and support to people who wish to make a complaint about NHS services. This service was formerly known as ICAS (Independent Complaints Advocacy Service).

The Trust also provides a Patient Support and Complaints Team leaflet, advising people of the services offered by the team and the various ways in which the service can be accessed. The leaflet incorporates an easy-to-complete complaints form, which people can return to the Patient Support and Complaints Team or put in the post. The leaflet is available in a range of languages.

The Patient Support and Complaints Team has increased its visibility on the Trust's external website, where, as well as providing contact information and details of the services offered, the public can now also access the Trust's quarterly and annual complaints reports.

11. Information, advice and support

In addition to managing complaints, the Patient Support and Complaints Team also deals with information, advice and support requests. The total number of enquiries received during 2014/2015 is shown below, together with the numbers from 2013/2014 for comparative purposes:

Type of enquiry	**Total Number 2013/2014**	**Total Number 2014/2015**
Request for advice / information	323	389
Request for support	64	43
Compliments	336	187
Total	**723**	**619**

Many service users will contact he team for reasons other than complaints. This may be about:

- Their treatment and care
- Services which the Trust provides
- Signposting to other local or voluntary services
- Outpatient clinic appointments (patients may occasionally ask a member of the team to attend with them)
- Liaison for carers and patients who have additional support needs and complex health problems
- Communication with patients' healthcare teams to facilitate both parties being able to work together in the future.

- Assisting families who arrive in Bristol with a patient but do not live locally and require local orientation and signposting to further help about finding somewhere to stay.

Examples of typical enquiries about advice and information include:

- What is the waiting time for xxx procedure?
- Who do I contact to discuss xxx?
- Can I have my treatment at a different hospital/location?
- Is it true that my operation has been cancelled due to cost cuts?
- I'm having an operation soon, who do I speak to about some concerns/questions that I have?
- I need a letter from my consultant in order that I can get my driving licence back.
- How do I make a complaint about my GP?
- My transport hasn't arrived and I'm going to miss my appointment. Who do I contact?
- I'm on the ward and I need to know the password for the Wi-Fi.
- I was an inpatient last week and lost my glasses. What do I need to do?

Examples of typical enquiries about support include:

- I would like someone to come to my outpatient appointment with me for support.
- I've arranged to meet with my consultant, would you be able to come with me?
- I need to arrange for a translator/interpreter to be available at my mother's appointment, can you help?
- Are you able to help me get hold of my consultant's secretary?
- Who do I need to contact to arrange hospital transport?

12. Training

The Patient Support and Complaints Team has begun to roll out complaints training for senior staff across the organisation in 2014/2015. This training focuses on effective investigation and response to complaints (including how to write a good response letter) and increasing staff confidence in dealing with complaints directly by helping to resolve problems quickly for patients. The training sessions, which last for three hours, include interactive role play and group discussion. The programme will continue into 2014/15; it is anticipated that all Divisions will have received training by October 2015, followed by regular quarterly briefings for new staff. The Patient Support and Complaints Team has also continued to deliver complaints training as part of the Trust's Leadership for Leaders sessions.

13. Looking ahead

University Hospitals Bristol NHS Foundation Trust continues to be proactive in its management of complaints and enquiries, acknowledging that all concerns are a valuable source of information. One of the Trust's nine key corporate quality objectives for 2015/16 is to improve the quality of complaints responses letters, and in turn to reduce the number of complainants who are dissatisfied with our complaints responses. Progress will be monitored by the Trust Board throughout the year. The Trust's complaints work plan for 2015/16 is available upon request.

Appendix 1

2014/2015 KO41a return

		Total Number of Formal Complaints Received
1	Hospital acute services: Inpatient	275
2	Hospital acute services: Outpatient	283
3	Hospital acute services: A&E	82
4	Elderly (geriatric) services	23
6	Maternity services	34
13	Other	82
Total		**780**

	Total Number of Formal Complaints Received
Medical (including surgical)	521
Dental (including surgical)	53
Professions supplementary to medicine	41
Nursing, midwifery and health visiting	120
Scientific, technical and professional	2
Maintenance and ancillary staff	23
Trust administrative staff/members	20
Other	0
Total	**780**

		Total Number of Formal Complaints Received
1	Admissions, discharge and transfer arrangements	32
2	Aids and appliances, equipment, premises (including access)	3
3	Appointments delay/cancellation: Outpatients	51
4	Appointments delay/cancellation: Inpatients	111
7	Attitude of staff	137
8	All aspects of clinical treatment	272
9	Communication/information to patients (written and oral)	82
10	Consent to treatment	1
11	Complaints handling	1
12	Patients' privacy and dignity	3
13	Patients' property and expenses	13
17	Personal records (including medical and/or complaints)	1
18	Failure to follow agreed procedures	2
19	Patients' status discrimination (e.g. racial, gender, age)	0
20	Mortuary and post mortem arrangements	0

21	Transport (ambulances and other)	10
22	Policy and commercial decisions of Trusts	0
23	Code of openness - complaints	0
24	Hotel services (including food)	2
25	Other	59
Total		**780**

Appendix 2

Equalities data

Information about the protected characteristics of people who complained about our services (or on behalf of whom a complaint was made) in 2014/15

Since 1st October 2014, the Patient Support and Complaints Team have been asking for the patient's ethnic group, age, gender, religion and civil status, if this data has not been pre-populated from the Medway patient administration system. Data for Quarter 3 2014/15 (421 complaints) and Quarter 4 2014/15 (517 complaints) is provided below[5]

Ethnic group of patient	Number
White British	738
Any Other White Background	35
White Irish	7
African or British African	5
Caribbean or British Caribbean	12
Pakistani or British Pakistani	5
Indian or British Indian	8
Chinese	3
Any Other Asian Background	11
Any Other Black Background	2
Any Other Mixed Background	7
Any Other Ethnic Group	3
Not Stated/Given	23
Not Collected At This Time	68
Unknown	11
Total	938

Age Group of Patient	Number
0-15	139
16-24	55
25-29	38
30-34	45
35-39	38
40-44	35
45-49	57
50-54	57
55-59	78
60-64	63
65+	321
Prefer not to say or Unknown	12
Total	938

Gender of Patient	Number
Male	462
Female	476

[5] The total number of complaints received in Q3 and Q4 was 938, hence the totals shown in these tables.

Prefer not to say or Unknown	0
Total	938

Religion of Patient	**Number**
Agnostic	4
Anglican	1
Atheist	5
Baptist	8
Buddhist	7
Catholic – Not Roman Catholic	7
Christian	60
Church of England	251
Congregationalist	1
Elim Pentecostalist	1
Greek Orthodox	1
Hindu	4
Jehovah's Witness	2
Methodist	13
Mormon	2
Muslim	17
New Apostolic Church	1
No Religious Affiliation	228
Other	6
Pagan	1
Protestant	1
Roman Catholic	48
Sikh	4
United Reform	3
Unknown	261
Total	938

Civil Status of Patient	**Number**
Co-Habiting	33
Divorced/Dissolved Civil Partnership	29
Married/Civil Partnership	275
Separated	3
Single	368
Widowed/Surviving Civil Partner	37
Unknown	193
Total	938

Appendix 3

Patients Association recommendations
(Trust responses in italics as reported to the Patient Experience Group)

1. Continue to offer every means of contact possible. Make clear in all communication that feedback and comment is desired. Make sure that all members of staff, especially those in public-facing areas such as outpatients and reception know about how to refer patients to make a comment or complaint.

   This is already standard practice, which is recognised in the PA report as they state that the Trust should continue to do this.

   A new training programme is being rolled out in 2015/16 which will include training for public-facing staff to give them the confidence to deal with complaints at the point of contact and/or know how to refer people to the PSCT when appropriate. This training also focuses on how to carry out a complaint investigation and on improving the quality of written responses.

2. Complainants are often angry, upset and frustrated. Continue to provide a friendly, professional and empathetic response and to demonstrate an understanding of the patient perspective in all communications.

   Again, this is standard practice and will continue to evolve as senior staff continue to receive the training outlined above.

3. Maintain timeliness of initial response to letters. Ensure phone calls are always answered promptly. Deliver on promises to call back in a certain timeframe.

   Acknowledgement of all complaints is monitored, whether they are received by telephone, email or letter. All verbal enquiries are to be acknowledged within two working days, with the majority of calls being returned on the same day. All email and written enquiries are acknowledged within three working days [6].

4. At first stage, involve the complainant more in the process. Establish a single point of contact for the complainant; find out how they want the complaint dealt with and respond to this choice of method; be sure that the full story is understood and the main points clarified; establish what outcome the complainant desires.

   The Patient Support & Complaints Team has committed to contact all complainants by telephone on receipt of their enquiry, regardless of whether sufficient information has been provided at that point. This ensures the complainant feels engaged with the complaints process and has had the opportunity to discuss their desired outcome.

5. Liaise with divisional teams as necessary to offer a meeting and/or mediated approach to complaints when appropriate.

   All complainants are offered the choice of a written response, a meeting or a telephone call. This is then agreed with the division. This ensures that the complainant receives the most timely and efficient method of response to meet their needs.

[6] See Section 8, Performance in responding to complaints

6. If action is planned, or still better has been taken, talk about it. Posters in the hospital of the 'You said we did' variety would give everyone the feeling that the hospital was taking notice. Send a follow-up letter to complainants about changes once they have happened.

   If action is planned or has already been taken, an Action Plan is drawn up and sent to the PSCT with the response letter/meeting minutes. This is then sent to the complainant with their response letter so they are reassured that a named person is taking responsibility for the specific action, by a set date.

   The PSCT caseworker sets a diary reminder for the date of when the last action is taken and chases the Division to ensure that the action plan has been completed as agreed.

7. Clarify guidance for those drafting the final response letter – key elements in addition to those about tone and style include:
   - Answer all the complainant's points
   - Accept responsibility and offer apology where appropriate
   - Check that action points have been identified and fully explained
   - Offer reassurance that there would be no impact on their future care
   - Sound genuinely pleased a complaint has been raised.

   There is a Standard Operating Procedure to assist staff in investigating and responding to a complaint. This has been shared across all Divisions.

   There is a training session aimed at teaching senior staff how to write a good response letter. The PA attended and delivered part of the last round of training on this subject and has provided us with their literature so that this can be included in future sessions.

   Regular review of the Trust's response letters is carried out by Bristol CCG and the PSCT have implemented their comments in their training programme and sharing the learning from their comments with the Divisions as part of ongoing learning Trustwide.

8. Be proactive in offering opportunities for people to raise concerns while undergoing care, to minimise formal complaints.

   This forms part of training for frontline staff in dealing with complaints at the time they are raised and giving staff the confidence to deal with these.

   It is also hoped that with the implementation of the Datix system for recording complaints, staff will be able to input informal issues they have dealt with directly onto the system without having to forward these to the division or to the PSCT.

9. Ensure that the investigation is thorough and independent – this may mean involving a different department – or having it reviewed by someone independent. Involve the complainant at the investigation stage if this is indicated. Ensure that appropriate responsibility is taken for any errors.

   This issue has been raised previously and discussion has taken place at PEG. It has been widely agreed that it would not be appropriate or practical for Divisions to investigate each other's complaints but that it makes more sense for the manager of the service involved to be able to investigate complaints about their own service so that they have an awareness of the

sort of complaints being made and any themes or trends that are developing in particular areas.

There is already an element of independence in that a senior investigating manager if appointed by the Division and we would never ask a member of staff/manager/clinician to investigate a complaint about themselves.

10. Once the complaint is under investigation, deliver to the promised timeframe.

    This is reported on a monthly basis as a KPI for formal complaints. Divisions do have the opportunity to extend the deadline (in agreement with the complainant) if, for example, a key member of staff is on leave.

11. Check to see if changes are possible and needed as a result of the complaint; and if so, set these in motion and tell the complainant. Triangulate patient feedback with other patient/hospital information and take action appropriately.

    For all complaints where actions are identified as a result of the complaint, these are drawn together in an Action Plan, which is shared with the complainant – see point 6 above.

    Data, themes and trends from complaints are shared Trustwide via Quarterly Complaints Reports, Annual Complaints reports and monthly data provided to the Board and shared at PEG.

12. Ensure adherence to good practice standards in complaints handling.

    The Patient Support & Complaints Manager ensures that good practice is maintained on a day to day basis by monitoring the team's casework, ensuring KPIs are met, reviewing processes and monitoring/reporting themes and trends in complaints.

    The Head of Quality (Patient Experience & Clinical Effectiveness) oversees and has overall responsibility for the complaints service, reporting directly to the Executive Lead for Complaints.

13. Above all, to satisfy the main requirement of complainants, ensure that complaints do make a difference and lead to positive change. Challenge all staff on this point. Consider a patient panel to scrutinise and question any 'no change' response.

    Any further review of complaint responses in addition to checks already made at Divisional level, PSCT and Executive level would need to be built into the agreed deadline by which the response is to be sent to the complainant. Careful consideration would need to be given to how this extra layer of checking would impact on deadlines and the time given to the Division to investigate the complaint.

    A random selection of complaints is already checked by the Head of Quality and by the commissioners and learning from this is fed back to the divisions.

    On the issue of whether the Trust is actually learning from complaints, this can be monitored through the existing identification of themes and trends but consideration needs to be given to whether one person within each division should take overall responsibility for ensuring that learning from complaints is shared across the whole division and subsequently Trustwide.

14. ‘Advertise’ the impact of complaints to show that the Trust is a learning, responsive and empathetic organisation.

    In addition to the work carried out as noted in Point 6 above, the Trust does publish its quarterly and annual complaints reports on its public website, as well as sharing patient stories and complaints information that is submitted to the Board each month.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
11. National In-patient Survey Results 2014
Sponsor and Author(s)
Sponsor: Chief Nurse, Carolyn Mills Author: Paul Lewis, Patient Experience Lead (surveys and evaluation)

Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary
Purpose To appraise the committee of the findings of the 2014 National Inpatient Survey. Key issues to note The headline results for UH Bristol in the 2014 national inpatient survey are as follows: - UH Bristol performed in line with the national average on 57 out of 60 survey questions. - On two questions, the Trust performed better than the national average: relating to explaining the risks and benefits of operations and discussing post-hospital care needs with patients. - The Trust received a below-national average score on availability of hand gels, however this was still one of UH Bristol's highest scores: 9.1/10 Two reports are provided in relation to this survey: - Local analysis report: this provides a more detailed analysis of UH Bristol's performance and outlines service improvement activity in relation to the key issues identified. - The Care Quality Commission Benchmark report: this report presents UH Bristol's score on each survey question relative to other trusts.
Recommendations
The Board is recommended to receive these reports for assurance.
Impact Upon Board Assurance Framework
This paper does not impact on the Board Assurance Framework
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
Participation and performance in the annual national in-patient survey is relevant to compliance with various CQC Fundamental Standards.
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	

Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Quality and Outcomes Committee
			22/7/15	28/7/15

2014 National Inpatient Survey Results: Local Analysis Report

1. Summary

This report provides an analysis of UH Bristol's performance in the 2014 national inpatient survey and presents a response to the key issues identified. The headline results are:

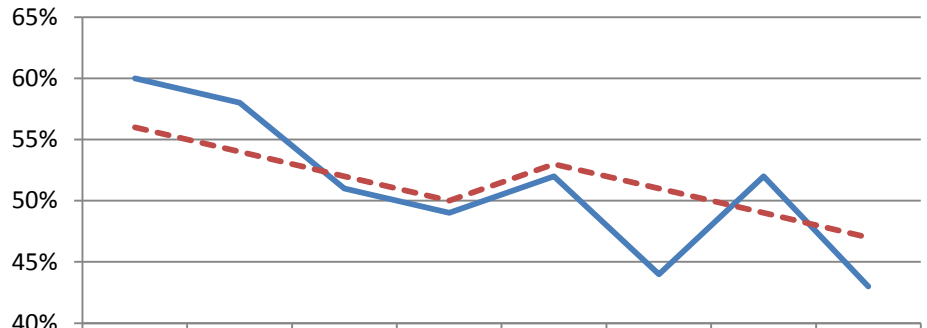
- UH Bristol performed in line with the national average on 57 out of 60 survey questions.
- On two questions, the Trust performed better than the national average (relating to explaining the risks and benefits of operations and discussing post-hospital care needs with patients).
- The Trust received a below-national average score on availability of hand gels (but this was still one of UH Bristol's highest scores: 9.1/10)

2. Background

In total, 154 specialist and acute trusts participated in the survey. As part of the survey, a questionnaire was sent by post to 850 UH Bristol adult inpatients (aged 16 and over) who attended during the latter half of July 2014[1]. The Trust received 354 responses - a response rate of 43%, compared to the overall national rate of 47%[2].

There have been sharp declines in response rates to national surveys over recent years (Chart 1). The reasons for this are uncertain, but given the large number of patient surveys now being carried out in the NHS, it seems likely that "survey fatigue" among patients is at least partly responsible. Even with these declines, the national survey delivers a valid national benchmark for trusts. However, this issue does affect the accuracy of the trust-level data and is likely to lead to larger year-to-year fluctuations in individual survey scores: this is something that may already be evident in UH Bristol's 2014 results (see next section). In response to this issue, the Care Quality Commission intends to increase the trust sample sizes for the 2015 national inpatient survey to 1250 patients.

Chart 1: national inpatient survey response rates (2007-2014)



	2007	2008	2009	2010	2011	2012	2013	2014
UH Bristol	60%	58%	51%	49%	52%	44%	52%	43%
National	56%	54%	52%	50%	53%	51%	49%	47%

[1] The survey does not include women admitted to maternity units.
[2] The response rate calculation excludes questionnaires that could not be delivered to the patient.

3. Care Quality Commission benchmark report: headline results

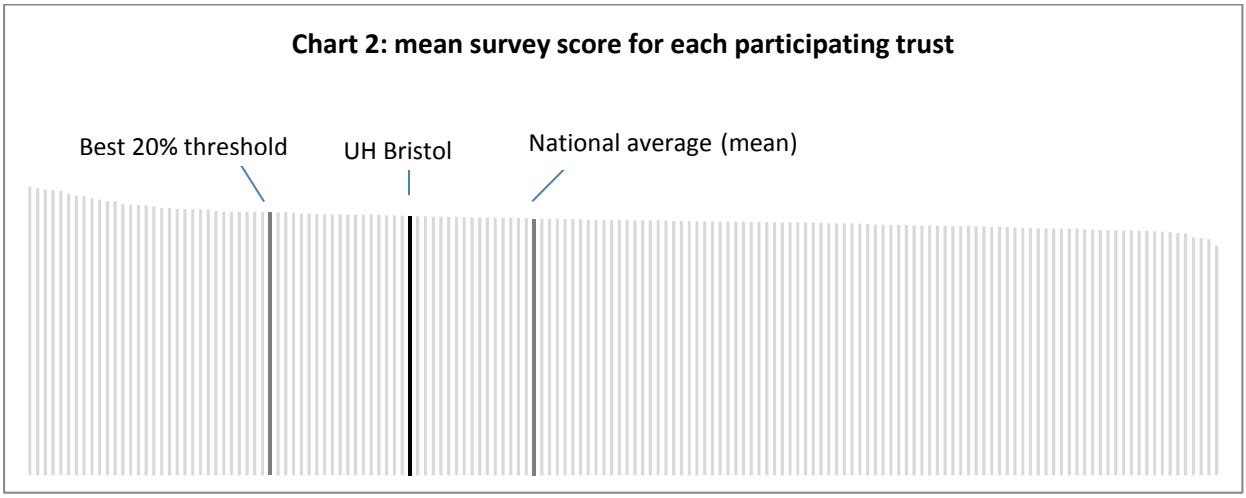
This local analysis report is accompanied by the Care Quality Commission's (CQC's) benchmark report. The benchmark report presents UH Bristol's score on each survey question relative to other trusts[3]. The headline results for UH Bristol are as follows:

- Two UH Bristol scores were better than the national average[4]:
    - Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (9.1/10)
    - Did a member of staff explain the risks and benefits of your operation or procedure? (9.3)
- One score was below the national average (although it was still one of UH Bristol's best survey scores):
    - Were hand-wash gels available for patients and visitors to use? (9.1)
- The remaining 57 scores were in line with the national average.

The sixty survey questions are also aggregated into ten over-arching section scores. For UH Bristol, all of the ten sections were classed as being "about the same as most other trusts" (i.e. in line with the national average).

Chart 2 presents an indication of UH Bristol's overall national position relative to other trusts[5]. It should be noted that this is a relatively simplistic analysis that doesn't take account of margins of error in the data. Nevertheless, the broad position that UH Bristol occupies (i.e. between the national average and top quintile) is typical of the Trust's performance in the national inpatient surveys.

Chart 2: mean survey score for each participating trust



[3] Scores are out of ten, with ten being the best. Scores give a "weight" to all response options to a survey question, rather than just taking the percentage ticking the best possible response option - see Appendix B for further details.

[4] The Care Quality Commission use the terms "better than most other trusts", "about the same as most other trusts", and "worse than most other trusts" – in lay terms these refer to better / same / worse than the national average.

[5] Charts 2 and 3 should not be considered a robust statistical analysis, but they are useful for illustrative purposes. For each participating trust, a mean score is taken across all of the survey question scores. These mean scores are then ranked, from highest (best) to lowest.

Using the same method of comparison as Chart 2 (above), Chart 3 shows the comparative performance of twenty-two large city-based teaching trusts. UH Bristol again occupies a positon that is slightly above the average of this peer group.

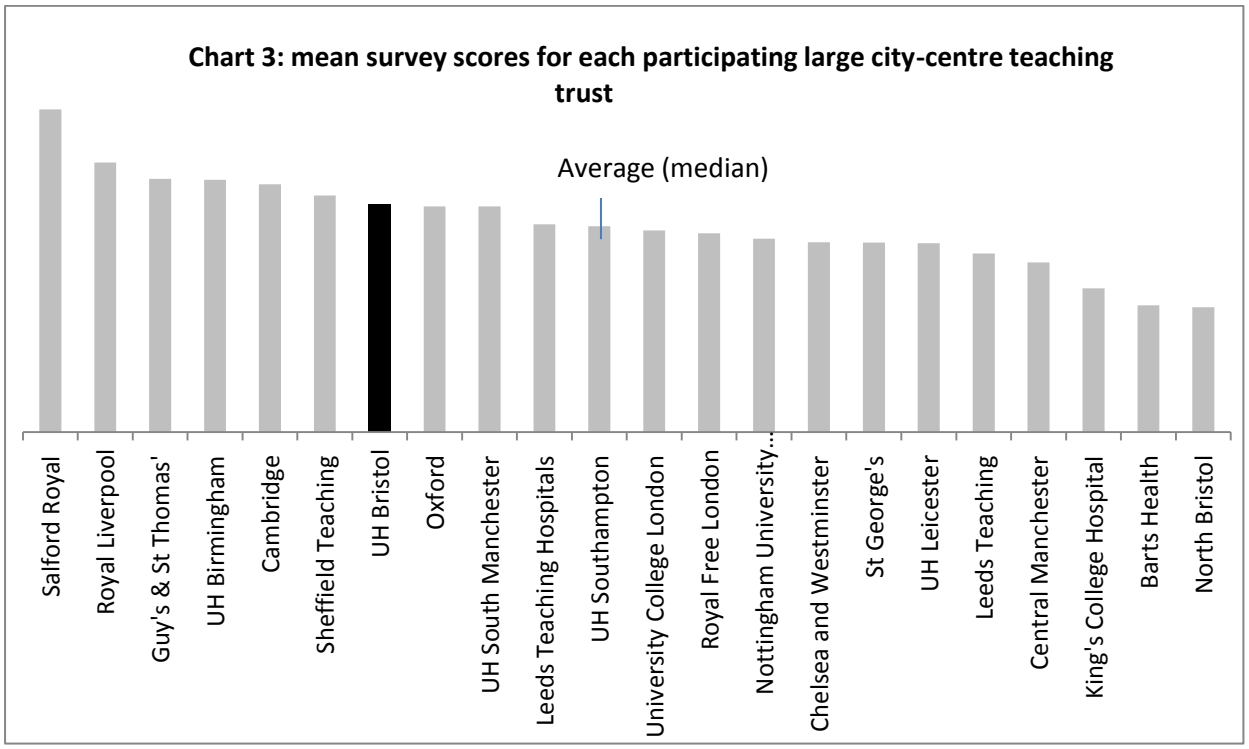


Table 1 presents the number of question scores that the Care Quality Commission classed as being above or below the "national average", for UH Bristol's geographical neighbours. On this basis an "overall score" is calculated for each trust. This is essentially what the public would see if they carried out their own comparison of local trusts via the CQC website[6].

Table 1: 2014 national inpatient survey - comparison with "local" Trusts

	A. Number of scores "better than most other Trusts" (/60)	**B. Number of scores "worse than most other Trusts" (/60)**	**"Overall Score" (A-B) 2014**	**2013 overall score**
Royal United Hospital Bath NHS Trust	2	0	2	-3
University Hospitals Bristol NHS FT	**2**	**1**	**1**	**-1**
Royal Devon & Exeter NHS FT	1	0	1	6
Yeovil District Hospital	0	1	-1	2
Gloucestershire Hospitals NHS FT	0	0	0	0
Great Western Hospitals NHS FT	0	4	-4	0
Weston Area Health NHS Trust	0	6	-7	0
North Bristol NHS Trust	2	13	-11	0

[6] http://www.cqc.org.uk/provider/RA7/survey/3

4. Comparison with the previous (2013) national inpatient survey results

In the 2013 national inpatient survey, no UH Bristol scores were better than the national average and one was worse (whether the patient had sufficient privacy in the Accident and Emergency Department[7]). There were a number of statistically significant changes between the 2013 and 2014 surveys:

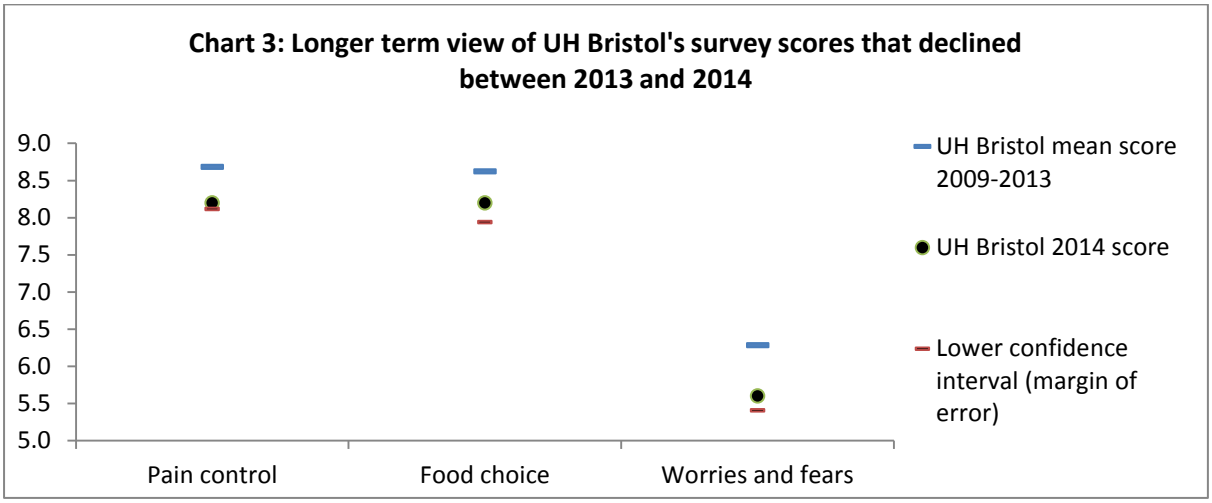
- Three scores declined (i.e. got worse) to a statistically significant degree:
    - Were you offered a choice of food? (from 8.8 in 2013 to 8.2 in 2014)
    - Did you find someone on the hospital staff to talk to about your worries and fears? (6.3 to 5.6)
    - Do you think the hospital staff did everything they could to help control your pain? (8.8 to 8.2)
- Four scores improved:
    - Did a member of staff explain the risks and benefits of the operation or procedure? (8.8 to 9.3)
    - Did a member of staff explain what would be done during the operation or procedure? (8.2 to 8.9)
    - Did a member of staff answer your questions about the operation or procedure? (8.4 to 9.1)
    - Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (8.3 to 9.1)

This is more fluctuation than is usually evident in the data for this survey (there were no statistically significant differences between the 2012 and 2013 surveys, for example), and this greater instability may be caused by declining response rates (see Section 2). One-year changes in survey scores can be misleading however: over a longer period of time, the three UH Bristol scores that declined in 2014 were lower than the scores the Trust usually achieves on these survey questions, but were within the survey's margin of error over a five year period (Chart 3 - over). In other words, these scores are "unusual", but consistent with random fluctuation in the data, rather than a real decline in service quality. A similar effect explains the three improved scores relating to communication about operations / procedures[8].

The question around whether staff discussed health and social care needs appears to be a genuine improvement, and has an identifiable underlying cause in the Trust's focus on improving links with local health and social care partners. However, caution is needed here as this question only went into the survey in 2012, and so we are not able to establish a full five-year trend against which to compare the 2014 result.

[7] This score / issue wasn't subsequently corroborated by the 2014 National Accident and Emergency Survey, carried out a few months later, and so was most likely caused by random fluctuation in the inpatient survey data.

[8] This conclusion is supported by UH Bristol's monthly survey of inpatients, which has a much greater level of accuracy than the national survey, and shows no change in the scores about finding a member of staff to talk to about worries and fears, or explaining risks and benefits of operations. Data for the other questions noted in Section 4 of this report are not collected in UH Bristol's survey.



5. Highest UH Bristol scores

Table 2 shows that a number of UH Bristol's highest (best) scores in the 2014 national inpatient survey are around themes of privacy, dignity and communication.

Table 2: Highest 2014 national inpatient survey scores for UH Bristol (all scores are out of ten, with ten being the best possible score)

	UH Bristol score	Best Trust score	UHB relative to national average
Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	10	About the same
Were you given enough privacy when being examined or treated?	9.5	9.9	About the same
Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.3	9.6	**Better**
In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	9.3	9.7	About the same
Did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.2	9.8	About the same
Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?	9.2	9.6	About the same
Did you have confidence and trust in the doctors treating you?	9.2	9.8	About the same

(UH Bristol highest scores continued)	**UH Bristol score**	**Best Trust score**	**UHB relative to national average**
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	9.1	9.7	**Better**
Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.1	9.6	About the same
Were hand-wash gels available for patients and visitors to use?	9.1	9.9	**Worse**
Was your admission date changed by the hospital?	9.0	9.9	About the same
Did you have confidence and trust in the nurses treating you?	9.0	9.7	About the same

6. Improvement themes

The following scores provide the basis of the Trust's response to the 2014 national inpatient survey:

- Any UH Bristol scores that are below the national average
- The lowest five scores for UH Bristol (in absolute terms)
- The five UH Bristol scores that are furthest away from the best trust score nationally

The scores that fall in to these categories are shown in Table 3. All of the themes were already a focus for the teams involved, and are therefore subject to the monitoring and improvement activity that is continually being carried out at UH Bristol.

Table 3: scores that form the basis of the Trust's response to the 2014 national inpatient survey (note: a full list of the UH Bristol and top national scores is provided in Appendix A)

		Reason for inclusion		
	UH Bristol score (national average in brackets)	**"Worse than most other trusts"**	**Among lowest UH Bristol scores**	**Among furthest from the best Trust score (best trust score in brackets)**
Were hand-wash gels available for patients and visitors to use?	9.1 (9.5)	x		
Did you find someone on the hospital staff to talk to about your worries and fears?	5.6 (5.8)		x	x (8.2)
How would you rate the hospital food?	5.3 (5.5)		x	x (8.0)
Did a member of staff tell you about medication side effects to watch for when you went home?	5.1 (4.9)		x	x (7.6)
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.1 (2.7)		x	x (5.8)
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7 (2.1)		x	x (6.0)

Were hand-wash gels available for patients and visitors to use?

This was one of UH Bristol's highest scores in the survey (9.1/10), but it declined slightly from 2013 (9.3) and this led to the Trust being classed as below the national average on this question[9]. In line with key national and international guidelines[10], the placement of hand gel is targeted at points of care - which are primarily at the end of a patient's bed and immediately outside patient rooms / bays. Ward staff are responsible for ensuring that gels are available in these areas and hand hygiene audits are carried out monthly as part of the "Safety Thermometer".

This issue will be further explored via the Trust's *Face2Face* interview programme (See Appendix C), to check that inpatients are aware that the hand-gels are at the end of their beds and that they have access to these. The Trust's Infection Prevention and Control (IPC) Team are also planning a Trust-wide audit of all hand hygiene provisions and locations in 2016, when the current ward moves have been completed[11].

Action 1: *Face2Face* interviews to assess patient access to hand gels.

Date: August 2015.

Owners: Tony Watkin, Patient Experience Lead (engagement and involvement); Joanna Davies; Senior Nurse for infection control.

Action 2: Trust-wide audit of hand hygiene provision.

Date: 2016 (on completion of ward moves).

Owners: Joanna Davies; Senior Nurse for infection control.

Did you find someone on the hospital staff to talk to about your worries and fears?

There are two key elements to improving the score on this question:

- Supporting UH Bristol staff to deliver the "softer" aspects of care.
- Ensuring that patients feel empowered to ask for emotional support if they need it.

The Trust's Compassion in Clinical Care programme brings together several inter-related projects, including the introduction of a version of "My name is…"[12], and the greater use of digital stories. The

[9] Even though this fall wasn't statistically significant (i.e. was probably due to chance) – nationally the scores are very tightly concentrated at the higher end of the scale, which makes it relatively easy to fall below the average. This occurred in combination with the high level of agreement amongst UH Bristol's survey respondents that hand gel was available: high levels of agreement on a survey question reduces the margin of error around the result, and so, paradoxically, makes it easier to be classed as being below average. These are essentially statistical effects rather than a reflection of service quality.

[10] National Patient Safety Agency and World Health Organisation.

[11] A number of ward moves are currently taking place at UH Bristol, linked to the building of a new ward block and the decommissioning of inpatient areas in the Old Building and Kind Edward Building of the Bristol Royal Infirmary.

[12] "My name is…" is essentially about ensuring that members of staff introduce themselves and their role to patients - providing an essential foundation to a positive, respectful relationship. Digital stories provide opportunities for staff to reflect on and develop their ability to deliver compassionate care.

Trust's Patient Experience Lead (engagement and involvement) also runs staff workshops on wards which attain relatively low patient experience scores in UH Bristol's surveys[13]. This allows time and space for staff to reflect on how their behaviours can influence a positive patient experience.

The Trust's monthly inpatient survey collects detailed data on the "worries and fears" question. This will be discussed with the Volunteer Services team, to explore the possibility of providing additional "befriending" support in areas that achieve particularly low scores on this question.

All of these work-streams are designed to support staff in delivering compassionate care, but it is also important that patients are aware that they can ask for support and feel confident to do so. The re-design of the Trust's Welcome Guide is currently taking place and provides an opportunity to re-enforce this message. The booklet is given to patients when they arrive on a ward, and the next edition will include a section about how and where to seek advice and support if it is needed (e.g. ward staff, chaplaincy etc).

Action 3: Patient experience workshops for staff in the maternity postnatal care pathway and on care of the elderly wards.

Date: ongoing, but these areas will be completed by December 2015.

Owner: Tony Watkin, Patient Experience Lead (engagement and involvement).

Action 4: Compassion in Clinical Care programme.

Date: Ongoing (there are various work-streams within this).

Owners: Helen Morgan, Deputy Chief Nurse / Jo Witherstone, Senior Nurse for Quality.

Action 5: Redesign Welcome Guide.

Date: November 2015.

Owners: Tony Watkin, Patient Experience Lead (engagement and involvement) / Kate Hanlon, Communications Officer.

Action 6: Explore the use of volunteers to provide additional patient support on wards which achieve relatively low scores on the "worries and fears" question.

Date: August 2015.

Owners: Paul Lewis, Patient Experience Lead (surveys and evaluation); Judith Reed, Volunteer Services Manager.

During your hospital stay, were you ever asked to give your views on the quality of your care?

This was the lowest score that UH Bristol achieved in the survey: 17% of respondents stated that they were asked for their views about the quality of care whilst in hospital[14]. This is not an accurate

[13] It should be noted that these survey low scores are often not an indication of poor care, but are a reflection of the challenges in providing a consistently positive experience to some patient groups (e.g. long-stay chronic conditions)

[14] This was slightly below the national average (2.1), but not to a statistically significant degree.

reflection of the number of patients who were asked for their feedback: based on the Friends and Family Test alone, 32% of UH Bristol's inpatients gave their views during this period[15]. It is likely that two factors affect the score on this question:

- The national inpatient survey is completed several months after the episode of care, and so respondents may have forgotten this relatively incidental aspect of their stay[16].
- Respondents are not interpreting the question as being related to patient feedback.

UH Bristol has a robust programme in place to collect inpatient views of the care that they received at the Trust (see Appendix C). This continues to evolve[17], but already generates large amounts of patient feedback that is used at all levels of the organisation. There will continue to be a focus on maintaining (and where necessary improving) response rates to the Friends and Family Test "exit survey", which is completed whilst patients are in hospital.

UH Bristol's ongoing collection and use of patient feedback is not necessarily apparent to patients and visitors. An informal audit was recently carried out of the Trust's patient feedback and complaints posters / touchpoints (e.g. comments boxes, survey touchscreens)[18]. This suggested that there is significant scope for a more cohesive presentational approach, to ensure that patients, visitors and staff receive (and take away) a clear impression that the Trust collects and values patient feedback. The basis of a branding strategy has already been developed ("Talking Point") and received support in principle from the Senior Leadership Team committee. Further development of this work-stream will form part of the Trust's updated Patient Experience and Involvement Strategy which will be completed during 2015/16.

Action 7: Ensure that a high response rate is maintained in the Trust's Friends and Family Test inpatient survey during 2015/16. Performance is reviewed monthly at the Patient Experience Group and is reported to the Trust Board in the Quality Dashboard.

Date: Ongoing.

Owners: Divisional Heads of Nursing.

Action 8: Include a Patient Experience "branding" theme in the updated Patient Experience and Involvement Strategy.

Date: Completed by March 2016

Owners: Chris, Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness); Tony Watkin, Patient Experience Lead (engagement and involvement); Paul Lewis, Patient Experience Lead (surveys and evaluation).

[15] See Appendix C for further details about the Friends and Family Test (FFT) and UH Bristol's wider patient feedback programme. The proportion of patients who were offered the chance to complete the FFT would have been even higher than this, as some will have chosen not to respond; there will inevitably have been other inpatient surveys going on at this time as well. Around 1100 adult inpatients per month also receive a questionnaire by post after their hospital stay (UH Bristol's monthly inpatient survey).

[16] The same question is included in the Trust's monthly inpatient survey, which is completed closer to the episode of care, and the score is higher at 25%.

[17] For example, the Friends and Family Test was launched in paediatric inpatient wards in April 2015.

[18] This was a "walk-around" by the members of the Quality Team and Communications Team

How would you rate the hospital food?

In the 2014 national inpatient survey, 56% of UH Bristol patients rated the food as very good or good, with 27% saying it was fair, and 16% rating it as poor. This suggests that most patients are broadly satisfied with the hospital food, but it is also one of the most frequently cited improvement issues that patients raise via their free-text comments in the UH Bristol monthly inpatient survey. In other words: people who don't like the food tend to feel very strongly about this issue. These differences of opinion make the patient experience of food a particularly difficult issue to address. Nevertheless, the Trust's Facilities Department carries out ongoing quality assurance to ensure that the food and food service are of a high standard. This includes a catering satisfaction survey (which is currently being re-designed to make it more user-friendly), and the annual PLACE[19] inspections which have consistently produced favourable results in respect of UH Bristol's food provision. The Facilities Team continually develop the catering service, for example all regeneration trollies now have improved thermostatic control, allowing improved regeneration capability for differing foodstuffs. UH Bristol's food service contract is due for renewal in 2015 and within this competitive tender process opportunities will be sought to further develop the service.

Action 9: Re-design / launch of food satisfaction patient questionnaire.

Date: August 2015.

Owner: Hannah Kedzia, Business Manager, Facilities Department.

Action 10: Carry out tender of the patient feeding contract.

Date: To be confirmed (2015).

Owner: Dena Ponsford, General Manager, Facilities Department.

Did a member of staff tell you about medication side effects to watch for when you went home?

Conveying information about medications prescribed to inpatients at discharge from hospital is a shared responsibility between drug manufacturers (in the form of medicine information sheets), UH Bristol pharmacists and the patient's clinical team. Even with this range of expertise, it is challenging to ensure that the right information is conveyed in the right way for each individual patient. This is reflected nationally, where the question about explaining medication side effects is one of the lowest for all trusts in the national inpatient survey.

In response to this issue, in 2014 UH Bristol's Pharmacy Department developed a database that ward staff could use to look up and print out medication side effects for a range of commonly used drugs. However, after piloting this in clinical areas a number of drawbacks were identified - in particular ensuring that the database contained a sufficiently comprehensive range of medications and that the information remained up to date (particularly as the Trust would be liable for its accuracy). A commercial solution has been identified that would address these issues[20] and funding has been secured by the Pharmacy Department to purchase this, initially for a two year evaluation period.

[19] Patient-led inspections of the care environment.
[20] http://misturainformatics.org/cms/mapps/

Action 11: Purchase and evaluate the commercial MaPPs database, to support the provision of medications information to patients.

Date: Implemented by December 2015.

Owner: Kevin Gibbs, Clinical Pharmacy Manager.

Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

This is one of the questions in the national survey for which the vast majority of providers achieve a comparatively low score. A reasonable hypothesis might be that patients will not necessarily notice information about how to make a complaint unless they actually have need of it. Nonetheless, there are some trusts that are performing significantly better than UH Bristol for this question; the Trust's Patient Support & Complaints Manager will therefore contact providers who are achieving the best scores to see if there is learning that could be applied here.

A number of channels are used to "advertise" the complaints process at UH Bristol, including:

- All wards and departments have a supply of Complaints Service information leaflets on display and/or readily available for patients and visitors.
- The Trust's Welcome Guide contains information about how to make a complaint and is given to patients on admission.
- The Trust's Patient Support and Complaints office has a prominent physical location in the Bristol Royal Infirmary Welcome Centre.

There are also posters on display around the Trust that draw attention to the different ways that people can give feedback, including complaints. However, a recent informal audit of these posters identified an opportunity to expand their use and to generally adopt a more coherent / coordinated approach to publicising these channels to patients and visitors (see also Action 8 above).

Action 12: contact (and potentially visit) the top performing trusts on this question, to see if there is learning from how they publicise / signpost their complaints service.

Date: August 2015

Owner: Tanya Tofts, Complaints Team Manager

Action 13: Review the use of the Trust's "Tell Us About Your Care" feedback posters to ensure they are displayed in prominent locations.

Date: September 2015 (to complete)

Owner: Tanya Tofts, Complaints Team Manager; Tony Watkin, Patient Experience Lead (engagement and involvement); Paul Lewis, Patient Experience Lead (surveys and evaluation).

Appendix A: UH Bristol scores with comparison to the best Trust score nationally[21]

	UH Bristol	Best score	Difference
19. Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	10.0	0.2
43. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.3	9.6	0.3
38. Were you given enough privacy when being examined or treated?	9.5	9.9	0.3
44. Beforehand, did a member of staff explain what would be done during the operation or procedure?	8.9	9.3	0.4
48. Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?	9.2	9.6	0.4
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	9.3	9.7	0.4
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.1	9.6	0.5
65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	9.1	9.7	0.6
25. Did you have confidence and trust in the doctors treating you?	9.2	9.8	0.7
11 and 13 Did you ever share share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.2	9.8	0.7
The Emergency/A&E Department (answered by emergency patients only)	8.7	9.4	0.7
58. Were you told how to take your medication in a way you could understand?	8.8	9.5	0.7
17. In your opinion, how clean was the hospital room or ward that you were in?	8.9	9.7	0.7
31. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	8.3	9.1	0.7
28. Did you have confidence and trust in the nurses treating you?	9.0	9.7	0.7
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.7	9.5	0.8
18. How clean were the toilets and bathrooms that you used in hospital?	8.7	9.5	0.8
29. Did nurses talk in front of you as if you weren't there?	8.8	9.7	0.8
20. Were hand-wash gels available for patients and visitors to use?	9.1	9.9	0.8
7. Was your admission date changed by the hospital?	9.0	9.9	0.9
16. Were you ever bothered by noise at night from hospital staff?	8.3	9.2	0.9
66. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.9	9.8	0.9
4. Were you given enough privacy when being examined or treated in the A&E Department?	8.7	9.6	0.9
27. When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	9.3	0.9
59. Were you given clear written or printed information about your medicines?	8.4	9.3	0.9
56. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.7	9.7	1.0
33. Did you have confidence in the decisions made about your condition or treatment?	8.4	9.4	1.0

[21] Please note that the CQC no longer provide a single report that directly compares UH Bristol with the national average in percentage terms.

	UH Bristol	Best score	Difference
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	7.5	8.5	1.0
67. During your time in hospital did you feel well looked after by hospital staff?	8.8	9.8	1.0
37. Were you given enough privacy when discussing your condition or treatment?	8.4	9.4	1.1
26. Did doctors talk in front of you as if you weren't there?	8.6	9.6	1.1
68. Overall... (Please circle a number)	8.1	9.2	1.1
24. When you had important questions to ask a doctor, did you get answers that you could understand?	8.4	9.4	1.1
Care and treatment	7.8	8.9	1.1
40. Do you think the hospital staff did everything they could to help control your pain?	8.2	9.3	1.1
41. How many minutes after you used the call button did it usually take before you got the help you needed?	6.5	7.8	1.3
49. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.7	9.0	1.3
54. How long was the delay?	7.6	8.9	1.3
22. Were you offered a choice of food?	8.2	9.6	1.4
64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	7.9	9.3	1.4
61. Did hospital staff take your family or home situation into account when planning your discharge?	7.1	8.6	1.5
63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.1	9.7	1.5
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	8.0	9.5	1.5
34. How much information about your condition or treatment was given to you?	7.9	9.5	1.6
50. Did you feel you were involved in decisions about your discharge from hospital?	7.0	8.7	1.6
23. Did you get enough help from staff to eat your meals?	7.7	9.4	1.7
32. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.5	9.2	1.7
60. Did a member of staff tell you about any danger signals you should watch for after you went home?	5.7	7.3	1.7
14. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	8.1	9.8	1.7
36. Do you feel you got enough emotional support from hospital staff during your stay?	7.2	9.0	1.8
55. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	7.2	9.1	1.9
62. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	6.1	8.1	2.0
51. Were you given enough notice about when you were going to be discharged?	7.3	9.2	2.0
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.9	9.9	2.1
Waiting to get to a bed on a ward	7.9	9.9	2.1
30. In your opinion, were there enough nurses on duty to care for you in hospital?	7.3	9.5	2.2
53 / 54. Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.1	8.3	2.2

	UH Bristol	Best score	Difference
15. Were you ever bothered by noise at night from other patients?	6.5	8.9	2.4
57. Did a member of staff tell you about medication side effects to watch for when you went home?	5.1	7.6	2.4
35. Did you find someone on the hospital staff to talk to about your worries and fears?	5.6	8.2	2.6
21. How would you rate the hospital food?	5.3	8.0	2.7
70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.1	5.8	2.7
69. During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7	6.0	4.3

Appendix B: Care Quality Commission Survey Scoring Mechanism

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the national survey questions have three or more response options. In the CQC benchmark report, each one of these response options contributes to the calculation of the score.

As an example: Were you treated with respect and dignity on the ward?

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*1 = 81
Yes, probably	0.5	18%	18*0.5 = 9
No	0	1%	1*0 = 0

The result is then calculated as (81+9) / 10 = 9.0

As the survey score is using a relatively small sample to draw conclusions about the wider population, it is an estimate and has a quantifiable margin of error around it. In this particular case the margin of error is +/-0.3, meaning that we can be 95% certain that the "true" score for UH Bristol is somewhere between 8.7 and 9.3.

Conceptually, this is how the CQC classify Trust scores against the national average for each question:

1. Take the mean score across all trusts nationally (i.e. add up all of the Trust scores for this question, and divide this by the number of Trusts). The mean Trust score on the respect and dignity is 8.9
2. For each trust, use the margin of error in their data to give the expected range of scores for that trust. So, given UH Bristol's margin of error for this question is +/-0.3, and national mean score is 8.9, the CQC would expect UH Bristol's score to be between 8.6 and 9.2
3. UH Bristol's score, at 9.0, falls within this range and is therefore classified as being "about the same as most other trusts".

Appendix C: UH Bristol inpatient experience feedback mechanisms

The Patient Experience and Involvement Team at UH Bristol manage a comprehensive programme of patient feedback and engage activities. If you would like further information about this programme, or if you would like to volunteer to participate in it, please contact Paul Lewis (paul.lewis@uhbristol.nhs.uk) or Tony Watkin (tony.watkin@uhbristol.nhs.uk). The following table provides a description of the core patient experience programme, but the team also supports a large number of local (i.e. staff-led) activities across the Trust.

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	At discharge from hospital, all adult inpatients, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

Appendix D: Publication Timeline

The CQC National Inpatient Survey reports and the Trust's Local Analysis were released on the following timetable:

14 April 2015	Data released to trusts under embargo
29 April 2015	Email summary of results to Executive Directors, Divisional Chairs / Managers, and Heads of Nursing
21 May 2015	Data released publically
27 June 2015	Results and local analysis report reviewed at Patient Experience Group
23 July 2015	Senior Leadership Team
28 July 2015	Quality and Outcomes Committee of the Trust Board
30 July 2015	Trust Board

Patient survey report 2014

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

Survey of adult inpatients 2014

Making patients' views count

National NHS patient survey programme
Survey of adult inpatients 2014

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Our purpose is to make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what we find, including performance ratings to help people choose care.

Survey of adult inpatients 2014

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The twelfth survey of adult inpatients involved 154 acute and specialist NHS trusts. Responses were received from over 59,000 people, a response rate of 47%. People were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts were given the choice of sampling from June, July or August 2014. Trusts counted back from the last day of their chosen month, including every consecutive discharge, until they had selected 850 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2014). Fieldwork took place between September 2014 and January 2015.

Similar surveys of adult inpatients were also carried out in 2002 and from 2004 to 2012. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

The Care Quality Commission will use the results from this survey in our regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of Intelligent Monitoring, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs that we produce for inspections. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold them to account for the outcomes they achieve. The NHS Trust Development Authority will use the results to inform quality and governance activities as part of their Oversight Model for NHS Trusts.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with other trusts. For more information, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S11 in the 'section scores' on page 5. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward,' 'doctors and nurses' and so forth.

This report shows the same data as published on the CQC website (www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way,

identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). Standardisation therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q42 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey. If there is no text the score is 'about the same.' These groupings are based on a rigorous statistical analysis of the data, as described in the following 'methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the **'expected range'** which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above/below what would be expected. If it is within this range, we say that its performance is 'about the same'. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance.

In some cases there will be no red and/or no green area in the graph. This happens when the

expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible for all trusts score (no red section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

Tables

At the end of the report you will find tables containing the data used to create the graphs. These tables also show the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed. The column called 'change from 2013' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2013. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

Where a result for 2013 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if a trust has merged with other trusts since the 2013 survey, or if a trust committed a sampling error, either in 2014 or 2013. Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?"

Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the question's wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q33: "Did you have confidence in the decisions made about your condition or treatment?" is a new question in 2014 and it is therefore not possible to compare with 2013.

Q52 and Q53: The information collected by Q52 "On the day you left hospital, was your discharge delayed for any reason?" and Q53 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q53 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q54: Information from Q52 and Q53 has been used to score Q54 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q67: "During your time in hospital did you feel well looked after by hospital staff?" is a new question in 2014 and it is therefore not possible to compare with 2013.

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2002 to 2013 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/767

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/public/hospital-intelligent-monitoring

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

Section scores

Best performing trusts

About the same

Worst performing trusts

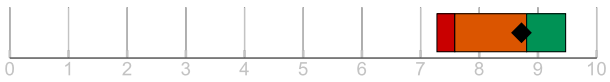
'Better/Worse' Only displayed when this trust is better/worse than most other trusts

◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2014
University Hospitals Bristol NHS Foundation Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Waiting list and planned admissions (answered by those referred to hospital)

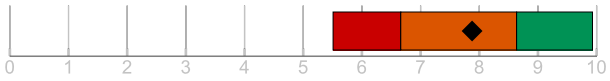
Q6. How do you feel about the length of time you were on the waiting list?

Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014
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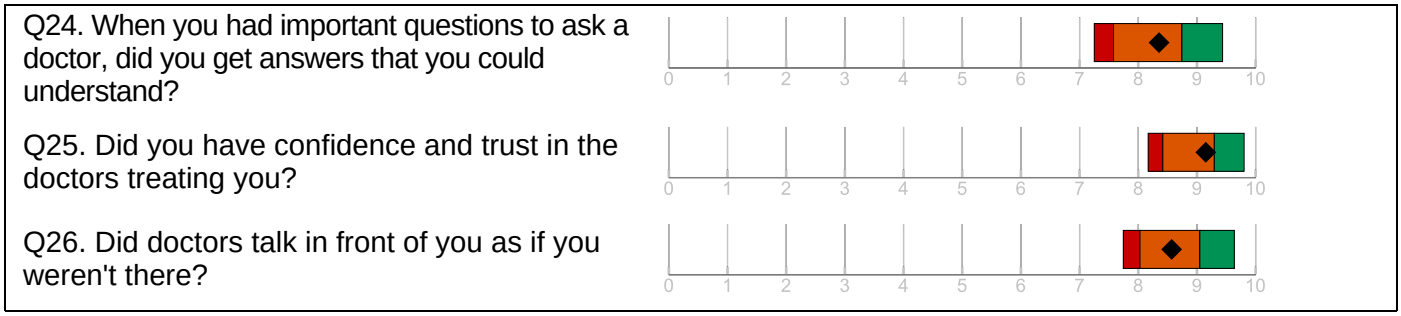
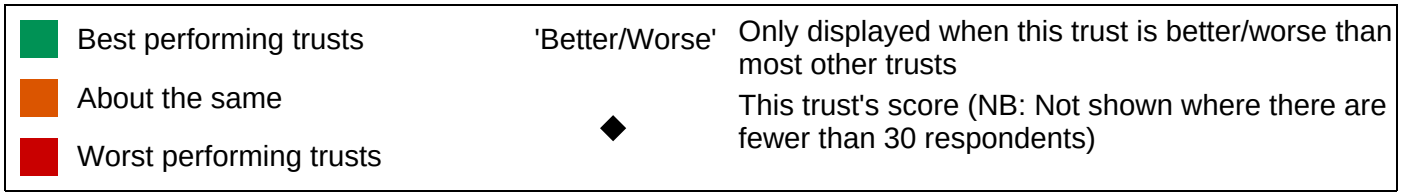
The hospital and ward

Doctors



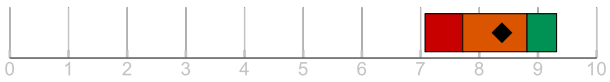


Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

Nurses

Q27. When you had important questions to ask a nurse, did you get answers that you could understand?



Q28. Did you have confidence and trust in the nurses treating you?

Q29. Did nurses talk in front of you as if you weren't there?

Q30. In your opinion, were there enough nurses on duty to care for you in hospital?

Care and treatment

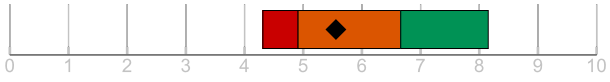
Q31. Did a member of staff say one thing and another say something different?

Q32. Were you involved as much as you wanted to be in decisions about your care and treatment?

Q33. Did you have confidence in the decisions made about your condition or treatment?

Q34. How much information about your condition or treatment was given to you?

Q35. Did you find someone on the hospital staff to talk to about your worries and fears?



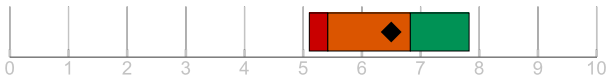
Q36. Do you feel you got enough emotional support from hospital staff during your stay?

Q37. Were you given enough privacy when discussing your condition or treatment?

Q38. Were you given enough privacy when being examined or treated?

Q40. Do you think the hospital staff did everything they could to help control your pain?

Q41. After you used the call button, how long did it usually take before you got help?



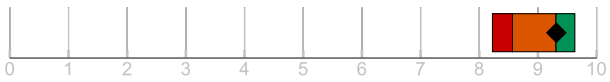
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

Operations and procedures (answered by patients who had an operation or procedure)

Q43. Did a member of staff explain the risks and benefits of the operation or procedure?



Better

Q44. Did a member of staff explain what would be done during the operation or procedure?

Q45. Did a member of staff answer your questions about the operation or procedure?

Q46. Were you told how you could expect to feel after you had the operation or procedure?

Q48. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

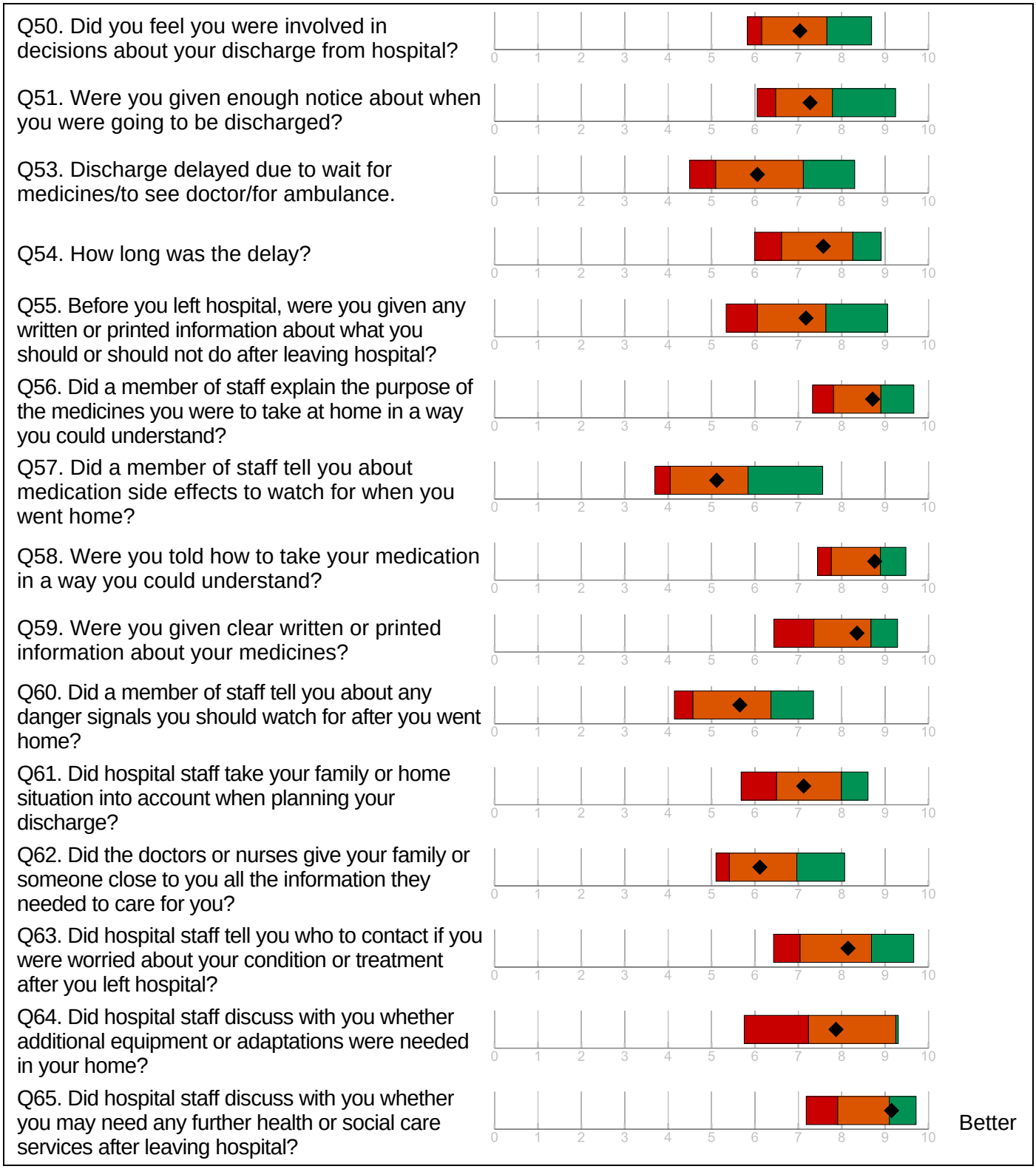
Q49. Afterwards, did a member of staff explain how the operation or procedure had gone?

Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

Leaving hospital

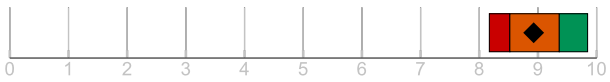


Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014
University Hospitals Bristol NHS Foundation Trust

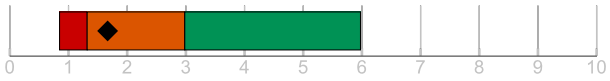
Overall views of care and services

Q66. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

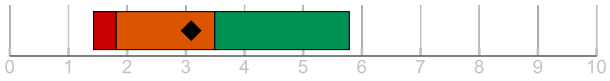


Q67. During your time in hospital did you feel well looked after by hospital staff?

Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?

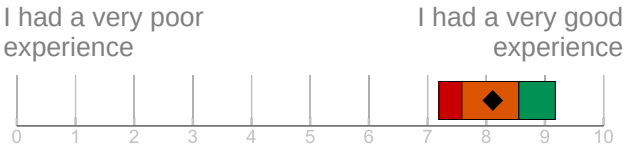


Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q68. Overall...



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.7	7.7	9.4			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.7	7.3	9.5	158	8.3	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.7	7.9	9.6	181	8.2	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.8	8.1	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	8.0	6.8	9.5	145	8.1	
Q7	Was your admission date changed by the hospital?	9.0	8.5	9.9	148	9.1	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.3	8.0	9.7	146	9.0	
Waiting to get to a bed on a ward							
S3	Section score	7.9	5.5	9.9			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.9	5.5	9.9	343	8.3	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
The hospital and ward							
S4	Section score	8.2	7.5	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.2	7.8	9.8	237	9.1	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.1	6.3	9.8	306	8.2	
Q15	Were you ever bothered by noise at night from other patients?	6.5	4.6	8.9	340	6.3	
Q16	Were you ever bothered by noise at night from hospital staff?	8.3	7.1	9.2	341	8.1	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	8.9	7.9	9.7	342	9.0	
Q18	How clean were the toilets and bathrooms that you used in hospital?	8.7	7.3	9.5	331	8.8	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.4	10.0	345	9.6	
Q20	Were hand-wash gels available for patients and visitors to use?	9.1	8.8	9.9	322	9.3	
Q21	How would you rate the hospital food?	5.3	3.9	8.0	319	5.6	
Q22	Were you offered a choice of food?	8.2	7.5	9.6	332	8.8	↓
Q23	Did you get enough help from staff to eat your meals?	7.7	5.9	9.4	109	7.7	
Doctors							
S5	Section score	8.7	7.8	9.5			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	8.4	7.3	9.4	308	8.3	
Q25	Did you have confidence and trust in the doctors treating you?	9.2	8.2	9.8	340	9.0	
Q26	Did doctors talk in front of you as if you weren't there?	8.6	7.7	9.6	343	8.5	
Nurses							
S6	Section score	8.4	7.4	9.3			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	7.1	9.3	298	8.3	
Q28	Did you have confidence and trust in the nurses treating you?	9.0	8.0	9.7	344	8.7	
Q29	Did nurses talk in front of you as if you weren't there?	8.8	7.6	9.7	343	8.8	
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	7.3	6.2	9.5	344	7.5	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
Care and treatment							
S7	Section score	7.8	6.8	8.9			
Q31	Did a member of staff say one thing and another say something different?	8.3	7.4	9.1	344	8.0	
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.5	6.1	9.2	342	7.6	
Q33	Did you have confidence in the decisions made about your condition or treatment?	8.4	7.2	9.4	343		
Q34	How much information about your condition or treatment was given to you?	7.9	7.0	9.5	343	8.1	
Q35	Did you find someone on the hospital staff to talk to about your worries and fears?	5.6	4.3	8.2	217	6.3	↓
Q36	Do you feel you got enough emotional support from hospital staff during your stay?	7.2	5.7	9.0	212	7.2	
Q37	Were you given enough privacy when discussing your condition or treatment?	8.4	7.5	9.4	341	8.6	
Q38	Were you given enough privacy when being examined or treated?	9.5	9.0	9.9	341	9.4	
Q40	Do you think the hospital staff did everything they could to help control your pain?	8.2	7.3	9.3	199	8.8	↓
Q41	After you used the call button, how long did it usually take before you got help?	6.5	5.1	7.8	192	6.7	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.6	7.7	9.2			
Q43	Did a member of staff explain the risks and benefits of the operation or procedure?	9.3	8.2	9.6	218	8.8	↑
Q44	Did a member of staff explain what would be done during the operation or procedure?	8.9	7.8	9.3	217	8.2	↑
Q45	Did a member of staff answer your questions about the operation or procedure?	9.1	7.8	9.6	188	8.4	↑
Q46	Were you told how you could expect to feel after you had the operation or procedure?	7.5	6.0	8.5	224	7.0	
Q48	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	9.2	8.2	9.6	189	8.9	
Q49	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.7	6.7	9.0	225	7.7	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
Leaving hospital							
S9	Section score	7.3	6.1	8.3			
Q50	Did you feel you were involved in decisions about your discharge from hospital?	7.0	5.8	8.7	336	7.1	
Q51	Were you given enough notice about when you were going to be discharged?	7.3	6.1	9.2	341	7.2	
Q53	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.1	4.5	8.3	326	6.2	
Q54	How long was the delay?	7.6	6.0	8.9	326	7.6	
Q55	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	7.2	5.3	9.1	339	7.4	
Q56	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.7	7.3	9.7	268	8.7	
Q57	Did a member of staff tell you about medication side effects to watch for when you went home?	5.1	3.7	7.6	234	5.2	
Q58	Were you told how to take your medication in a way you could understand?	8.8	7.4	9.5	232	8.7	
Q59	Were you given clear written or printed information about your medicines?	8.4	6.4	9.3	244	8.5	
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.7	4.1	7.3	258	5.6	
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	7.1	5.7	8.6	236	7.1	
Q62	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.1	5.1	8.1	237	6.3	
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.1	6.4	9.7	308	8.2	
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	7.9	5.8	9.3	74	7.5	
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	9.1	7.2	9.7	170	8.3	↑

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2013 scores for this NHS trust	Change from 2013
Overall views of care and services							
S10	Section score	5.6	4.8	7.7			
Q66	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.9	8.2	9.8	342	9.0	
Q67	During your time in hospital did you feel well looked after by hospital staff?	8.8	7.8	9.8	343		
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.7	0.8	6.0	295	1.5	
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	3.1	1.4	5.8	282	2.9	
Overall experience							
S11	Section score	8.1	7.2	9.2			
Q68	Overall...	8.1	7.2	9.2	328	8.1	

↑ or ↓	Indicates where 2014 score is significantly higher or lower than 2013 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2013 data is available.

Survey of adult inpatients 2014
University Hospitals Bristol NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	354	59083
Response Rate (percentage)	43	47

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	48	47
Female	52	53
Age group (percentage)	(%)	(%)
Aged 16-35	9	6
Aged 36-50	9	11
Aged 51-65	22	23
Aged 66 and older	59	59
Ethnic group (percentage)	(%)	(%)
White	86	89
Multiple ethnic group	0	1
Asian or Asian British	3	3
Black or Black British	1	1
Arab or other ethnic group	1	0
Not known	9	6
Religion (percentage)	(%)	(%)
No religion	27	16
Buddhist	0	0
Christian	68	78
Hindu	0	1
Jewish	0	0
Muslim	1	2
Sikh	0	0
Other religion	2	1
Prefer not to say	1	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	93	94
Gay/lesbian	1	1
Bisexual	0	0
Other	2	1
Prefer not to say	4	4

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
12. Speaking Out Policy
Sponsor and Author(s)
Sponsor: Sue Donaldson, Director of Workforce & OD Author: Trish Ferguson-Jay, Head of Organisational Development and Alex Nestor, Deputy Director of Workforce and OD

Intended Audience									
Board members	√	Regulators		Governors		Staff	√	Public	

Executive Summary

Purpose

For the Board to receive the updated Speaking Out Policy, following a response to the recommendations from the Francis Freedom to Speak Up Review (February 2015). The Board has previously reviewed relevant documentation and requested some further amendments, which have been made.

Key issues to note

The focus of the revised documentation is the Policy. The detailed procedure that supports its application has been signed off by the Senior Leadership Team and a review of its effectiveness will be taken to the Audit Committee, who has a responsibility to monitor cases, in the Autumn.

There has been extensive benchmarking and wide stake holder involvement around the recommendations from the Francis Review and the required amendments within the Policy/Procedure. This has been discussed at the Policy Group and Industrial Relations Group; Workforce & OD Group (which includes our Staff Side partners); Senior Leadership Team; Quality Outcomes Committee; and Trust Board. In addition, the Policy has also been reviewed by the National Whistleblowing Helpline Policy Manager and received very positive feedback.

In support of the Policy revisions, the Senior Leadership Team agreed that, once approved, the Trust will publish a summary of the Speaking Out Policy into a simple guide. This will be disseminated widely across the Trust.

It should be noted that the national consultation on the Francis Freedom to Speak Up Review ended on the 4th June. The outcomes of this consultation are awaited. Therefore Speaking Out Policies and Procedures nationally may need to change further to reflect the outcome of this consultation. Specifically, guidance is awaited on the role of the Freedom to Speak Up Guardians. It is expected that all Trusts will be required to appoint a Guardian and that this may alter reporting lines for all Trusts' Speaking Out/Whistleblowing policies. We anticipate further recommendations being brought to the Board later this year, once guidance has been received.

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 at Appendix B

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)**
26/05/2015				22/04/2015	08/07/2015

Speaking Out (Whistleblowing) Policy and Outline Procedure

Document Data		
Subject:	Speaking Out (Whistleblowing) Policy and Outline Procedure	
Document Type:	Policy	
Document Status:	Draft	
Document Owner:	Head of Organisational Development	
Executive Lead:	Director of Workforce and Organisational Development	
Approval Authority:	Trust Board	
Estimated Reading Time:	10 minutes	
Review Cycle:	24 months	
Next Review Date:	**Date of First Issue:**	**Date Version Effective From:**
[Next Review Date]	01/06/2015	01/06/2015

Document Abstract
The purpose of this Policy is to provide a safe mechanism for anyone who works for the Trust to come forward and raise any concerns they have about any aspect of the Trust's work, and to be able to do so without fear of detriment or reprisal.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
January 2010	V1	Medical Director / Head of Communications	Major	Scheduled Revision
April 2011	V2	Head of Communications/ Director of Workforce & Organisational Development	Minor	Scheduled Revision
May 2013	V3	Director of Workforce and Organisational Development	Major	Revision to reflect change in the law arising from the Enterprise and Regulatory Reform Bill
April 2015	V4	Head of Organisational Development	Major	Response to recommendations from The Francis Freedom to Speak Up review, February 2015

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Appendices

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'. It is important that you feel empowered to come forward and raise concerns without fear of intimidation and that a culture of openness is fostered.

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 timely 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.

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]. Examples of things you might speak out about include:

- **Patient care and patient safety – including safeguarding the child / adult**
- **Health and safety issues**
- **Financial matters**
- **Unlawful conduct**
- **Breaches of the NHS Codes of Conduct on Governance**
- **Breaches of legal obligations**
- **Damage to the environment**
- 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.

You do not need to have firm evidence before raising a concern, but please explain, as fully as you can, the information or circumstances which have given rise to your concern.

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 process.

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

2.4 YOUR RESPONSIBILITIES

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

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.

2.5 TRUST RESPONSIBILITIES

The Trust will:

- 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 are being 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

- **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.

2.6 CONFIDENTIALITY

- 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 or if the Trust is required by law to break that confidentiality. In such

circumstances you would be informed of this course of action and a support plan would be mutually agreed.

2.7 OTHER RELEVANT POLICIES AND PROCEDURES

The Speaking Out Policy should always be read in conjunction with other relevant Trust policies and procedures, which in certain circumstances may be more appropriate. These are:

- Counter Fraud Policy and Procedure
- Equality and Diversity Policy
- Safeguarding Adults Policy
- Safeguarding Children, Young People and Unborn Babies from Abuse Policy
- Tackling Harassment and Bullying at Work Policy
- The Trust Disciplinary Policy and Procedure
- The Trust's Performance Management Policy and Procedure
- The Trust Staff Conduct Policy

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).

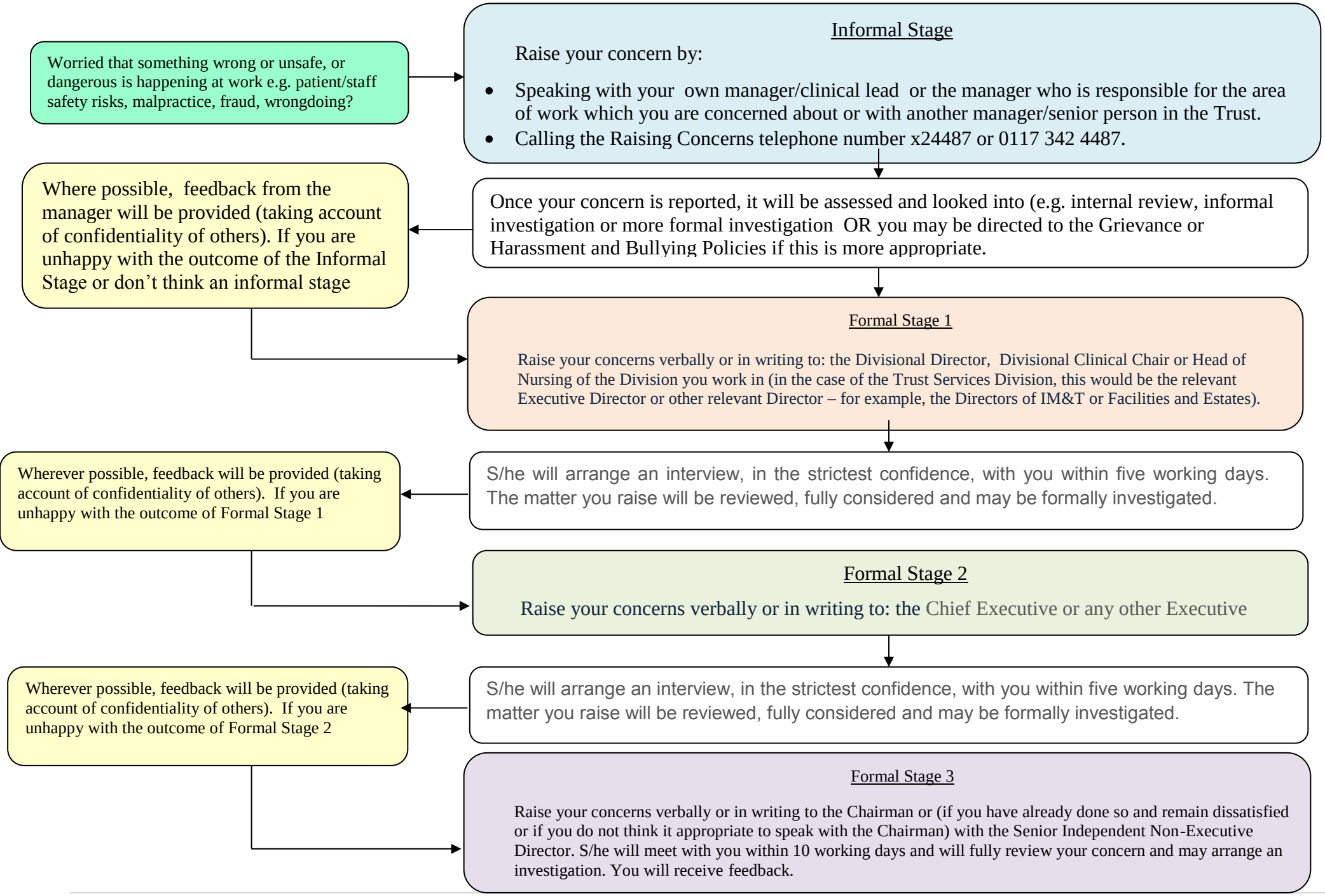
2.8 DUTIES, ROLES AND RESPONSIBILITIES

The Trust's leads for the Speaking Out Policy are the Director of Workforce and Organisational Development 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 has been made against.

On behalf of The Trust Board, 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 on a regular basis. An annual report will be presented to The Board.

3.0 PROCEDURE

To support this Policy there is a detailed Procedure which sets out both informal and formal processes and supporting information. A brief summary of this can be found at Appendix A. The full detail is available on the HR intranet site.



Appendix A – Summary of Procedure

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

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

Report Title									
13. Annual Revalidation Report April 2014 – Mar 2015									
Sponsor and Author(s)									
Sponsor: Sean O'Kelly, Medical Director Author: Dr Patricia Weir									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To satisfy NHS England requirements that Board recieve an annual report on revalidation Key issues to note - Revalidation has now been in operation for two years - 90% of appraisals for all medical staff groups are completed on time - In the first year 74 positive recommendations were made, 4 deferrals (5%), 1 non engagement. 100% response to revalidation recommendations. - In year two, 194 Positive recommendations, 24 deferrals (11%) and 0 non engagement notifications were made. - Triangulation with performance information is allowing the Medical Director's Team to have a good overview of practice within the Trust. - E-Portfolio now well established and revalidation system working well.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									
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)**
					Workforce & OD

University Hospitals Bristol NHS
NHS Foundation Trust

Appraisal and Revalidation at University Hospital Bristol NHS Foundation Trust

Annual report April 2014 – Mar 2015

Patricia M Weir

Associate Medical Director for Revalidation

2014/15

Appraisal and Revalidation at University Hospitals Bristol NHS FT

Annual Report 2014 /15

EXECUTIVE SUMMARY

- Revalidation of a doctor's General Medical Council licence to practice has now been operational for two years
- Revalidation is based on annual appraisal with evidence consistent with Good Medical Practice
- Each designated Body (DB) has a Responsible Officer (RO) who is responsible for making one of three recommendations to the General Medical Council regarding medical practitioners; positive recommendation, deferral or non-engagement.
- Appraisal is well embedded in the Consultant and permanent non-consultant doctor group (SAS doctors) at UHBristol with a high level of appraisals completed on time. (90% for all medical staff groups)
- In the first year 74 positive recommendations were made, 4 deferrals (5%), 1 non engagement. 100% response to revalidation recommendations.
- The number of doctors due for revalidation in year two are significantly greater.
- In year two, 194 Positive recommendations, 24 deferrals (11%) and 0 non engagement notifications were made.
- There has been a significant increase in the deferral rate in 2014/15. The first year was significantly below the national average (9%). This will in part have been due to the fact that the Trust asked for volunteers for the first year of operation, which resulted in a low deferral rate.
- The reasons for deferral are outlined in the exception report below.
    - 11 were unavoidable factors.
    - 13 were due to lack of sufficient evidence.

  Within this group we have identified a number of doctors who require support with both the appraisal and revalidation system and other aspects of their roles.
- Triangulation with performance information is allowing the Medical Director's Team to have a good overview of practice within the Trust
- Overall the revalidation system is working smoothly and the e-portfolio system is now well established

University Hospitals Bristol NHS
NHS Foundation Trust

Annual Quality Assurance Report for Appraisal and Revalidation

University Hospitals Bristol NHS Foundation Trust

Responsible Officer : **Dr Sean O'Kelly, Medical Director**

Associate Medical Director for Revalidation: **Dr Patricia Weir**

Report produced by: **Patricia Weir**

Time period covered in report: 1st April 2014 – 30th March 2015

Management of Appraisal and Revalidation at UHBristol

Annual appraisal is well embedded in Consultant and SAS doctors (Specialist and Associate Specialist) working practice at UHBristol. This is supported by an e-portfolio system (PReP) which allows supporting evidence to be available to the Responsible Officer (RO)/ Medical Director and Associate Medical Director for Revalidation (AMD). This system is also available for Clinical Fellows /Non training doctors working in the Trust for six months or more. The e-portfolio was launched in January 2013 and the majority of appraisals are now on this system. A small number of non-permanent doctors use an appropriate college based system or the Revalidation Support Teams MAG format.

Revalidation is a requirement for all doctors holding a licence to practice and came into force in December 2012 with the first revalidation dates for doctors in the Trust being from April 2013. A recommendation for Revalidation is made by the Responsible Officer if the doctor has had satisfactory annual appraisals with supporting evidence of good medical practice. This evidence consists of continuing professional development, quality improvement activity, 360 feedback from colleagues and patients, log of significant events and review of compliments and complaints.

This information is reviewed by the AMD and cross referenced to any concerns that have been logged with the Medical Director's Team. These concerns may feed from the complaints department (monthly feed), significant events (patient safety (ongoing)), medico-legal (ongoing) , HR disciplinary or concerns (2 monthly formal feedback), feedback from Clinical Chairs (sought 3 monthly).

Support with the Revalidation process is available for doctors in the form of drop-in training sessions, awareness sessions at Trust Away Days, tri-monthly newsletters, HMC sessions, Appraiser and Appraisee Training, Appraiser forums and open access to the AMD for any unresolved problem or issue.

The AMD is supported by an administrative assistant and all information is formally reviewed by the RO before a recommendation is made.

Doctors for whom a concern has been raised are discussed at the monthly Medical Directors Team meetings. Where thought appropriate the doctor is invited to discuss the concerns with the Medical Director and AMD and appropriate action/ support / remediation is organised if required.

For further detail on the process of revalidation see Appendix 1

Activity Levels - Revalidation

	Total (April 14 –Mar 15)	%	Year 1 (April 13 – March 14)
Number of doctors for whom UHBristol is Designated Body	556 *		
Number of positive recommendations for revalidation (for details see exception report below)	194	35% of all doctors on list	74
Number of deferments (for details see exception report below)	24	11% of eligible doctors	4
Number of notices on non engagement (see exception s report)	0	0	1

*This number is greater than our staff appraisal list. This is in part due to flux of doctors who have worked part of the year at UHBristol and have not yet changed DB but also probably contains doctors who no longer have a prescribed connection. There remains an issue of knowing when a doctor has left the Trust.

Activity Levels - Appraisal

Doctor	Total numbers	Appraisals in year (appraisal undertaken in last 14 months)	% of total possible
Consultant	414	394	95%
SAS doctor	39	35	90%
Clinical Fellows	59	34	58%
Total	512	463	90%

Clinical fellows remain a difficult group to track and undertake educational supervision and appraisal using a number of different systems including local, college, MAG forms and Trust e-portfolio.

Activity Levels - Governance

The Medical Director's team maintains a list of potential governance concerns under the headings in the table below. These are reviewed regularly for revalidation purposes and doctors for whom the concern may cause doubt about the RO's ability to make a positive recommendation for revalidation are invited to discuss the issues with the RO and AMD for Revalidation.

Area of potential concern	Number in Year (April 2014- March 2015	Comment
General Medical Council	5 new cases, all closed	Currently no doctors under investigation by GMC or who have revalidation recommendations on hold
Serious Incident Reporting	1	
Complaints	51	Most noted with no action indicated. Doctor seen by MD if concerns
HR Disciplinary concerns	2	2 remain under active review
Performance reviews including outcome date	1	Data reviewed, Lead clinician and MD involvement. Recovery plan remains in place
Litigation	1	
Concerns raised by Clinical Chairs	1	Followed up by Deanery as involved teaching issue

Exception report

1: Deferred Recommendations

Doctor	Grade	Date of deferral	Reason for deferral	New revalidation date	Outcome
1	Clinical Fellow	01/04/2014	Insufficient evidence - joined Trust 6 weeks pre Revalidation date	30/07/2014	Revalidated 16/7 14
2	Consultant	09/04/2014	Family circumstances	07/08/2014	Revalidated 25/07/2014
3	SAS doctor	01/04/2014	Insufficient evidence - new to system	30/08/2014	left trust

4	SAS doctor	05/05/2014	insufficient evidence	05/09/2014	Revalidated 01/09/2014
5	Consultant	09/05/2014	insufficient evidence /illness	02/10/2014	Revalidated 21/08/2014
6	Locum Consultant	12/05/2014	Insufficient evidence / new to system	02/10/2014	Revalidated 02/10/2014
7	Consultant	12/05/2014	Insufficient evidence / 360 patient confusion	02/10/2014	Revalidated 21/08/2014
8	Consultant	15/05/2014	insufficient evidence / patient 360 not done	02/10/2014	Revalidated 02/10/2014
9	Consultant	19/05/2104	Insufficient evidence /off sick stress	19/11/2014	Revalidated 03/11/2014
10	Consultant	12/06/2014	Insufficient evidence / appraisal not done	27/10/2014	Revalidated 13/08/2014
11	Consultant	25/06/2014	insufficient evidence	01/12/2014	Revalidated 01/12/2014
12	Clinical fellow	24/06/2104	insufficient evidence	03/11/2014	Revalidated 03/11/2014
13	Clinical fellow	02/07/2013	insufficient evidence	03/11/2104	Revalidated 03/11/2014
14	Consultant	15/07/2014	insufficient evidence / on long term sick leave	17/11/2014	Remains on sick leave 2nd deferment
15	SAS doctor	23/07/2014	insufficient evidence	23/11/2014	returned to Spain
15	Consultant	09/08/2014	mat leave	11/11/2015	
17	Clinical Fellow	21/08/2014	Just started back after 2 years mat leave/anatomy post	30/06/2015	
18	Consultant	22/08/2014	insufficient evidence	02/02/2015	Revalidated 28/1/2015
19	CHSW Consultant	06/08/2014	family tragedy	02/11/2015	Rescinded licence
20	Consultant	12/02/2015	on sabbatical in USA for 17 mo back Sept 15	26/03/2016	
21	SAS doctor	16/03/2015	insufficient evidence /return to work jan15 after 5 years	16/03/2016	
22	Honorary Consultant	16/03/2015	insufficient evidence	16/07/2015	
23	Consultant	18/03/2015	insufficient evidence	01/12/2015	
24	Clinical Fellow	18/03/2015	Insufficient evidence	01/08/2015	

Eleven deferments were requested for unavoidable reasons (maternity leave, sickness, sabbatical, new to NHS system or returning to work after significant break)

Thirteen deferments were requested due to insufficient evidence. Contained within this are a number of doctors who are struggling with their workload from a number of aspects. It has been useful to be able to identify these doctors and initiate support both for the appraisal and revalidation process but also to ensure there is a wider network of support.

9/24 deferments were from the SAS doctor and Clinical Fellow group. The latter is a particularly challenging group as they have often trained overseas, have a limited understanding of the system of appraisal and revalidation and change jobs frequently. Consequent to all of the above these doctors also pose significant risk to any Trust and adequate clinical and educational supervision is imperative.

Three doctors have severed connections with UHBristol without revalidating. Two SAS doctors have left the Trust, one of whom has returned to Spain. One doctor has decided to put her licence on hold for family reasons.

One doctor remains on long term sick leave at present.

The majority (14/24) have successfully revalidated before their second revalidation date.

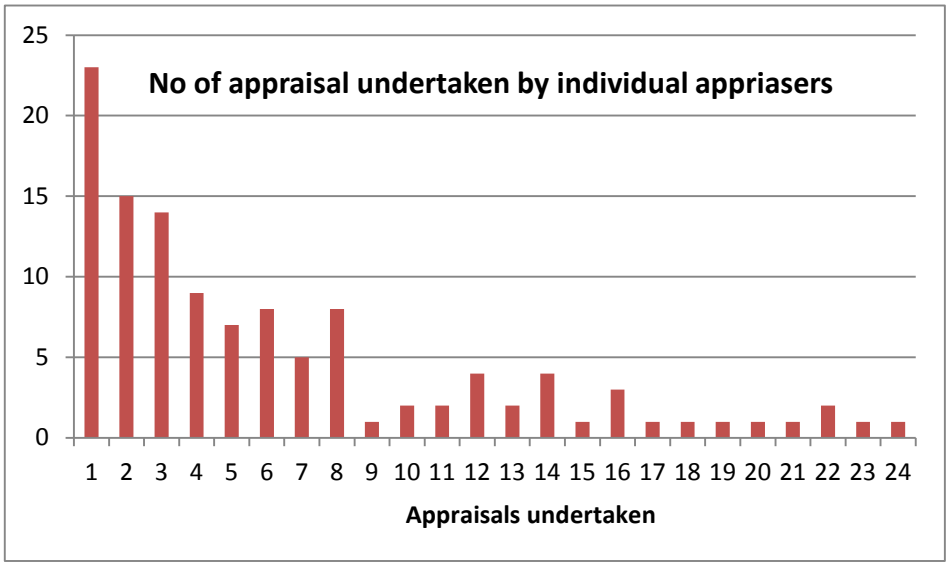
2: Non Engagement

No reports of non-engagement in year 2014 /15

Quality Assurance of Appraisal System

The Trust's on-line Revalidation system provides significantly more information for revalidation than previous paper system. All appraisals for revalidation are reviewed by the AMD for revalidation. Poorly completed output forms are fed back individually to the appraiser.

On completion of an appraisal the appraisee is asked to fill out an online feedback form. The e-portfolio system has been running for less than a year and to date we have feedback on 117 appraisers who have undertaken between 1 and 24 appraisals each over the 2 year period.



There are a significant number of doctors who have undertaken only one or two appraisals. This data includes a mix of circumstances including:

- doctors who undertake educational supervision for doctors undergoing training outwith the deanery scheme who have elected to use the Trust e-portfolio system
- dentists using e-portfolio system
- doctors who have left the Trust
- Doctors who have just started as appraisers

The Trust must ensure that doctors are appropriately trained and remain up to date with appraisal skills. All doctors on the Appraiser system have either undertaken appraiser or educational supervision training.

The Appraisal feedback form asks for a score out of 5 over 9 domains, giving a possible total score of 45. There is ability to add free text in addition.

The domains covered are:

1. Management Of The Appraisal System
2. Access To The Necessary Supporting Information
3. Their Preparation For My Appraisal
4. Their Ability To Conduct My Appraisal
5. Their Ability To Review Progress Against Last Years Personal Development Plan
6. Their Ability To Help Me Review My Practice
7. Usefulness For My Professional Development
8. Usefulness In Preparation For Revalidation
9. Usefulness Of My New Personal Development Plan

The range of scores (for doctors who have undertaken >1 appraisal) is 30 - 44.25. Average 39.8.

This has been collated and fed back to appraisers who have undertaken 5 or more appraisals.

The feedback system also asks for length of time of the appraisal meeting. The range is from 0.75 – 3 hours (Average 1.58). The majority of appraisal meetings are between 1 and 2.5 hours.

Independent External Review

An independent review of the Trust's revalidation process was undertaken in the autumn of 2014. This was organised by Russell Caton, principal internal auditor for the Trust. Unfortunately the initial review could not be completed due to staffing issues in Internal Audit and it has therefore been restarted in March 2015. It is hoped that the results of this should be available soon.

NHS Southwest also run an independent audit of revalidation and we expect to be audited within the next year.

Risks

Clinical Fellows:

Data for clinical fellows remains difficult to track. This group of doctors has a high turnover and requires close working with HR. Turnover of staff in HR and lack of dedicated medical HR makes this challenging to keep on top of. As a result there exists the possibility of a Clinical Fellow working in the Trust but not having a self-declared prescribed connection to UHBristol.

Mitigation: HR are issuing all new Clinical Fellows with a letter explaining the system for making a prescribed Connection with a Designated Body and the responsibilities of the doctor. It is the doctors responsibility to keep this information up to date with the GMC.

The GMC is aware that there is a problem for Trusts not being able to access Revalidation dates for Doctors who have not made a prescribed connection to the Trust and have stated that they are attempting to remedy this situation.

Summary of Second Year of Revalidation at UHBristol

Generally the Trust's Revalidation process is running smoothly, with a high rate of appraisals (90% over all groups of doctors with a prescribed connection).

UHBristol has a strong tradition of consultant appraisal and of employing high performing and highly motivated doctors. This is reflected in the high quality of evidence submitted for revalidation and the outstanding performance of many of the consultants reviewed.

There has been a significant increase in the deferral rate in 2014/15 from 4% to 11%. The first year was significantly below the national average (9%). This will in part have been due to the fact that the Trust asked for volunteers for the first year, which resulted in a low deferral rate. The national figures are not yet available. However 9/24 were from the Clinical Fellow/SAS group. The Clinical Fellows in particular remain a difficult group to monitor. There are multiple possible reasons for this including;

- Recent arrival from overseas and poor understanding of UK/UHB processes
- Short term contracts which makes tracking of starters and leavers difficult
- Lack of previous documentation, making recommendations of revalidation impossible until evidence obtained , necessitating deferment

More work needs to be done with HR to assist these doctors.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
15. Finance Update									
Sponsor and Author(s)									
Sponsor: Paul Mapson, Director of Finance & Information									
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 Trust's reported financial position at the end of June 2015 is a surplus of £0.443m (before technical items). With technical items (donated income, donated asset depreciation and impairments) included the surplus rises to £1.314m. This compares to the original Monitor Plan of a £0.263m deficit for the quarter (before technical items) i.e. a favourable variance of £0.706m.

The adverse Divisional position of £1.398m compares to the operating plan phased adverse position of £1.359m i.e. £0.039m adverse to the phased plan. Whilst there continues to be major risks to delivering the Operating Plan deficit of £2m, the position is encouraging. The main risks relate to the delivery of contracted clinical activity which at the end of June is £0.77m behind plan.

The Trust has the opportunity to submit a revised financial plan to Monitor by the end of July. The financial position to date suggests that the Trust has significantly improved its performance since the original plan was agreed and it is therefore recommended that the Trust Board approves a revised financial plan to be notified to Monitor of break-even for the financial year (before technical items), £1.133m deficit after technical items.

Recommendations

The Board is recommended to:

- Receive the report for **assurance**; and
- **Approve** a revised break even (before technical items) plan to be submitted to Monitor at the end of July

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	**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)**
	24 July			22 July	

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £0.443m (before technical items) for the first three months of the financial year. With technical items (donated income, donated asset depreciation and impairments) included the surplus rises to £1.314m.

This compares to the original Monitor Plan of a £0.263m deficit for the quarter (before technical items) i.e. a favourable variance of £0.706m.

The main drivers for this improved position are as follows:

- **Corporate Income**

  The original plan, project year end position and year to date variances are shown below and represent the result of intensive negotiations with Commissioners over the past few months.

Surplus / (Deficit)	**Original Plan £'000**	**Projected for year £'000**	**Year to date Variance £'000**
Fines and penalties	(3,500)	(3,000)	210
Specialised Marginal Tariff rebate	(3,500)	(2,500)	220
Corporate share of higher activity levels in SLAs	-	3,200	640
Other	-	300	40
Totals	**(7,000)**	**(2,000)**	**1,110**

The projected improvement for the year is estimated at c.£5m, and £1.11m is generated to month three (quarter 1). The year to date improvement is slightly lower than expected (i.e. £1.11m versus £1.25m) due to lower activity levels in the first quarter – hence the Corporate Share is also lower.

- **Divisions**

  The adverse variance on Clinical and Corporate Divisions is £1.398m to month three (£1.557m adverse for Clinical Divisions and £0.159m favourable for Corporate Divisions). This compares to the phased Operating Plan position of £1.359m adverse.

  Whereas there are still clearly major risks to Operating Plan delivery of the £2m planned deficit, this position is encouraging in the context of the overall Trust Financial Plan.

  The main risks relate to the delivery of the contracted clinical activity in year which can be seen by the under-performance to month three of £0.77m (mostly in elective and out-patient services).

The analysis by Division is shown below:

Variance Favourable/(Adverse) Divisions	Month 3 £'000	Operating Plan Phased £'000
Diagnostic and Therapies	59	(16)
Medicine	(265)	(175)
Specialised Services	(177)	(42)
Surgery, Head and Neck	(1,045)	(864)
Women's and Children's	(129)	(262)
Subtotal - Clinical Divisions	**(1,557)**	**(1,359)**
Corporate Divisions	159	-
Total - Clinical and Corporate Divisions	**(1,398)**	**(1,359)**

- **Financing (Capital Charges and Interest Payable/Receivable)**

  The favourable variance of £2m for the year, included in the operating plan, generates £0.5m to month three. It is unlikely that the year-end favourable variance will drop below £2m and could increase towards £2.5m depending mainly on the progress of capital spending.

- **Reserves**

  Any Divisional adverse variance beyond the £2m included in the Operating Plan must be covered by an equivalent favourable variance on Reserves (topped up potentially by Financing costs favourable variances in excess of £2m). An early assessment has been made and current levels of Divisional spend can be accommodated from the following areas:

  - Surplus on inflation provisions;
  - Slippage in cost pressures;
  - Re-assessment of provisions from 2014/15;
  - Potential underspends on contingency funds; and
  - Slippage in the Histopathology transfer

  It is too early in the year, however, to make detailed assessments of the scope of the above items. These will be reviewed on a quarterly basis. However it is probable that the scope will be sufficient to manage reasonable assumptions re the Divisional position.

2. Revised Financial Plan

The Trust has the opportunity to submit a revised financial plan to Monitor by the end of July. The position described in section 1 suggests that the Trust has significantly improved its performance since the original plan was agreed – primarily due to the impact of successful contract negotiations (reduction in fines, CQUINs that are earnable, reduced impact of marginal tariff and higher than expected planned activity and resilience funding).

Hence, it is recommended that the Trust Board approves a revised financial plan to be notified to Monitor of break-even for the financial year (before technical items), £1.133m deficit after technical items.

This action has a number of merits including:

- It is consistent with the request to Foundation Trusts to reduce the currently forecasted Foundation Trust deficit reported (c£1billion) by the Chief Executive of Monitor;
- It enables the capital schemes that were deferred due to the liquidity shortfall to be reinstated in year;
- It places the Trust at the top end of the financial performance in the country enhancing its reputation and enabling the Trust to consider new investments and potentially significant transactions from a position of financial strength;
- The Trust can defend its actions against a backdrop of delivering a break-even position as opposed to a deficit position; and
- The advice of the Finance Director is that the revised break-even plan is the right balance of realism and challenge for the Trust especially in the context of the long term plan requirements.

It should, therefore, be noted that the Long Term Financial Plan (LTFP) still requires a 1% surplus each year (c.£6m) to finance its debt principal repayment. So more still needs to be done to get back on track from 2016/17 – however, much depends on national decisions on tariff etc. – there is no information on this currently.

3. Divisional Financial Position

The table below shows the Clinical Divisions and Corporate Services income and expenditure position setting out the variances on the four main income and expenditure headings. This generates an overspending against divisional budgets of £1.398m. Detailed information and commentary for each Division is to be considered by the Finance Committee.

Divisional Variances	Variance to 31 May	June Variance	Variance to 30 June
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(1,118)	571	(547)
Non Pay	1,582	(847)	735
Operating Income	207	(98)	109
Income from Activities	(1,277)	663	(614)
Sub Totals	(606)	289	(317)
Savings Programme	(677)	(404)	(1,081)
Totals	**(1,283)**	**(115)**	**(1,398)**

Pay budgets have underspent by £0.571m in the month. Allocations of contract transfer funding within Surgery Head and Neck has improved their pay position in month by £0.841m. Adjusting for this re-profiling results in a Divisional pay overspend in the month of £0.270m. The cumulative overspending is £0.547m. The principal areas of overspending are Specialised Services (£285k) and Women's and Children's (£403k). For the Trust as a whole, agency spend is £3.330m to date. The average monthly spend of £1.110m compares with £0.967m for 2014/15. The greatest increases being in Surgery, Head and Neck which has increased from an average monthly spend of £106k in 2014/15 to £201k in 2015/16 and Women's and Children's for which the figures are £154k and £234k respectively. Waiting list initiatives costs remain high at £0.889m in the first three months.

N**on-pay budgets** show an adverse variance of £0.847m in the month. The allocation of contracts transfer funding to pay in Surgery, Head and Neck reduces the Divisional position to broadly

breakeven in the month. The cumulative underspending is £0.735m and relates in the main to divisional support funding and lower activity related expenditure.

Operating Income budgets show an adverse variance of £0.098m for the month to give a cumulative favourable variance of £0.109m. This relates to commercial research and training income.

Income from Activities shows a favourable variance of £0.663m for June reducing the cumulative adverse variance to £0.614m. The principal areas of under achievement to date are Medicine (£0.215m), Surgery, Head and Neck (£0.461m) and Specialised Services (£0.284m) offset by an over achievement in Women's and Children's (£0.231m) and Diagnostic and Therapies (£0.118m). Further details are provided in section 5.3 within the Divisional reports.

Divisional Management Position

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

	Variance to 31 May	June Variance	Variance to 30 June
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic and Therapies	25	34	59
Medicine	(264)	(1)	(265)
Specialised Services	(180)	3	(177)
Surgery, Head and Neck	(801)	(244)	(1,045)
Women's and Children's	(154)	25	(129)
Estates and Facilities	33	12	45
Trust HQ	15	8	23
Trust Services	43	48	91
Totals	**(1,283)**	**(115)**	**(1,398)**

These are described in detail in section 4 of this report and under agenda item 5.3 in the Finance Committee papers.

Savings Programme

The savings requirement 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 £3.889m have been realised for the first quarter of 2015/16 (78% of Plan), a shortfall of £1.124m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £0.884m and a further £0.240m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £43k.

The year end forecast outturn is a shortfall of £2.596m which represents delivery of 87%. It should be noted that in order to achieve this outturn the rate of savings delivery will have to increase over and above that delivered in the first quarter. This is in line with plan, however there remains some risk with this particularly regarding to schemes relating to reductions in agency spend.

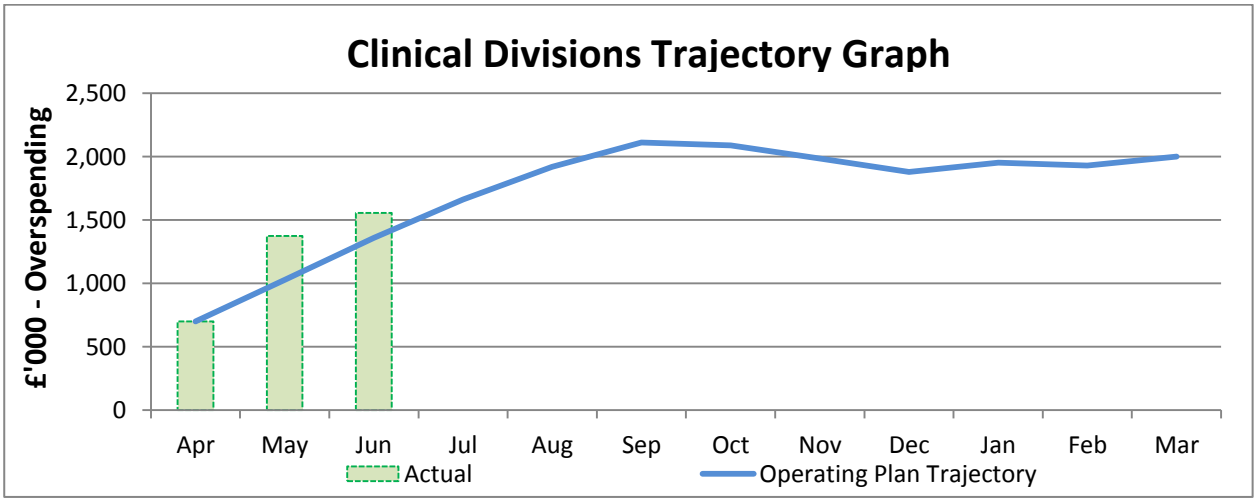
A summary of progress against the Savings Programme for 2015/16 is summarised below. The Finance Committee will receive a more detailed report on the Savings Programme under item 5.4 on this month's agenda.

	Savings Programme to 30 June 2015			1/12ths Phasing Adj Fav / (Adv)	Total Variance Fav / (Adv)
	Plan	Actual	Variance Fav / (Adv)		
	£'000	£'000	£'000	£'000	£'000
Diagnostics and Therapies	517	358	(159)	(19)	(178)
Medicine	478	547	69	(78)	(9)
Specialised Services	458	533	75	62	137
Surgery, Head and Neck	1,541	697	(844)	66	(778)
Women's and Children's	1,154	788	(366)	83	(283)
Estates and Facilities	267	274	7	(7)	-
Trust HQ	74	157	83	(59)	24
Other Services	524	535	11	(5)	6
Totals	**5,013**	**3,889**	**(1,124)**	**43**	**(1,081)**

4. Divisional Reports

In total, Divisions have overspent by £0.115m in June (£1.398m cumulatively). 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.

Clinical Divisions are £1.557m overspent to date against a combined operating plan trajectory of £1.359m. The June position is £0.198m above trajectory as shown in the graph below.



Three Divisions are red rated for their financial performance for the year to date.

Division of Medicine

The Division reports an adverse variance to Month 03 of £265k; this represents deterioration from Month 02 of £1k which reflects a significant slowing in the rate of overspending from the prior months. The Division is £89k adverse to its Operating Plan trajectory to date.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on income from activities of £215k – this is due to lower than planned emergency admissions, outpatient attendances and A&E attendances.

- An adverse variance on pay of £71k due to costs associated with agency nursing and medical staffing. However, it should be noted that agency spending has reduced for the second consecutive month.
- Both non pay and the CIP programme are broadly breakeven and are not presenting cause for concern at present.

Actions being taken to restore performance to trajectory or better:

- Recruitment to key posts in order to increase capacity to deliver outpatient Service Level Agreements.
- additional outpatient clinics in order to recover the shortfall on outpatient activity related income, pending successful recruitment
- Review of uncoded activity to assess whether this is having an adverse effect on income received to date.
- An intensive nurse recruitment programme continues across the Division with further new starters anticipated throughout Quarter 2. This will further reduce expenditure on agency nursing in line with the Operating Plan.

Division of Specialised Services

The Division reports an adverse variance to Month 03 of £177k, this represents an improvement from Month 02 of £3k and as such reflects a significant slowing of the previous rate of deterioration; the Division is £135k adverse to the Operating Plan trajectory to date.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on income from activities of £284k due to lower than planned activity in cardiac surgery of £421k, with smaller adverse variances due to activity in other specialties. This is offset to some extent by a favourable variance on Private Patient income of £96k. This under performance on cardiac surgery is attributable to reduced access to cardiac Intensive Care beds arising from a peak in acuity (affecting length of stay) and staffing constraints resulting in fewer beds being opened over the period.
- An adverse variance on nursing and midwifery pay of £235k, this is particularly within the BHI, and the reasons for this are still being investigated.
- A favourable variance on Non Pay of £273k due to the proportionate share on divisional support funding and unallocated contract transfer funding showing in this area.
- The CIP programme is showing a favourable variance of £136k, which is very positive.

Action being taken to recover adverse variance

- Review of the scheduling of high acuity patients in order to address flow in CICU
- Review of the possibility of opening the 21st general ITU bed to accommodate CICU patients, in times of bed pressures in future – contingent upon staff recruitment
- A review of nurse staff deployment, including rostering and controls for bank and agency staffing is underway, overseen by the Chief Nurse
- A recruitment and retention drive is underway to improve the levels of permanent staff in CICU.
- Sickness levels in CICU are being addressed.

Division of Surgery Head and Neck

The Division reports an adverse variance to Month 03 of £1,045k; this represents deterioration from Month 02 of £244k which reflects a significant slowing in the rate of overspending over prior months. The Division is £181k adverse to the Operating Plan trajectory to date.

There has been a drive this month to ensure budgets are allocated in line with the Division's Operating Plan, this has resulted in a significant change in the reported variances for pay and non-pay, which now enables a better understanding of the Division's financial position to date and in relation to its Operating Plan.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on income from activities of £461k due to lower than expected activity within the Division, primarily in oral surgery, ophthalmology and upper GI surgery. A third of Surgery Head and Neck's overspend, reflects its share of the underperformance on cardiac surgery within Specialised Services is £145k.
- After the correct reallocation of budgets to reflect the operating plan, variances on pay and non pay are relatively small this month at £53k adverse for pay and £140k favourable for non pay; the non pay variance being largely due to lower than planned spend on clinical supplies due to lower than planned activity.
- An underperformance on the Division's CIP programme, resulting in an adverse variance to date of £778k. The majority of this relates to the year to date proportion of unidentified CIPS's in the Operating plan of £693k, the balance mainly relates to shortfalls on income related schemes. The most significant being increased income from the national Bowel Screening Programme (flexible sigmoidoscopy) which has been slowed down by the national programme and as such is not recoverable. The incoming Divisional Director is focussing upon the identification of further CIP.
- A favourable variance on Operating Income of £107k due to higher than planned commercial research income and income from training supplied by the Bristol Eye Hospital, as well as higher than planned income for peripheral clinics.

The key reasons for the Division being off trajectory to its Operating Plan are:

- Slippage on the CIP programme, mainly flexible sigmoidoscopy scheme (income related) £85k
- Higher than planned outsourcing of services e.g. to the Nuffield Hospital £78k
- Income from activities adverse to plan (including the share of cardiac surgery) £229k
- A favourable variance on Operating Income, see above, £107k
- Higher than planned agency costs £111k
- Clinical supplies favourable variance £272k

Actions being taken:

- The Division is implementing a revised Operating Plan to address improved utilisation rates within theatres which will reduce the number of Waiting List Initiatives required.
- For Oral Surgery and Dental Specialities, the Division is further increasing capacity by recruiting to the required levels of nursing and consultant staff.
- The Division is planning to increase capacity at South Bristol Hospital including scheduling additional sessions in the evenings and at weekends.
- The Division is working with Specialised Services to explore the possibility of utilising a general ITU bed to prevent cancellations caused by the lack of CICU capacity (See Specialised Services above).
- A recruitment and retention strategy is being implemented to address areas where lack of permanent staff is causing high levels of agency usage and excessive turnover. The retention strategy will be focussed on the training, development and succession opportunities for staff in theatres and critical care based upon insights gained from recent exit interviews.

One Division is amber/red rated for its financial performance for the year to date.

The Division of Women's and Children's Services

The Division reports an adverse variance to Month 03 of £129k this represents an improvement from Month 02 of £25k. The Division is £133k adverse to the Operating Plan trajectory to date.

The key reasons for the adverse variance against budget to date are:

- An adverse variance on pay of £403k due to higher than planned agency costs both within medical staff (NICU cover) and nursing (including 1-1 care). Non clinical staff is overspending by £123k driven by requirements such as validating waiting lists and completion of missing outcomes.
- A favourable variance on income from activities of £231k due to over performance to date in paediatric medical specialties £441k, offset by underperformance on other specialties mainly paediatric cardiac and critical care – the latter being addressed through the move to five day operating (from four).
- A favourable variance on non pay of £328k, the favourable variance being caused by a proportionate share of capacity funding and corporate support funding released to date £790k, offset by adverse variances on management budgets including drugs £80k, clinical supplies £149k, other smaller adverse variances including drugs and blood £181k (related to increased tissue typing and stem cell therapies re BMT activity).
- An underperformance on the Division's CIP programme, resulting in an adverse variance to date of £282k. The majority of this relates to the year to date proportion of unidentified CIP's in the Operating Plan £291k, offset by overachievement to on non pay schemes.

Action being taken:

- Concerted effort to identify further savings opportunities
- Further action to minimise agency payments via improved and efficient recruitment and retention
- Improve cost control and budgetary performance including Profin compliance.

The remaining three Divisions are green rated.

Diagnostic and Therapies Division

The Division reports a favourable variance to Month 03 of £59k, this represents an improvement from Month 02 of £34k; the Division is £75k favourable to the Operating Plan trajectory to date.

The Facilities and Estates Division

The Division reports a favourable variance to Month 03 of £45k this represents an improvement from Month 02 of £12k, the Division is £46k favourable to the Operating Plan trajectory to date.

Trust Headquarters

The Division reports a favourable variance to Month 03 of £37k, this represents an improvement from Month 02 of £22k; the Division is £26k favourable to the Operating Plan trajectory to date.

5. Income

Contract income was £1.41m higher than plan in June but £0.73m lower than plan for the year to date. Activity, penalties and pass through payments were all higher than plan. The table below summarises the overall position.

The position is described in more detail in agenda item 5.2.

Clinical Income by Worktype	In Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance
	£'m	£'m	£'m	£'m
Activity Based				
Accident & Emergency	0.03	3.67	3.74	0.07
Emergency Inpatients	0.16	17.92	18.48	0.56
Day Cases	(0.04)	9.1	8.79	(0.31)
Elective Inpatients	(0.15)	12.82	12.01	(0.81)
Non-Elective Inpatients	(0.14)	3.91	3.45	(0.46)
Excess Bed days	0.39	1.72	2.11	0.39
Outpatients	0.09	19.20	18.72	(0.48)
Bone Marrow Transplants	0.01	2.28	2.59	0.31
Critical Care Bed days	0.27	10.28	10.46	0.18
Other	(0.03)	22.97	22.75	(0.22)
Sub Totals	**0.59**	**103.87**	**103.10**	**(0.77)**
Contract Rewards / Penalties	0.60	0.08	0.52	0.44
Pass through payments	0.22	17.90	17.50	(0.40)
Totals	**1.41**	**121.85**	**121.12**	**(0.73)**

6. Risk Ratings

The Trust's overall continuity of services risk rating based on results for the month ending 30 June is 3 compared with a rating of 4 in May. The deterioration is in line with plan and reflects the first loan principal repayment of £2.8m being made in June relating to the Trusts £70m loan with the Independent Trust Financing Facility. This reduces the Capital service Capacity metric from 3 to 2. Further information showing performance to date is given at Appendix 4.

	March	April	May	June	Annual Plan 2015/16
Liquidity					
Metric Performance	5.61	6.32	6.96	7.23	(3.48)
Rating	4	4	4	4	3
Capital Service					
Metric Performance	2.86	1.78	2.27	1.48	1.55
Rating	4	3	3	2	2
Overall Rating	**4**	**4**	**4**	**3**	**3**

The Finance Committee previously received a report outlining Monitor's proposed changes to the existing Risk Assessment Framework (RAF) including the introduction of a new Sustainability & Financial Performance Risk Rating (S&FPRR). The proposed changes are subject to consultation which ended on 1st July 2015. The Trust's shadow S&FPRR for quarter 1 is summarised below.

Metric	Weighting	Metric Result	Metric Rating	Weighted Rating
Liquidity	25%	7.23	4	1.0
Capital service cover	25%	1.48	2	0.5
Income & expenditure margin	25%	1.6%	4	1.0
Variance in I&E margin	15%	1.2%	4	0.6
Variance in capital expenditure	10%	48%	1	0.1
Overall S&FPRR				**3.2**
S&FPRR rounded				**3**

7. Capital Programme

A summary of income and expenditure for the three months ending 30 June is given in the table below. Expenditure for the period of £4.602m equates to 52% of the capital expenditure plan to date.

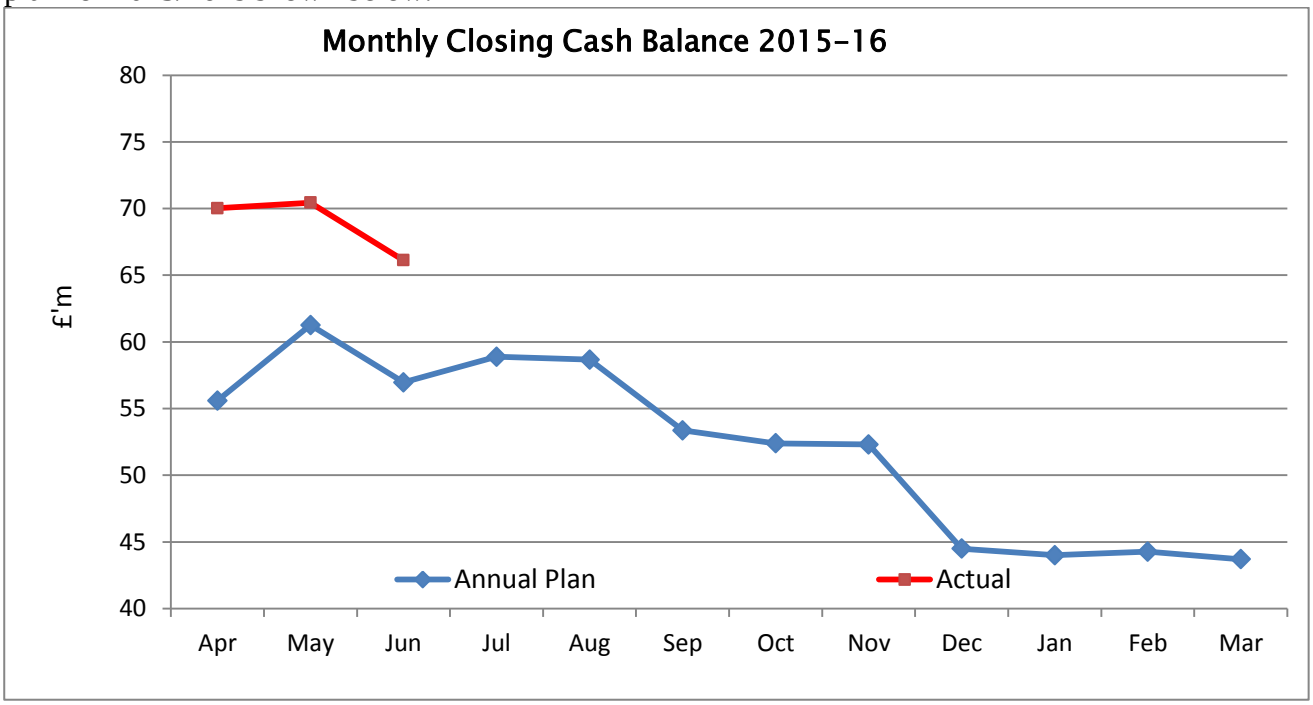
	Annual Plan	Month Ending 30 June 2015		
		Plan	Actual	Variance
	£'000	£'000	£'000	£'000
Sources of Funding				
Donations	4,563	2,301	2,311	10
Sale of Property	1,100	1,100	1,100	-
Recovery of VAT/Grants	1,130	954	1,040	86
Retained Depreciation	20,814	5,112	5,099	(13)
Cash	7,023	(609)	(4,948)	(4,339)
Total Funding	**34,630**	**8,858**	**4,602**	**(4,256)**
Expenditure				
Strategic Schemes	(15,842)	(2,928)	(2,432)	496
Medical Equipment	(4,248)	(2,655)	(486)	2,169
Information Technology	(3,171)	(1,241)	(518)	723
Estates Replacement	(2,202)	(230)	(517)	(287)
Operational Capital	(9,167)	(1,804)	(649)	1,155
Total Expenditure	**(34,630)**	**(8,858)**	**(4,602)**	**4,256**

The Finance Committee is provided with further information on this under agenda item 6.1.

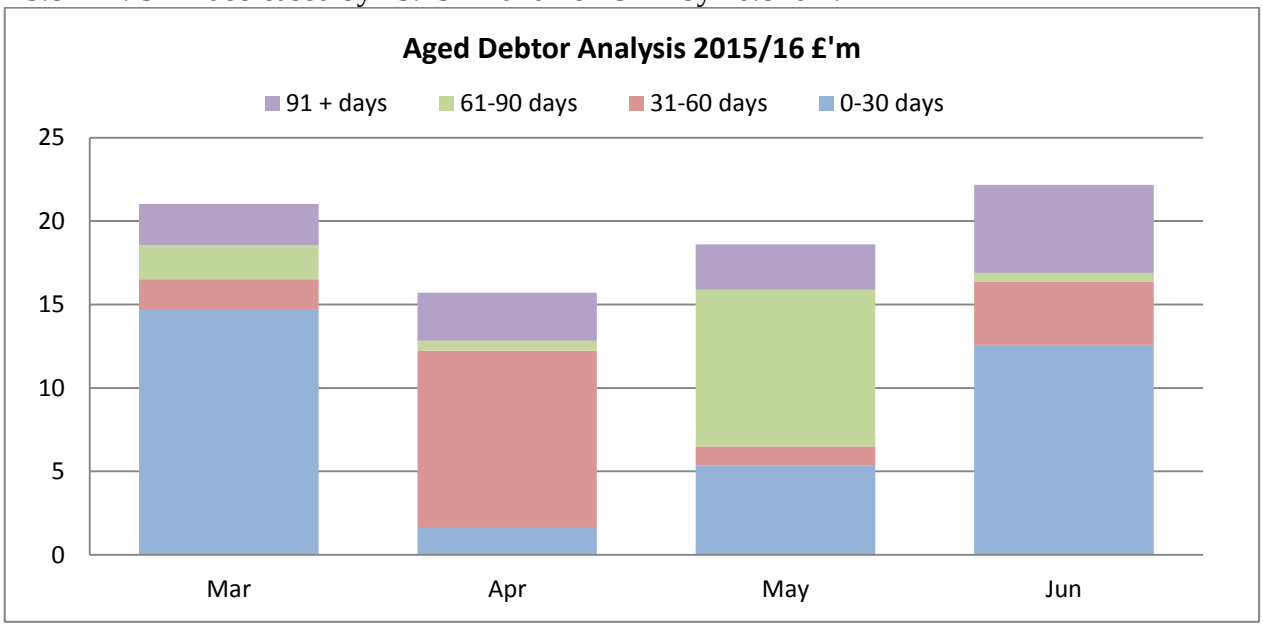
8. Statement of Financial Position and Cashflow

Overall, the Trust has a strong statement of financial position with a positive working capital balance of £22.072m as at 30 June 2015, £5.759m ahead of plan.

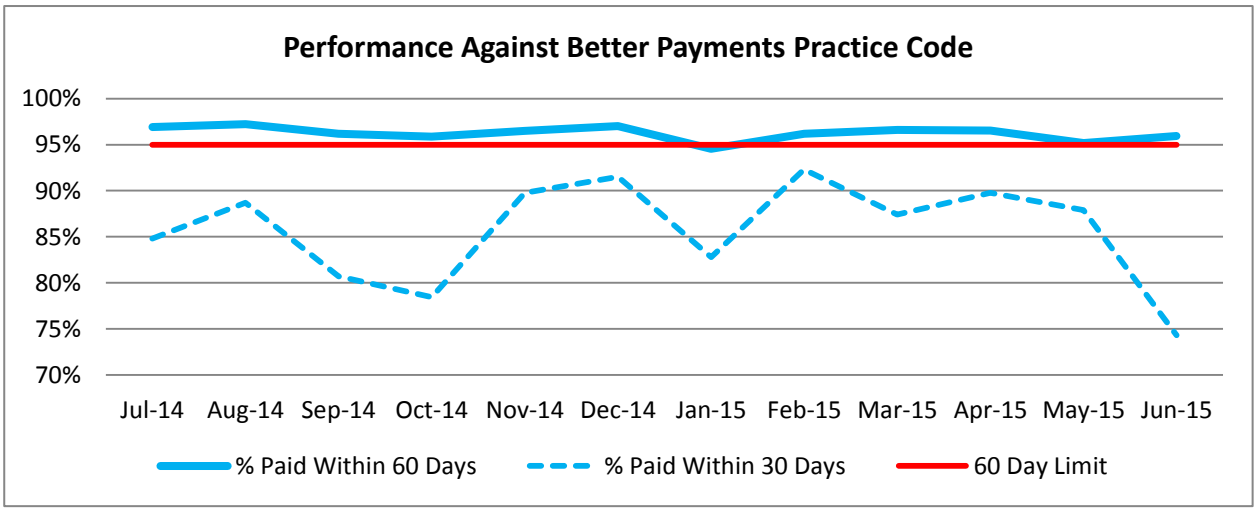
Cash - The Trust held a cash balance of £66.127m as at 30 June. Actual compared to the annual plan for 2015/16 is shown below.



Receivables - The total value of debtors has increased by £3.567m to £22.175m. SLA increased by £2.316m and non SLA by £1.251m. Debts over 60 days old have decreased by £6.277m to £5.822m. SLA decreased by £5.431m and non SLA by £0.846m.



Accounts Payable Payments – In June the Trust paid 96% of invoices within 60 days compared with the Prompt Payments Code target of 95%. The number of invoices paid in 30 days was lower than usual due to staff illness and a higher than usual number of queries.



9. Reporting

A review of the Finance Report is underway. The intention will be to ensure the content provides clarity. On an interim basis Appendix 3, Executive Summary, and Appendix 5, Key Financial Risks, have been removed from the report pending replacement sections from month 5.

Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Executive Summary (deferred)
Appendix 4 – Continuity of Services Risk Rating
Appendix 5 – Key Financial Risks (deferred)
Appendix 6 – Financial Risk Matrix
Appendix 7 – Monthly Analysis of Pay Expenditure 2015/16
Appendix 8 - Release of Reserves May 2015

Appendix 1

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

Approved Budget / Plan 2015/16	Heading	Position as at 30th June			Actual to 31st May
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
497,888	From Activities	123,319	123,619	300	79,649
88,331	Other Operating Income	22,177	22,525	348	15,244
586,219	**Sub totals income**	**145,496**	**146,144**	**648**	**94,893**
	Expenditure				
(341,795)	Staffing	(86,800)	(87,480)	(680)	(58,055)
(199,239)	Supplies and Services	(49,963)	(50,219)	(256)	(32,412)
(541,034)	**Sub totals expenditure**	**(136,763)**	**(137,699)**	**(936)**	**(90,467)**
(15,634)	Reserves	(500)	–	500	–
29,551	**EBITDA**	**8,233**	**8,445**	**212**	**4,426**
	Financing				
–	Profit/(Loss) on Sale of Asset	–	7	7	7
(21,920)	Depreciation & Amortisation – Owned	(5,338)	(5,161)	177	(3,428)
244	Interest Receivable	61	68	7	44
(314)	Interest Payable on Leases	(79)	(80)	(1)	(53)
(3,192)	Interest Payable on Loans	(798)	(790)	8	(533)
(9,369)	PDC Dividend	(2,342)	(2,046)	296	(1,364)
(34,551)	**Sub totals financing**	**(8,496)**	**(8,002)**	**494**	**(5,327)**
(5,000)	**NET SURPLUS / (DEFICIT) before Technical Items**	**(263)**	**443**	**706**	**(901)**
	Technical Items				
4,558	Donations & Grants (PPE/Intangible Assets)	2,250	2,311	61	28
(4,719)	Impairments	(1,555)	(1,071)	484	–
500	Reversal of Impairments	–	–	–	–
(1,472)	Depreciation & Amortisation – Donated	(369)	(369)	–	(246)
(6,133)	**SURPLUS / (DEFICIT) after Technical Items**	**63**	**1,314**	**1,251**	**(1,119)**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2015 - Divisional Income & Expenditure Statement

Approved Budget / Plan 2015/16	Division	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st May
			Pay	Non Pay	Operating Income	Income from Activities	CRES		
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income								
494,148	Contract Income	121,848	-	-	8	(8)	-	-	-
(6,534)	Overheads, Fines & Rewards	(524)	-	-	-	1,110	-	1,110	71
38,590	NHSE Income	9,532	-	(294)	294	-	-	-	-
526,204	**Sub Total Corporate Income**	**130,856**	**-**	**(294)**	**302**	**1,102**	**-**	**1,110**	**71**
	Clinical Divisions								
(50,434)	Diagnostic & Therapies	(12,741)	85	(124)	158	118	(178)	59	25
(72,019)	Medicine	(18,517)	(71)	6	24	(215)	(9)	(265)	(264)
(83,375)	Specialised Services	(20,808)	(285)	273	(17)	(284)	136	(177)	(180)
(99,321)	Surgery Head & Neck	(25,901)	(53)	140	107	(461)	(778)	(1,045)	(801)
(114,584)	Women's & Children's	(28,813)	(403)	328	(3)	231	(282)	(129)	(154)
(419,733)	**Sub Total - Clinical Divisions**	**(106,780)**	**(727)**	**623**	**269**	**(611)**	**(1,111)**	**(1,557)**	**(1,374)**
	Corporate Services								
(35,384)	Facilities And Estates	(9,301)	(13)	23	4	29	2	45	33
(24,187)	Trust Services	(6,091)	251	(222)	(48)	19	23	23	15
(1,532)	Other	(239)	(58)	311	(116)	(51)	5	91	43
(61,103)	**Sub Totals - Corporate Services**	**(15,631)**	**180**	**112**	**(160)**	**(3)**	**30**	**159**	**91**
(480,836)	**Sub Total (Clinical Divisions & Corporate Services)**	**(122,411)**	**(547)**	**735**	**109**	**(614)**	**(1,081)**	**(1,398)**	**(1,283)**
(15,817)	Reserves	-	-	500	-	-	-	500	334
(15,817)	**Sub Total Reserves**	**-**	**-**	**500**	**-**	**-**	**-**	**500**	**334**
29,551	**Trust Totals Unprofiled**	**8,445**	**(547)**	**941**	**411**	**488**	**(1,081)**	**212**	**(878)**
	Financing								
-	(Profit)/Loss on Sale of Asset	7	-	7	-	-	-	7	7
(21,920)	Depreciation & Amortisation - Owned	(5,161)	-	177	-	-	-	177	184
244	Interest Receivable	68	-	7	-	-	-	7	3
(314)	Interest Payable on Leases	(80)	-	(1)	-	-	-	(1)	(1)
(3,192)	Interest Payable on Loans	(790)	-	8	-	-	-	8	(1)
(9,369)	PDC Dividend	(2,046)	-	296	-	-	-	296	197
(34,551)	**Sub Total Financing**	**(8,002)**	**-**	**494**	**-**	**-**	**-**	**494**	**389**
(5,000)	**NET SURPLUS / (DEFICIT) before Technical Items**	**443**	**(547)**	**1,435**	**411**	**488**	**(1,081)**	**706**	**(489)**
	Technical Items								
4,558	Donations & Grants (PPE/Intangible Assets)	2,311	-	-	61	-	-	61	-
(4,719)	Impairments	(1,071)	-	484	-	-	-	484	-
500	Reversal of Impairments	-	-	-	-	-	-	-	-
(1,472)	Depreciation & Amortisation - Donated	(369)	-	-	-	-	-	-	-
(1,133)	**Sub Total Technical Items**	**871**	**-**	**484**	**61**	**-**	**-**	**545**	**-**
(6,133)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**1,314**	**(547)**	**1,919**	**472**	**488**	**(1,081)**	**1,251**	**(489)**
-	Profile Adjustment	-	-	-	-	-	-	-	-
(6,133)	**Trust Totals Profiled**	**1,314**	**(547)**	**1,919**	**472**	**488**	**(1,081)**	**1,251**	**(489)**

University Hospitals Bristol NHS
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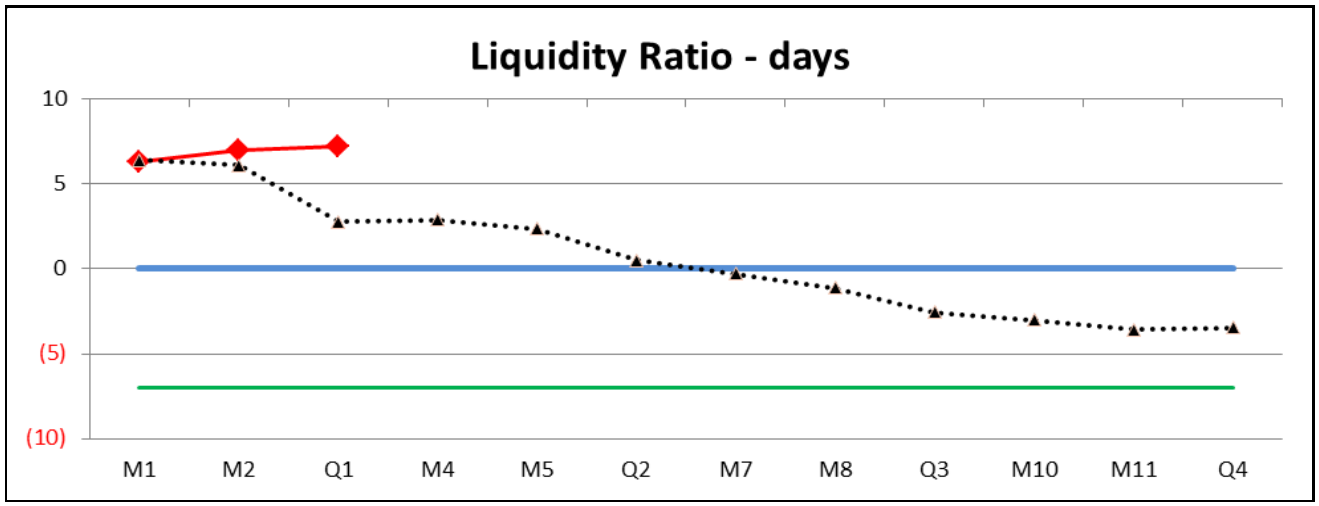
Appendix 4

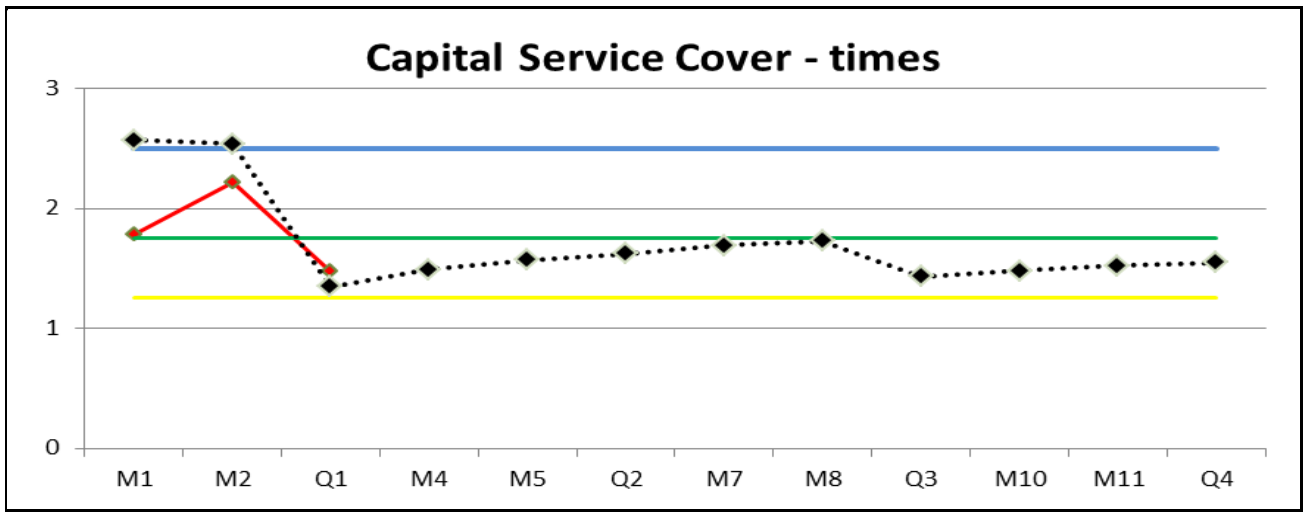
Continuity of Services Risk Rating – June 2015 Performance

The following graphs show performance against the two Continuity of Services Risk Rating (CoSRR) 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 **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.

	Outturn March 2015	Plan March 2016	Actual April 2015	Actual May 2015	Actual June 2015
Liquidity					
Metric Result	5.61	(3.48)	6.32	6.96	7.23
Rating	4	3	4	4	4
Capital Service Cover					
Metric Result	2.86	1.55	1.78	2.27	1.48
Rating	4	2	3	3	2
Overall CoSRR	**4**	**3**	**4**	**4**	**3**



	Plan March 2016 £'000	Actual April 2015 £'000	Actual May 2015 £'000	Actual June 2015 £'000
Annual Operating Expenses	**555,561**	**546,684**	**542,802**	**550,796**
Current Assets	81,245	102,115	100,190	97,907
Less Inventories	(10,087)	(11,769)	(11,373)	(11,006)
Less Assets held for Sale	-	-	-	-
Current Liabilities	(76,530)	(80,749)	(78,329)	(75,835)
Total	**(5,372)**	**9,597**	**10,488**	**11,066**
Metric Result – liquidity days	**(3.48)**	**6.32**	**6.96**	**7.23**



	Plan March 2016 £'000	Actual April 2015 £'000	Actual May 2015 £'000	Actual June 2015 £'000
Surplus / (Deficit) after technical items	(6,133)	(1,049)	(1,119)	1,314
Impairments	4,219	-	-	1,071
PDC Expense	8,184	682	1,364	2,046
Depreciation	22,286	1,838	3,674	5,530
Interest payable on loans and leases	3,396	288	586	870
Gain / loss on asset disposals	-	-	(7)	(7)
Donations / Grants	(4,558)	(28)	(28)	(2,311)
Total – revenue available for debt service	**27,394**	**1,731**	**4,470**	**8,513**
PDC Dividend	8,184	682	1,364	2,046
Interest on Borrowings	3,088	261	533	790
Interest on Finance Leases	308	27	53	80
Loan Principal Repayments	5,834	-	-	2,787
Finance Lease Capital Repayments	269	-	23	67
Total – capital servicing costs	**17,683**	**970**	**1,973**	**5,770**
Metric Result – capital service cover	**1.55**	**1.78**	**2.27**	**1.48**

Sustainability & Financial Performance Risk Rating – June 2015 Performance

The Finance Committee previously received a report outlining Monitor's proposed changes to the existing Risk Assessment Framework (RAF) including the introduction of a new Sustainability & Financial Performance Risk Rating (S&FPRR). The proposed changes are subject to consultation which ended on 1st July 2015. The Trust's shadow S&FPRR for quarter 1 is summarised below.

Metric	Weighting	Metric Result	Metric Rating	Weighted Rating
Liquidity	25%	7.23	4	1.0
Capital service cover	25%	1.48	2	0.5
Income & expenditure margin	25%	1.6%	4	1.0
Variance in I&E margin	15%	1.2%	4	0.6
Variance in capital expenditure	10%	48%	1	0.1
Overall S&FPRR				**3.2**
S&FPRR rounded				**3**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 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	5.0
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	5.0
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	3.0
4248	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	-

Analysis of pay spend 2014/15 and 2015/16

Division		2014/15							2015/16							2013/14	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,162	10,066	10,037	10,206	40,471	3,373		3,419	3,450	3,488	10,357	10,357	3,452		3,294	
	Bank	64	91	86	74	315	26	0.8%	26	24	32	82	82	27	0.8%	26	0.8%
	Agency	79	184	387	395	1,045	87	2.6%	106	115	155	377	377	126	3.7%	28	0.9%
	Waiting List initiative	45	46	65	113	269	22	0.7%	37	34	27	98	98	33	1.0%	19	0.6%
	Overtime	101	94	111	99	405	34	1.0%	34	47	65	147	147	49	1.4%	26	0.8%
	Other pay	9,772	9,435	9,675	9,492	38,375	3,198	95.0%	3,209	3,216	3,148	9,572	9,572	3,191	93.2%	3,179	97.0%
	Total Pay expenditure	10,062	9,850	10,324	10,173	40,409	3,367	100.0%	3,412	3,437	3,427	10,276	10,276	3,425	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	100	216	(287)	33	62	5		8	14	60	82	82	27		16	
Medicine	Pay budget	11,591	11,880	12,506	13,320	49,297	4,108		4,284	4,253	4,304	12,841	12,841	4,280		3,679	
	Bank	805	870	1,019	872	3,566	297	7.1%	303	329	265	897	897	299	6.9%	275	6.9%
	Agency	451	630	1,058	1,356	3,495	291	7.0%	324	248	254	826	826	275	6.4%	196	4.9%
	Waiting List initiative	26	39	34	94	193	16	0.4%	27	15	9	51	51	17	0.4%	13	0.3%
	Overtime	36	19	16	20	91	8	0.2%	4	6	6	16	16	5	0.1%	16	0.4%
	Other pay	10,704	10,399	10,587	11,130	42,820	3,568	85.4%	3,722	3,710	3,780	11,212	11,212	3,737	86.2%	3,479	87.4%
	Total Pay expenditure	12,022	11,957	12,715	13,471	50,165	4,180	100.0%	4,381	4,308	4,313	13,002	13,002	4,334	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(431)	(77)	(209)	(152)	(868)	(72)		(97)	(54)	(10)	(161)	(161)	(54)		(300)	
Specialised Services	Pay budget	9,577	9,653	9,727	10,232	39,189	3,266		3,347	3,384	3,399	10,130	10,130	3,377		3,060	
	Bank	309	335	357	292	1,293	108	3.2%	112	127	163	402	402	134	3.9%	99	3.1%
	Agency	509	664	677	885	2,735	228	6.7%	205	219	247	671	671	224	6.4%	157	5.0%
	Waiting List initiative	91	90	133	194	508	42	1.3%	47	30	48	125	125	42	1.2%	32	1.0%
	Overtime	55	40	22	30	147	12	0.4%	9	11	9	29	29	10	0.3%	15	0.5%
	Other pay	8,813	8,894	9,028	9,211	35,946	2,995	88.5%	3,043	3,074	3,072	9,189	9,189	3,063	88.2%	2,840	90.4%
	Total Pay expenditure	9,777	10,022	10,215	10,613	40,627	3,386	100.0%	3,416	3,460	3,538	10,415	10,415	3,472	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(200)	(369)	(488)	(381)	(1,438)	(120)		(70)	(76)	(139)	(285)	(285)	(95)		(82)	
Surgery Head and Neck	Pay budget	17,951	18,025	18,188	18,190	72,354	6,030		6,275	5,769	7,322	19,366	19,366	6,455		5,911	
	Bank	463	511	587	463	2,024	169	2.7%	191	178	190	559	559	186	2.9%	155	2.5%
	Agency	226	327	275	448	1,276	106	1.7%	172	190	241	603	603	201	3.1%	67	1.1%
	Waiting List initiative	366	456	446	395	1,663	139	2.2%	138	140	129	407	407	136	2.1%	116	1.9%
	Overtime	184	114	39	43	380	32	0.5%	11	13	14	38	38	13	0.2%	40	0.7%
	Other pay	17,464	17,399	17,639	17,809	70,313	5,859	92.9%	5,966	5,873	6,014	17,853	17,853	5,951	91.7%	5,766	93.8%
	Total Pay expenditure	18,703	18,808	18,988	19,157	75,656	6,305	100.0%	6,478	6,394	6,589	19,461	19,461	6,487	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(752)	(783)	(800)	(967)	(3,302)	(275)		(203)	(625)	733	(95)	(95)	(32)		(235)	

Analysis of pay spend 2014/15 and 2015/16

Division		2014/15							2015/16							2013/14	2013/14
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	20,433	21,521	21,945	22,234	86,133	7,178		7,378	7,627	7,557	22,562	22,562	7,521		6,123	
	Bank	530	485	631	528	2,174	181	2.5%	182	180	171	533	533	178	2.3%	151	2.5%
	Agency	384	397	411	650	1,842	154	2.1%	189	230	284	703	703	234	3.1%	117	1.9%
	Waiting List initiative	88	87	76	139	390	33	0.5%	69	67	69	205	205	68	0.9%	30	0.5%
	Overtime	82	79	95	99	355	30	0.4%	38	42	33	113	113	38	0.5%	19	0.3%
	Other pay	19,455	20,428	20,875	20,758	81,516	6,793	94.5%	7,090	7,104	7,207	21,401	21,401	7,134	93.2%	5,843	94.9%
	Total Pay expenditure	20,539	21,476	22,088	22,174	86,277	7,190	100.0%	7,568	7,623	7,765	22,956	22,956	7,652	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(106)	45	(144)	60	(144)	(12)		(190)	3	(207)	(393)	(393)	(131)		(36)	
Facilities & Estates	Pay budget	4,638	4,916	4,931	4,936	19,421	1,618		1,726	1,669	1,662	5,057	5,057	1,686		1,536	
	Bank	227	316	271	251	1,065	89	5.5%	80	106	111	296	296	99	5.8%	46	3.0%
	Agency	80	115	133	174	502	42	2.6%	47	33	65	145	145	48	2.9%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	244	255	273	193	965	80	5.0%	79	65	82	225	225	75	4.4%	75	4.9%
	Other pay	4,109	4,129	4,274	4,218	16,729	1,394	86.9%	1,491	1,473	1,442	4,406	4,406	1,469	86.9%	1,366	90.1%
	Total Pay expenditure	4,660	4,815	4,951	4,835	19,261	1,605	100.0%	1,697	1,676	1,699	5,072	5,072	1,691	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	(23)	101	(20)	101	161	13		30	(8)	(38)	(16)	(16)	(5)		20	
Trust Services (Incl R&I and Support Services)	Pay budget	6,524	6,903	7,257	9,053	29,738	2,478		2,163	2,094	2,230	6,487	6,487	2,162		2,458	
	Bank	165	154	189	178	686	57	2.4%	50	66	61	176	176	59	2.8%	57	2.4%
	Agency	135	139	154	280	707	59	2.5%	(3)	13	(5)	5	5	2	0.1%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	1	2	3	3	1	0.0%	0	0.0%
	Overtime	31	27	33	19	110	9	0.4%	7	8	7	22	22	7	0.3%	9	0.4%
	Other pay	6,061	6,433	6,362	7,822	26,678	2,223	94.7%	2,042	2,021	2,028	6,092	6,092	2,031	96.7%	2,285	95.9%
	Total Pay expenditure	6,392	6,754	6,737	8,298	28,180	2,348	100.0%	2,096	2,109	2,093	6,299	6,299	2,100	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	132	149	520	755	1,557	130		67	(15)	137	188	188	63		75	
Trust Total	Pay budget	80,876	82,964	84,592	88,172	336,604	28,050		28,593	28,245	29,962	86,800	86,800	28,933		26,060	
	Bank	2,564	2,762	3,140	2,657	11,124	927	3.3%	944	1,010	992	2,946	2,946	982	3.4%	809	3.0%
	Agency	1,865	2,455	3,096	4,187	11,603	967	3.4%	1,040	1,049	1,241	3,330	3,330	1,110	3.8%	625	2.4%
	Waiting List initiative	616	718	754	935	3,023	252	0.9%	318	287	284	889	889	296	1.0%	210	0.8%
	Overtime	734	628	589	503	2,454	204	0.7%	182	192	217	590	590	197	0.7%	201	0.8%
	Other pay	76,378	77,117	78,440	80,436	312,370	26,031	91.7%	26,564	26,470	26,691	79,725	79,725	26,575	91.1%	24,759	93.1%
	Total Pay expenditure	82,157	83,680	86,019	88,718	340,574	28,381	100.0%	29,048	29,007	29,425	87,480	87,480	29,160	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(1,281)	(716)	(1,427)	(546)	(3,970)	(331)		(455)	(762)	537	(680)	(680)	(227)		(543)	

Release of Reserves 2015/16 **Appendix 8**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	1,000	5,111	40,114	(268)	11,131	6,050	63,138									
April movements	(220)	(2,511)	(29,556)	-	(4,872)	(1,047)	(38,206)	4,075	5,792	4,807	9,850	7,758	967	4,922	35	38,206
May movements	(30)	288	(5,225)	312	(2,481)	(3,500)	(10,636)	(219)	2,155	193	89	106	17	153	8,142	10,636
June Movements																
Service Developments			(108)				(108)					108				108
Local CEAs			(276)				(276)	8	39	30	96	103				276
EWTD					(145)		(145)	10	37	20	25	50	2	1		145
Resilience Funding			(54)				(54)				43	11				54
Outpatient review	(46)						(46)		46							46
BRI Redevelopment					(100)		(100)						100			100
RTT						(90)	(90)							90		90
Well Led Review	(44)						(44)							44		44
Other	1	(26)	(91)		(89)	(27)	(232)	12	40			48	40	34	58	232
Month 3 balances	661	2,862	4,804	44	3,444	1,386	13,201	3,886	8,109	5,050	10,103	8,184	1,126	5,244	8,235	49,937

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
16. Quarterly Capital Projects Status Report									
Sponsor and Author(s)									
Sponsor: Deborah Lee, Chief Operating Officer / Deputy Chief Executive Author: Andy Headdon, Programme Director of Strategic Development									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
To update the Board on the current status of the Trust's major capital development schemes and to provide assurance that the schemes are effectively governed.

Key issues to note

- Cost for KEB refurbishment exceed budget by c5% - works now proceeding to tender to establish firm costs
- Costs for Level 8 and 9 works exceed budget due to change in scope
- Programme completion to time now imperative due to pending sale of Old Building and contractual requirements for timely vacant possession

Recommendations

The Trust Board is recommended to receive this report by the Chief Operating Officer and Deputy Chief Executive for **assurance** that the capital programme is being delivered in line with the plan, and where not, that adequate mitigations and contingencies are in place.

Impact Upon Board Assurance Framework

Provides assurance regarding the delivery of strategic objective 2.1

Impact Upon Corporate Risk

Risks 4103 and 4104 refer

Implications (Regulatory/Legal)

None

Equality & Patient Impact

Continuation of services, from sub-optimal estate, for a further three month period over the original plan.

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

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

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

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Quarter 2
30th July 2015 Trust Board

1. Introduction

This status report provides a summary update for Quarter 2 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

Bristol Royal Infirmary Redevelopment Phase 3, Centralisation of Specialist Paediatrics and the Bristol Haematology and Oncology Centre have all completed, with final accounts settled and final submissions made to HMRC to finalise VAT recovery amounts.

BRISTOL ROYAL INFIRMARY Phase 4 and Queens Facade		
1	**Decisions required**	None
2	**Progress**	**Contractors Site Village** Consideration being given to temporary use to facilitate the closure of the Old Building and the sale agreement. Current cost estimates substantial and further work in hand to reduce these. **BRI Phase 4** The following refurbishment schemes have been completed • Restaurant which opened on the 11th May 2014 • Central Health Clinic- Pain Clinic relocated from St Michaels The following schemes are in construction/planning • Refurbishment of Wards A524,525,528 • Conversion of Lecture Theatre - project recommenced following a design review. • Refurbishment of ward A518- due to complete mid-August • Refurbishment of A522, C808 • Refurbishment of King Edward Building (c£9m), scheme due out to tender. **Queens Façade** Contracts have been signed and work on site commenced with a range of preparation works for the main façade underway. Support brackets for the parapet cladding have commenced and the first delivery and installation of new windows is scheduled for the end of August. A meeting has been held with the Urban Design team of the council to review the design development since planning approval and all but one pre commencement condition has been discharged by the Council.

3	**Budget**	A total capital allocation of £115.7m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m. The final account has been settled and final submissions made to HMRC to agree VAT recovery amounts The scheme is currently in excess of budget by c£1.5m in respect of cost pressure in the large KEB scheme (currently out to tender) and additional costs associated with a change in scope to Level 8 and 9 works. Work to eliminate these costs is in hand.	
4	**Programme**	The phase 4 programme remains on programme to achieve the required vacation date of the Old Building to facilitate the sale agreement subject t to mobilisation of temporary office accommodation.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Tendered works, exceed the budgeted sums	The budget for all phase 4 schemes is being managed as one, creating flexibility to manage both under and overspends within the total budget. Strict controls to specifying works to ensure project scope "creep" doesn't import cost pressure.
		Projects in train slip and programme is not delivered on time with resulting operational impacts	Additional external project management support has been retained to oversee largest projects to strengthen project management arrangements.

3. Conclusion

The Trust Board is requested to receive this report for information, noting the risks that have been identified and the mitigation/contingency plans that have been developed.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 14.07.2015

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

Report Title									
17. Clinical Research Network Annual Plan 2015/16									
Sponsor and Author(s)									
Sponsor: Dr Sean O'Kelly, Medical Director Author: Dr Mary Perkins Chief Operating Officer, West of England Clinical Research Network									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose: As the host organisation for the WECRN, the Board are asked to approve this plan on behalf of the member organisations. UH Bristol as signatory to the contract with the Department of Health is accountable for the network activities. Robert Woolley is the accountable officer and Dr Sean O'Kelly is the delegated executive officer. All member organisations assisted in the preparation of this plan and the partnership group of the WECRN have approved this plan for submission to the UH Bristol Board. The national coordinating centre have also provided feedback on a draft plan and their feedback has been acted upon in this version Key issues to note: We run a devolved network with many responsibilities sitting with partner organisations research and development departments. For 2014/2015 we exceeded our targets. This plan covers all organisations in our geographic area. , including primary care and social care. Recruitment targets are set by each partner organisation and the LCRN leadership team taking account of trials we know will happen and those we have advance notice of. The plan is written in the format requested by the coordinating centre.									
Recommendations									
That the Board approve this plan									
Impact Upon Board Assurance Framework									
Supports UH Bristol to discharge their role as host for the network and signatory to the network contract with the Department of Health									
Impact Upon Corporate Risk									
None									
Implications (Regulatory/Legal)									
This plan supports UH Bristol to discharge their responsibilities as contract signatory									
Equality & Patient Impact									
None									
Resource Implications									
Finance		Information Management & Technology							

Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	**X**	For Information	
Date the paper was presented to previous Committees							
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**		
					April/May/June 2015 LCRN Partnership Group, Executive Group, Clinical Leaders Group and Operational Management Group. NIHR National Coordinating Centre		

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

Host organisation Accountable Officer for CRN: West of England		
Name:	Mr Robert Woolley	*Contact details* Email: Robert.Woolley@UHBristol.nhs.uk Tel: 0117 342 3720
Host nominated Executive Director for CRN: West of England		
Name:	Dr Sean O'Kelly	*Contact details* Dr Sean O'Kelly Medical Director University Hospitals Bristol NHS Foundation Trust Marlborough Street Bristol
Job title:	Medical Director	

		Avon BS1 3NU Email (PA): Claudette.Young@UHBristol.nhs.uk
CRN: West of England Clinical Director		
Name:	Dr Stephen Falk	*Contact details* Email: Stephen.falk@uhbristol.nhs.uk Tel: 0117 3421375
CRN: West of England Chief Operating Officer		
Name:	Dr Mary Perkins	*Contact details* Email: mary.perkins@nihr.ac.uk Tel: 0117 3421375

To be completed by the Host organisation

Please briefly outline the process of engagement and consultation with LCRN Partners and other stakeholders regarding the submitted LCRN 2015-16 Annual Plan and local recruitment goals
Please note: The Royal United Hospital Bath NHS Trust received Foundation Trust authorisation 1 November 2014 and acquired the Royal National Hospital for Rheumatic Diseases, 1 February 2015. The organisation is now called Royal United Hospitals Bath NHS Foundation Trust. The Chief Operating Officer and Clinical Director have had face to face meetings with each Partner Organisation to discuss the Annual Plan. Each organisation provided data which have been collated and used to set the local recruitment goals. Partner Research and Development departments are represented on the Operational Management Group, Clinical Leaders Group, the Executive Group and the Partnership Group. These groups have all been part of setting the strategy and operational priorities for our next year. The RDMs and Divisional Research Leads have worked closely with specialty group leads to agree direction of travel within each specialty. Financial allocations followed the financial principles paper agreed with all parties prior to finalisation of this report. The Partnership Group reviewed this amended annual plan at their meeting on 10th June

<table>
<tr><td colspan="4">2015 and approved the plan for release. It will be submitted to the Host Trust Board for final approval. Evidence of that approval will be forwarded to the Coordinating Centre in due course.</td></tr>
<tr><td colspan="4">Nominated Executive Director Assurance</td></tr>
<tr><td colspan="2">LCRN Host organisation nominated Executive Director signature confirming the following are in place for the LCRN:
• an assurance framework and risk management system;
• robust and tested local business continuity arrangements;
• an Urgent Public Health Research Plan.</td><td colspan="2"></td></tr>
<tr><td colspan="4">Confirmation of approval of the Annual Plan by the Host organisation Board</td></tr>
<tr><td>Name:</td><td>Mr Robert Woolley</td><td colspan="2">Email: Robert.Woolley@UHBristol.nhs.uk
Tel: 0117 342 3720</td></tr>
<tr><td>Role:</td><td colspan="3">Chief Executive</td></tr>
<tr><td>Signature:</td><td></td><td>Date:</td><td></td></tr>
<tr><td colspan="4">Contact for any communication regarding the CRN: West of England Annual Plan</td></tr>
<tr><td>Name:</td><td>Dr Mary Perkins</td><td colspan="2">Email: mary.perkins@nihr.ac.uk
Tel: 0117 3421375</td></tr>
<tr><td>Role:</td><td colspan="3">Chief Operating Officer</td></tr>
</table>

Table 1. LCRN plans and goals for contributing to NIHR CRN High Level Objectives 2015-16

Objective		Measure	CRN Target	LCRN Goal	Specific key local activities for 2015-16	Timescale
1	Increase the number of participants recruited into NIHR CRN Portfolio studies	Number of participants recruited in a reporting year into NIHR CRN Portfolio studies	650,000	25257	For each HLO and measure please outline up to 3 key initiatives and projects planned for 2015-16 by your LCRN to contribute towards achievement of the objective(s); business as usual activities will be assumed and need not be outlined. Please also outline briefly the process by which provisional local recruitment goals have been reached, and the rationale for the proposed local goals for HLO1 and HLO7.	Please enter associated timescale(s)
					1. Recruitment training planned with Professor Jenny Donovan, Director of NIHR CLAHRC West. Over the past decade, Professor Donovan has led research understanding recruitment processes and developed the Quintet Recruitment Intervention which can be integrated into specific RCTs. There are opportunities now to develop training courses and sessions for recruiters based on the findings of the research. We are starting work with this team in late March 2015 – to pilot this approach. If the intervention delivers improved recruitment, there is potential for this model to be refined and then rolled out across the whole CRN. There is understandably considerable excitement about this work, but there are risks. The risks are that a) we are not able to translate the effective parts of the specific intervention into generic training; b) recruiters may not find the training helpful. We will attempt to mitigate these risks by evaluating the training and monitoring recruitment. 2. Development and roll out of a flexible cohort of study staff – comprising initially of two nurses and two Health Care Assistants, this team will support new areas in primary care initially and if successful, the team will be expanded either in numbers or in scope. 3. Identification and recruitment of specialist nurses in the community to take on Principal Investigator (PI) roles. This builds on the work we are doing to identify and support non-medic PIs and is led by our consultant nurse.	Pilot March 2015-September 2015 In post June 2015 Ongoing 2015
					• Recruitment goal was estimated by triangulation of estimates from the partner organisations, broken down by specialty and by the Research Delivery Managers (RDMs) working with the Clinical Divisional Leads (CDLs) and Clinical Research Speciality Leads (CRSLs) with data from the portfolio to inform expected targets. These targets were then increased for each specialty to provide a stretch target based on local knowledge of potential to deliver and likelihood of additional studies in that specialty.	Financial Year
2	Increase the proportion of studies in the NIHR CRN Portfolio delivering to recruitment target and time	A: Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed Network sites	80%	80%	• Promote the importance and impact of recruitment to time and target metrics to all LCRN staff, partner organisations and stakeholders including patients and the public.	March 2016
					• Training staff about the importance of robust feasibility (as part of Industry Masterclass).	March 2016
					• Ensure all staff understand that recruiting to time and target supports patients by enabling more patients to participate in trials; improves our reputation and creates an environment in which the West of England is recognised as a good area to place commercial contract studies. • Continued focus on feasibility to ensure achievable targets are set – including training and mentoring naïve staff, liaising with CRSL to confirm targets, continued development of resources and tools to support feasibility and realistic target setting. • Industry Manager to act as a single point of contact for issues with recruitment, directing these to the RDM where appropriate.	March 2016
		B: Proportion of non-commercial studies achieving or surpassing their recruitment target during their planned recruitment period	80%	80%	• Use databases where available to allow more accurate feasibility. • Triangulate investigators expectations with local research and development (R&D) office knowledge.	
					• Develop culture of Continuous Improvement in Partner Organisations.	
					• Focus on accuracy of feasibility.	
					• Develop portfolio facilitator role to support RDMs and CRSLs.	
3	Increase the number of commercial contract studies	A: Number of new commercial contract studies entering the NIHR CRN Portfolio	600	N/A	• Develop promotional materials to showcase CRN: West of England to commercial partners as a strong and reliable network for commercial studies.	March 2016

Objective		Measure	CRN Target	LCRN Goal	Specific key local activities for 2015-16	Timescale
	delivered through the NIHR CRN				• Work towards more CRN: West of England sites achieving partner site status with global Clinical Research Organisation (CRO) Quintiles.	March 2016
					• Industry Manager to act as the single point of contact to industry partners to explain the eligibility and feasibility process and highlight the benefits of inclusion on the NIHR Portfolio. • Establish second general practitioner (GP) consortium along the lines of the BARONET practices.	March 2016
		B: Number of new commercial contract studies entering the NIHR CRN Portfolio as a percentage of the total commercial MHRA CTA approvals for Phase II–IV studies	75%	N/A	• As per plan for 3a.	March 2016
4	Reduce the time taken for eligible studies to achieve NHS Permission through CSP	Proportion of eligible studies obtaining all NHS Permissions within 40 calendar days (from receipt of a valid complete application by NIHR CRN)	80%	80%	• Review of research management and governance (RM&G) services across the locality to assess effective use of RM&G resources • Local Health Research Authority (HRA) support person is a member of Operational Management Group (OMG). Provides regular updates and support for Partner Organisations to adopt/understand new ways of working. • All local R&D managers are a part of OMG. This metric and other continuous improvement initiatives are planned, developed and implemented through this group. • Key studies discussed in-depth, led by one Partner Organisation to increase ability to harness the power of the collaborative at OMG and support meetings arranged for key personnel so set-up is smooth and rapid.	March 2016
					• Provision of single point of contact for CSP during research and development NHS Permissions process. • Maintain the performance of RM&G staff completing study-wide and local governance reviews by providing monthly RAG reports to all Partner Organisations and requesting feedback. • Weekly study tracker monitoring progress of studies through the NHS Permissions process provided to Partner Organisations.	March 2016
					• Maintain competencies of RM&G staff by delivering ad-hoc targeted CSP training.	March 2016
5	Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies	A: Proportion of commercial contract studies achieving first participant recruited within 30 calendar days of NHS Permission being issued or First Network Site Initiation Visit, at confirmed Network sites	80%	80%	• Deliver Commercial Masterclasses to ensure study teams are prepared to recruit first patient within given timeframe.	March 2016
					• Ensure all Partner Organisations utilise the NIHR costing template and mCTA, provide training and support where needed.	March 2016
					• Develop and update materials to share best practice, celebrate success and drive peer support.	March 2016
		B: Proportion of non-commercial studies achieving first participant recruited within 30 calendar days of NHS Permission being issued	80%	80%	• All Partner Organisations now collecting data on this and working together to address barriers.	
					• Discussion item at OMG.	
					• Focus for Continuous Improvement within Partner Organisations.	
6	Increase NHS participation in NIHR CRN Portfolio Studies	A: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	99%	99%	• Maintain at 100%	
		B: Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio commercial contract studies	70%	70%	• Establish mentoring scheme to grow new PIs to understand the benefits of working with industry.	March 2016
					• Further development of commercial research activity in primary care through Continuous Improvement projects and establishing second consortium of GP practises using a hub and spoke consortium delivery model.	March 2016

Objective		Measure	CRN Target	LCRN Goal	Specific key local activities for 2015-16	Timescale
					• Develop materials and methods to share learning with commercial leads in each Partner Organisation and primary care organisation.	March 2016
		C: Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	25%	60%	• Work to maintain and increase the current high levels of GMPs (51%) recruiting into NIHR CRN studies through RSI scheme.	March 2016
7	Increase the number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	13,500	440	• Support the full roll out of Join Dementia Research (JDR) across all settings; the continued support of a JDR Project Officer facilitates the work of the dementia health improvement team.	Ongoing
					• Continue with development of West of England Dementia Collaborative to ensure studies are placed in the appropriate settings within the region, with other centres acting as PIC sites.	Ongoing
					• Establish model of working that ensures staff are able to work flexibly across the region to support open studies to minimise risk of studies not delivering to time and target.	Ongoing

Table 2. LCRN plans to contribute to achievement of NIHR CRN Clinical Research Specialty Objectives 2015-16

GROUP 1: INCREASING THE BREADTH OF RESEARCH ENGAGEMENT IN THE NHS
Increasing the opportunities for patients to participate in NIHR CRN Portfolio studies

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
1.1	Cancer	Increase the opportunities for cancer patients to take part in research studies, regardless of where they live, as reflected in National Cancer Patient Experience Survey responses	Number of LCRNs which have an action plan to increase access in each sub-specialty (e.g. by opening studies, increasing awareness and forming referral pathways for access to research)	15	• Maintain link with Strategic Clinical Network cancer site specific group infrastructure to engage with clinicians and reflect patient pathways in oversight of the tumour specific portfolios. • Sub-specialty leads (SSLs) to develop their network wide study list and disseminate (web link, newsletter, sub specialty group (SSG) meetings etc.) to all relevant clinical teams to encourage intra network referrals. • SSLs to encourage discussion re new studies in terms of whole network e.g. expressions of interest (EOI) representing full network population in forecast. • Map cancer service provision across the network to include patient referral pathways into and out of the network for specialist care and treatment. • Coordinate south west research/education events in conjunction with CRN: South West Peninsula and CRN: Wessex to raise awareness amongst clinical teams, and encourage new studies and patient referrals where appropriate.
1.2	Children	All relevant sites that provide services to children are involved in research	Proportion of NHS Trusts recruiting into Children's studies on the NIHR CRN portfolio	95%	• With a major tertiary centre in the LCRN, need to ensure that other relevant trusts providing children services are given the opportunity to act as PIC sites, if not appropriate to set up as a self-contained site. 85% of relevant Partner Organisations are already actively recruiting to children's studies as sites in their own right. • Provide an opportunity to bring staff delivering to children's studies across the region together to explore more collaborative approaches (similar to the current quarterly Division 4 delivery staff meetings). • Explore methods of funding shared core activities to support the non-tertiary centres.
1.3	Critical Care	Increase intensive care units' participation in NIHR CRN Portfolio studies	Proportion of intensive care units recruiting into studies on the NIHR CRN Portfolio	80%	• Set up face to face meetings every six months for doctors, research nurses etc. involved in Critical Care / Intensive Care Unit research / those who wish to become involved to facilitate sharing of best practice / group problem solving / to provide peer support / encourage networking and peer support. • CRSL to focus on encouraging and supporting currently research active ICUs and taking a stepwise approach to working with potential Principal Investigators at other units to encourage them to become research active.
1.4	Dermatology	Increase NHS participation in Dermatology studies on the NIHR CRN Portfolio	Number of sites recruiting into Dermatology studies	150	• Engage with any qualified provider to increase number of healthcare providers of dermatology services. • Work with Dermatology CRSL to understand barriers to research in our area and identify strategies to overcome those barriers. • Develop Principal Investigators and local collaborators.
1.5	Ear, Nose and Throat (ENT)	Increase NHS participation in Ear, Nose and Throat studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting into ENT studies on the NIHR CRN Portfolio	40%	• CRSL to complete site visits for all five acute NHS Trusts with ENT services to meet with clinical staff to map research interest. • Produce ENT specific newsletter to facilitate communication and raise awareness of opportunities to participate in CRN portfolio research. • Build on progress made in 2014-15 (no recruitment in 2013-14, then in 2014-15 a commercial study recruited at two sites, exceeding target) by seeking to open at least one ENT study in 2-3 sites (40-60% of acute NHS Trusts with ENT services) as available (Bath, Gloucester, UHBristol). Liaise with trusts to ensure that study moves forward successfully. At these sites there is an enthusiasm to take on ENT studies, limited only by the availability of portfolio studies. The CRSL and RDM will continue to search for suitable studies for these sites. • The CRSL is preparing a grant application at present and so there is a potential for some "home grown" studies in due course.

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
1.6	Gastroenterology	Increase NHS participation in Gastroenterology studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting into Gastroenterology studies on the NIHR CRN Portfolio	90%	• Flag studies seeking sites to the trusts to maintain and grow the portfolio at the acute trusts (6/6 appropriate trusts recruiting in 2014-15 i.e. excludes a community trust and two mental health trusts).
1.7	Haematology	Increase NHS participation in Haematology studies on the NIHR CRN Portfolio	Proportion of eligible NHS Trusts undertaking Haematology studies in each LCRN	50%	• Ensure Oncology and Haematology delivery staff have capacity to deliver Haematology studies. • More than 50% of eligible NHS Trusts are already currently undertaking Haematology studies, with new studies recently opened and due to open, we should be able to improve on this figure.
1.8	Injuries and Emergencies	Increase NHS major trauma centres' participation in NIHR CRN Portfolio studies	Proportion of NHS major trauma centres recruiting into NIHR CRN Portfolio studies	100%	• Link with major trauma centre at North Bristol NHS Trust to explore potential avenues for growing the CRN portfolio research portfolio in major trauma.
1.9	Injuries and Emergencies	Increase NHS emergency departments' participation in NIHR CRN Portfolio studies	Proportion of NHS emergency departments recruiting into NIHR CRN Portfolio studies	30%	• 7/8 Emergency departments in CRN: West of England recruited to portfolio studies in 2014-15. Potential new studies will be flagged up to Emergency Departments to maintain and grow the portfolio. • Build on existing links with the Ambulance Trust (based in CRN: South West Peninsula, but responsible for services in CRN: West of England) to facilitate joint working.
1.10	Musculoskeletal	Increase NHS participation in Musculoskeletal studies on the NIHR CRN Portfolio	Number of sites recruiting into Musculoskeletal studies on the NIHR CRN Portfolio	300	• Develop capacity and expertise at sites where the musculoskeletal portfolio is historically less well established. • Develop Principal Investigators and local collaborators.
1.11	Ophthalmology	Increase NHS participation in Ophthalmology studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting into Ophthalmology studies on the NIHR CRN Portfolio	60%	• Three Acute Trusts recruited to ophthalmology studies in 2014-15. In 2015-16 the potential for ophthalmology portfolio studies at the two other Acute Trusts with ophthalmology departments will be explored.
1.12	Renal Disorders	Increase the proportion of NHS Trusts recruiting into Renal Disorders studies on the NIHR CRN Portfolio which actively engage renal and urological patients in research	Proportion of NHS Trusts recruiting into Renal Disorders studies on the NIHR CRN Portfolio which implement Patient Carer & Public Involvement and Engagement (PCPIE) strategies for Renal Disorders research	25%	In liaison with trusts with Renal Services: • CRSL/ RDM to engage transplant users group in conjunction with the PCPIE workstream to request their ideas for increasing visibility of research opportunities for patients. • Link with the CRN:WE PCPIE workstream to facilitate the introduction/ increase the visibility of displays of research publicity materials in outpatients units and dialysis units • The primary focus in the first instance will be on North Bristol Trust (recruited to 16 renal led studies in 2014-15) and Gloucestershire Hospitals (3 renal led studies in 2014-15). Feedback on work implemented in these trusts will be used to influence design of materials for other trusts with open studies.
1.13	Stroke	Increase the proportion of NHS Trusts, providing acute Stroke care, recruiting to Stroke studies on the NIHR CRN Portfolio	Proportion of NHS Trusts, providing acute Stroke care, recruiting participants into Stroke studies on the NIHR CRN Portfolio	80%	• All Trusts with acute stroke care services contributed to stroke studies in 2014-15. Flag studies seeking sites to the trusts to maintain and grow the portfolio at the trusts and monitor resourcing for stroke studies. Maintain an active portfolio at all these sites. • Set up monthly teleconferences for staff (especially research nurses) supporting CRN Stroke studies across CRN: West of England to allow trouble shooting, problem solving, sharing intelligence on pipeline studies that maybe available to additional sites. • Work with R&D depts. to promote support for the stroke portfolio and to ensure its specific requirements (e.g. recruitment in the acute setting, recruitment of individuals who may not be able to provide consent for themselves) are understood and resourced appropriately. This will be measured through maintained / improved recruitment and take up of opportunities to be involved in new studies.
1.14	Surgery	Increase NHS participation in Surgery studies on the NIHR CRN Portfolio	Proportion of acute NHS Trusts recruiting patients into Surgery studies on the NIHR CRN Portfolio	85%	• In 2014-15 all six acute trusts recruited to surgery studies. For 2015-16 the aim will be to facilitate continued engagement and flag potential new studies to maintain the study pipeline.

GROUP 2: PORTFOLIO BALANCE
Delivering a balanced portfolio (across and within Specialties) that meets the needs of the local population and takes into account national Specialty priorities

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
2.1	Ageing	Increase access for patients to Ageing studies on the NIHR CRN Portfolio	Proportion of Ageing-led studies which are multicentre studies	50%	• Work with CRSL to promote research opportunities. • Develop Principal Investigators and local collaborators. • Collaborate with Dementia specialty leads to increase research opportunities. • Promote research opportunities through disease specific registers.
2.2	Cancer	Increase the number of cancer patients participating in studies, to support the national target of 20% cancer incidence	Number of LCRNs recruiting at or above the national target of 20%, or with an increase compared with 2014-15	15	• CRN: West of England forecasting 22% for 2014-15. Recruitment has been above national target for last 3 years. • Undertake robust forecasting exercise with all cancer trials teams across network for the 2015-16 year and monitor recruitment against this forecast through the year with SSLs, Divisional Lead and regular contact with teams. • Review cancer portfolio maps on NCRI website to horizon scan for new studies and disseminate to sub specialty leads for review. • Encourage more intra network working between cancer trials teams at EOI, set up and recruitment phases for commercial and non-commercial portfolio by providing a forum for 'shared portfolio' working to expand opportunities for patients and improve recruitment particularly to rare cancer studies. • Link with genetics, primary care and surgery specialties to raise awareness of cross cutting cancer studies and any resource issues.
2.3	Cancer	Increase the number of cancer patients participating in interventional trials, to support the national target of 7.5% cancer incidence	Number of LCRNs recruiting at or above the national target of 7.5%, or with an increase compared with 2014-15	15	• Forecasting 9.2% for 2014-15. Recruitment has been above the national target for the last 3 years. • Each SSG/SSL to hold a well balanced portfolio of studies across the network with regard to interventional and non-interventional studies with the ultimate aim of having a study to offer patients at each stage of the patient pathway e.g. screening, prevention, diagnostic, treatment etc.
2.4	Cancer	Deliver a Portfolio of studies including challenging trials in support of national priorities	Number of LCRNs recruiting into studies in: • Cancer Surgery • Radiotherapy • Rare cancers (cancers with incidence <6/100,000/year) • Children's Cancer & Leukaemia and Teenagers & Young Adults	15	• Identify cancer surgery studies on the national and local portfolio. SSL to discuss at SSG and encourage participation at appropriate locations. • Map radiotherapy service provision across the network. Link with radiotherapy specialist commissioning group. Appoint a radiotherapy SSL for the network. Include all relevant radiotherapy studies in all SSG discussions. • Support centres to open rare cancer studies where they are the main referral centre for the network and link in with national and international rare cancer initiatives. Provide business intelligence to enable partners to understand the importance and complexity of rare disease studies and the need for each network to maximise opportunities for patients by making these available. • Principal Treatment Centre (PTC) to continue to coordinate children's cancer research across the network. Network to continue to support essential non recruitment research activities at Paediatric Oncology Shared Care Units (POSCUs) by ensuring that these activities are resourced with the most efficient skill mix, that partners understand that recruitment at the PTC is on behalf of the whole network and that their activities contribute to that.
2.5	Cardiovascular Disease	Increase access for patients to Cardiovascular Disease studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into multi-centre studies in at least five of the six Cardiovascular Disease sub-specialties	15	• In 2014-15 the LCRN recruited to studies across all the subspecialties. In 2015-16 the balance of studies across the subspecialties will continue to be monitored, in order to maintain this position and to grow the portfolio, particularly in DGHs. • CRSL to develop links with clinical teams at each relevant Partner Organisation with one-to-one contacts, to promote take up of a growing portfolio of studies. In particular work with North Bristol Trust to support the growth of its portfolio of studies, increasing its number of open and recruiting studies from one in 2014-15 to at least 2-3 in 2015-16. • CRSL and RDM to build links with Cardiology and Cardiac Surgery research teams at UHBristol to support and as a minimum to maintain 2014-15 high levels of recruitment (666 recruits to Cardiovascular Disease managed studies). • Trial promotion of participation in cardiovascular research through social media in conjunction with the Communications team through (e.g. during

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					Heart Rhythm Week)
2.6	Diabetes	Increase support for areas of Diabetes research where traditionally it has been difficult to recruit	Number of LCRNs recruiting into diabetic foot studies on the NIHR CRN Portfolio	15	• Continue to recruit to diabetic foot studies, flagging opportunities to participate in appropriate new studies to teams and exploring potential for recruiting in additional settings.
2.7	Diabetes	Increase access for people with Type 1 Diabetes to participate in Diabetes studies on the NIHR CRN Portfolio early after their diagnosis	Number of LCRNs approaching people with Type 1 Diabetes to participate in interventional Diabetes studies on the NIHR CRN Portfolio within six months of their diagnosis	15	• Monitor progress of current industry study for newly diagnosed patients and provide support if required. • Encourage teams across the network to recruit to ADDRESS 2.
2.8	Gastroenterology	Increase the proportion of patients recruited into Gastroenterology studies on the NIHR CRN Portfolio	Number of participants (per 100,000 population), recruited into Gastroenterology studies on the NIHR CRN Portfolio	15	• CRSL to meet with key colleagues to determine where research activity can be expanded through adding studies to the portfolio /increasing recruitment to current portfolio.
2.9	Genetics	Increase access for patients with rare diseases to participate in Genetics studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into multi-centre Genetics studies through the NIHR UK Rare Genetic Disease Research Consortium	14	• Already recruiting into multi-centre genetics studies through the NIHR UK Rare Genetic Disease Research Consortium. • Work with Genetics CRSL to identify ways to increase access for patients to these studies, likely to include increased promotion via social media (detailed in communications plan)
2.10	Haematology	Increase access for patients to Haematology studies undertaken by each LCRN	Number of LCRNs recruiting into studies in at least three of the four following Haematology sub-specialties : Haemoglobinopathy, Thrombosis, Bleeding disorders, Transfusion	15	• Already recruiting into studies in at least 3 of the 4 subspecialties. Work with CDL and relevant R&D departments to ensure increased capacity to take on studies where appropriate.
2.11	Hepatology	Increase access for patients to Hepatology studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into a multi-centre study in all of the major Hepatology disease areas (including Viral Hepatitis, NAFLD, Autoimmune Liver Disease, Metabolic Liver Disease)	15	• Increase number of PIs recruiting to CRN: West of England hepatology studies, through horizon scanning and direct invitation from CRSL to take on new studies. Plan to scope service provision in the LCRN for NAFLD and approach service providers with potential studies. • Work with local researchers to develop cross referral in rare subsets • Link with paediatrics as necessary for Metabolic Liver Disease studies (although paediatric hepatology refers to Birmingham so possibilities maybe limited) • Increase recruitment and number of portfolio studies from the number in 2014-15 of 1 study at 3 sites, 3 studies at UHBristol. • Recruit to multi-centre studies in all the major hepatology disease areas for at least one site (depending on availability of portfolio studies). This will involve reviewing the current portfolio for gaps and then seeking out multicentre studies in the “missing” hepatology disease areas. The CRSL and RDM will then seek out clinical teams prepared to take on these studies and follow through to ensure timely set up of the studies within CRN: West of England. Identify potential new and ongoing studies that can be taken on at other sites, as they enter the portfolio, to broaden and grow the portfolio.
2.12	Infectious Diseases and Microbiology	Increase access for patients to Infectious Diseases and Microbiology studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into antimicrobial resistance research studies on the NIHR CRN Portfolio	15	• Continue to facilitate recruitment to antimicrobial resistance research studies.
2.13	Metabolic and Endocrine Disorders	Increase access for patients with rare diseases to participate in Metabolic and Endocrine Disorders studies on the NIHR CRN Portfolio	Number of LCRNs recruiting into established studies of rare diseases in Metabolic and Endocrine Disorders on the NIHR CRN Portfolio	15	• Identify clinical champions within each organisation with the appropriate clinical services, leading to a balanced portfolio with effective cross referral between organisations for rare subgroups. Leading to appointment of CSRL. • Increase the number of open and recruiting Metabolic & Endocrine led studies in the LCRN from 5 in 2014-15 to at least 6 in 2015-16 and increase recruitment to the metabolic & endocrine portfolio by at least 15% (n=29 in 2014-15), including the prioritisation and promotion of rare condition studies as available.
2.14	Oral and Dental	Increase access for patients and practitioners to Oral and Dental studies on the NIHR CRN Portfolio	A: Proportion of Oral and Dental studies on the NIHR CRN Portfolio recruiting from a primary care setting	20%	• Currently there is no recruitment activity into oral and dental studies in Primary Care. The RDM and CRSL will make contact with the community based oral and dental providers to scope research interest and readiness as well as identifying any training needs. There are currently 2 potential studies on the national portfolio that can be promoted. Aim for at least one Principal Investigator from the community dental services. We will achieve

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					this by: o working with study teams to promote primary care based providers as an additional source of recruitment o promoting portfolio studies in primary care using various media and forums o having a dedicated presentation slot for study promotion on the agenda at primary care annual event and inviting community dental service providers to this o using the CRSL and GP Champions to promote oral and dental research as well as identifying research champions from the community dental providers • Work with oral health and dentistry CRSL to identify and develop research opportunities in the locality. • Work with oral health and dentistry CRSL to identify and grow potential local collaborators and Principal Investigators and develop Chief Investigators. • Work closely with Bristol Dental school to facilitate potential new research development and delivery
			B Proportion of participants recruited from a primary care setting into Oral and Dental studies on the NIHR CRN Portfolio	30%	• Increase number of primary care organisations recruiting patients into oral and dental studies by 5-10%. We will achieve this by: • Expanding the Research Sites Initiative scheme to include community dental providers. Monthly identification of suitable studies on the portfolio by RDM and disseminate if new opportunities arise.
2.15	Primary Care	Increase access for patients to NIHR CRN Portfolio studies in a primary care setting	Proportion of NIHR CRN Portfolio studies delivered in primary care settings	15%	• CRN: West of England currently has the highest level of practice engagement, 226 out of 273 practices (83%) are engaged in research. This year we will maintain this high level of engagement through the RSI scheme. • Refresh the RSI scheme to ensure there is equity in research activity funding. • Increase number of practices working together as a collaborative by promoting this model as a way of working together to share resources in order to increase overall recruitment. • We will develop and implement an additional support structure in primary care (research support team) to increase capacity and provide direct research delivery support to practices to improve study set-up, delivery and recruitment. This resource will be a request service available to all RSI practices in CRN: West of England locality. The Research Support Team will: o develop the portfolio of NIHR research in primary care o complement the existing research workforce in primary care o assist with the setup, conduct and delivery of studies (especially more complex ones) o support less experienced practices to deliver research o champion clinical research in primary care • Promote research opportunities for practices through disease specific registers, starting with 'Join Dementia Research'. • Plan and develop support materials and implement 'ENRICH' project to engage with care homes to increase recruitment of residents to eligible studies. • Development of specific materials to support practices who are naïve to commercial research. • Highlight studies in secondary care that could be suitable for primary care
2.16	Renal Disorders	Increase NHS participation in Renal Disorders studies on the NIHR CRN Portfolio	A. Proportion of acute NHS Trusts recruiting into multi-centre Renal Disorders randomised controlled trials on the NIHR CRN Portfolio	30%	• Facilitate continued support across the four acute trusts already participating in these studies and promote new opportunities as appropriate and feasible
			B. Proportion of Renal Units recruiting into multi-centre Renal Disorders randomised controlled trials on the NIHR CRN Portfolio	80%	• RDM will continue to proactively support CIs in CRN: West of England regarding advice on research delivery and access to CRN support nationally (especially urology). • Through 1:1 engagement and liaison with R&D/ local CRN staff, CRSL/RDM

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					focus to expand portfolio at Gloucestershire Hospitals, which provides dialysis and investigations, from 2014-15 level (1 multicentre RCT, 9 participants) • Maintain / grow the currently limited portfolio at the other acute trusts in CRN: West of England with renal / urology services through flagging of new study opportunities in conjunction with R&D, with follow through to optimise take up. • Explore studies that span specialties to optimise cross-working. • CRSL to work closely with colleagues at the tertiary renal centre for CRN:WE, North Bristol NHS Trust, to improve the take up of new multicentre randomised controlled trial (RCTs) within the unit thereby significantly increasing both recruitment and the number of active studies from 2014-15 levels (5 multicentre renal /urology RCTs with 65 recruits at North Bristol Trust).
2.17	Respiratory Disorders	Increase access for patients to Respiratory Disorders studies on the NIHR CRN Portfolio	Number of LCRNs recruiting participants into NIHR CRN Portfolio studies in the Respiratory Disorders main disease areas of Asthma, COPD or Bronchiectasis	15	• RDM and CRSL to agree detailed priorities for 2015-16 (meeting arranged for 22/6/2015), which will be shared with the Coordinating Centre. • Build links with more recently appointed consultants to facilitate broadening of local portfolio. • Build on current levels of engagement through enhanced communications (e.g. newsletter, face to face meetings) and through identification of respiratory research leads in key trusts.
2.18	Stroke	Increase the proportion of patients recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	Number of patients (per 100,000 population) recruited into Stroke randomised controlled trials on the NIHR CRN Portfolio	8	• Appoint a stroke clinical research specialty lead to work with the RDM to encourage take up and delivery of stroke RCTs • Set up teleconferences for staff delivering CRN portfolio stroke studies to promote sharing of best practice and joint problem solving to optimise recruitment
2.19	Stroke	Increase activity in NIHR CRN Hyperacute Stroke Research Centres (HSRCs)	A: Number of patients recruited to Hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN HSRC	50	• No Hyperacute Stroke Research Centre (HSRC) in CRN: West of England. However CRN: West of England will encourage continued recruitment to studies on the HSRC portfolio (e.g. TICH 2, and there is potentially interest in STABILISE at one Trust) where this is feasible without the full facilities of an HSRC in place.
			B: Number of patients recruited to complex Hyperacute Stroke studies on the NIHR CRN Portfolio in each NIHR CRN HSRC	15	• As in 2.19 A above, but less likely to be feasible for these complex studies

GROUP 3: RESEARCH INFRASTRUCTURE
Developing research infrastructure (including staff capacity) in the NHS to support clinical research

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
3.1	Cancer	Establish local clinical leadership and a defined portfolio across the cancer sub-specialty areas	Number of LCRNs with, for each of the 13 Cancer sub-specialties, a named lead and a defined portfolio of available studies	15	• All SSLs in place by May 2015. SSL are also SSG research leads. Divisional lead and RDM to meet for formal review annually with each SSL. RDM to support SSLs to publish updated study portfolio monthly and make available on website/newsletter and to inform twice yearly SSG research reports.
3.2	Anaesthesia, Perioperative Medicine and Pain Management	Establish links with the Royal College of Anaesthetists' Specialist Registrar networks to support recruitment into NIHR CRN Portfolio studies	Number of LCRNs where Specialist Registrar networks are recruiting into NIHR CRN Portfolio studies	4	• Dr Ronelle Mouton is both the CRN: West of England Specialty Lead and Consultant Supervisor for the Severn Trainees Anaesthetic Research Group (STAR). The LCRN will build its links with STAR through Dr Mouton's membership of the STAR executive which meets quarterly. For each study STAR takes on an overall trainee lead and consultant lead, and there is a consultant and trainee lead for each of the participating hospitals. This worked well for SNAP and ISOS and is a model that will continue to be used going forward. The plan is to continue and further increase participation in portfolio studies through STAR in 2015-16. • Monitor the portfolio to suggest new studies for CRN: West of England sites,

ID	Specialty	Objective	Measure	Target	LCRN activities and initiatives to contribute to achievement of objective(s)
					particularly those suitable for STAR to assist with, to build on the success in 2014-15 of ISOS (446 recruits from 6 sites) & the National Survey of Patient Reported Outcome after Anaesthesia (569 recruits across 6 sites). • STAR plans a joint project with SWARM, the Peninsula trainee network and has representation on RAFT, the national network. • Work in conjunction with CRN: SW Peninsula to develop links with the Society of Anaesthetists of the South Western Region to promote recruitment to portfolio studies. • Map current joint working on portfolio studies and portfolio development between this specialty and others where there are synergistic links to enhance recruitment opportunities (e.g. critical care and surgery) The critical care lead and this specialty lead, outside of their CRN: West of England roles, are jointly preparing grant proposals for future portfolio studies. • Collate intelligence on the pipeline of studies in development locally, to provide early support. • Seek appropriate areas for collaboration with the Bristol Health Partners Pain Health Integration Team (http://www.bristolhealthpartners.org.uk/health-integration-teams/integrated-pain-management-hit/)
3.3	Dementias and Neurodegeneration (DeNDRoN)	Optimise the use of "Join Dementia Research" to support recruitment into DeNDRoN studies on the NIHR CRN Portfolio	The proportion of people identified for DeNDRoN studies on the NIHR CRN Portfolio via "Join Dementia Research"	3%	• Continued support of JDR Project Officer within CRN WE to ensure full roll out of JDR across all settings including primary care. Aim to ensure all patients on existing dementia registers and all those with a new diagnosis are informed of JDR. • Support to local researchers to ensure JDR can be used a recruitment tool where Lead site is agreeable in appropriate studies.
3.4	Dementias and Neurodegeneration (DeNDRoN)	Increase the global and psychometric rating skills and capacity of LCRN staff supporting DeNDRoN studies on the NIHR CRN Portfolio	Proportion of LCRN staff who support DeNDRoN studies who have successfully completed Rater Programme Induction and joined the national Rater database	40%	• Work with relevant R&D departments to ensure that staff have access to training and opportunity to ensure Raters have opportunities to use ratings to remain eligible for database.
3.5	Infectious Diseases and Microbiology	Maintain research preparedness to respond to an urgent public health outbreak	Number of LCRNs maintaining a named Public Health Champion	15	Dr Peter Muir, Consultant Clinical Scientist & Head of Virology, Public Health Laboratory Bristol, Public Health England. Peter.Muir@phe.gov.uk • Continue to refine Urgent Public Health Plan collaboratively with R&D departments. • Maintain up to date list of sleeping studies on the local portfolio for review and assessment of any forward planning that would facilitate delivery when the studies are activated.
3.6	Mental Health	Maintain and enhance the skills and capacity of staff supporting Mental Health studies on the NIHR CRN Portfolio in frequently used Mental Health study eligibility assessments (e.g. PANSS, MADRS, MCCB)	Number of staff trained in frequently used Mental Health study eligibility assessments	139	• Work with relevant R&D departments and CRSLs to ensure that staff have access to training and opportunity to ensure Raters have opportunities to use ratings to remain eligible for database. Support arrangements of localised training if appropriate.
3.7	Neurological Disorders	Increase clinical leadership capacity and engagement in each of the main disease areas in the Neurological Disorders (MS; Epilepsy and Infections) Specialty	Number of LCRNs with named local clinical leads in MS; Epilepsy and Infections	15	• Continue to work with CDL to identify and appoint an appropriate CRSL in Neurological Disorders. • Work with Neurological Disorders CRSL (and in the interim CDL) and Consultant nurse to identify appropriate individuals to support clinical leadership and engagement in the main disease areas in the specialty.
3.8	Reproductive Health and Childbirth	Increase engagement and awareness of the Reproductive Health and Childbirth Specialty	Number of LCRNs with a named midwifery lead to increase engagement and awareness	15	• Named midwifery leads in place. Co-CRSL is a midwife. Ensure continued support to increase engagement and awareness. • A locally developed study IMOX is good potential vehicle through which to establish collaborative ways of working and raise the profile locally.

Table 3. LCRN plans against the Operating Framework 2015-16

POF Area	Operating Framework requirement	Operating Framework Reference	Information required	Planned LCRN actions/activities for 2015-16 or other requested information	Milestones & outcomes once complete	Timescale
LCRN Governance	The Host organisation shall develop and maintain an assurance framework including a risk management system	3.12	Assurance that a framework and system are in place to be provided by the Host organisation nominated Executive Director's signature on Annual Plan coversheet and submission of a copy of the latest version of the LCRN's risk register as Appendix 1 to the Annual Plan	N/A. In place. CRN team to be trained in RiskWeb - the online system used by the host to replace the attached written risk register – this will allow for automatic escalation of issues as agreed with the host.	N/A	N/A
	The Host organisation will ensure that robust and tested local business continuity arrangements are in place for the LCRN. This is to enable the Host organisation to respond to a disruptive incident, including a public health outbreak, e.g. pandemic or other related event, maintain the delivery of critical activities / services and to return to 'business as usual'. Business continuity arrangements should be in line with guidance set out by the national CRN Coordinating Centre.	3.14	Assurance that robust and tested local business continuity arrangements are in place for the LCRN to be provided by the Host organisation nominated Executive Director's signature on Annual Plan coversheet	N/A In place	N/A	N/A
	The Host organisation must ensure that appropriate arrangements are in place to support the rapid delivery of urgent public health research, which may be in a pandemic or related situation. It shall ensure that the LCRN has an Urgent Public Health Research Plan which can be immediately activated in the event that the Department of Health requests expedited urgent public health research. The Host must also appoint an active clinical investigator as the LCRN's Public Health Champion to act as the key link between the LCRN and the national CRN Coordinating Centre and support the Urgent Public Health Research Plan in the event of it being activated.	3.15	Assurance that the LCRN has an Urgent Public Health Research Plan in place to be provided by the Host organisation nominated Executive Director's signature on Annual Plan coversheet	Existing plan to be activated upon request.	As per plan	Not known
			Confirm name and contact details of LCRN's Public Health Champion against Specialty objective 3.5	Provided via completion of Table 2.	N/A	N/A
	The Host organisation must ensure that LCRN activity is included in the local internal audit programme of work	3.17	Date of planned audit or anticipated timescale if exact date not yet known	Audit commissioned from host Trust internal audit team. Scope followed guidance suggested.	Report to be released.	April 2015
Research Delivery	The Host organisation shall ensure that all LCRN organisations adhere to national systems, Standard Operating Procedures and operating manuals in respect of research delivery as specified by the national CRN Coordinating Centre. The Host organisation shall ensure that the LCRN management team provides excellent study performance management, in line with the standards and guidance issued by the national CRN Coordinating Centre, in order to ensure that all NIHR CRN Portfolio studies recruit to agreed timelines and targets.	6.1-6.20	Provide confirmation that the LCRN has a link person for the CRN Study Support Service programme and describe how information is cascaded to relevant colleagues	Link person is: Mary Griffin, Research Delivery Manager. • Information is cascaded by email, via OMG and ad-hoc communications to the LCRN central team, R&D Managers in Partner and Member Organisations in the locality. CRN: West of England is a devolved network. The OMG is therefore a highly collaborative forum that meets face to face monthly. Weekly performance management of all studies with actions if not to time and target. • Feasibility advice and support and site identification is provided by Research Delivery Managers. • Use of Coordinated System for gaining NHS Permissions continues in accordance with CRN processes and guidance. • Provision of arrangements to enable NHS and non-NHS staff to conduct research activities across the locality and NHS. • Work with partner and member organisations to identify areas of non-compliance. • Report and discuss area of concern at OMG to find solutions.	LCRN adheres to adhere to national systems, Standard Operating Procedures and operating manuals in respect of research delivery and all NIHR CRN Portfolio studies recruit to agreed timelines and targets.	March 2016
			Provide a brief outline (1-2 paragraphs) of the LCRN's plans for implementation and delivery of the Study Support Service	Work with the HRA Approval Change Lead South West (based in one of our partner organisations and a member of our OMG): • define what functions HRA will support • scope partner organisations to assess capacity and capability	Responsibilities of the LCRN are met and there is a consistent approach to research	December 2015

				• ensure the LCRN workforce is supported and trained to transition to focussing from research governance to research management • ensure all LCRN responsibilities are met • keep up to date with SSS progress via working group teleconferences and communications • continue scoping current SSS provision alongside preparation for HRA readiness • implement central SSS initiatives as they develop from CRN SSS working group and pilot • Measure impact on performance	support and delivery.	
			Provide a summary of expertise and skills that you have available locally to support implementation of AcoRD including the number of individuals able to provide advice on the attribution of activities in line with the Attributing the costs of health and social care Research & Development (AcoRD) guidance[1] and a description of the model(s) the LCRN has used to date in providing advice	• Our devolved model means there are multiple staff that are able to provide advice across our partner organisations. In the LCRN, the named individuals are Chantal Sunter, Research Delivery Manager and Mary Griffin, Research Delivery Manager. Advice is provided by email or by telephone as required.	N/A	N/A
	The Host organisation will ensure that all LCRN Partner organisations adopt NIHR CRN research management and governance operational procedures. The Host organisation will ensure that quality, consistency and customer service are central to the LCRN's purpose in the implementation, delivery and oversight of NIHR CRN research management and governance services.		Provide a brief outline of local plans for supporting CSP BAU activities within local delivery structures in accordance with POF, and noting clauses 5.28 & 5.29 when planning RM&G local delivery structures	• Our devolved model means there are multiple staff proficient at CSP and RM&G activities across the locality. This means we can rely on partner organisations to support CSP functions if necessary. • We will continue to provide training and support to LCRN staff and performance manage the CSP metrics to maintain HLO 4. • We will continue to provide a single point of contact for CSP BAU within LCRN central office. • As a central team at LCRN, we will liaise with partner and member organisations to ensure there is sufficient expertise whilst CSP is being decommissioned. • We will get agreement from Partnership Group and Operational Management Group to adhere to the agreed plan and timescales and provide peer to peer support if necessary. • We will use knowledge and expertise from HRA Approval Change Lead South West (based in one of our partner organisations and a member of our OMG) to inform local plans and build resilience.	Impact on RM&G activities is minimised and CSP BAU continues.	December 2015
	The Industry Operations Manager will work closely with the Chief Operating Officer to establish and enable the implementation of the NIHR CRN Industry Strategy within the LCRN. The Industry Operations Manager will establish and lead the cross-divisional Industry function, including the single point of contact service, within the LCRN. The Industry Operations Manager will work closely with each Divisional Research Delivery Manager across all research divisions to ensure consistency of feasibility, study delivery and coordination across all divisions within the LCRN. The Industry Operations Manager will be responsible for the promotion of the Industry agenda to LCRN Partner organisations and investigators, delivering aspects of a national NIHR CRN Industry Strategy within the LCRN.	6.21	Provide an outline for the performance management of the provision of local feasibility information (site intelligence and site identification) for commercial contract studies. To include action plans for improvement in performance[2].	The role and functions of the Industry Operations Manager is shared between the Industry Manager and RDMs who together form the industry team. We run a devolved network and as such the Iidustry team and dedicated industry contacts within the R&D departments work together with the clinical teams to manage study delivery and ensure robust feasibility is carried out. The RDMs support delivery of the commercial portfolio alongside the non-commercial portfolio. We have an industry strategy/plan in place for 2015/16 which details how we will deliver on the High Level Objectives relating to Industry. A single point of contact (SPOC) service is run by the industry team and provides full time cover of the mailbox dedicated to industry related queries and correspondence. The industry team will lead the promotion of the industry agenda by ensuring it is highlighted at internal and external events, such as our annual conference where we will have a stand to promote the benefits of collaborating with industry. The wider LCRN team also play a part in advocating the industry agenda whenever appropriate. The provision of local feasibility information is overseen by the LCRN industry team, with new studies across all divisions being	The industry agenda has been promoted whenever possible and our partners are aware of the importance and benefits of collaborating with industry. We have a fully operational system for carrying out the local feasibility service which is consistent across all divisions. Robust feasibility is carried out and informative site identification & intelligence data is provided to commercial companies upon request.	March 2016

[1] Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351182/AcoRD_Guidance_for_publication_May_2012.pdf
[2] Information on recent performance provided by national CRN Coordinating Centre on 30/01/15

				disseminated and collated via specialty specific tailored pathways by the SPOC. Robust feasibility is conducted by the clinical team and R&D department and performance data is either provided by the trust or obtained from the NIHR CRN RAG report. Impending deadlines for site identification or intelligence services are monitored via the Industry SIF Tracker Database and overdue services are flagged as red until complete. An update is emailed to the co-ordinating centre if a service is likely to miss the deadline, and an anticipated completion date provided. On a monthly basis, the industry team will review performance against the service deadlines for site intelligence and identify teams/trusts that are consistently missing the deadline. Updates on the flow of commercial feasibility requests and individual site responses are provided regularly to the RDMs for information. The OMG is also provided with data on the feasibility activity taking place across all Partner Organisations and specialties, including reasons for declining study participation. A log is kept of all submissions of feasibility in our LCRN and the number that lead to site selection, in order to provide a basis for improving our conversion rate. The industry team liaises with sponsor and R&D departments where necessary to resolve issues with study set-up of commercial studies and advise on use of the NIHR costing template. The industry team produce localised site level RAG reports for commercial studies on a monthly basis, which are distributed to Partner Organisations and the RDMs. Monthly meetings will be held between the RDMs and Industry Team to review performance and address any studies that require escalation. The industry team or RDM as appropriate attends national teleconferences to discuss study performance wherever necessary, works with the national industry team and RDMs to gather feedback on studies falling behind, and shares best practice on succeeding studies.	Performance against feasibility service timelines is reviewed monthly and issues escalated. Monthly reports provided to RDMs. Quarterly reports for OMG. Conversion rate is reviewed by Industry Team and RDMs on a quarterly basis. Reports distributed and discussions held monthly. Teleconference attended/ study feedback gathered as required	
			Provide details of local strategies for achieving LCRN wide usage and adoption by Host and Partner organisations of the NIHR CRN costing template	• Agreement from Partnership Group to adhere to the use of the costing template • Agreement from OMG to adhere to the use of the costing template • Distribute guidance to all R&D Managers in Partner Organisations • Promote use of template using various media	NIHR CRN Costing template adopted LCRN wide.	March 2016
Delivering on the Government Research Priority of Dementia	The Host organisation will ensure the LCRN supports this strategy by: Identifying and nominating clinical Research Leads in each of these disease areas (dementias, Parkinson's disease, Huntington's disease and motor neurone disease) to support the delivery of the Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio through local clinical leadership and participation in national activities, including national feasibility review	7.1-7.7	Please provide names and contact details for identified clinical Research Leads for each of these disease areas	Dementias:	Professor Roy Jones r.w.jones@bath.ac.uk 01225 476 420	
				Parkinson's disease:	Tarun Kuruvilla Tarun.kuruvilla@glos.nhs.uk 01242 634 460	
				Huntington's disease:	Tarun Kuruvilla Tarun.kuruvilla@glos.nhs.uk 01242 634 460	
				Motor neurone disease:	Tarun Kuruvilla Tarun.kuruvilla@glos.nhs.uk 01242 634 460	
Patient and Public Involvement and Engagement (PPIE)	The Host organisation will support the development and implementation of the NIHR CRN Strategy for PPIE and deliver a work plan with measurable targets for ensuring that patient choice, equality and diversity, experience, leadership and	8.1-8.6	Provide a comprehensive patient and public involvement and engagement plan in line with agreed format and guidance	Provide via completion of Table 4		

	involvement are integral to all aspects of LCRN activity, in partnership across NIHR CRN.					
	The Host organisation must identify a senior leader to take responsibility for Patient and Public Involvement and Engagement (PPIE) within the LCRN. The identified lead will participate in nationally agreed PPIE initiatives and support the delivery of an integrated approach to PPIE across the NIHR CRN.		Provide the name and contact details for the senior leader with identified responsibility for patient and public involvement and engagement	Chantal Sunter Research Delivery Manager and Lead for Communications, Engagement and PPIE Chantal.Sunter@nihr.ac.uk 0117 342 1292	N/A	N/A
Continuous Improvement (CI)	The Host organisation will promote and sustain a culture of innovation and continuous improvement across all areas of LCRN activity to optimise performance	9.1-9.6	Provide an assessment of the LCRN's current position in relation to Continuous Improvement	Two RDMs recently started training in Lean Six Sigma. COO already trained. Adopting continuous improvement as business as usual. We are in the process of delivering two improvement projects through the Lean Six Sigma training, in business intelligence and industry in primary care. They will be completed in June 2015. One R&D manager in a local partner has also recently completed training and keen to work with the CRN to further embed the culture of continuous improvement.	N/A	N/A
			Provide an action plan for promoting and sustaining a culture of innovation and continuous improvement across all areas of LCRN activity, including the LCRN's approach to developing capacity and capability of the LCRN workforce (the latter to be evidenced in the LCRN's submitted workforce development plan)	Provide via completion of Table 5		
			Provide details of continuous improvement projects to be delivered locally in 2015-16 (via CRN Central)	All planned projects have been uploaded to CRN central following approval by our Continuous Improvement lead, Mary Griffin, 0117 342 1289 mary.griffin@nihr.ac.uk		
Workforce, Learning and Organisational Development	The Host organisation will develop a workforce plan for LCRN staff that will enable a responsive and flexible workforce to deliver NIHR CRN Portfolio studies. This will be developed in partnership with Local Education and Training Boards (LETBs) and other stakeholders and other local learning providers, including Academic Health Science Networks (AHSNs)	10.1-10.10	Provide a workforce plan in line with agreed format and guidance	Provided via completion of Table 6		
			Provide the name and contact details for the senior leader with identified responsibility for LCRN workforce development	Maxine Taylor Senior Research Delivery Manager and Lead for Workforce Development Maxine.taylor@nihr.ac.uk Tel: 0117 342 1811	N/A	N/A
Information Systems	The Host organisation must ensure that appropriate, reliable and well maintained information systems and services are in place and fully operational as specified	13.1-13.19	Confirm LPMS systems are live and operational as required	Yes. Migration of complete 2014-15 recruitment data to EDGE on track. Host and all partner organisations have access to EDGE.	N/A	N/A
			Confirm arrangements are in place for provision of an LCRN Service Desk function and provide contact details	Yes. This is provided by the Business Intelligence team. BIU.WestEngland@nihr.ac.uk	N/A	N/A
			Provide the name and contact details of the identified lead for the Business Intelligence function	Mike Lacey, 0117 342 1370; mike.lacey@nihr.ac.uk	N/A	N/A
Engagement and Communication	It is the responsibility of the Host organisation to ensure that there is a specialist, experienced and dedicated communications function to support the work of the LCRN, with a sufficient budget line. The Host organisation will support the development and implementation of the NIHR CRN Strategy for Communications and ensure that the LCRN communications function develops and delivers a local communications delivery plan that recognises the LCRN's position as part of a national system. The plan should also encompass local delivery of national NIHR/NIHR CRN campaigns.	14.1	Describe the dedicated communications function the LCRN has in place	Chantal Sunter is the Lead for Communications, Event, and PPIE. There is a dedicated Band 5 communications, events and PPIE officer. We also receive support from the host communications department.	N/A	N/A
		14.2	Outline up to 5 priorities/priority activities contained in the LCRN's local communications delivery plan	1) Fully functioning website to support the clinical research community with their engagement with CRN: West of England.	1a) Website fully developed and functioning b) Up to date	a) Q1 2015/16 b) Ongoing
				2) Development and implementation of social media workstream to link with PPIE and delivery activities.	2a) Identification of key social media platforms appropriate to CRN WE b) Development & testing of those platforms c) Launch and active use of those platforms	a) Q1/Q2 2015/16 b) Q3 2015/16 c) Q4 2015/16

				3) Production of a newsletter every two months.	3) Bimonthly newsletter produced	Bimonthly
				4) Organisation of specialty specific engagement and other events to increase collaboration and engagement with clinical research within the region. Support of national NIHR campaigns locally as appropriate	4a) Clinical Specialty Lead engagement event b)International Clinical Trials Day c) Tri network conference d) Primary Care Event e) Other events ongoing as required	a) May b) May c) October d) Spring e) ongoing
		14.3	Budget line identified in Annual Financial Plan for 2015-16	N/A	N/A	N/A
Information Governance	Actively promote and enable good information governance relating to all areas of LCRN activity	15.2	Provide the Information Governance Toolkit 2013-14 (version 11)[3] score for the LCRN Host organisation and confirmation of attainment of Level 2 or above on all, or any exceptions which arise from or impact on LCRN-funded activities	2		
		15.5	Provide a copy of the LCRN's documented process for reporting information governance incidents arising from LCRN-funded activities to the national CRN Coordinating Centre	Submitted as Appendix 2		
		15.8	Provide the name, email address and contact number(s) for the individual with specialist knowledge of information governance identified to respond to queries raised relating to LCRN-funded activities	Maxwell Allen, Information Governance Officer maxwell.allen@uhbristol.nhs.uk 0117 342 3701	N/A	N/A
		15.9	Provide details of information systems utilised in LCRN activities and assurance/evidence that these are in line and comply with the 2013 NIHR Information Strategy[4]	• EDGE Local Portfolio Management System (meets the LPMS System of Choice Framework Requirements) • NIHR CRN Hub (Google platform) is used for email, calendar, file storage, website	N/A	N/A

[3] https://www.igt.hscic.gov.uk/
[4] https://docs.google.com/a/nihr.ac.uk/file/d/0B6w0JTB5jHBSSldZT0Qyc05lVms/edit?usp=drive_web

Table 4. LCRN Patient and Public Involvement and Engagement Plan 2015-16

Planned actions in 2015-16	Milestones and outcomes once actions complete	Timescale	Lead
1 The Host organisation has a duty to promote research opportunities, in line with the NHS Constitution for England, including informing patients about research that is being conducted within each LCRN, and actively involving and engaging patients, carers and the public in research.	**MILESTONES** 1. The CRN PPIE Lead is an active member and supporter of the joint PPIE initiative - People in Health West of England (PHWE), bringing together CLAHRC West, WEAHSN, Bristol Health Partners, Healthwatch and others.	April 1st 2015	PPIE Lead
	2. Regular meetings are held with public contributors to plan PPIE priorities for the future	On-going	PPIE Lead & COO
	3. Workshops held with CLAHRC West to help members of the public develop their research ideas and become more research aware	Autumn 2015	PPIE Lead & PHWE
	4. A joint approach is developed with CLAHRC West to encourage participation in research (CRN - Everyone Included; CRN & WEAHSN – Join Dementia Research, CLAHRC – Reach West).	July 2015	PPIE Lead & CLAHRC West
	5. Different methods of social media are in place to keep patients/carers and public informed of opportunities for involvement and participation	Ongoing	PPIE Lead & Comms Lead
	6. CRN WE is active in the Partner's Communications Network, linking in websites and liaising over joint messages	Ongoing	PPIE Lead & Comms Lead
	7. Patient stories collected and campaign promoted across the network	Dec 2015	Comms Lead
	8. Participate in PHWE Away day to review progress and future priorities	Dec 2015	PPIE Lead & PHWE
	9. Bank of PPIE tools and resources developed and shared across the network	Sept 2015	PPIE Lead & PHWE
	10. Appointment of additional Join Dementia Research Patient Champions to support the roll out of Join Dementia Research across CRN WE	Ongoing	PPIE Lead & PHWE

	OUTCOMES 1. Increased recognition of CRN WE as a best practice provider of high quality clinical research support to the NHS 2. Increase in demand for and participation in portfolio research studies by members of the public 3. Increase in demand for materials review service and PPIE tools 4. Greater contribution from CRN WE's public contributors 5. Public and staff have increased awareness of value of taking part in a research study		
2 The Host organisation will establish and deliver a work plan with measurable targets for ensuring patient choice, equality and diversity, experience, leadership	**MILESTONES** 1. Develop PPIE plans with all portfolio research leads and embed into overall CRN WE strategy 2. Work with PHWE to put in place a plan to address the lack of diversity in applied health research 3. Promote PHWE learning & development opportunities 4. Support national campaigns such as OK to ASK and Breaking Boundaries 5. Support International Clinical Trials day **OUTCOMES** • Greater clarity amongst portfolio research leads on embedding PPIE at all levels of the work • Greater awareness of how to address the lack of diversity in research • Demography of research participants more diverse and	Sept 2015 Dec 2015 On-going On-going April 2015	PPIE Lead PPIE Lead/ PHWE Comms Lead/ PHWE PPIE Lead/ PHWE Comms/ PPIE Leads

	research topics more reflective of equalities communities. • PPIE becomes embedded into job roles as a core activity - is everyone's business and responsibility.		
3 The Host organisation will ensure that the Host organisation and LCRN Partners actively engage and involve patients, carers and the wider public in all aspects of LCRN activity to improve the quality and delivery of NIHR CRN Portfolio research	**MILESTONES** 1. Two Public Contributors have been selected and contribute to CRN WE Board and long term planning processes 2. A plan is in place to embed PPIE in all the CRN portfolio research 3. Involvement is encouraged through widening participation in the Materials Review project – new members of the public selected and trained 4. Patient / carer case studies and stories are gathered, collated and analysed on an on-going basis and then utilised within communication activities wherever possible 5. Constructively use findings for performance improvement **OUTCOMES** • The quality of research proposals are improved at all stages – from pre-ethics to completion • A culture of working collaboratively is developed and strengthened by supporting involvement and engagement opportunities with key stakeholders	April 2015 July 2015 July 2015 On-going On-going	PHWE PPIE Lead/ CRN WE Staff PPIE Lead/ PHWE Comms Lead PPIE Lead/ CEO
4 The Host organisation will gather feedback from participants in NIHR CRN Portfolio studies as well as patients, carers and the public, directly involved in supporting delivery of NIHR CRN Portfolio studies, by undertaking annual surveys, as required by	**MILESTONES** 1. Use case studies/patient stories to assess the impact of patients, carers and the public who are actively involved in supporting the delivery of NIHR portfolio studies. 2. Carry out exit questionnaire for all patients/ public taking	Oct 2015	PPIE Lead/Comms Lead

the national CRN Coordinating Centre. NIHR CRN Performance & Operating Framework	part in CRN portfolio research **OUTCOMES** Feedback from patients/carers/ public contributors continuously informs the network to improve systems/process/training	Nov 2015	PPIE Lead/ PHWE
5 The Host organisation will collate numbers of actively involved patients, carers and the public accessing NIHR CRN learning and development resources, as specified by the national CRN Coordinating Centre	**MILESTONE** 1. Attendance at PHWE learning & development training events are monitored and feedback provided to the PHWE Strategy Group **OUTCOMES** Learning & development programme and materials continuously updated based on evaluations from completion of programmes	On-going	PHWE
6 The Host organisation must identify a senior leader to take responsibility for Patient, Public Involvement and Engagement (PPIE) within the LCRN. The identified lead will participate in nationally agreed PPIE initiatives and support the delivery of an integrated approach to PPIE across the NIHR CRN	**MILESTONES** 1. PPIE Lead appointed and working closely with public contributors and PHWE 2. Regular reports provided by PPIE Lead to Performance meetings , Partnership group , Operational groups on a regular basis on national and local initiatives 3. The Partners Communications Network meets quarterly and includes PPIE and Comms Leads supporting involvement and engagement opportunities with key stakeholders 4. PPIE Lead attends national PPIE Leads meetings on a regular basis to ensure CRN WE representation at a national level and engagement with relevant nationally led initiatives	April 2015 Sept 2015 Ongoing Ongoing	PPIE Lead PPIE Lead PPIE Lead PPIE Lead

Table 5. LCRN Continuous Improvement Action Plan 2015-16

Planned actions in 2015-16	Milestones and outcomes once actions complete	Timescale	Lead
Improving processes for routine and ad hoc business intelligence reporting • Define problem and agree scope • Collect and measure data to understand current state • Analyse data to verify causes affecting inputs and outputs • Learn from project and implement improvements • Complete project work and hand over improved process with procedures for maintaining the gains.	Identified streamlined processes for effectively managing both routine and ad hoc reporting.	Completion by June 2015	Ruth Allen
• Improving the number of primary care organisations delivering commercial research • Define problem and agree scope • Collect and measure data to understand current state • Analyse data to verify causes affecting inputs and outputs • Learn from project and implement improvements • Complete project work and hand over improved process with procedures for maintaining the gains.	Identified real and perceived barriers to delivering commercial research in primary care. Resources/toolkit produced for primary care to address barriers.	Completion by June 2015	Mary Griffin
Creating a Lean culture in CRN: West of England • Agree scope with support team • Share and agree priorities and best practice • Identify inputs and outputs required • Develop support materials • Implement new standards • Evaluate efficiency and effectiveness	Best practice ways of working agreed. Support materials agreed and developed. Quality standards set. Standardised ways of working created. Increased efficiency in working practices and outputs. Culture of continuous improvement embedded in the team. Streamlined, efficient and high quality service delivered.	Best practice agreements completed by August 2015. Support materials developed by October 2015. New measures implemented and evaluated by March 2016.	Mary Griffin

Senior Team Development • Agree scope of development • Collect data to understand strengths of existing team • Analyse strengths of team and how to maximise performance Learn from development and use it to inform ways of working • Complete initial development process, sustain strong senior management team and develop ways to enhance team performance based on new knowledge	Learning and practitioner needs analysis performed. Development days held for Senior Management. Focussed on becoming a high performing team. Enhanced and sustained Senior Management team performance.	Development begins March 2015 and then ongoing. Senior Management away days completed by July 2015	Mary Perkins

Table 6. LCRN Workforce Development Plan 2015-16

Planned actions in 2015-16	Milestones and outcomes once actions complete	Timescale	Lead
Roll out of 'Let's talk Trials' communications training • Train the trainer (2 cohorts) • Programme available • Evaluate • Facilitators supported	First cohort of volunteer trainers complete the train the trainer exercise and are signed off as competent to deliver the course. Second cohort signed off as competent to deliver. Training programme available to workforce.	May 2015 Aug/Sept 2015 May 2015	Maxine Taylor
Roll out of Fundamentals of Research training • Programme available • Evaluate • Facilitators support	Programme finalised for two-three courses through the year at sites around network.	June/July 2015	Maxine Taylor
Establish CRN – WE facilitators staff group to support all of the network's training facilitators	Establish google group. Support meetings planned for biannually. Each course to have a lead facilitator with national engagement where required - GCP, Consent, TTT, FOR, RATER etc. Content review panels as required.	April 2015	Maxine Taylor
Training needs analysis of the whole research workforce	Survey circulated. Responses collated. Use to inform training and education programme for next two years. Use to provide ad hoc training as required e.g. dry ice. Use to signpost workforce to online learning opportunities.	June 2015 August 2015	Maxine Taylor
Coordinate workshops on: • 'how to undertake robust study feasibility' • 'portfolio balance'	Planning groups established through OMG. Stand-alone events or workshops within larger event e.g. network annual event.	May 2015	Maxine Taylor

• 'research team skill mix'			
Coordinate network support team training and development	Twice a year away day. Programme of team training at monthly meetings. Research awareness sessions. Staff to link personal objectives to local and national objectives.	September 2015 and March 2016	Maxine Taylor
Develop research apprenticeship	Agree job description and person specification through Senior Research professionals group, HR and OMG. Business case to LCRN Executive Management Group Roll out to partner organisations who wish to pursue. Consider role within network support team.	May June	Maxine Taylor
Implementation of a flexible Nursing Cohort for Primary Care.	Operational Planning meeting with Divisional Lead and RDM primary care. Executive Management Group sign off project. Advertisement of posts. Appointment to posts.	17 March 2015 30 March 2015 May 2015 June 2015	Sue Taylor
Professional Development day for nurses and allied health professionals	Workshop delivered regarding revalidation for nursing. Standards and quality workshop all research active non-medical professionals.	2 June 2015	Sue Taylor
Redeployment Plan for clinical research workforce.	To agree a regional/local redeployment plan during clinical pressures with the Senior Research Professionals Strategic Leadership group.	May 2015	Sue Taylor
Continued development of non- medical PIs	Senior Research Professionals Strategic Leadership group will continue to explore opportunities to engage and develop non-medic PIs across the region, specifically for priority areas (division 2).	Ongoing	Sue Taylor

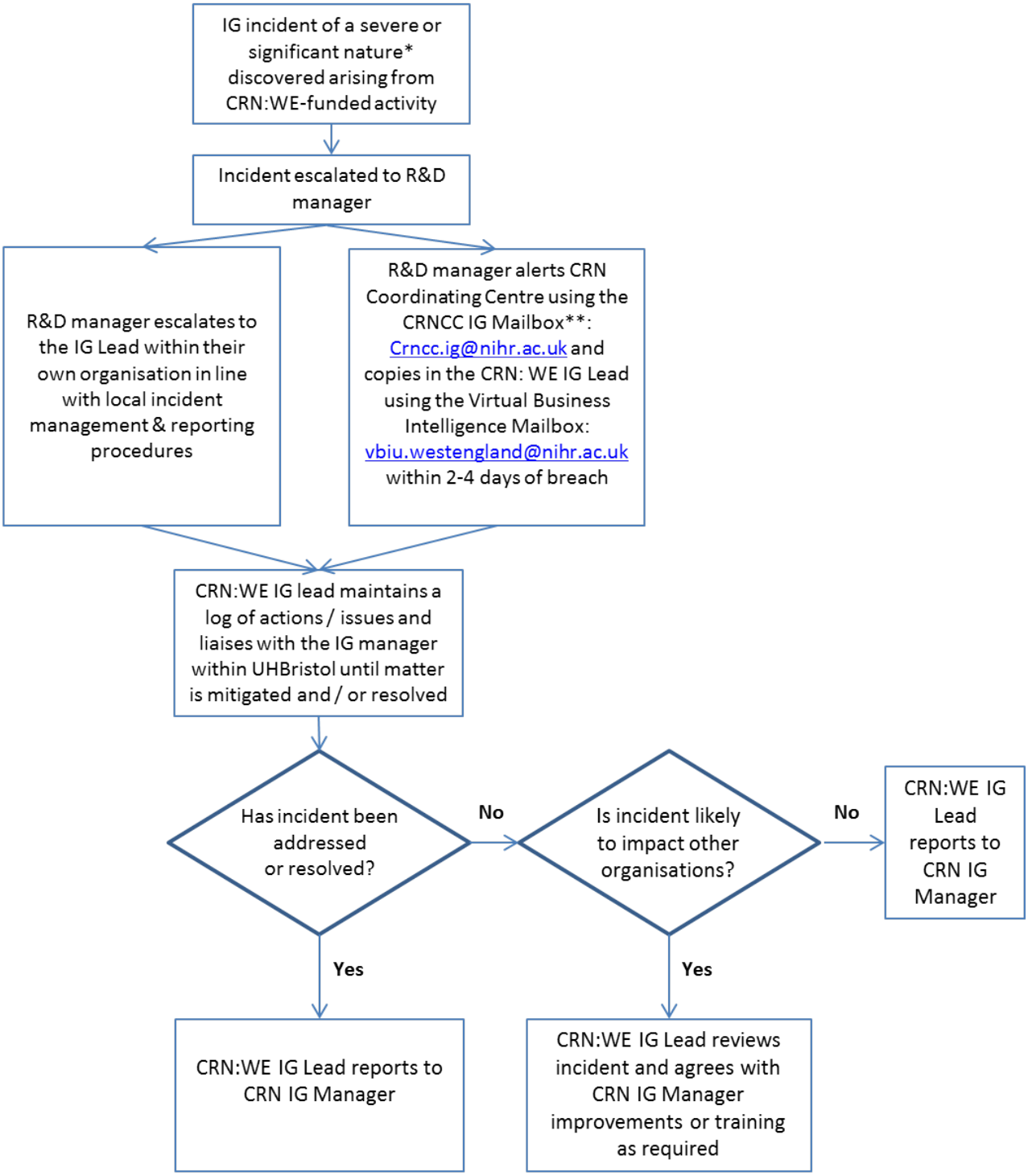
Appendix 1: Risk Register

RISK ANALYSIS										RISK TREATMENT PLAN									
Risk Reference	**Category**	**Author**	**Date registered**	**Nature of Risk**	**Risk Description**	**Proximity**	**Probability**	**Impact**	**Score**	**Risk Owner**	**Risk Response Categories**	**Control (Action)**	**Risk Response**	**Assurance/ Update**	**Risk Actionee**	**Additional Comments**	**Residual Probability**	**Residual Impact**	**Residual Risk Rating**	**Last review**	**Risk Status**
BI1	Business Intelligence	Ruth Allen	04/10/2014	Technical	As a result of primary care and mental health data not being included in Edge, there is a risk that Edge is not fit for purpose, which will result in decisions that are not data driven.	6 months	3	3	9	Ruth Allen	Reduce	1. Work with Edge team and Primary Care to scope requirements and find solutions.	Liaise with (1) CRN staff supporting primary care studies (2) mental health trust EDGE champions (3) EDGE provider to work on implementation in these areas	Successful test upload of recruitment data for primary care studies to EDGE. Ongoing liaison with primary care and mental health CRN / R&D staff	Mike Lacey	Issues resolved and implementation nearly complete.	1	1	1	31/03/2015	Active
BI2	Business Intelligence	Ruth Allen	06/10/2014	Timescale	As a result of delay in the national launch of CPMS, there is a risk that the LCRN will not have access to complete and accurate national data, which will result in the BI team amalgamating data from multiple sources which is time consuming and increases the margin for error.	6-12 months	4	1	4	Ruth Allen	Reduce	1. Focus on full LPMS implementation to reduce reliance on CPMS (i.e. good local data).	"Business as usual" can continue with the existing UKCRN portfolio database until CPMS is ready.	No launch date currently specified	Mike Lacey	Launch date still unknown.	4	1	4	31/03/2015	Active
CE1	Clinical Engagement	Holly Vallance	11/11/2014	Operational	As a result of the geographical changes of the networks and late appointment of Specialty Leads we have lost opportunities for growth in certain specialties i.e. Dermatology and Cardiovascular Disease - this is an ongoing risk to not meeting the commercial specific specialty objectives.	3-6 months	4	3	12	Holly Vallance	Reduce	Work with Specialty leads when in place to develop an action plan to address this	Work with Specialty leads when in place to develop an action plan to address the threats to commercial portfolio	Not all leads appointed, plan to work with leads that are appointed	Holly Vallance	Majority of leads in place, but not all. Work with leads as appointed.	2	3	6	31/03/2015	Active

Residual Risk Descriptor
Extreme risk
Partially controlled risk
Controlled risk
Well controlled risk

Matrix from NPSA risk matrix 2011: http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/risk-assessment-guides/risk-matrix-for-risk-managers/

Appendix 2: NIHR Clinical Research Network: West of England Process for reporting information governance incidents arising from LCRN-funded activities to the national CRN Coordinating Centre



*Severe IG breach leading to suspension of service, release of PID belonging to 100+ individuals. Significant IG breach negatively impacting service delivery, a breach resulting in sanctions/reprimands from ICO/authorities, repeated occurrence of a breach, release of PID belonging to 30+ individuals.

**The required level of detail is just the high level descriptor of the breach. There is no requirement to send PID/Commercially sensitive information to the CRNCC.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
18. Q1 Risk Assessment Framework Monitoring and Declaration Report
Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive Authors: Deborah Lee, Chief Operating Officer / Deputy Chief Executive Paul Mapson, Director of Finance and Information Xanthe Whittaker, Associate Director of Performance

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

Executive Summary

Purpose

All NHS Foundation Trusts require a licence from Monitor stipulating specific conditions that they must meet to operate including financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach and their use of the framework to assess individual FT compliance with two specific aspects of their work: the Continuity of Services and Governance conditions in their provider licences.

The purpose of a Monitor assessment under the framework is to highlight when there is a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or poor governance.

It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk

Key issues to note

This report provides an analysis of governance risk (Appendix A) and commentary on financial risk (Appendix B). Following making the necessary enquiries, the Senior Leadership Team confirmed that it is not aware of any matters arising during the quarter requiring an exception report to Monitor which have not previously been reported.

The recommendation to the Committee is to declare the standards failed in quarter 1 to be, the RTT Non-Admitted, Admitted and Ongoing pathways standards, the A&E 4-hour standard, the 62-day GP and 62-day Screening cancer standards. It is also recommended that the planned ongoing failure of the RTT standards as part of the agreed recovery trajectory is flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-day GP cancer standards, and the A&E 4-hour standard, as part of the narrative that accompanies the declaration.

Recommendations

The Board is asked to approve the following Quarter 1 declaration for submission to the Board of Directors on 30th July 2015:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 1 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 recommendation that the planned ongoing failure of these standards are flagged to Monitor, as part of the narrative that accompanies the declaration;
- Confirmation that the Board anticipates that the Trust will continue to maintain a Continuity of Services risk rating of at least 3 over the next 12 months; and
- Confirmation that there are no matters arising in the quarter requiring an exception report (as per Diagram 6, page 22 of the Risk Assessment Framework)

Impact Upon Board Assurance Framework

To support the strategic objectives to: consistently deliver high quality individual care, delivered with compassion; ensure the Trust is financially sustainable to safeguard the quality of services for the future and that the strategic direction supports this goal; and ensure the Trust is soundly governed and are compliant with the requirements of the regulators.

Impact Upon Corporate Risk

N/A

Implications (Regulatory/Legal)

Failure to comply with the conditions of the NHS Provider Licence could result in breach of the Health and Social Care Act 2012

Equality & Patient Impact

There are no equality implications as a result of this report. Potential impact on patient experience as a result of the Trust's failure to meet targets.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	**X**	For Information	

Date the paper was presented to previous Committees

Finance Committee	Audit Committee	Remuneration & Nomination Committee	Quality & Outcomes Committee	Other (specify)
			28/7/15	

Monitor Quarter 1 declaration against the 2015/16 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 1 declaration of compliance with the 2015/16 Monitor Risk Assessment Framework by the 31st July 2015.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 1, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

Monitor also uses other information to signal potential Governance Concerns, using patient and staff metrics such as satisfaction rates, turn-over rates, levels of temporary staffing and other information from third party organisations.

The resultant Governance Rating that Monitor publishes will depend on further investigations it conducts following Governance Concerns being triggered. The following shows the rationale for the application or either a GREEN or a RED rating:

Table 1 Monitor's process for determining the Governance 'status' of a Foundation Trust

Governance 'status' of the Foundation Trust		Governance rating: What Monitor will publish
No evident concerns	→	Green
Issue identification **Prioritisation** **Consideration of breach**	Emerging concerns (e.g. persistently failing access targets; major third party concerns, financial issues) Further information requested Concerns serious enough to trigger formal investigation Breach or likely breach identified; formal/informal action pending	**Current status and a description of:** • Factors driving concerns • Actions Monitor is taking/considering • Next steps
Action Formal regulatory action under sections 105 (Enforcement undertakings), 106 (Discretionary requirements), and/or 111 (Licence condition and Powers of removal, suspension and disqualification of directors and governors)	→	Red

Each quarterly declaration to Monitor must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to Monitor as part of the narrative that accompanies the submission.

Monitor compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent

review of its self-certification and associated processes. In the 2015/16 Monitor Annual Plan the Trust declared standards to be at risk of failure in quarter 1 and quarter 2 to be as follows:

	Quarter 1	Quarter 2
Standards not forecast to be met	RTT Non-admitted RTT Admitted RTT Incomplete/Ongoing 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted RTT Incomplete/Ongoing 62-day GP cancer 62-day Screening cancer
Score	**3.0**	**3.0**

2. Performance in the period

Table 2 shows the performance in quarter 1 against each of the standards in Monitor's Risk Assessment Framework. The following six standards were not achieved in the quarter:

- A&E 4-hour standard (1.0)
- 62-day GP and 62-day Screening cancer standards (combined score of 1.0)
- RTT (Referral to Treatment) Non-admitted pathways standard (1.0)
- RTT Admitted pathways standard (1.0)
- RTT Incomplete/Ongoing pathways standard (no score - RTT standards failure capped at 2.0)

The A&E 4-hour standard was not achieved in the quarter, but was not declared as being at risk in the period, as part of the Annual Plan declaration.

With the cap on the failure of the three RTT standards taken into consideration, this gives a Service Performance Score of 4.0. Under the rules set-out within the Risk Assessment Framework, the failure of the RTT standards, 62-day GP standard and the A&E 4-hour standards in quarter 1 would trigger Governance Concerns for repeated failures of the same standard. However, Monitor has recently restored the Trust to a GREEN rating but will continue to monitor progress with achievement of recovery trajectories.

Please note that in the Q1 reporting template that Monitor has recently issued (see Annex B), failure of the admitted and non-admitted RTT standards are no longer scored, meaning that the Trust is holding a Service Score of 3 rather than 4. We are seeking further clarity from Monitor regarding this, as this potentially conflicts with other information received from NHS England.

Please also note that performance against the cancer standards is still subject to final national reporting at the beginning of August and therefore the position shown in Table 2 remains draft.

Quarter 2 2015/16 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in Monitor's 2015/16 Risk Assessment Framework in quarter 1, along with the key risks to target achievement for quarter 2 2015/16. The mitigating actions that are being taken are also provided, along with the residual risk.

The trajectory for reducing the number of patients waiting over 18 weeks RTT on a non-admitted pathway was met in each month of the quarter. Although the admitted reduction trajectory was not achieved at the end of June, the backlog continued to reduce in June, with the reported level the lower since September 2014. Of particular note was the reduction in the number of patients waiting over 40 weeks, down from 119 at the end of quarter 4 to 38 at the end of quarter 1, against a target for quarter-end of 72. The failure of the three RTT standards in the quarter was forecast, and a necessary part of the recovery plan. In line with the agreed recovery trajectories, the three RTT standards are expected to be failed in quarter 2 2015/16.

The A&E 4-hour 95% standard was achieved in June, although the recovery trajectory of 94.8% was narrowly missed, with performance reported at 94.5% for the quarter. Performance for July to date is above the 'realistic' trajectory the Trust has set itself, and whilst noting risks posed by significant changes to local providers of domiciliary care packages, and planned bed closures at North Bristol Trust, the recovery trajectory of 95.0% is forecast to be met for the quarter.

There continues to be the potential for failure of the 62-day Screening standard, following the transfer out of the Avon Breast Screening service. This is because the bowel screening pathway is now the highest volume reported pathway, but is a difficult one to complete within 62-days due to patient choice and other causes of breaches outside of the Trust's control. Like in quarter 4 2014/15, the 90% standard was failed in quarter 1 due to patient choice and medical deferrals. As noted in previous quarters, although it is expected the 90% standard will be achieved in some quarters, it is unlikely to be achieved every quarter. It is therefore recommended that the high risk of failure of this standard continues to be flagged to Monitor for quarter 2, and future quarters.

One standard, in addition to A&E 4hours, is flagged as having a moderate residual risk of failure, which is the 31-day subsequent surgery cancer standard. Further details of the risks to achievement of this standard are provided in Table 2. It is recommended that the potential risk to failure of the 62-day GP cancer standard that our case-mix and late tertiary referrals brings, continues to be flagged to Monitor as part of the narrative that accompanies the declaration. These two standards, along with all those currently not being met, will remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

3. Recommendation

The recommendation to the Senior Leadership Team is to declare the standards failed in quarter 1 2015/16 as being the three RTT standards, the 62-day GP cancer standard, the 62-day Screening cancer standard and the A&E 4-hour standard. It is also recommended that the narrative that accompanies the declaration should flag the specified potential risks to failure against the 62-day GP and 62-day screening standard, for the reasons set-out in section 3 above.

Table 2 Summary of performance in quarter 1 2015/16, and the risks to quarter 2 compliance

Indicator	Score	Achieved in Q1 2015/16?	New risks to Q2 2015/16?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for admitted pathways (aggregate)	1.0	No – failed each month; reduction trajectory met in April and May (not June)	No – ongoing risk from Q1 of high backlogs and RTT non-admitted clearance	- Long waits for first outpatient appointments in dental specialties in particular, with capacity constraints due to recruitment challenges and loss of capacity; - Additional new outpatient appointments continue to be put in place to shorten waiting times, which in time will effect shorter Admitted RTT pathways, but in the interim will continue to create a 'bulge' in the waiting list; - Admitted backlogs high and above sustainable levels in Paediatric specialties (ENT, Plastics, Surgery and T&O) Upper GI, Cardiology, Oral Surgery and Ophthalmology in particular.	- Further additional activity planned during quarter 2 as part of agreed delivery plans, to reduce the size of the backlog as set-out in the recovery trajectory; - Waiting list transfers to other providers (e.g. Independent Sector Treatment Centre) where possible and appropriate - Internal validation team, focusing on validating long waiters and improving data quality; - Robust monitoring and escalation to optimise the number of long waiters booked each month; - Planned move to direct reporting from Medway (Patient Administration System), which will enable real time reporting and as a result improve pathway management capabilities; - RTT steering group overseeing the implementation of the recovery plans.	High	High

[1] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

18-weeks Referral to Treatment for non-admitted pathways (aggregate)	1.0	No – failed each month; reduction trajectory met in each month of the quarter	No – Ongoing from Q1	- Non admitted RTT performance cannot be planned/managed in the same way as admitted pathways, because attendance at an outpatient appointment may, or may not, stop a patient's RTT clock - See RTT admitted also	- See RTT admitted	High	High
18-weeks Referral to Treatment for incomplete pathways (aggregate)	1.0	No – failed each month; trajectory met in each month of the quarter	No – ongoing risk of high admitted and non-admitted backlogs from quarter 1	- Same as for RTT admitted	- See RTT admitted	High	High
A&E Maximum waiting time 4 hours	1.0	No – although 95% standard achieved in June. Recovery trajectory of 94.8% was narrowly missed (94.5% for the quarter)	Yes	- Delayed Discharges rose sharply during May and are at risk of rising again due to significant changes in providers of domiciliary care packages in quarter 2; - Pressure on other local Emergency Departments may increase due to planned bed closures at North Bristol Trust;	- Wide ranging system-wide Resilience Plan, supported by additional funding; - Additional actions, both internally and from partner organisations, planned in response to CQC report; - Further Transformation efforts focused on discharges earlier in the day, and improving flow within the Children's Hospital. - Historically, consistently good performance in Q2.	High	Moderate
Cancer: 62-day wait for first treatment – GP	1.0	No – adjusted performance, taking account	No – continued risks from	- High levels of late tertiary referrals - High levels of medical	- Cancer Performance Improvement Group focusing on pathway redesign for high volume, lower	High	High

Referred		of late referrals, remains below 85%, mainly due to very high levels of other, unavoidable breaches (i.e. medical deferrals and clinical complexity)	Q4	deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are difficult to mitigate) - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Intensive Therapy Unit (ITU) / High Dependency Unit (HDU) bed related cancellations - Awareness raising campaigns likely to increase demand for surgical treatments	performing, tumour sites by implementing 'ideal timescale' pathways; - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work; - Additional Thoracic Surgery theatre capacity made available from October 2014, continuing to reduce breaches due to a shortfall in elective capacity; - Patients on the cancer patient tracking list continue to be actively managed and any delays escalated to Divisional Directors and Chief Operating Officer; - Further focus on how to increase nurse staffing in order to maximise number of adult ITU/HDU beds that can be kept open in situations of high patient acuity.		
Cancer: 62-day wait for first treatment – Screening Referred		No – performance below 90% due to reasons outside of the control of the Trust – i.e. patient choice, medical deferral.	No – continued risks from Q1	- Following the transfer of the Avon Breast Screening Service in quarter 2, the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, unlike bowel which nationally performs well below the 90% standard;	- Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored; - Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers; - Need for additional elective capacity for colorectal surgery continuously reviewed; - All CT colon scanning and	High	High

				- All bowel screening pathways originate at the Trust, and capacity constraints at other providers will have a knock-on impact on performance for shared pathways; - Patient choice in bowel screening pathway; - Numbers of cases reported under this standard are now low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact.	reporting delays escalated, and further work has been undertaken to reduce delays; - Patient choice and medical deferral related breaches cannot be fully mitigated, and for this reason the residual risk remains high.		
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	Yes	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds) - Having enough surgical capacity to meet peaks in demand, especially for the hepatobiliary service - Unpredictably high volume of delays due to medical deferrals in some quarters.	- Book dates for surgery at least 7 days before the breach date whenever possible, to enable the patient to be re-booked if cancelled on the day for unavoidable reasons; - Ongoing proactive management of cancer patient tracking list, to identify bulges in demand as early as possible; - See also action under 62-day GP regarding ITU/HDU bed capacity.	High	Moderate
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day		Yes	No	- No significant risks	- Continue to pro-actively manage	Low	Low

wait for subsequent treatment - subsequent radiotherapy					patients on the Cancer patient tracking list		
Cancer: 31-day wait for first definitive treatment	1.0	Yes	No	- Peaks in demand from emergencies for ITU/HDU beds, resulting in cancellations of surgery - Unpredictable shortfall in surgical capacity for certain specialties during peaks in demand	- Additional thoracic capacity came online in October 2014, following the planned transfer-out of the Vascular service, which has reduced the number of breaches; - Book dates for surgery at least 7 days before the breach date to enable the patient to be re-booked if cancelled on the day for unavoidable reasons; - Divisions to continue to pro-actively manage patients on the Cancer patient tracking list; - See also action under 62-day GP regarding ITU/HDU bed capacity.	Moderate	Low
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	1.0	Yes	No	- The Trust's skin cancer clinic capacity is limited at Weston, but patient demand relatively high, with patients choosing to wait over 14 days; - Very high levels of demand now being experienced in some months, for reasons not well understood.	- Patients referred with a query skin cancer being offered an earlier appointment at the BRI first, before being offered an appointment at Weston; - Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	Yes, although still awaiting confirmation of the number of cases deemed	No	- Flat profiling of annual target continues to be imposed by Monitor; - Bristol community is an outlier for antibiotic	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary	Low	Low

		by the commissioners to be potentially avoidable.		prescribing	antibiotics - An antibiotic prescribing phone application has been implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a lapse in quality of care to be demonstrated to the commissioners.		
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	1.0	Yes	No	- No significant risks	See the standard set-out in Appendix 1, which the Trust is declaring compliance with.	Low	Low

Annex A – Learning Disability Access Criteria

Criteria	Trust evidence
1. Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• The Trust has a clinical alert system which has approximately 3,000 patients registered and is managed by the learning disabilities Nurse/team. This system has proven to be an effective way of identifying known patients with learning disabilities when accessing both inpatient and outpatient services • The Trust has an informative learning disabilities internal web page which includes referral pathways and documentation tools to support assessments, implementation and reasonable adjustments. The learning disabilities risk assessment gives opportunity for staff teams to record all reasonable adjustments made against the identified needs • When individuals with learning disabilities are referred to the learning disabilities team from carers or external providers (local authority), the team is able to support pre-planned admissions and make reasonable adjustments according to identified needs. As a Trust we are able to provide multiple procedures under one general anaesthetic, bringing diverse teams together as required for treatment and/or investigations
2. Does the NHS foundation trust provide readily available and comprehensive information to patients with learning disabilities about the following criteria: - Treatment options - Complaints and procedures and - Appointments?	• The Trust has a series of `Easy Read' leaflets. Easy Read uses pictures to support the meaning of text. It can be used by a carer/staff teams in support of the decision making process regarding treatment and care • The Trust 'Easy Read' range includes: ➢ Healthcare and treatment options ➢ Consent ➢ How to contact patient support and complaints team ➢ Going into hospital and what happens ➢ Learning disabilities liaison nurse ➢ Being discharged from hospital • The Trust has various appointment letters to support individuals individual needs
3. Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• The trust has a `Welcome pack' which profiles the Trust providing a range of information around admission and orientation when visiting • The learning disabilities risk assessment has a section to identify the needs of family and carers to ensure reasonable adjustments are made for them as well as the individual receiving direct care

	• The learning disabilities team provide support to all carers identified for individuals accessing both inpatient and outpatient services and continues from preadmission through to discharge planning. • The Trust has a Carers' Strategy and Carer support worker to support the needs of carers
4. Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff?	• The Trust `essential training' programme including at Trust induction learning disabilities awareness training for non-clinical and clinical staff and includes medical staff • The LD nurse delivers custom made training to meet the needs of existing staff groups as required • Annual training events are hosted for link nurses to support their knowledge and skills in caring for patients with learning disabilities
5. Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• The Trust consults with Learning Disability user groups when strategies and Easy Read materials are in draft format for comments • The Trust provides annual training events whereby users groups attend and receive training around health needs, procedures and support systems available when accessing acute services
6. Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	• The Trust has a Learning Disabilities Strategy that informs the work plan for the Steering Group and sets the standards • Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives • The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care • The Learning Disability Steering Group reports to the Patient Experience Group

Annex B - Targets & Indicators template for Q1

Click to go to index

Declaration of risks against healthcare targets and indicators for 201516 by University Hospitals Bristol NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

			Annual Plan	Quarter 1			
Target or Indicator (per Risk Assessment Framework)	**Threshold or target YTD**	**Scoring Per Risk Assessment Framework**	**Risk declared**	**Performance**	**Declaration**	**Comments / explanations**	**Scoring Per Risk Assessment Framework**
Referral to treatment time, 18 weeks in aggregate, admitted patients	90%	N/A	Yes	79.9%	Not met	Averg. for quarter 80.4%	N/A
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	N/A	Yes	90.2%	Not met	Averg for quarter 90.8%	N/A
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	Yes	90.4%	Not met	Averg for quarter 90.6%	1
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	1.0	Yes	94.5%	Not met	Achieved 95.2% in June	1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	Yes	76.8%	Not met	Subj to national reporting	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	Yes	78.6%	Not met	Subj to national reporting	1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation				76.8%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation				78.6%			
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	No	94.1%	Achieved	Subj to national reporting	
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No	99.3%	Achieved	Subj to national reporting	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No	96.7%	Achieved	Subj to national reporting	0
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	No	96.8%	Achieved	Subj to national reporting	0
Cancer 2 week (all cancers)	93%	1.0	No	94.8%	Achieved	Subj to national reporting	
Cancer 2 week (breast symptoms)	93%	1.0	N/A	0.0%	Not relevant		0
C.Diff due to lapses in care (YTD)	11.25	1.0	No	1	Achieved	Limit for Q1 = 11	0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)				10			
C.Diff cases under review				5			
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	N/A	Achieved	Standards met.	0
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	N/A		No		
Date of last CQC inspection	N/A		N/A		No		
CQC compliance action outstanding (as at time of submission)	N/A		N/A		No		
CQC enforcement action within last 12 months (as at time of submission)	N/A		N/A		No		
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		N/A		No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		N/A		No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		N/A		No		
Overall rating from CQC inspection (as at time of submission)	N/A		N/A		No		
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		N/A		No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		N/A		No		
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A		N/A		No		
Service Performance Score							3

Annex C - Governance narrative to accompany the submission

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A There are six targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 1. These are: the A&E 4-hour standard, the RTT Non-admitted, Admitted and Incomplete pathways standards, and the 62-day GP and 62-day screening cancer standards.

The Trust performed at 94.5% against the A&E 4-hour standard in the period, against the recovery trajectory for the quarter of 94.8%, and achieved the 95% national standard for the month of June. Two factors affected the achievement of the 95% standard in the quarter. These were 1) the increase in emergency admissions into the Children's Hospital in May, at 18% above the same month last year, which is above the baseline level of activity with the Centralisation of Specialist Paediatrics transfer accounted for and similar to levels experienced in Dec 14, 2) the increase in delayed discharges from 40 at the end of April to a peak of 81 in May. Additional risks at play in quarter 2 are the re-commissioning of domicilary care packages within the community, from 51 to 4 providers, and the planned reduction in beds in North Bristol Trust by 78 (with parallel closure of beds in RUH Bath and Clevedon Hospital), from July through to November. The Trust is continuing to mitigate system risks through an action plan with partner organisations which was put in place during the latter half of quarter 2 2014/15. The impact of the schemes within the actions plan have been assessed, from which an improvement trajectory was developed. It is estimated that 35% of the forecast improvement in performance against the 4-hour standard will arise from actions taken by partner organisations.

B Due to the transfer of Head & Neck services from North Bristol NHS Trust and the associated transfer of a large number of patients with extended waits, the Trust declared in its 2013/14 Annual Plan significant risks to the Trust's achievement of the non-admitted RTT standard. The 95% standard continued to be failed in 2014/15, despite backlog levels reaching a sustainable level (i.e. greater than 95% of patients on ongoing non-admitted pathways were waiting < 18 weeks). Over the last 12 months the Trust has seen a significant increase in GP referrals, especially in capacity constrained specialties such as dental specialties and dermatology, the latter reflecting lack of adequate service provision in other parts of the community.

A decision was taken during quarter 2 2014/15, following the national request for a failure of the admitted and non-admitted standards to support backlog clearance, to have a planned failure of the three RTT standards during 2014/15. During quarter 3 2014/15, the Trust undertook detailed capacity and demand modelling, supported by the Interim Management and Support (IMAS) team, and has established delivery plans to meet the required level of both recurrent and non-recurrent capacity. Recovery trajectories for reducing the over 18-week backlogs have been developed, and the activity required to deliver these agreed with commissioners. The Trust achieved its Incomplete/Ongoing pathway trajectory through the planned backlog reduction during each month of quarter 1 2015/16. A further period of planned failure of the standards during quarter 2 2015/16 to support backlog clearance has been agreed (cont'd below)

C The 62-day GP cancer standard has been failed since quarter 4 2013/14, primarily due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice). Cancer pathway improvement work continues, focusing on both further minimising internal causes of breaches, through reductions in waits for the 2-week wait step, and implementation of ideal timescale pathways, but also on working with other providers to reduce late referrals. The case mix of patients treated (typically having a -3.5% impact on performance) and late referrals into the Trust continues to make achievement of the 62-day GP standard challenging. During quarter 2 the Avon Breast Screening service transferred to North Bristol Trust. As a result performance against the screening standard is largely being now based on a relatively small number of bowel screening treatments, which nationally performs well below 90%. In quarter 1 a total of 3 breaches of standard in accountability terms were incurred, taking performance below the 90% standard. Breach analysis demonstrates the reasons for the breaches to be patient choice and medical deferral.

University Hospitals Bristol NHS
NHS Foundation Trust

For consideration and approval by

Finance Committee	24th July 2015 – Agenda Item 8
Trust Board	30th July 2015 – Agenda Item 18

QUARTER 1 FINANCIAL PERFORMANCE COMMENTARY FOR MONITOR RETURN

Director of Finance
July 2015

1. EXECUTIVE SUMMARY

This commentary covers the results for the quarter ending 30th June 2015. The Trust reports an EBITDA[1] surplus of £8.445m. This is £0.720m higher than the Annual Plan of £7.725m. The Continuity of Service Risk rating is 3 (actual 3.0).

	2014/15	June 2015	Plan 2015/16
Liquidity			
Metric Performance	5.61	7.23	(3.48)
Rating	4	4	3
Capital Service Capacity			
Metric Performance	2.86	1.48	1.55
Rating	4	2	2
Overall Rating	**4**	**3**	**3**

4	**3**	**2**	**1**
0	**(7)**	**(14)**	**<(14)**
2.5	**1.75**	**1.25**	**<1.25**

The summary income and expenditure statement for the quarter ending 30th June 2015 shows a surplus of £0.443m (before technical items). This represents a favourable variance of £0.706m against plan for quarter 1 2015/16. After technical items the net surplus is £1.314m, a favourable variance of £1.250m against the Monitor Plan.

[1] Earnings Before Interest Taxation Depreciation and Amortisation

2. NHS CLINICAL INCOME

NHS Clinical Income is £0.784m higher than the Monitor Q1 Plan at £121.805m. NHS Clinical Income includes income from NHS Commissioners and Territorial Bodies.

Performance by Point of Delivery

Table 1 - NHS Clinical Income by Point of Delivery

Worktype	YTD Plan £m	YTD Actual £m	YTD Variance £m
Elective Inpatients	12.823	12.010	(0.814)
Day Cases	9.100	8.786	(0.314)
Non-Elective Inpatients	21.674	21.589	(0.084)
Outpatients	18.103	17.622	(0.481)
Accident & Emergency	3.656	3.737	0.081
Pass Through Costs	18.281	18.764	0.482
Other NHS Clinical Income	37.384	39.297	1.912
Totals	121.022	121.806	0.784

i. Elective Inpatients

Elective Inpatients are £0.814m below plan. Adult Cardiac Surgery is lower than plan due to availability of critical care beds in this area. Paediatric Cardiac Surgery is also below plan due to delays in creating operating capacity to undertake planned growth.

ii. Day Cases

Day Cases are £0.314m below plan. Clinical Oncology is lower than plan but this if offset by higher than planned activity in Elective Inpatients and Outpatients. Oral Surgery is below plan due to challenges recruiting theatre staff and specialty dentist posts.

iii. Non-Elective Inpatients

Non-Elective Inpatients are £0.084m below plan. Adult Medical Emergencies are lower than plan primarily due to the case-mix of activity. A similar variance has been noted in the previous year, though the position recovered through the later summer months and into the winter. Elderly and Respiratory admissions in particular are expected to increase throughout the hotter months and as the weather turns colder (i.e. during the more extreme temperatures).

iv. Outpatients

Outpatients are £0.481m below plan. There are recruitment challenges in the Medical Retina and Glaucoma services, which is limiting Ophthalmology capacity. The Trust has also struggled to recruit to specialty dentist posts, although this is now back on track and additional sessions will be planned to continue recovery.

v. Accident & Emergency

Accident & Emergency is £0.081m above plan.

vi. Pass Through Costs

Pass Through Costs are £0.482m above plan.

vii. Other NHS Clinical Income

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, Prior Year Income, Contract Penalties, CQUINs and specialised services such as Bone Marrow Transplants. This category is £1.911m ahead of plan.

Performance by Commissioner

Table 2 below shows the cumulative NHS Clinical Income variances by commissioner.

Table 2 Performance by Commissioner

Commissioner	YTD Plan £m	YTD Actual £m	YTD Variance £m
Bristol CCG	37.598	37.412	(0.186)
North Somerset CCG	9.623	9.845	0.222
South Gloucestershire CCG	7.127	6.954	(0.173)
NHS England	55.874	55.393	(0.481)
Other South West Commissioners	7.350	7.476	0.126
Welsh Commissioners	2.472	2.337	(0.135)
Variable Estimates	(1.507)	(2.059)	(0.552)
Provider Trusts	0.509	0.497	(0.011)
Prior Year Income	-	1.085	1.085
Other Commissioners	1.977	2.865	0.888
Totals	121.022	121.806	0.784

3. NON-NHS CLINICAL INCOME

Private Patient Revenue

Private Patient Revenue is £0.283m below plan.

Other Clinical Revenue

Other Clinical Revenue is higher than planned by £0.006m for the quarter.

4. OTHER OPERATING INCOME

Overall other income is £1.214m higher than planned for the quarter. The main reasons are:

- Higher than planned income from the Trust's Research and Innovation contract £0.454m;
- Higher than planned Education and Training Income £0.273m;
- Higher than planned other income £0.487m. This includes higher than planned income for sales of goods and services of £0.239m and small higher than planned income for Catering, Accommodation and PTS services.

4. EXPENDITURE

Overall operating costs of £137.699m for the quarter are £1.001m higher than plan. Trust pay costs are £2.183m higher than plan and non pay costs are £1.182m lower than plan.

4.1 Pay Costs

Pay costs at £87.480m for the quarter were £2.183m higher than plan due to higher than planned spend on agency staff £1.542m, permanent staff particularly nursing and other clinical staff £2.172m these adverse variances are offset by favourable variances due to vacancies £1.531m.

4.2 Drugs excluding pass through

Drug costs of £6.031m are £0.146m higher than plan for the quarter due to lower than planned CIP delivery and activity related factors.

4.3 Clinical supplies and services excluding pass through

Clinical supplies and services costs at £9.885m for the quarter were £0.024m lower than planned due to higher than planned CIP delivery £0.243m offset by higher than planned spend due to activity factors £0.219m.

4.4 Supplies and Services General

Supplies and services general were £0.239m lower than planned for the quarter.

4.5 Other Non Pay Expenses

Other costs were £1.065m lower than planned for the quarter.

5. CAPITAL

The Trust's Annual Plan Capital Programme was £34.439m at the plan submission in May 2015. The table provided below shows a comparison of the Trust's revised spending plan with actual expenditure for the quarter ending 30th June 2015.

	Quarter Ending 30th June 2015		
	Plan	Actual	Variance Fav / (Adv)
	£'000	£'000	£'000
Sources of Funding			
Donations	2,301	2,311	10
Sale of Assets	1,100	1,100	-
Grants/Contributions	954	1,040	86
Retained Depreciation	5,112	5,099	(13)
Cash balances	(609)	(4,948)	(4,339)
Total Funding	**8,858**	**4,602**	**(4,256)**
Expenditure			
Strategic Schemes	(2,928)	(2,432)	496
Medical Equipment	(2,655)	(473)	2,182
Information Technology	(1,070)	(518)	552
Roll Over Schemes	(200)	(517)	(317)
Operational	(2,005)	(662)	1,343
Total Expenditure	**(8,858)**	**(4,602)**	**4,256**

The actual capital expenditure for the quarter ending 30th June 2015 is £4.6m against a plan of £8.9m representing 52% of plan. This significant variance on the Quarter 1 position demonstrates that the profiles submitted in the 2015/16 Monitor Plan do not reflect the current delivery of the capital programme. To ensure the Trust has robust monthly forecast going forward, a full re-profiling exercise is being undertaken which will update the monthly expenditure profiles going forward.

6. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

6.1 Non Current Assets

The balance of £383.059m at the end of June is £4.517m lower than plan. This mainly reflects capital position.

6.2 Inventories (formerly referred to as Stock)

The value of inventories held totalled £11.006m. This is £1.081m lower than planned due to earlier than expected consumption of additional stock and close management of stock levels.

6.3 Current Tax Receivables

The balance of £0.935m at the end of June represents moneys owed to the Trust by the HMRC for additional VAT that is recoverable under legislation. This is £0.29m higher than planned due to additional recoveries identified and being claimed before the 31 July cut off for 2014/15 transactions.

6.4 Trade and Other Receivables (Including Other Financial Assets)

The balance of trade and other receivables of £16,594m is £2.547m less than plan. The decrease is due to the Trust issuing estimated invoices for activity earlier allowing the Trust to receive cash sooner.

6.5 Prepayments

The prepayment balance at the end of the quarter is £3,107m. This is mainly due to payments for maintenance contracts for servicing of equipment. This is broadly in line with the plan.

6.6 Non Current Assets held for Sale

The sale proceeds following the disposal of the Grange site have been received and included in the Trust's cash position.

6.7 Deferred Income

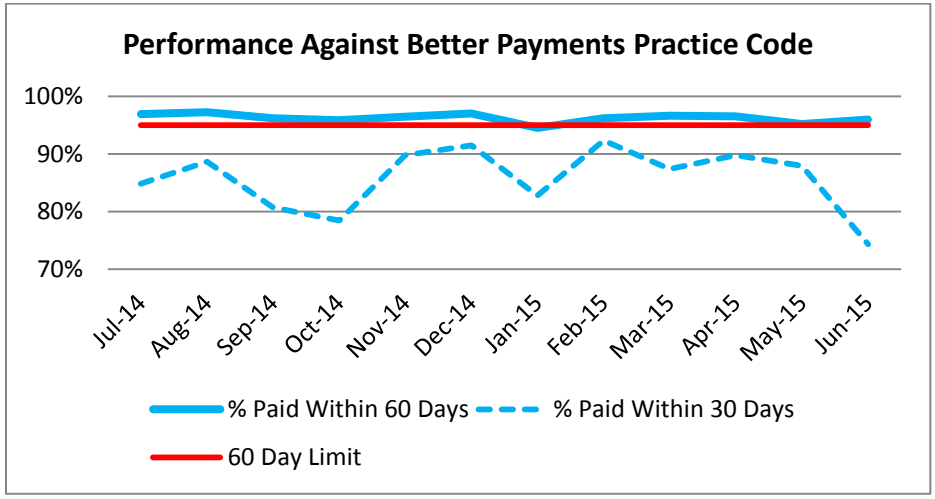
Deferred income of £3.224m is £0.714m below plan. This relates to moneys received in divisions for specific projects with expenditure later in the year.

6.8 Trade/Other/Capital/PDC Payables

These total £22.881m at the end of the first quarter. This is £1.495m above the plan projection of £21.386m.

The Trust aims to pay at least 95% of undisputed invoices within 60 days with a view to moving towards 30 days as the norm.

The Trust is a signatory of the Prompt Payments Code (PPC), a scheme run by the Department of Skills and Innovation and the Confederation of British Industry. The PPC stipulates that its signatories should pay 95% of invoices within 60 days and aim to move towards 30 days as a norm. In June the Trust paid 96% of invoices within the 60 day limit. The Trust also continues to operate strict financial controls around supplier price increases.



6.9 Other Financial Liabilities

The closing balance for accruals at £31.046m is £0.494m lower than the plan of £31.540m reflecting the Trust's current estimate of amounts owing for which invoices had not been received at the quarter end.

6.10 Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th June together with comparative information taken from the Trust's Annual Plan.

Summary Statement of Financial Position

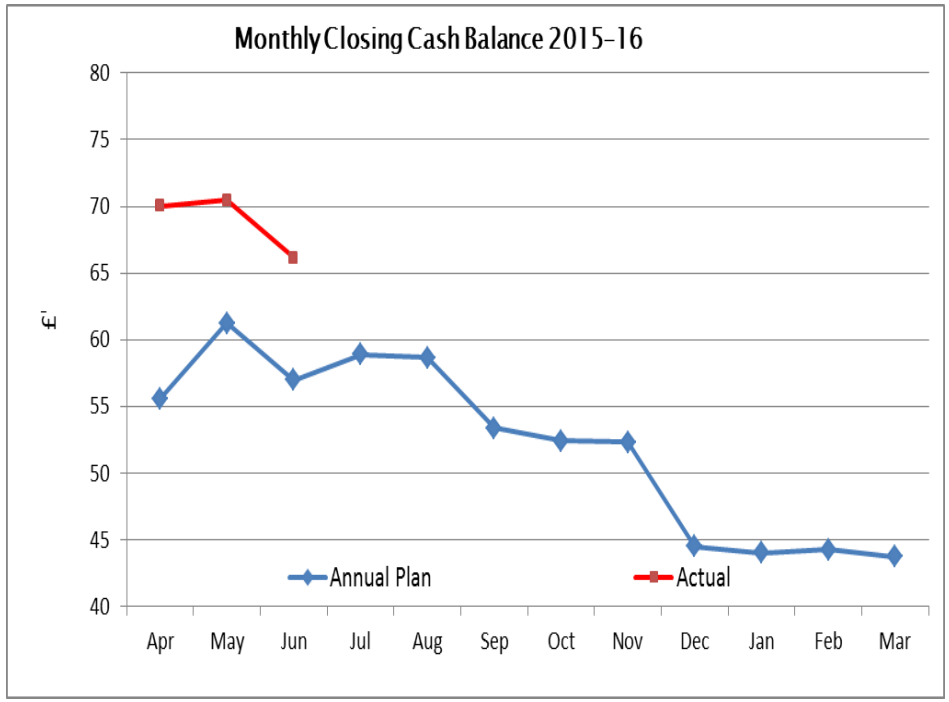
	Position as at 30TH June 2015		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current assets			
Intangible	7,060	6,745	(315)
PPE*	380,516	376,314	(4,202)
Non current assets total	**387,576**	**383,059**	**(4,517)**
Current assets			
Inventories	12,087	11,006	(1,081)
Current Tax Receivables	645	935	290
Trade, Other Receivables	19,037	16,490	(2,547)
Other Financial Assets	104	104	-
Prepayments	2,872	3,107	235
Cash & Cash Equivalents	56,958	66,265	9,307
Current assets total	**91,703**	**97,907**	**6,204**
TOTAL ASSETS	**479,279**	**480,966**	**1,687**
Current Liabilities			
Loans	(5,834)	(5,834)	-
Deferred Income	(3,938)	(3,224)	714
Provisions	(199)	(231)	(32)
Current Tax Payables	(6,640)	(6,768)	(128)
Trade and Other Payables	(21,386)	(22,881)	(1,495)
Other Financial Liabilities	(31,957)	(31,462)	495
Other Liabilities	(5,436)	(5,436)	-
Current liabilities total	**(75,390)**	**(75,835)**	**(445)**
NET CURRENT ASSETS/(LIABILITIES)	**16,313**	**22,071**	**5,758**

	Position as at 30th June 2015		
	Plan £'000	Actual £'000	Variance Fav/ (Adv) £'000
Non current liabilities			
Loans	(85,142)	(85,142)	-
Provisions	(154)	(145)	9
Finance Leases	(5,214)	(5,212)	2
Non current liabilities total	**(90,510)**	**(90,499)**	**11**
TOTAL ASSETS EMPLOYED	**313,379**	**314,631**	**1,252**
Taxpayers' and Others' Equity			
Public Dividend Capital	194,126	194,126	-
Retained Earnings	66,059	71,144	5,085
Revaluation Reserve	53,109	49,276	(3,833)
Other Reserves	85	85	-
TOTAL TAXPAYERS' EQUITY	**313,379**	**314,631**	**1,252**

*PPE – Property, Plant and Equipment
*NCA – Non Current Assets

7. Cash and Cash Flow

The Trust held cash balances at the end of June of £66.265m. This is £9.307m higher than the Plan of £56.958m. This is primarily due to lower than planned capital expenditure of £5.262m and favourable working capital movements: inventories are £1.081m lower than plan; receivables and accrued income balances are £2.547m lower than plan; and payables are £0.445m higher than plan. The graph shown below provides a comparison of actual and projected month-end cash balances for 2015/16.



8. 2015/16 Forecast Outturn

The Trust has re-assessed its financial position following the substantial conclusion of SLA negotiations and firming up of other significant considerations and proposes to review its financial plan for the year from a £5m deficit to a break-even position. This is before technical items (donated income and depreciation, impairments etc.). After technical items the revised plan shows a £1.133m deficit.

However, guidance is awaited from Monitor in respect of the treatment of these technical items re the RAF consultation.

The Trust's forecast closing cash balance reflects the £5.0m reduction in the I&E deficit and the disposal receipt for the BRI Old Building.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
19. Board Assurance Framework 2015 / 16 – Quarter 1 update
Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive Author: Debbie Henderson, Trust Secretary

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

Executive Summary
Purpose The Board Assurance Framework is used to track progress against the Trust's strategic objectives and specifically to track progress against the annual objectives which were derived as part of the 2015/16 annual planning cycle. Following a re-fresh of the Trust's Strategy, the Strategic Objectives continue to reflect the agreed vision for the Trust. The annual objectives reflect the progress required in the current year to ensure delivery of the strategic objectives. Importantly, the framework also describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised. The Board Assurance Framework is a major source of assurance to the Board that the Trust is on track to meet its strategic and annual objectives. Greater emphasis has been applied to the provision of detail of current risks to achieving the annual objective. Key issues to note: The Board Assurance Framework provides detail on: key activities underway to achieving each annual objective; progress in percentage terms *at the current time*; current risks to achieving the annual objective, and actions and controls in place to mitigate these risks; and internal and external sources of assurance to ensure the risks are being mitigated appropriately. The BAF also detailed the residual risk to achieving annual objective. This is a RAG rating as Red (expectation that the annual objective is *unlikely* to be achieved at the year-end), Amber (expectation that the annual objective is *likely* to be achieved at the end year-end) and Green (expectation that the annual objective *will be fully* achieved at the year-end). Of the 36 annual objectives, as at 30th July 2015, there are 20 objectives where delivery is forecast with a residual rating of GREEN and 16 Amber rated objectives.
Recommendations
The Board is recommended to receive this report for assurance.
Impact Upon Board Assurance Framework

Not applicable
Impact Upon Corporate Risk
Risk to delivery of objectives in the BAF are captured in the Corporate Risk Register.
Implications (Regulatory/Legal)
The BAF is an importance source of assurance to external regulators.
Equality & Patient Impact
Not applicable

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				22nd July 2015	Risk Management Group – 8th July 2015

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
1	We will consistently deliver high quality individual care, delivered with compassion.	**1.1.** To improve patient experience by ensuring patients have access to care when they need it and are discharged as soon as they are medically fit - we will achieve this by delivering the agreed changes to our Operating Model	Focus the improving early discharge (time of day) and reducing delayed discharges integrated discharge processes, team and hub. Undertake a review of the need for, and nature of, further additional out of hospital capacity and notably "discharge to assess" capacity Introduce changes in the unscheduled care pathways which improve flow and promote prompt discharge Maintain and further develop the Planned Care model across surgical areas to improve throughput, efficiency and patient and staff experience Deliver an agreed programme across surgical services in the BRCH to improve efficiency and throughput and align capacity and demand Review adult critical care provision across the organisation with the aim of eliminating cancelled operations due to access to critical care Plan and deliver a Breaking the Cycle Together event to further embed the SAFER bundle across the Trust and support improvements introduced by the Operating Model projects	25-50%	Integrated discharge hub established and evaluating positively. Progress being on related Quality Objectives, though rated AMBER due to ongoing risks Discharge to Assess capacity established with immediate benefit but now requires further focus to ensure flow through these beds. Flow transformation project ongoing, with evidence of impact. Ward Processes bundle delivering early benefit and roll out underway. Terms of Reference for review of critical care in development - discussion on-going in respect of scope. Breaking the Cycle concluded.	System partners do not sustain their focus on UH Bristol pathways and flow. Reduction in bed base of NBT, RUH and Clevedon during summer months. Recommissioning of large volume if homecare providers	Urgent Care Working Group actively managing risks and developing mitigation plans. Weekly operational meetings with system partners to enable early escalation of emerging issues Daily Alamac calls to enable cross partner discussion regarding flow and operational issues	UCWG holds Bristol system risk register, and SRG holds BNSSG wide risk oversight. UH Bristol Executive Directors represented on both groups	A	753	COO	Senior Leadership Team	Transformation Board 1st June. SDG 15th June
		1.2. To ensure patients receive evidence based care by achieving compliance with all key requirements of the service specifications for nationally defined specialist services or agree derogation with commissioners	Deliver action plan to achieve compliance with all areas where derogation has not been agreed, in line with timescales set by commissioners and mitigate any risks associated with on-going non-compliance	0% - 25%	Commissioning and Planning Group has been reconvened and working where appropriate with the Clinical Strategy Group which will oversee service specification requirements.	Risk that the number of centres being proposed for Congenital Heart Disease acts as a barrier to any individual centre to achieve required compliance.	The Trust continues to work closely with NHS Providers and others to propose a solution to NHS England.	NHS England Commissioning Planning Group	G	TBC	DS&T	Clinical Strategy Group	
		1.3. To address existing shortcomings in the quality of care and exceed national standards in areas where the Trust is performing well.	Deliver the quality improvements as per 15/16 CQUIN schedule Deliver all annual quality objectives described in the Trust's quality report To ensure services are compliant with national quality standards including compliance with the draft standards for paediatric cardiac services	0% - 25%	Details of 2015/16 Patient Safety CQUINs (sepsis and acute kidney injury) being agreed with commissioners The Trust identified 9 corporate quality objectives for 2015-16. Based on progress and performance year to date, four objectives are 'green' rated (ensuring patients are treated on the right ward for their clinical condition; improving how the Trust communicates with patients; improving the quality of written complaint responses; and improving experience of cancer patients), one is amber rated (reducing appointment delays in outpatients and keep patients better informed about delays) and three are red-rated (reducing cancelled operations; minimising inappropriate patient moves between wards; and improving patient discharge). One objective has not yet been rated (improving the management of Sepsis) Awaiting National Standards from NHS England with regard to Paediatric Cardiac Services. The Trust are not aware of any services which are not compliance with accepted national standards	Non-acheivement of patient flow objectives	Cancelled ops performance continues to be monitored through divisional performance reporting; patient moves performance continues to be monitored through the emergency access steering group; and patient discharge performance continues to be monitored through the Transformation Board	Internal assurance: Divisional performance reporting Emergency Access Steering Group Transformation Board Quality and Performance reporting via the Quality and Outcomes Committee CQUIN reports to the Clinical Quality Group CQG monitors and reviews standards of care on a monthly basis External Assurance: Care Quality Commission intelligence monitoring on a quarterly basis Commissioners quality meeting	A	TBC	MD / CN	SLT and CQG for CQUINs Clinical Quality Group for quality objectives;	SLT 22/7/15 Clinical Quality Group 2/7/15
		1.4. To ensure the Trust's reputation reflects the quality of the services it provides	Subject to resources, review and redevelop the Trust website to promote the Trust to as wide a group of stakeholders as possible. Work proactively with media and other key stakeholders to actively promote positive coverage of the Trust's activities	0% - 25%	Preparatory work done to make recommendations on how website could be redeveloped. Next steps are to engage divisions and seek input and agreement, apply for funding and tender for a supplier. Media work - fully on track. Working with a range of media to achieve short term, medium and longer term results	Funding not achieved. Media work - negative events are extensively reported in the media and we cannot maintain the same level of proactive work.	Substantial maintenance being done on current website to ensure it remains functional. Media - Maintaining good relationships with the media to maintain balanced reporting of negative events. Looking at longer term coverage that would not be as affected by short term negative events.		A	TBC	Deputy CEO	Senior Leadership Team	22/07/2015
		1.5. Reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.	Successful programme management of Trust Patient Safety Improvement Programme - deliver on process improvement measures and outcomes	0% - 25%	Launch of Trust Patient Safety Improvement Programme planned 31st July 2015. Work streams set up.	Delay in launch of the patient safety programme due to vacancies in the central patient safety team Failure to identify and implement effective actions and reduce harm Ensure a focus on, and understanding of, reduction on 'avoidable' deaths	Interim support sourced, pending the commencement of the permanent Patient Safety Programme Manager. Having a reliable process to identify causes of harm including RCA process Increase understanding of 'avoidable' deaths	Internal assurance: Patient Safety Programme reports to the Patient Safety Group, Clinical Quality Group	A	TBC	MD	Senior Leadership Team	22/07/2015
2		**2.1.** To successfully complete phase	Complete the ward re-furbishments in Queens Building.		Good progress being maintained on majority of schemes,	Failure to successfully mobilise contingency	Redevelopment Board continues to have	Project Risk Register		2476 & 759	COO	BRI Redevelopment	29/06/2015

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
		4 of the BRI Redevelopment	Complete the refurbishment of the outpatient departments in the King Edward Building. Staff Restaurant opened Q1.	0% - 25%	however delay of transfer of pathology services to Southmead had impacted on forward programme. De-commissioning of Old Building currently on track as a result of mobilising contingency plan to address delayed service transfers. Office planning exercise concluded which confirms adequate space for reprovision, though significant work to do to achieve appropriate co-locations. Façade due to be completed by Q1 2016/17.	plan for clearing Old Building of all services. Further delay to service transfers. Failure to address budget constraints associated with KEB work programme.	oversight of all Phase 4 risks, and is responsible for developing actions to adequately mitigate.	presented to KB on monthly basis. External Gateway Review GREEN rated, providing assurance re approach to project and risk management.	G			Group	
			Identify and implement solution for office accommodation, aligned to vacation of Old Building										
			Successfully deliver Queen's Building Façade Project										
	We will ensure a safe, friendly and modern environment for our patients and our staff	**2.2.** Ensure Emergency Planning processes for the Trust are 'fit for purpose' and that recommendations from internal and external audit have been implemented	Review and restructure as appropriate the Civil Contingencies Committee and its sub groups (Major Incident Planning, Business Continuity and Communicable Disease.	25% - 50%	The Terms of reference for the Civil contingencies steering group were reviewed and amended following the Civil Contingencies steering group meeting on 15/06/2015. The Trust Major incident plan was issued in February 2015, an exercise to test the plan will be held in conjunction with an exercise to stress test the helideck functionality.	That there will be a delay in recruiting into the vacant post in the resilience team caused by the current resilience manager retiring.	A new resilience Manager has been recruited and following successful completion of the HR process will commence employment with the trust	EPRR annual assurance process due for submission in September 2015, progress will be monitored by the Civil Contingencies Steering group and deputy COO	G	TBC	COO	Senior Leadership Team	22/07/2015
			Embed and test for revised Major Incident Plan.										
		2.3. Set out the future direction for the Trust's Estate	Agree and implement approach to future of Old Building Site	0% - 25%	Strategy agreed, update provided to Board June 30th 2015	Planning permissions is not secured, for planned use. Unable to secure a transaction that reflects best value or development partner not able to be identified in timeline to support current decommissioning timeline.	External advisers (HTC) and District Valuer (DV) engaged to provide advice to capital team. Pre-application discussions with planners established.	DV and HTC have provided third party assurance regarding Trust approach and value expectations. Capital Programme Steering Group	G	TBC	COO	Senior Leadership Team	22/07/2015
			Scope future priorities for refurbishment of remaining estate post BRI Redevelopment and incorporate into forward strategic capital programme - Campus Phase V	0% - 25%	Process for Phase V evaluation being developed.								
			Agree and implement revised Governance arrangements for forward capital programme.	0% - 25%	Draft governance structure has been developed. Terms of Reference for new structure being developed.								
3		**3.1.** Developing Leadership and Management Capability: Deliver a comprehensive approach to leadership and management training and development. The immediate focus will be front line supervisory and managerial roles across the Trust.	Roll-out new internal Leadership Programme for front line managers and supervisors	25% - 50%	The new leadership programme is in place and will be evaluated from January to June 2015. Almost 400 managers have been trained so far this year. Masterclasses were launched in February 2015, to date over 120 leaders have attended and early evaluation has demonstrated an increase in confidence with the leadership model and real value in coming together as a community to reflect on leadership in practice.	There is a risk that we do not improve the capability of front line leaders as approach not targetted effectively.	A review of approach to leadership development is underway focussing on ensuring we are clear about capability gaps we are trying to close.	Risks are managed through the Workforce & OD group and Transformation Board	A	TBC	DWOD	Workforce and OD Committee QOC	08/07/2015
			Launch monthly Leadership masterclasses based on the leadership healthcare competency model. These workshops encourage leaders to 'make leadership real in practice' and work as a community/action learning set to develop and consolidate skills										
			Use the Teaching and Learning system to record appraisals and support individuals with their learning records										
			Develop a 'development centre' approach for managers and leaders to enable them to understand and map their competencies and enable them to plan their development to support the Trusts priorities										
		3.2. Staff Engagement: Improve two way communication, including a programme of listening events	a) Ensure the programme of listening events are responding to local actions to support staff survey outcomes b) Develop with divisions other interactions that support listening opportunities for staff c) Achieve a better understanding of staff concerns/issues by drilling down from themes of the Staff Survey d) Undertake more regular pulse checks and ensure actions are fully and accurately reflected in Divisional Plans	25% - 50%	Divisions have their own engagement and Staff Survey action plans. Extensive work being carried out to listen to and engage with staff, co-designing solutions to identified problems. These include "fix it" boxes, smaller surveys, engagement events relating to the operating plans, focus groups on specific issues, the findings from which are translated into impactful actions.	Risk that staff engagement does not improve as listening events not prioritised and/or not well attended. Failture to act on feedback.	Staff Experience/ Leadership Development Group debating the management of risk to the agenda. Recommendations are under consideration and will be shared with Workforce and OD group/SLT.	National Staff Survey findings. Staff Experience and Leadership Development Sub-Group, Workforce and OD group and Transformation Board	A	TBC	DWOD	Workforce & OD Group	08/07/2015
			Conducted a full census staff survey. Carry out more regular pulse checks and ensure actions are fully and accurately reflected in Divisional plans										
		3.3. Recruiting and Retaining the Best. Key priority; develop a structured marketing approach which is tailored to target staff groups, improve the speed of recruitment application to appointment	Identify and implement improvements within the end to end recruitment process, focussing particularly on the known areas of inefficiency	25 - 50%	Areas for improvement to create efficiency were identified through the rapid improvement programme - optimising the speed of staff recruitment. The roll out of the new recruitment system is on schedule to go live by the end of June 2015 - once fully operational, full measurement of the end-to-end recruitment process will enhance recruitment performance. Training for appointing managers is being rolled out. Work remains ongoing to identify improvements in processes and systems within the TSB. Concerted efforts continue to improve the compilation of staff exit information. Benchmarking is underway and evaluating results from a recent survey on staff benefits, the outcomes of which will ensure that the framework is responsive and improves retention.	There is a risk that we fail to recruit and retain staff key staff groups due to national shortages; timeliness of recruitment and failing to address high turnover.	Recruitment group overseeing detailed plan to ensure we achieve staff numbers with OPP. WFOD Group overseeing retention/staff engagement plan	The Recruitment Sub-group of the Workforce and OD Group and the Workforce and OD Group.	A	2841	DWOD	Workforce & OD Group	Recruitment Sub-Group 15 July 2015, workforce & OD group 8 July 2015
			Procure and implement a recruitment management system which delivers the required efficiencies within the recruitment process and deliver improved management information and performance monitoring.										
			Review processes, systems and practice within the Temporary Staffing Bureau to ensure a fit for purpose and efficient service delivery in order to meet the increasing demands of the Trust's temporary workforce.										
			For existing staff, develop retention and reward initiatives, informed by the exit data, FFT and staff survey, including mobilisation of staff engagement plans.										

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
	We will strive to employ the best and help all our staff fulfil their individual potential.		Improve exit data to understand key reasons for leaving.										
			Develop a strong identity through innovative branded advertising solutions.										
		3.4 Reward and Performance Management: Improve the quality and application of staff appraisal	Clarify role, responsibilities and objectives for all individuals and teams	0% - 25%	Benchmarking underway, results from staff survey 2014; feedback session with from the Staff Engagement Sub-group w/c 15/6 ; Trust working with Kallidus (IT system provider) to understand the capacity to record appraisal information including objectives and scoring; Staff Health appraisals included in Ward Health and Safety Audits; Aston pilot on team objectives underway. All these actives will shape the work required to ensure that all staff will have clarity of their role, responsibilities and clear objectives.	Risk that employees do not feel the quality of appraisals has improved due to inadequate IT systems, capacity to coach/train staff/managers, - confusion caused by revalidation for nursing staff.	Develop better understanding of IT capability, targetting training and coaching resources to jave maximum impact; and working with Nurse Directorates to anticipate requirements of revalidation	Risks reviewed by the Workforce & OD group	A	TBC	DWOD	Workforce & OD Group	08/05/2015
			Clearly identified competences and training to enable staff to deliver against objectives										
			To include staff health appraisal process with 100% of appraisals conducted, which will change immunisation status, physical and emotional health and promote health and well being.										
			Regular recognition for achievement and holding to account where performance falls short of required levels										
			Develop a better understanding of what constitutes a 'high performing team' including productivity of measures /KPIs derived from best practise benchmarking	0% - 25%	Aston pilot on effective team working (including team objectives) underway - 2 cohorts received training on team coaching and will be working with chosen Trust teams. High performing teams which have completed Aston will see an increase in the quality and effectiveness of care, improved inter-professional team working, increased well being of team members, and reduced turnover and sickness.								
			Develop a pay and reward framework which supports the development of high performing individuals and teams	25% - 50%	Benchmarking underway and evaluating results from a recent survey on staff benefits, the outcomes of which will ensure that the framework is responsive and improves retention.								
		3.5. Education, Learning and Development: Provide high quality training and development programmes to support a diverse, flexible workforce	Develop an appropriate infrastructure and strategy to deliver high quality training and development, including strengthening partnerships with other organisations	25% - 50%	Strategy signed off by SLT and TB. New governance via Education Group and L&D group in place. Restructuring of T&L team with workforce portfolio underway	Risk of insufficient progress against the objective due to lack of clarity of the priorities education, teaching and learning	Ensuring resource and limited investment targetted at appropriate staff (we must understand the gap we are trying to close)	Risks reviewed by the Education Group and the Workforce Management Group	A	TBC	DWOD	Workforcve & OD Group	08/07/2015
			Work with Divisions to scope priorities for training to deliver service and organisational requirements and to ensure safe and effective patient care to develop a trust wide plan	25% - 50%	An activity template has been developed and completed by divisions in partnership with education, learning and development. Further work with the divisions to prioritise training against organisational requirements will be introduced as part of the business planning round in 2015/16								
			Monitor and evaluate equity of opportunity, consistency of approach and a measureable return on investment, highlighting gaps and implementing appropriate measures to respond	50% - 75%	A quality assurance framework is embedded within learning and development practice and will be further extended within education, learning and development strategy. There is a plan to review the approach to ensure equity of access during 2015/16								
		3.6. Strategic Workforce Planning: Improve workforce planning capability, aligning our staffing levels with capacity and financial resource, using workforce models and benchmarks which ensure safe and effective staffing levels	Develop Trust wide workforce planning capability to ensure that key managers have the necessary skills to plan and develop their staffing	25% - 50%	Training programme for HR and finance leads sourced via HESW. Workforce plans developed as an integral part of Operating Planning process, aligned to activity and financial plans.	Risk to delivering workforce plans due to lead in times for recruitment and shortage of some staff groups. Risk of higher than planned use of agency staff to fill gaps.	Options appraisal, including overseas recruitment, under development. Steps taken to increase supply of bank staff.	Risks reviewed by Workforce and Organisational Development and Risk Management Group. Also Finance Committee and Quality and Outcomes Committee.	A	2841 & 1404	DWOD	Workforce & OD Group / Risk Management Group	08/07/2015
			Support divisions to assess any hard to recruit staff groups or specialties impacted by age profiles and enable them to develop different ways of staffing their services where appropriate.										
4		**4.1.** We will continue to deliver a programme to support the long-term vision of the Trust's Clinical Systems Strategy (2012) whereby every member of our staff will have access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again.	Continue/commence implementation: UPACS, Electronic Document Management, Critical Care Information System, Laboratory Information Management System, Clinical Task Management & Communication, Electronic Prescribing, Connecting Care - Stage 2 and replace VPLS. Also introduce a number of Medway related projects i.e. Patient self check-in and clinical noting functionality	75%-100%	Various projects within the programme in hand and will be implemented by the year end. The next phase is ongoing progress. Phase 3 will be scoped and agreed in year	IT implementations are inherently high but with adequate mitigation.	Proper programme monitoring and management processes will manage the risks through the various Project Boards, IM&T Committee and CSIP Committee.	IM&T Committee and CSIP Committee	G	TBC	DoF	Information Management and Technology Group	
			Start to work up and agree CSIP plans for the next phase										
		4.2. We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within	(a) Develop and initiate project(s) within the 'delivering research' work stream to identify the opportunities to improve our performance to time and target for non commercial trials.		(a) Initial project identifying reasons for not meeting time and target approaching conclusion; will inform planning for further projects. (b)Pending completion of (a)	(a) (b) Competing priorities for fixed resource. (c) High levels of expert resource will be required to support implementation of	(a) (b) - appropriate planning and monitoring of performance against plan and actual performance; review of resource requirements for this and other projects and	Trust Research Group Clinical Research Network Annual Plan and Annual Report, reported to the		TBC	MD	Trust Research Group	Jun-15

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR)	(b) Following (a), make changes to the way we manage our research to increase the rate of delivery to time and target for non commercial research (c) Support the Division of Medicine in developing a sustainable staffing model to deliver research by the end of 2015/16.	0% - 25%	(c) Plan of work has commenced - information gathering phase ongoing. On track.	change, with strong buy-in from divisional management team. Absence of this will put implementation at risk.	reprioritisation if necessary. (c) Close engagement with divisional management staff ensuring awareness of timelines of the plan and when input and leadership will be required. Monitoring of progress against the plan. Extensive oversight of Clinical Research Network performance on a monthly basis via the Medical Director and Director of Finance	Board of Directors. NIHR - review the performance of the CRN and feedback on any issues and concerns	G				
		4.3. We will maintain NIHR grant applications at a level required to maintain Department of Health allocated Research Capability Funding within the upper quartile nationally (published annually by NIHR)	(a) Improve systems and processes for setting up NIHR grants within UH Bristol and across Bristol Health Partners, increasing the rate of meeting planned timelines for grant setup, and thereby optimising NIHR grant income. (b) Work with our partners in Bristol in developing strong bids for the expected NIHR biomedical research centre/unit call in 2016, to maintain the infrastructure already in place to support cardiovascular and nutrition research.	0% - 25%	(a) Regular cross-organisational meetings taking place. Admin support provided to group by BHP. Changes to systems and processes required identified. Metrics and timelines agreed and incremental changes taking place. System in place within UHBristol to monitor setup times. (b) High level strategic discussions ongoing in preparation for the calls, after which collaborative work on the bids will commence.	Risk that NIHR reduces the Research Capability funding.	(a) (I) Engagement with BHP Director ongoing; group self monitors progress against plan; for UHBristol, regular updates to head of R&I by UHBristol team member (grants manager); (ii) Contributors to group from organisations are appropriate and can contribute to change. Monitored and reviewed by oversight of the CRN	Trust Research Group Clinical Research Network Annual Plan and Annual Report, reported to the Board of Directors. NIHR - review the performance of the CRN and feedback on any issues and concerns	G	TBC	MD	Trust Research Group	Jul-15
		4.4. We will demonstrate the value of research to decision makers within and outside the trust	(a) Routinely identify recently completed grants and collate information about the outputs and potential impact (b) Identify clinical areas where the conduct of research has had a defined impact on the service delivery (c) Disseminate information to relevant stakeholders (internal and external)	0-25%	(a) Ongoing activity, supported by newly appointed grants and contracts facilitator (b) Ongoing engagement with band 7 research nurses to draw this information out. (c) Ongoing discussions to identify appropriate routes of dissemination within the trust. Ad hoc dissemination is taking place to relevant partners as required.	(a) completion rates of locally led grants is low, making momentum difficult to maintain (b) tangible benefit difficult to quantify, reducing the likelihood of impacts being identified and reported (c) Low throughput so routine standard systems for dissemination may not be effective	(a) Incorporation into routine checklists within R&I for grants and contracts facilitator (b) continual engagement with research staff via research matron and other routes (c) develop tailored approach as required Reporting to Board and stakeholders via the Annual Quality Report	Trust Research Group Clinical Research Network Annual Plan and Annual Report, reported to the Board of Directors. NIHR - review the performance of the CRN and feedback on any issues and concerns	G	TBC	MD	Trust Research Group	Jul-15
		4.5. We will develop transformation priorities to deliver improved patient pathways and adopt innovation.	Support the objectives identified in the Operating Model initiatives (Ref 1). Review objectives for 15/16 to further improve Trust wide efficiency. Deliver a theatre transformation programme to drive more efficient use of theatres, better patient and staff experience	25-50%	A re-scoping exercise has been undertaken and mobilisation of the agreed programmes of work is underway. A detailed review of progress is held monthly Programmes are underway in each theatre suite, led by local teams, but addressing common themes. The overarching programme ensures good practice is shared, supports teams in implementation, and has established common performance reporting and progress monitoring.	Do not identify the right actions to address underlying issues We allow progress to drift Do not convert good project work into sustained improved performance	Structured review by Transformation Board Detailed benefits realisation plans and performance tracking. Strong engagement of clinical teams at all levels	Progress updates to Trust Board	G	TBC	DS&T	Transformation Board	
5	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**5.1.** Ensure organisation support for developments under the Better Care Fund	Work with community partners to reduce avoidable emergency admissions through initiatives supported by the Better Care Fund. Work with community partners to reduce delayed transfers of care by 50% over two years (Jan 15 - Dec 16).	0% - 25%	Better Care Fund Board (BCFB) presentation to SLT 1st July. Urgent Care Working Group (UCWG) currently reviewing and refreshing System Emergency Access Recovery Plan. Internal Emergency Access Steering Group reviewed and format and focus revised. Insufficient progress on reduction in delayed discharge. Renewed focus.	Community partners do not engage with objectives of BCF programme. Insufficient capacity in community to support 50% reduction in delayed discharges	Multiple actions are in place to mitigate the impact of any single initiative failing. The collective impact of individual actions exceeds that required in total.	UCWG , BCFB and SRG all retain oversight of progress and internal group reports directly to Trust Service Delivery Group, whilst Divisional actions are scrutinised through the Divisional review framework.	A	TBC	COO	Senior Leadership Team	1st June 2015 - Unscheduled Care and Discharge Group
		5.2. We will effectively host the Operational Delivery Networks that we are responsible for.	Establish governance arrangements for both Critical Care Networks.	50% - 75%	Medical Director membership of Governing Body established. Host of two Operational Delivery Networks. Medical Director is a member of the NHS England Governing Body. Governance arrangements are fully embedded	Risk to maintaining robust governance arrangements	Governance arrangements in place Review of hosting arrangements to be reported to Audit Committee	Report to NHS England Governing Body Report and assurance regarding hosting arrangements to be reported via the Audit Committee	G	TBC	MD	Senior Leadership Team	22/07/2015
		5.3. We will play an active part in the research and innovation landscape through our contribution to Bristol Health Partners, West of England Academic Health Science Network and Collaborative for Leadership and Applied Research and Care.	Fully engage with BHP agenda and governance. Fully engage with AHSC governance and assist with strategic planning.	50% - 75%	CEO membership of Bristol Health Partners and AHSN Boards.	Risk of failure to effectively engage	Full engagement in place. The Chief Executive and Medical Director are members of the BHP Board Chief Executive is a member of the AHSN Board	Regular reporting to the Senior Leadership Team and Board of Directors WEAHSN quarterly reports to the Board	G	TBC	MD	Senior Leadership Team	22/07/2015

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
		5.4. We will be an effective host to the networks we are responsible for including the CLARHC and Clinical Research Network	Establish robust internal governance including Board reporting for the CRN and CLARHC	50% - 75%	CRN Governance and Exec group established.	Risk to maintaining robust governance arrangements	Governance arrangements in place Review of hosting arrangements to be reported to Audit Committee	Report and assurance regarding hosting arrangements to be reported via the Audit Committee	G	TBC	MD	Senior Leadership Team	22/07/2015
6	We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal	**6.1.** Deliver agreed financial plan	Achieve positive contract settlement with CCG and NHSE commissioners	0 - 25%	SLA signed in line with Heads of Terms	Under performance of activity Under delivery of CIPS Failure to deliver performance	Monthly Divisional Reviews Finance Committee Board of Directors	Oversight by operational planning core group	G	741	DoF	Finance Committee	23/06/2015
		6.2. Develop better understanding of service profitability using Service Line Reporting and use these insights to reduce the financial losses in key areas.	SLR development Use of result in informing Business Planning	50% - 75%	Q4 14/15 by October 2015	Staff in place plus systems development	Finance Department Operating Plan		A	TBC	DoF	Finance Committee	23/06/2015
		6.3. Deliver minimum cash balance	Maintain ratio of at least 15 days and cash balance of no less than £15m	100%	Current cash at month 2 £70m - plan at end of 15/16 £43.7m	Delivery of financial plan	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	G	TBC	DoF	Finance Committee	23/06/2015
		6.4. Deliver the annual Cost Improvement Plan (CIP) programme in line with the LTFP requirements	Ensure robust in year oversight of Divisional Cost Improvement Plans through monthly Finance & Operations Review. Develop robust CIP plans to ensure annual CIP is delivered in 15/16 in addition to carry forward shortfalls from 14/15.	0% - 25%	Focus of work programme. Recently reviewed. Workstream Terms of Reference being clarified. Renewed focus on CIP pipeline at Divisional level.	Further opportunities to reduce costs cannot be identified and / or planned CIP schemes are delayed or do not materialise	Savings Board supports identification of CIP opportunities, including commissioning of work looking at RCI and service opportunities there in. Monthly Divisional CIP Review meetings to monitor progress of current plan and ensure recovery actins if required.	Monthly Reports to Savings Board and Finance Committee. External benchmarking to provide assurance on Trust approach taken.	A	741	COO	Finance Committee	22/06/15 & 23/06/15
		6.5. Ensure 2015-16 Operating Plans addresses risks to sustainability	Ensure 15/16 Operating Plans are reviewed at quarterly executive reviews to ensure robust implementation.	0% - 25%	Monthly & Quarterly Divisional review format, function, and paperwork recently revised, changes evaluating well.	Plans are unable to be implemented due to factors outside Trust control such as failure to recruit.	Monthly reviews flag early warning to risks to delivery, which in turn requires recovery plans to be developed for review and implementation		G	TBC	COO	Senior Leadership Team	Monthly review w/c 22nd June
		6.6. Thoroughly evaluate the major strategic choices facing the Trust in the forward period so the Board is well placed to take decision as they arise.	Appraise the risks and benefits associated with forthcoming major, strategic choices and decision e.g. SBCH and Community Child Health and ensure the Board is adequately briefed and supported to make choices.	0% - 25%	Issues being reviewed by Clinical Strategy Group. Work for Community Child Health has started.	Capacity to deliver Strategic Implementation Plan and multiple bids.	Agreement to get external resource for Community Child Health.	Senior Leadership Team	G	TBC	DS&T	Senior Leadership Team	22/07/2015
		6.7. Continue to develop private patient offer for the Trust	Develop robust systems and controls for private and overseas patients, working closely with finance function Develop a co-ordinated Trust-wide programme of private patient activity.	0%-25%	Finance Project has commenced with focus on overseas patients. Private patient cost recovery will form second part of project. Currently recruiting into vacancy for Private patient support manager post	Failure to recruit to post	Development of post which is attractive to potential candidates	Progress reports to SDG and Finance Committee.	A	TBC	COO	Senior Leadership Team	22/07/2015
7		**7.1.** Maintain a Monitor Continuity of Services Risk Rating (COSRR) of 3 or above.	Achieve Liquidity and Capital Debt Service metrics in line with plan	75 - 100%	COSRR at month 2 is overall 3.	Delivery of CIP plans and reduction of premium cost services. Increase in volume of clinical activity to secure income from activities income in line with SLA and Trust Plan	Monthly Operational and Financial Reviews chaired by COO with Exec Director support.	Monthly reports to Finance Committee and Trust Board. Quarterly Reporting to Monitor via Finance Committee and Trust Board.	G	741	DoF	Finance Committee	23/06/2015
		7.2. Restore Trust's Monitor governance rating to GREEN and maintain throughout 2015/16.	Delivery of recovery plans in areas of A&E, cancer services and Referral To Treatment Time targets. Develop response and implement agreed actions arising from Well Led Review Develop and implement RTT Reporting Migration Plan in line with agreed timescale	0% - 25%	On track to deliver RTT recovery plans for Q1. A&E trajectory not achieved but month of June likely to be achieved. 62 day cancer standard remains at risk, but adjusted performance achieved. Final Deloitte Report now received, recommendations now being considered for Board review at July Seminar.	Activity exceeds plans, partners do not deliver benefits in flow as predicted, recruitment is delayed or unsuccessful	Performance Improvement "architecture" established for all three areas and reporting to SLT. Divisional actions closely monitored through monthly review mechanism. System oversight achieved through UCWG.	Monthly reports to Quality & Outcome Committee and Trust Board. Quarterly Reporting to Monitor via QOC and Trust Board.	A	TBC	COO	Board of Directors	17th June 2015
		7.3. Establish an effective Trust Secretariat to ensure all principles of good governance are embedded in practice and policy	Conclude the Well Led Governance Review and ensure action is taken to remedy any identified short-comings in Trust Governance and push forward on exemplar practice. To agree direction of travel for Trust Document Management System and agree plan for forward approach.	0% - 25% 0% - 25%	Draft report commented upon and final report received for Board review in July. Deloitte feedback to Board and Divisions completed. Board Retreat held in July to review recommendations and agree priority themes for the Board. Options appraisal undertaken for the development of a new fit for purpose DMS, which addresses shortcomings in current system. Discussion regarding infrastructure requirements are ongoing between Trust Secretariat and IT.	Lack of engagement/communication to enforce statutory and regulatory compliance on a Trustwide basis. Risk that the infrastructure for the new Document Management System and Procedural Document Framework remains not fit for purpose.	Board Retreat have considered the 62 recommendations and have agreed priority themes with a view to agreeing a delivery plan in September. DMS working group established, reporting to Risk Management Group to ensure aims are achieved. Cost provision made in 2015/16 Trust Services Operating Plan. Agreement with Internal Audit to re-audit the system before and following implementation to ensure all risks have been mitigated.	Regular updates to Trust Board Quarterly Updates to Risk Management Group	G	1854/ 2619	Deputy CEO	Risk Management Group	Jul-15
	We will ensure we are soundly governed and are compliant with the requirements of our regulators	**7.4.** To achieve regulatory compliance against CQC fundamental standards.	Deliver all aspects of CQC action plans: - Must do's -Should do's - System wide (UH Bristol objectives)		System-wide inspection action plan has been closed - remaining actions subsumed into business as usual for Bristol Urgent Care Working Group. An update of internal must-do actions will be reported to Quality & Outcomes Committee in September with a view to closure	Risk that governance arrangements are not robust to facilitate oversight of ongoing compliance.	CQC inspection action plans are monitored by CQG, SLT and QOC. Fundamental Standards assurance is monitored by CQG and Quality and Outcomes Committee	CQC inspection action plans are monitored by CQG, SLT and QOC. Fundamental Standards assurance is monitored by		TBC	CN	Senior Leadership Team	22/07/2015

Reference	Strategic Objectives	Annual Objective 2015 - 16	Key Activities 2015/16	Progress Towards Achievement of 2015-16 Objective %	Progress Towards Achievement - Narrative	Current risks to achieving Annual Objectives 2015-16	How are the risks to achievement being mitigated? (controls)	Source of Assurance (Internal and External) that Risks are Actively Managed	Residual Risk To Achieving Annual Objective	Risk Register Reference (if applicable)	Executive Owner	Executive Management Group and Date last reviewed	Date reviewed at Monitoring Group
			Implement the revised CQC compliance assurance process and ensure ongoing compliance	50% - 75%	Committee in September. With a view to closure. Progress against 'should do' actions continues to be monitored by Clinical Quality Group. A baseline assessment of compliance with CQC Fundamental Standards is complete. A summary of identified gaps and opportunities to strengthen assurance will be presented to Clinical Quality Group and Quality and Outcomes Committee in August.		Committee.	assurance is monitored by CQG and Quality and Outcomes Committee.	G				
		7.5. Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	To recover admitted RTT by the end of Quarter 4. To recover non-admitted RTT by the end of Quarter 3. To deliver the agreed monthly RTT recovery trajectories on a monthly basis.	0% - 25%	At the end of May the Trust remains on track with all RTT recovery trajectories (admitted, non-admitted and incomplete/ongoing), with the exception of over 52-week waiters for which one was reported against a target of zero. This was a case sent to London for second opinion.	Difficulties sustaining the required level of capacity in dental specialties, and also potential risk to elective flow at the BCH due to higher than expected levels of emergencies. Neurology service also below capacity due to recruitment difficulties.	Divisions review options for increasing/restoring capacity on a week to week basis. Issues escalated to monthly Divisional Reviews. Weekly reporting of progress against RTT trajectories, with opportunities for over-performing in some areas to compensate for delivery risks, explored.	Weekly RTT Operations Group reviews management of longest waiters and backlog management more generally, at a patient level. Monthly RTT Steering Group, overseeing progress with backlog reductions and implementation of the wider RTT plan.	A	TBC	COO	Senior Leadership Team	22/07/2015
		7.6. Improve cancer performance to ensure delivery of all key cancer targets	Achievement of 62 day cancer standard with the exclusion of late referrals across the year, demonstrating performance improvement quarter by quarter. To work with SRG to establish a BNSSG Cancer Group to improve performance and patient experience.	75% - 100%	The BNSSG Cancer Working Group is in place and meets regularly. The Trust is well represented and an active member	None	N/A	N/A	G	1412	COO	Senior Leadership Team	22/07/2015

RED	Expectation that the annual objective is unlikely to be achieved at the year-end	**KEY TO TABLE STRUCTURE**	
AMBER	Expectation that the annual objective is likely to be achieved at the year-end	**Key activities**	key activities which underway to achieving the annual objective (and associated progress toward achieving the strategic objective
GREEN	Expectation that the annual objective will be fully achieved at the year-end	**Progress towards achieving the annual objective**	progress in percentage terms and a narrative of achievement of the annual objective as it currently stands
		Current risks and mitigation of risks	risks to achieving the annual objective, and actions and controls currently in place to mitigate these risks.
		Source of Assurance	including internal and external to ensure the risks are being mitigated appropriately.
		Residual risk to achieving annual objective	RAG rated as Red (expectation that the annual objective is unlikely to be achieved at the year-end), Amber (expectation that the annual objective is likely to be achieved at the end year-end) and Green (expectation that the annual objective will be fully achieved at the year-end).

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
20. Corporate Risk Register

Sponsor and Author(s)
Sponsor: Debbie Henderson, Trust Secretary Author: Sarah Wright, Risk Manager

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The Corporate Risk Register (CRR) contains risks identified as having a potential impact on corporate objectives and includes risks identified in, and escalated from divisions. Divisional risks rated 15 and above are considered for escalation to the CRR in the context of the achievement of corporate objectives. Risks are formally approved for inclusion on and removal from the CRR by the Senior Leadership Team.

Key Issues to note

New Corporate Risks:

- **2030** - Risk to quality of patient care arising from failure to consistently achieve internal turnaround standards for urgent blood tests from St Michael's Hospital. Risk escalated from Women & Children's Divisional risk register
- **1412** - Risk of failure to deliver care that meets National Cancer Waiting Time Standards. Risk escalated from Trust Services risk register

Risks De-escalated to Divisions:

- **741** - Risk of plans under achieving and impacting on trust annual and planned outturn (Trust Services Divisional Risk Register)
- **2126** - Risk of reputational damage arising from adverse media coverage of Trust (Trust Services Divisional Risk Register)
- **2344** - Risk to achievement of one or more strategic objectives (Trust Services Divisional Risk Register)
- **1704** - Potential increased harm to patients queuing outside the main Emergency Department in the corridor. (Medicine Divisional Risk Register)

No risks have been closed.

The Board of Directors is asked to note that the Trust is currently reviewing its approach to reporting risks to the Board and has decided that risks scored 12+ (as opposed to 15+) would be reported in the future. This work is expected to be concluded for presentation to the October meeting of the Risk Management Group, with a view to commencing wider reporting to the Board from quarter 2 onwards.

Recommendations
The Board of Directors is asked to review the content of the risk register.
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
There are no equality or patient experience implications as a result of this report.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Risk Management Group**
				23/04/2015	08/04/2015

Risk Register Report

Risk Number:	Risk Title	Risk Rating
1412	Risk of failure to deliver care that meets National Cancer Waiting Time Standards	Very High (Red)
2030	Risk to quality of patient care arising from failure to consistently achieve internal turnaround standards for urgent blood tests from St Michael's Hospital	Very High (Red)

Risk Register Report

Risk Number: 1412 **Date Added:** 20/04/2009 **Status:** Action Required **Risk Title:** Risk of failure to deliver care that meets National Cancer Waiting Time Standards

Risk Level	Domain	Monitoring Group	Review Due	Risk Assessor	Risk Owner	Initial Risk Rating	Current Risk Rating	Target Risk Rating
Corporate Trust Services Trustwide	Quality	Cancer Board	18/10/2015	Hannah Marder	Xanthe Whittaker	12 High (Amber)	16 Very High (Red)	8 High (Amber)

Risk Description

Failure to meet Cancer Targets, specifically 2-week, 31-day and 62-day target, resulting in poor patent experience, reputational and regulatory issues. Clincial risks as a result of delayed pathways are covered by separate risks when applicable.

Details of Controls	Effectiveness
Weekly meetings held with all Divisions to review cancer patient tracking. Performance reviewed every two weeks at the Service Delivery Group and at the Trust Management Executive via SDG. Performance reported to Cancer Board at every meeting.	High
Cancer performance action plan in place and reviewed at fortnightly Cancer Performance Improvement Group, with new actions identified and added regularly.	Medium
Ongoing efforts to engage other providers and commissioners in performance improvement, for example by leading on pathway timescale development.	Low

Action Plan for	1412	Action	3	Responsibility Of:	Hannah Marder	Target	31/03/2016

Use of ongoing cancer performance target action plan to manage specific actions to improve performance e.g. pathway redesign. Actions identified via monthly breach reviews and weekly PTLs. Action plan updated fortnightly and reviewed by Service Delivery Group.

Action Plan for	1412	Action	4	Responsibility Of:	Hannah Marder	Target	31/03/2016

Ongoing close patient level management of cancer PTL, including a weekly cross-divisional review meeting

Action Plan for	1412	Action	5	Responsibility Of:	Hannah Marder	Target	31/03/2016

Manage response to new NICE guidance together with BNSSG colleagues

Risk Register Report

Risk Number: 2030 **Date Added:** 25/01/2013 **Status:** Action Required **Risk Title:** Risk to quality of patient care arising from failure to consistently achieve internal turnaround

Risk Level	Domain	Monitoring Group	Review Due	Risk Assessor	Risk Owner	Initial Risk Rating	Current Risk Rating	Target Risk Rating
Corporate Womens And Children NICU (StMH)	Quality	Divisional Management Meeting W&C	09/12/2015	Carolyn Donovan	Judith Hernandez Del	16 Very High (Red)	15 Very High (Red)	4 Low (Green)

Risk Description

This risk occurs on a daily basis, and relates to the failure to meet the internal turnaround standard of one hour for urgent bloods - which has the potential to cause harm though the occasions when it does are infrequent (as evidenced by incident reporting)

The pneumatic Chute system is unreliable and had been placed on the Risk register June 2004.

St. Michael's Hospital does not have a laboratory or a blood bank. All specimens, blood and blood products need to be transferred via motor vehicle or pneumatic chute.
The chute system was upgraded and the issue was removed from the 'active Risk Register', however, the reliability has not significantly improved and there have been numerous incidents where treatment has been delayed whilst awaiting for test results

In 2011 legal services received a letter of claim from parents who attribute their baby's profound bilateral hearing loss to failure to monitor bilirubin levels. On review of patient safety incidents for this baby staff have reported two delays in obtaining bilirubin results as specimens were lost in the chute system (Ulysses number 46135 and 46136)
There have been several instances where women's treatment/procedure has been delayed whilst waiting for urgent results.

The chute is a vital piece of equipment for the transfer of urgent specimens not only for NICU and delivery suite but also for the fertility clinic, early pregnancy clinic and the gynaecology ward.
The NICU team have audited transportation of specimens via the chute and have found:-
The mean time for specimens to be transported from NICU to laboratory mean 84 minutes(14 minutes for same time period in BRI ED)
The mean time for blood samples to be analysed and for results available is mean 67 minutes (58 minutes for same time in BRI ED

An additional risk identified is that the chute system now becomes very hot and damages

Details of Controls

Samples and blood and blood products can be transported by:-
1. Taxi,
2. NICU ambulance transport staff

Staff member could walk to the BRI with sample or /and return with blood or blood products.

Discussion with laboratory: can expedite analysis, or inform clinical teams that repeat sample needed

Emergency treatment such as blood transfusion, dextrose infusion, anticonvulsant based on clinical symptoms

Emergency 'O negative ' blood is available on delivery suite

In hours specimens are collected and blood delivered by routine transport at 09.00, 10.30, 11.30, 14.40 and 16.00

Repeat test and transport blood and blood products via Taxi

Effectiveness

Medium

(overheat and breakage of glass bottles the specimens and blood and blood products which are transported

Action Plan for	2030	Action	1	Responsibility Of:	Judith Hernandez Del Pino	Target	28/11/2014

Improve transportation chute on site in NICU and delivery suite all blood samples sent to the lab by chutes robust alternative when chute down e.g. dedicated Porter to walk to and from the BRI Review staffing in the laboratory 24/7 to ensure that urgent specimens sent from high risk areas - theatres, CDS, HDU, NICU are prioritised and delay with a timely fashion Develop audit standards for the analysis of blood test and the release of results. Sufficient WTE MLA lab staff to deal with workload (2 vacant posts at present Review of chute system to identify reason for the raised temperature within the system which is damaging the specimens

Action Plan for	2030	Action	2	Responsibility Of:	Judith Hernandez Del Pino	Target	23/01/2015

Following meeting in October 2014 agreed to look at trial of having a dedicated driver for STMH to transport samples directly to the laboratory in BRI. Without the need for taxis. It is hoped to carry out the trial whilst further work on the chute is carried out. This would be a spend to save project based on current taxi usage.

Action Plan for	2030	Action	3	Responsibility Of:	Judith Hernandez Del Pino	Target	16/06/2015

Business case and planning for new chute

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
21. Register of Interests									
Sponsor and Author(s)									
Sponsor: Debbie Henderson, Trust Secretary Author: Amanda Saunders, Head of Membership & Governance									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose The purpose of this report is to present the Register of Interests for consideration by the Trust Board. The Register is maintained on an ongoing basis via the Trust Connect pages, with an annual reminder issued to all members of the Board. There is also a requirements to declare a Nil Return.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
Regulatory and statutory requirement to undertake this report annually									
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			

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
		Previous version of Board Declaration of Interests 9/6/2015			

Trust Board - Register of Business Interests - Updated July 2015

University Hospitals Bristol NHS
NHS Foundation Trust

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
John	Savage	Chairman	Executive Chairman of Bristol Chamber of Commerce and Initiative	Yes	21.07.15
			Canon Treasurer of Bristol Cathedral Chapter	No	
			Chairman of Destination Bristol	No	
			Chairman Learning Partnership West	No	
			Financial Director Bristol Cultural Development Partnership Limited	No	
			Director of Price Associates Limited	Yes	
Robert	Woolley	Chief Executive	Director of West of England Academic Health Science Network	No	01.06.15
			Member of the governing body of Health Education South West	No	
Deborah	Lee	Deputy Chief Executive and Chief Operating Officer	Nil return	N/A	01.06.15
Paul	Mapson	Director of Finance and Information	Nil return	N/A	02.06.15
Carolyn	Mills	Chief Nurse	Nil return	N/A	05.06.15

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
Sean	O'Kelly	Medical Director	Non-Executive Director Somerset Clinical Commissioning Group Special Advisor, Care Quality Commission Member of Monitor's Clinical Advisory Forum	Yes No No	08.06.15 08.07.15
James	Rimmer	Executive Director of Strategy and Transformation	Trustee of St. Matthew's Church, Bristol Trustee, Changing Times	No No	08.06.15
Sue	Donaldson	Director of Workforce & Organisational Development	Nil return	N/A	06.06.15
Emma	Woollett	Non- Executive Director, Vice-Chair	Woollett Consulting Ltd, consultancy services to NHS organisations, avoid conflict of interest with UH Bristol role Associate with KPMG including NHS projects, avoid conflict of interest with UH Bristol role Trustee of Above and Beyond (until Sept 2015)	Yes Yes No	01.06.15
John	Moore	Non-Executive Director, Chair of Audit Committee	Managing Director at Ezitracker Ltd until May 2015, part if CMM Ltd which supports community based organisations - NHS and other	Yes	05.06.15

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
			In process of establishing domiciliary care business in Bristol	No	
Lisa	Gardner	Non-Executive Director, Chair of Finance Committee	Interim Finance Director at Above & Beyond Director of Watershed Trading Limited & Watershed Trust	Yes No	01.06.15
Alison	Ryan	Non-Executive Director, Chair of Quality & Outcomes Committee	CEO Weldmar Hospicecare Trust - voluntary sector specialist palliative care agency in Dorset	Yes	01.06.15
David	Armstrong	Non-Executive Director	Head of Profession at Chartered Quality Institute, registered charity under Royal Charter	Yes	02.06.15
Julian	Dennis	Non-Executive Director	Nil return	N/A	01.06.15
Guy	Orpen	Non-Executive Director	Deputy Vice-Chancellor and Provost Bristol University Director of the Bristol 2015 Company – links with Bristol City Council and Bristol Green Partnership Member of the Council (Board) of the Natural Environment Research Council	Yes No Yes	08.06.15

First Name	Surname	Trust Position	Description of Interest	Remunerated	Date of declaration
Jill	Youds	Non-Executive Director	Non-Executive Director, NEST	Yes	01.06.15
			Corporate and Trustee for NEXT Pension Scheme	Yes	
			Chair, Judicial Pensions Board	Yes	
			Chair, Northern Ireland Judicial Pensions Board	Yes	
			Non-Executive Director, Hoople Ltd	Yes	
			Managing Director, Cresco Business Solutions	Yes	

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
22. Register of Seals									
Sponsor and Author(s)									
Sponsor – Robert Woolley, Chief Executive Author – Debbie Henderson, Trust Secretary									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**
Executive Summary									
Purpose To report applications of the Trust Seal as required by the Foundation Trust Constitution. Key issues to note Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing. The attached report includes all new applications of the Trust Seal to July 2015 since the previous report on Thursday 30 April 2015.									
Recommendations									
The Board is recommended to receive this report to note.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
Compliance with the Trust's Constitution and Standing Orders									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	**X**		

Date the paper was presented to previous Committees

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)

Register of Seals – May 2015 – July 2015

Reference Number	Date signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
751	13/05/15	IC2011 Intermediate Building Contract. Refurbishment of Wards A528, A525, A524.	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary	Debbie Henderson, Trust Secretary
752	13/05/15	MW2011 Minor Works Building Contract 2011 Central Health Clinic, Refurbishment of the Pain Clinic (x2 copies)	Robert Woolley, Chief Executive	Deborah Lee, Chief Operating Officer/ Deputy Chief Executive	Debbie Henderson, Trust Secretary
753	03/06/15	DAC Beachcroft (Topland Mercury Ltd) with UH Bristol. Deed of variation relating to Suite B, Fourth Floor and one car parking space, Whitefriars, Lewins Mead, Bristol, BS1 2NT.	Robert Woolley, Chief Executive	Not required	Debbie Henderson, Trust Secretary
754	03/06/15	Counterpart Reversionary Lease by reference to an existing lease between Topland Mercury Lts and UHB re Suite B, Fourth Floor and one car parking space, Whitefriars, Lewins Mead.	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance & Information	Debbie Henderson, Trust Secretary

755	22/06/15	Internal Refurbishment Works to bedrooms, bathrooms and shower rooms – Central Delivery Suite – St Michael's Hospital. Ian Williams GD. (x2 copies)	Paul Mapson, Director of Finance & Information	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary
756	25/06/2015	Section 278 Agreement Works to highway at the front of the hospital in connection with Queens Façade Scheme (x2 copies)	Paul Mapson, Director of Finance & Information	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary
757	25/06/2015	Queens Façade Contract between the Trust and D&B Facades for the works to the Queens Building Façade (x2 copies)	Paul Mapson, Director of Finance & Information	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary
758	23/07/15	Tenancy at Will relation to the Eye Bank, Bristol Eye Hospital	Paul Mapson, Director of Finance & Information	Robert Woolley, Chief Executive	Debbie Henderson, Trust Secretary

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
23. West of England Academic Health Science Network Board Report – June 2015									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive Author: N/A									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To update the Boards of the member organisations of the West of England Academic Health Science Network of the decisions, discussion and activities of the Network Board. Key issues to note There are no key issues to note.									
Recommendations									
The Trust Board is recommended to note this report.									
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)**				

Report from West of England Academic Health Science Network Board, 10 June 2015

1. Purpose

This is the eighth quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website http://www.weahsn.net for information.

2. West of England Genomics Medical Centre

West of England organisations are working together on a bid to become a Genomics Medical Centre, as part of the 100,000 Genomes project.

We have created a Partnership Board which includes 17 partners drawn from the NHS, our Universities, Health Education South West and Patient Contributors. It is to be chaired by Tony Gallagher, who is the Chair of the Avon and Wiltshire Partnership Mental Health NHS Trust. NHS England is expected to announce invitations to bid by the end of June with an expectation that the procurement process will be completed by October.

Seven short-life Task and Finish Groups have been established which include subjects like education and training, consent and communication and informatics. The areas of clinical focus will be around Cancer and rare diseases in the first instance.

The project manager for the Genomics Medical Centre is Rachel Ferris. Further details can be found here.

The West of England Academic Health Science Network will host a website page for the West of England Genomics Medical Centre and the first newsletter can be found here.

3. Business Plan 2015/16

The Business Plan for 2015/16 was approved by the Board in late March and by NHS England. Each member organisation is asked to confirm that it is supportive of the Business Plan, and this request has been sent separately to Chief Executives and Company Secretaries as appropriate.

4. Improving Outcomes Through Patient Flow

The Board meeting and the Senior Leaders meeting which preceded it both discussed an offer which the Academic Health Science Network is making with The Health Foundation on improving outcomes through addressing Patient Flow. All health and social care communities are working with great focus to strengthen patient flow through their urgent care systems and this initiative will be pitched carefully to complement existing local work.

The next stage will be to invite expressions of interest and map existing patient flow-related activities with a view to sharing good practice at the Academic Health Science Network's Annual Conference in October.

5. Test Beds

The Five Year Forward View included an initiative called "Test Beds" in which innovator companies will be matched with local areas which demonstrate strong leadership, connected data, potential to scale up and an ability to test combinations of innovations. Each Academic Health Science Network was asked to identify three or four potential Test Beds by 12 June. In the West of England, we have had intensive engagement from many of our organisations and were able to submit three "Test Bed Proposals" which were:

- Mobile Health Diabetes Challenge – a West of England-wide challenge which currently involves 12 of our social enterprises, NHS Trusts and Clinical Commissioning Groups. **Lead organisation:** West of England Academic Health Science Network.
- West of England Early Warning Score – communications in the pre-hospital setting. **Lead organisation:** Royal United Hospitals Bath NHS Foundation Trust, for the West of England Patient Safety Collaborative.
- BNSSG Connecting Care – constructing an interactive "patient portal". **Lead organisation:** Bristol Clinical Commissioning Group for the Connecting Care Consortium.

The Academic Health Science Network has also supported proposals for Test Beds submitted by Avon and Wiltshire Partnership Mental Health NHS Trust and Bristol Community Health.

6. Emergency Department Safety Checklists - Scaling Up Application

The Academic Health Science Network has partnered with University Hospitals Bristol, the South West Academic Health Science Network and the College of Emergency Medicine on a proposal to roll out the Emergency Department Patient Safety Checklist to all Emergency Departments in the South West.

If we are successful, early implementation will start in time for this winter.

7. Developing Capacity and Capability through the West of England Academy

The West of England Academy has run over 35 events over the last year, focussing particularly on Quality Improvement and Patient Safety.

It was given a mandate by the Board to offer a wide-ranging programme and evaluate feedback. Our events have been very well received and the Board agreed that we should now have a three month period of engagement with all member organisations to discuss how we can best develop sustainable support on Quality Improvement science, Patient Safety, Enterprise and Informatics across the West of England. A link to the draft strategy is here.

8. Academic Health Science Network 360° Stakeholder Survey

All Academic Health Science Networks will be part of a 360° Stakeholder Survey commissioned by NHS England, which will take place at the beginning of July 2015 and will be an important part of our quality assurance. Senior Leaders and clinicians from all member organisations and a wide range of partners will be encouraged to take part.

9. Annual Report 2014/15

Our Annual Report for 2014/15 has been published and circulated widely; click here to view the report.

10. Highlights from Quarter 1

Highlights from our work programme between April and June include:

- Atrial Fibrillation – we have finished our pilot work with 11 GP Practices and are analysing it before rolling the work out to every GP practice in Gloucestershire. Four other Clinical Commissioning Groups are interested in adopting this programme.
- We held our first Health Innovator Programme for 21 participants drawn from NHS Trusts, CCGs, Universities and local companies. These individuals worked on developing specific ideas they have into a Business Case which were tested by our 'Dragons' (Chief Executives!).
- We ran a highly successful Patient Safety and Quality Improvement conference in Swindon during April.
- Our Medicines Safety programme was launched at our Medicines Optimisation workshop on 7 May, which was attended by over 70 delegates. The focus of our work will be on medicines safety at transfers of care and insulin safety.

11. Engagement and Events

Read our latest patient safety newsletter here.

SAVE THE DATE

Early Warning Score Workshop, Thursday 17 September, Bath University. Please see attached flyer for more information. Click here to register!

West of England Academic Health Science Network Annual Conference, held jointly with the West of England Local Clinical Research Network and CLAHRC*West* on Thursday 15 October, Cheltenham Racecourse.

Deborah Evans
June 2015

Patient Safety Collaborative Workshop

West of England Academic Health Science Network

Safer Care Through Early Warning Scores

Chaired by Anne Pullyblank, Clinical Director, West of England Patient Safety Collaborative

The launch event of the Safer Care Through Early Warning Scores programme in March 2015 brought together representatives from the West of England Patient Safety Collaborative to work to achieve a single Early Warning Score right across our health care system.

We are now inviting all stakeholders back to feedback on progress; learn from one another and to strengthen understanding on the Breakthrough Series model for implementation.

Thursday 17 September
9.30am – 4.30pm
Bath University
The Chancellor's Building
Claverton Down Road, Bath, BA2 7AY

At this workshop we will:

- Learn about Breakthrough Series Collaborative Models of working.
- Focus on measurement strategies and metrics.
- Revisit the pledges made at the launch event and hear on progress.

The objectives are:

- Increase understanding on how the benefits of a single Early Warning Score can be demonstrably measured.
- Improve knowledge on Breakthrough Series Quality Improvement methodology and programmes.
- Hear how organisations across health communities are working together to achieve a single outcome.

Registration
Please visit our website:
www.weahsn.net/events

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
24. 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: Since the last report was noted at Board, a further 6 new items have been added to the log. 3 items have been updated with a response, and 5 items are now outstanding, pending Executive response – please note only 1 is overdue at the time of issuing this report (item 123).
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 16.07.15

ID **Governor Name**

130 **Mo Schiller** ***Theme:*** Management of patient records ***Source:*** Governor Direct

Query **13/07/2015**

Can the Trust advise on policy and procedure for updating records following the death of a patient. What checks are in place to ensure records are accurately maintained and patients or their family members aren't contacted by the Trust unnecessarily?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 21/07/2015

Response

Pending

Status: *Assigned to Executive Lead*

129 **Karen Stevens** ***Theme:*** Medicines management ***Source:*** Governor Direct

Query **15/07/2015**

What pre-operative and post-operative medicines reconciliation processes are in place? Are they sufficiently robust to ensure patient safety? Are there any measures which could be introduced to reduce potential avoidable harm to patients?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 21/07/2015

Response

Pending

Status: *Assigned to Executive Lead*

128 **Brenda Rowe** ***Theme:*** Access to the hospital ***Source:*** From Constituency/ Members

Query **17/07/2015**

Please can the Trust advise on the rationale for the current free hospital bus service route? Has the Trust considered extending the route to cover other parts of the city, including North and South Bristol, to further support patients who find getting to hospital via Public Transport challenging?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 21/07/2015

Response

Pending.

Status: *Assigned to Executive Lead*

127 **Wendy Gregory** ***Theme:*** Medical Staff ***Source:*** Governor Direct

Query **17/07/2015**

As referenced in the Trust's 2015/16 Operational Plan (page 15):
'Changes to junior doctor numbers -
Work by the Director of Medical Education has helped to confirm that 10 posts will be lost from 2016 (5 Foundation Year 1 doctors and 5 Foundation Year 2 doctors) as a result of the national change to increase community placements. Work programmes to address the shortfall will be developed when the specialties have been identified, but are likely to include changes in workforce models and roles.'

Please can the Trust provide detail with regard to how these changes in workforce models are developing and the potential outcomes that are anticipated to fellow staff members and patients alike

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 21/07/2015

Response

Pending

Status: *Assigned to Executive Lead*

ID	Governor Name		
126	**Clive Hamilton**	***Theme:*** Fracture Neck of Femur Target	***Source:*** Governor Direct

Query **20/04/2015**

We have not been able to achieve Best Practice Tariff since February 2014 and it seems that the main issue is lack of Trauma Theatre capacity to cope with fluctuating demand.
The September 2014 Board report (Pages 34-36) set out a comprehensive action plan with a trajectory for achievement of the Best Practice Tariff of 90% by Quarter 4 (January –March 2015). The monthly trajectory targets have not been achieved since then but February 2015 performance was more encouraging with a Best Practice Tariff performance of 82.8% and 89.7% patients treated within 36 hours (March Board report page 65).
The February Board report (page 61) describes a situation during the weekend of 23rd January when breaches of the 36 hour standard occurred due to seven hip fracture patients being admitted over the 2 days, one of whom died in the operating theatre.
Given this history, I request assurance that our trust will ensure that there is sufficient capacity to meet all three 90% standards from now on.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/07/2015**

At the April Trust Board this matter was raised by Clive Hamilton, Governor representative for the public constituent of North Somerset. In response Sean O'Kelly, Medical Director, referred to ongoing work to address capacity. He went on to explain that this service can see significant peaks in demand and analysis of our own data shows we struggle to achieve the theatre standard when 2 or more patients present on the same day, although of note the majority of patients do have their surgery within 48 hours. Also of note is the Trust's mortality data, which shows that despite a minority of patients not achieving theatre within 36 hours, the service achieves good outcomes for its patients.

Whilst the theatre standard remains an importance measure, the Best Practice Tariff captures 9 aspects of care, the majority of which the Trust performs well against. Finally, the question has recently been posed as to whether patients should be admitted to Southmead at times of peak pressure in the BRI; there are three key reasons that suggest this would not be an appropriate step at this time 1) NBT did not achieve the 36 hour theatre standard in either 2013/14 or 2014/15 2) pre-hospital diagnosis of a fractured femur, in the absence of access to imaging, is not reliable 3) Southmead have advised that their own performance is very fragile and any swing of patients to them would lead to an inevitable further deterioration in their own performance.

Finally, the Division remains focussed on making improvements where it can. Analysis of the time and day of breaches, indicates that the biggest single benefit would come from actions that avoid the cancellation of the patient who is scheduled for theatre in the afternoon but is then cancelled because either, the list is overrunning and thus the case is not started if it would end after 5pm or a clinical priority is identified during the course of the day. Given this context, two actions are being focussed upon – attention to the Golden Case (# NOF going first on the trauma list), addition of a # NOF to the elective limb reconstruction list and staffing of an additional theatre overrun (currently staffed for one per day but to be increased to two). The latter has the most to contribute to performance but will take the longest to implement due to high vacancy rates.

It has been agreed, through the Quality and Outcomes Committee (QOC), that the quality dashboard will be amended to reflect two further measures of # NOF performance to include % seen within 48 hours and the longest wait (for non-clinical reasons).

Status: *Awaiting Governor Response*

125	**Mo Schiller**	***Theme:*** Workforce	***Source:*** Governor Direct

Query **30/06/2015**

Research by the Royal College of Nursing (RCN) claims changes to immigration rules — set to be enforced in 2017 — could cause staffing issues for the NHS. Under the new rules, people from outside the European Economic Area (EEA) must be earning £35,000 or more before they are allowed to stay in the UK after six years. The RCN claims 3,365 nurses working in the UK are potentially affected by these changes, Band 5 staff nurses earn £21.692 - £28.180, the mainstay of registered nursing staff in the Trust, and Band 6,senior staff nurses earn £26.041 - £34.876. Can the Trust advise what the likely impact might be at UH Bristol? In the future will the focus on recruitment will now be within the EU.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **09/07/2015**

Currently the Trust has no plans to undertake targeted nurse recruitment campaigns outside the European Economic Area, however it is very mindful of the potential impact of government immigration policy decisions on workforce supply markets. UHBristol is monitoring national consultations around the proposed changes to immigration rules with regards to an increase in salary thresholds. The Trust's initial assessment is that the impact is anticipated to be low if the new enforcements are set in 2017 on existing nursing staff from outside the EEA, but developments will be monitored and a proactive review will be undertaken as more is known.

Status: *Awaiting Governor Response*

ID **Governor Name**

124 **Wendy Gregory** ***Theme:*** Workforce - Exit Interviews ***Source:*** Governor Direct

Query **01/06/2015**

Can the Trust advise what is the percentage of exit interviews being undertaken in relation to the total numbers of staff leaving the Trust? Also has the format and timing of the exit interview been reviewed to inform if at times it would be possible to encourage an employee to stay with the Trust.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **18/06/2015**

In Q4 the HR Employee Services team had a 31.4% return rate of exit data as a result of a combination of exit questionnaires completed by leavers and exit interviews. This reflects 74 'exit responses' out of 236 leavers in this period.

Concerted efforts continue to be made by the Employee Services team to increase the number of exit interviews being undertaken with staff leaving the organisation and also to improve the quality of information received on reasons for staff leaving the organisation, in order to better inform recruitment and retention strategies.

Furthermore, managers continue to be encouraged to engage with their staff known to be leaving the organisation as early as possible, by way of exploring with their staff member the possibility of remaining with the Trust.

Status: *Closed*

123 **Mo Schiller** ***Theme:*** Nursing Recruitment ***Source:*** Governor Direct

Query **01/06/2015**

When recruiting nurses from Europe and overseas from outside of the EEC, what is the cost comparison for recruitment from the UK? How many of those selected need to follow an adaptation course and what is the time scale for this? Do all staff recruited from Europe and overseas have a language proficiency test and mathematics calculation test for medication?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **01/06/2015**

Pending Executive response.

Status: *Assigned to Executive Lead*

122 **Ray Phipps** ***Theme:*** GPs ***Source:*** Project Focus Group

Query **29/05/2015**

A recent BMA poll of 15,000 GP`s suggests that:
•33% were considering retirement in the next five years.
•25% were considering part time working.
•10% were thinking of moving abroad.

As GP care is an essential part of the overall healthcare system, can the Trust advise how it links and works with local GPs to inform planning for future service delivery and does the Trust recognise or for see an impact on our services based on any potential decline of GPs locally?

Division: Other ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:***

Response **02/06/2015**

We engage with our GPs and other primary care colleagues at various levels, both formally and informally. As Clinical Commissioning Groups are GP member organisations, they are our primary partner in collaboratively planning for future service delivery. However, we do engage directly with GP practices and their local network forums on a range topics.

As the NHS England 5 year forward view places an strong emphasis on care closer to home and innovative new models of care through primary and community services, NHS England has recognised the need for more GPs. Without this, the impact on our hospitals is likely to be that demand for our services will continue to grow.

We are therefore working very closely with our colleagues in Bristol, North Somerset and South Gloucestershire CCGs, local authorities and other partners to improve the resilience of the Bristol (and surrounding area) health and social care system to meet such challenges in the future.

Status: *Closed*

ID	Governor Name		
121	**Bob Bennett**	***Theme:*** Infection Control	***Source:*** From Constituency/ Members

Query **29/05/2015**

Following a query received from a member of the public, please can the Trust advise on the correct policy and procedure for staff wearing clinical uniform – specifically theatre scrubs and other 'sterile' uniforms – in public areas of the Trust such as Costa Coffee in the Welcome Centre? What is the infection control guidance with regards to wearing such items in non-clinical areas, when it would appear that staff are then going to go back into a clinical environment?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **16/06/2015**

Clinical uniform such as scrubs are permitted to be worn outside of clinical areas, as guided by the Trust's Uniform Policy. Specifically 'raspberry' coloured scrubs should be covered with a disposable gown when outside of a clinical area. The Policy states that:

'Scrubs - Only appropriate designated clothing should be worn. When designated, hats should fully cover hair. If footwear such as theatre clogs are required they should be clean and in a good state of repair and of appropriate Health and Safety design. Caps/masks/beard coverings should be removed when travelling out of the department. Specifically designed footwear such as theatre clogs should not be worn outside the department. Raspberry coloured scrubs must be covered with a disposable gown whilst travelling within the hospital setting, but not within the department. Staff must not wear theatre scrubs outside the Trust buildings, unless in extreme circumstances, for example in the event of a fire alarm.'

Whilst we recognise the potential for the public to feel concerned about staff in clinical uniform in public areas of the Trust, it is important to note that there is no evidence to show that there is any issue of infection with such clothing being worn out of (and then back into) a clinical area.

Status: *Closed*

120	**Sue Milestone**	***Theme:*** Inpatient Facilities	***Source:*** Project Focus Group

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?

Division: Trust-wide ***Executive Lead:*** *Director of Finance* ***Response requested:***

Response **18/05/2015**

TV and Radio:
1.Parity Bedside Patient TV and Radio provided by the Trust – These devices provide patients with access to multi-channel TV, Radio and Hospital Radio and are sited in: The New Ward Block (BRI), Bristol Heart Institute, Bristol Haematology & Oncology Centre and Bristol Eye Hospital. There are no charges to the patients for use of these facilities.

2.Premier Bedside Patient TV and Radio provided by Premier Telesolutions – These devices are provided by a commercial company and provide access to multi-channel TV, Radio and Hospital Radio. The cost of running these services was previously at a charge to patients but these services are now funded by Above & Beyond. These devices are sited in: Queens Building (BRI) and St Michaels Hospital.

3.Bristol Children's Hospital – Locally provide/manage access to TV and Radio to all patients. In the majority of cases devices are funded via charitable funds including donations to ward funds and from The Grand Appeal.

Telephone access:
1.Most patients through choice tend to utilise their own mobile phone (the Trust funded the installation of a network solution within the New Ward Block to allow patients to continue to use their mobile phones to contact friends and family).
2.Each ward either has a phone they are able to allow patients to utilise if no other option available to them.
3.There are a small number of pay phones available around the Trust.

Internet access:
Internet access is possible for patients and carers via the Trust Wi-Fi system e.g. for laptop, smartphone or tablet. Ward teams are able to advise regarding log-on details, and there is specific guidance for access for children in line with the Trust's safeguarding practices.

Status: *Closed*

119	**Graham Briscoe**	***Theme:*** Agency Rates	***Source:*** Governor Direct

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?

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **26/06/2015**

From recent Trust records it has been identified that the highest hourly rate paid to a medical Consultant was £150 per hour (hours per shift are variable, e.g. total payment of £1,800 for a 12 hr shift), and the highest shift rate paid to a nurse was £1,814 for an 11.5 hour shift on a Bank Holiday.

Status: *Awaiting Governor Response*

ID	Governor Name		
118	**Clive Hamilton**	***Theme:*** Infusion Pumps	***Source:*** Governor Direct

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?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:***

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: *Closed*

117	**Mo Schiller**	***Theme:*** Performance & Finance - Waiting List Initatives	***Source:*** Governor Direct

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?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **27/05/2015**

(The response relates to adult surgical service provision and excludes paediatrics.)

Number of waiting lists in total?
In the Division of Surgery, Head and Neck there were about 350 extra theatre lists within the division.

In the Division of Specialised Services there were 297 Cardiology lists and 120 Cardiac Surgery lists calculated by the volume of consultant WLI payments. The majority of these take place within core hours (e.g. not weekends). The division has a planned under provision of consultant capacity which is then used flexibly to respond to demand when needed.

Number of lists outsourced to other providers?
In Surgery, Head and Neck the use of outsourced activity is that individual patient cases are outsourced rather than whole lists, although in other divisions whole lists are outsourced

In Specialised Services there are no outsourced lists.

What is the cost of running a WLI against a 'normal list?'
In both Divisions we have calculated the baseline cost of providing a standard session against a waiting list and the comparison is a follows;

Theatre list: £ 933 (Standard session) / £1,395 (WLI)
Endoscopy/Cardiology list: £634 (Standard Session)/ £950 (WLI).

These cannot be considered as exact costs as there will always be variances in cost to some extent, for example the list may be scheduled when the theatre recovery is already staffed adequately to manage the additional work and thus incur no further staffing requirements. Alternatively an additional list at a weekend may require additional staff in theatre recovery. Similarly on the ward as staffing levels are lower at weekends routinely when there is no elective planned activity.

When is it determined that a Waiting List Initiative is required and what is the criteria for patient selection?

Waiting List Initiatives are used when additional capacity is required, beyond that which can be delivered through usual capacity. They are typically delivered at weekends and in the early evening. There are no specific patients booked onto waiting lists, beyond them all being patients who need to be treated in the period because they are either clinically urgent or are long waiting patients who we must treat in order to reduce our backlogs at the rate we have agreed.

It is our goal to reduce reliance upon waiting list initiatives however, they will always be a necessary (and useful) part of our delivery plans as they are an effective means of responding to unpredictable peaks in demand.

Status: *Closed*