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 October 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 agenda	Chairman	–
3. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 30 September 2015	Chairman	3
4. Matters Arising (Action log) To review the status of actions agreed	Chairman	17
5. Chief Executive's Report To receive the report to note	Chief Executive	18
Delivering Best Care and Improving Patient Flow		
6. 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	22
7. Quality and Outcomes Committee Chair's report To receive the report for assurance	Quality & Outcomes Committee Chair	To follow
8. Transforming Care Programme Update To receive the report for assurance	Chief Executive	To follow
9. Children's Services Annual Report 2014/15 To receive the report for assurance	Chief Nurse	To follow
10. Research and Innovation Quarterly Update Report To receive the report for assurance	Medical Director	71
Renewing our Hospitals		
11. Quarterly Capital Projects Status Report To receive the report for assurance	Chief Operating Officer/Deputy CEO	76
Delivering Best Value		
12. Capital Investment Policy To receive the policy for approval	Director of Finance & Information	81
13. Finance Report To receive the report for assurance	Director of Finance & Information	94
14. Finance Committee Chair's Report To receive the report for assurance	Finance Committee Chair	To follow

Compliance, Regulation and Governance		
15. Monitor Q2 Risk Assessment Framework Declaration To approve the declaration for submission to Monitor	Chief Operating Officer/Deputy CEO	126
16. Board Assurance Framework – Q2 update To receive the report for assurance	Chief Executive	147
17. Corporate Risk Register To receive the register for assurance	Chief Executive	156
Information		
18. Governors' Log of Communications To receive the Governors' log to note	Chairman	162
19. National Paediatric Survey Results and action plan To receive the report to note	Chief Nurse	167
20. 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 November 2015, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of the Meeting of the Trust Board of Directors held in Public on 30 September 2015 at 11:00am, Conference Room, Trust Headquarters, Marlborough Street, BS1 3NU

Board members present:
John Savage – Chairman
Emma Woollett – Non-Executive Director/Vice Chair
Robert Woolley – Chief Executive
Deborah Lee – Chief Operating Officer/Deputy Chief Executive
Paul Mapson – Director of Finance & Information
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
Guy Orpen – Non-executive Director
Lisa Gardner – Non-executive Director
Jill Youds – Non-executive Director
Alison Ryan - Non-executive Director
John Moore – Non-executive Director

Present or in attendance:
Debbie Henderson – Trust Secretary
Amanda Saunders – Head of Membership and Governance
Sarah Murch – Membership & Governance Administrator (Minutes)
Tony Watkin – Patient Experience Lead (Engagement and Involvement) (Items 1-6)
Gloria Clark - Patients Association (Items 1 – 6 only)
Carol Sawkins - Nurse Consultant, Safeguarding Children/Named Nurse (Item 13)
Dr Steve Falk – Clinical Director, West of England Clinical Research Network (Item 17)
Dr Mary Perkins – Chief Operating Officer, West of England Clinical Research Network (Item 17)
Clive Hamilton – Public Governor
Mo Schiller – Public Governor
Sue Silvey – Public Governor
Angelo Micciche – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Marc Griffiths – Appointed Governor
Tom Bullock – Member of the public
Rachel Smith – Member of the public

88/09/15 Chairman's Introduction and Apologies (Item 1)
John Savage, Chairman welcomed everyone to the meeting. Apologies for absence were received from Anita Randon, Interim Director of Strategy and Transformation

89/09/15 Declarations of Interest (Item 2)
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. No declarations of interest were received.

90/09/15 Minutes and Actions from Previous Meeting (Item 3)
The Board considered the minutes of the meeting held in public on 30 July 2015. Three amendments were agreed:

With regard to 65/07/15, it was noted that a report on the business case for the redevelopment of Trust Headquarters including proposals for car parking would be presented to October's Trust Board meeting, not September.

With regard to 68/07/15, it was agreed that an action be included in the action log that assurance be provided to the Board that staff were adequately trained to deal with unexpected circumstances and variants from the standard process of expected presentation of patients to departments.

With regard to 70/07/15, it was agreed to amend Mo Schiller's question to refer to 'operating department practitioners' rather than 'medical practitioners'. It was:

RESOLVED:
- **That the minutes of the meeting held 30 July 2015 be agreed as an accurate record of proceedings, subject to the amendments outlined in the minutes.**
- **That assurance be provided to the Board regarding training for staff to deal with unexpected patient presentations to wards and departments**

91/09/15 Matters Arising (Item 4)
Outstanding and completed actions were noted by the Board. With reference to the outstanding actions related to workforce, Sue Donaldson confirmed that work was ongoing to build these into the annual reporting process, and they would form part of the next quarterly reports. It was agreed to close the action on that basis.

92/09/15 Chief Executive's Report (Item 5)
The Board received a written report of the main business conducted by the Senior Leadership Team in August and September 2015. Robert Woolley, Chief Executive, provided a verbal report of matters of topical importance to the Trust.

Robert reported that UH Bristol had submitted a baseline report on seven-day working at the request of Monitor, NHS England and the Trust Development Authority, and were awaiting feedback from the Department of Health regarding the next steps.

In the last month, an application had been submitted for a genomic medicine centre for the West of England. UH Bristol had co-ordinated the bid but it had been based on a wide partnership of providers. The Trust had progressed through the pre-qualification stage, and would now submit an invitation to tender response by 20 October, to be followed by an assessment visit from Genomics England in November.

The Trust had not been successful in its joint application with North Bristol Trust (NBT) into the NHS England Acute Care Collaboration Vanguard programme. However, UH Bristol and NBT had nevertheless agreed to pursue the content of the application locally. This had also been supported by commissioners.

The Executive team of NHS England had visited UH Bristol on 10 September, and the visit was followed by a meeting with Simon Stevens, Chief Executive of NHS England and local health service leaders.

In relation to the Trust's work on staff engagement, several workshops had been organised to actively engage staff views. These had been well-attended and had provided useful feedback, which was being considered by the Senior Leadership Team and would lead to a series of actions. Another three sessions had been arranged to take place during October and November. The national staff survey had also been issued to staff this month.

Four of the Trust's hospitals had received official certificates for being among the first 100 hospitals to recognise 'John's Campaign', a campaign to encourage hospitals to welcome carers to stay with inpatients with dementia in order to support them.

The Independent Review of Children's Congenital Heart Surgery in Bristol was currently making arrangements to interview members of staff. Meetings would take place between now and the end of December. The review hoped to publish its findings in Spring 2016. Robert and the Divisional Clinical Chair had written to all staff involved to offer support from the Trust during the process.

As part of the Trust's work to support NHS England's Review of Congenital Heart Services, a proposal for a new congenital heart network would be submitted in the coming weeks.

It had been widely reported nationally that junior doctors had balloted for strike action over the next three months. The dispute concerned the perception of a threat to impose a new contract on junior doctors without sufficient consultation. Dialogue was still ongoing and hopefully a strike could be averted. Locally, discussions were taking place with junior doctors through formal liaison arrangements.

David Armstrong enquired whether the Trust required a risk mitigation strategy in relation to the strike. Robert explained that, while the impact would be significant, it was too early for a strategy to be put in place, as it was not yet clear what form the strike action could take and whether it could be averted.

Jill Youds enquired about news reports last week regarding histopathology at North Bristol Trust (NBT) and confusion about the involvement of UH Bristol. Robert explained that the reports had concerned a locum cellular cervical pathologist employed by NBT who had made misdiagnoses in a number of cases. Contrary to reports, he had not been working at St Michael's Hospital; however, the Consultant had reported on specimens belonging to women at St Michael's Hospital. UH Bristol and NBT were now working together to ensure that all the women had been informed and were able to seek advice and support.

Emma Woollett requested further information about the tri-partite preparations for winter alluded to in the Senior Leadership Team report. Deborah Lee responded that UH Bristol was working with its partners in Bristol through the Urgent Care Working Group to co-ordinate the city's preparations for winter. The key risk was that the system was not recovering as quickly as expected from the changes that had been made earlier in the year to the way that domiciliary care was provided in Bristol. There was an added complication in that UH Bristol's bed base was dramatically different from previous years: the Trust's decisions around the decommissioning of the Old Building and the changes to the King Edward Building meant that for the first time the Trust would approach winter without the physical capacity though which to escalate care if necessary.

Deborah explained that the Urgent Care Working Group was exploring various mitigations including a 'virtual ward' model – a model that could provide care in their own homes for around 35 patients who had needs that were typically met in hospital. Deborah acknowledged the great commitment and engagement in the wider system; however, could not provide assurance that all mitigations were in place for a winter in which standards for patient flow would be achieved.

Emma Woollett enquired whether the Better Care Fund was having an impact, and Deborah responded that the Better Care Fund was not as yet entirely meeting its objectives in this area.

Non-executive Directors discussed the reduction of UH Bristol's escalation beds, the lack of resilience in the community, and the implications for the coming winter. They felt that they needed a better understanding of the issues and it was agreed to explore them in greater depth at a future Board Development Seminar.

Mo Schiller, Public Governor enquired whether there was yet a replacement for Dr Robert Pitcher as Joint Clinical Lead for the transfer of cellular pathology to North Bristol Trust (NBT). Robert Woolley responded that interim leadership was in place but that NBT would not be seeking to appoint a replacement until April when the combined service would be available. It was:

RESOLVED:

- **That the Board note the report from the Chief Executive**
- **That the city's preparations for patient flow in the winter be explored by the Board in depth at a Board Development Seminar**

93/09/15 Patient Experience Story (Item 6)

Carolyn Mills introduced the Patient Experience Story, which was presented to Board members on a monthly basis in order to set a patient-focussed context for the meeting. This month's story was presented by the Patients Association who had been working with the Trust to understand the experience of patients and their families receiving treatment for cancer at UH Bristol, and how this could be improved in light of the Trust's poor performance in the National Cancer Patient Experience Surveys.

Tony Watkin (Patient Experience Lead) and Gloria Clark (Patients Association) were in attendance to present the stories. The stories were told from the perspective of two patients ('Paula' and 'Bernard'), who were fictional, but whose stories drew upon the reported experiences of 38 patients who participated in the Patients Association cancer project in 2014. The stories attempted to paint a picture of the 'composite experience' and describe the key themes for patients, both positive and negative.

Gloria also reported the conclusions from the Patients' Association work. Most feedback from patients had been positive, particularly in relation to quality, dedication of and care from staff. Where patients had a poor experience, there were three main themes: shared care with other providers, delays in diagnosis or treatment, and a lack of support (e.g. where there was no Clinical Nurse Specialist and no-one else fulfilling that role). The Patients Association made recommendations for improvements in these areas, which UH Bristol had accepted in full.

On behalf of the Trust Board, Robert Woolley thanked Gloria and was appreciative of the value of using the Patients' Association for the work undertaken. Carolyn Mills added that an action plan had been drawn up from the recommendations which had been received by the Quality and Outcomes Committee and the Governors' Quality Focus Group. Alison Ryan noted that the Quality and Outcomes Committee had made some additions to the action plan, and had particularly emphasised the importance of communicating the findings to the staff across the Trust and in other organisations. Lisa Gardner enquired whether the Trust had sufficient numbers of Clinical Nurse Specialists, as while it appeared to be a key role in the care-giving process, it appeared that not every patient had access to one, and Carolyn Mills responded that this was currently under consideration. It was:

RESOLVED:

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

94/09/15 Quality and Performance Report (Item 7)

Overall Performance

Deborah Lee introduced the monthly report which reviewed the Trust's performance in relation to Quality, Workforce and Access standards. Deborah noted that system pressures had impacted on many of the headline indicators reported, particularly in relation to patient flow.

A&E 4-hour standards had achieved a strong performance of94.5% for August, narrowly missing the national target but a significant improvement on previous months. The Trust had experienced an extremely challenging operational weekend last weekend, with South West Ambulance Service reporting more activations over the weekend than ever before. Deborah provided assurance that the Trust was doing everything possible to support a good patient experience in the Emergency Department.

There had been a reduction in the total number of patients waiting over 18 weeks from Referral to Treatment (RTT). The admitted backlog was now the lowest it had been since January 2014; however the non-admitted standards were still above trajectory for patients on outpatient pathways, which was a cause for concern but was limited to a small number of specialities and plans for recovery were in place.

Following the Trust's submission of their improvement plan for cancer waiting times, they had received a response that the regulators were not yet assured that the Trust's plans would restore the system to compliance with the standard. However, internal performance continued to improve.

Carolyn Mills added her assurance that while the Summary Scorecard on the new dashboard appeared red-rated for all the safety headline indicators, the report itself described the underpinning reasons, and in fact the findings on quality of care were very positive.

Sue Donaldson noted that the workforce issues identified in the report had been debated in depth at both the Quality and Outcomes Committee and the Finance Committee. There had been considerable time spent looking at turnover, use of agency staff and sickness absence. Efforts had been made to strengthen health and wellbeing and to invest in staff development in order to address attrition rates.

Jill Youds enquired about ongoing attempts to resolve the issue of delayed discharges. Deborah Lee outlined one high-impact initiative that had been identified - 'Discharge to Assess pathway' - which aimed to move the patient from hospital to a community bed for assessment to take place. Due to issues around community capacity, this initiative had not yet commenced.

Marc Griffiths enquired whether the autumn intake of graduates would help to relieve the workforce pressures. Carolyn Mills responded that this would begin to impact over the next few months.

Jill Youds expressed interest in how the workforce actions had been communicated to staff and asked that future reports include information about internal communication. Sue Donaldson responded that to aid internal communication the Chief Executive's briefing sessions to staff had been expanded to include other Executives. Robert's video broadcasts to staff were now getting 600-700 hits via the Trust's Intranet.

Lisa Gardner referred to a graph in the report on staff turnover rate by month and enquired about the causes of the sharp increase from February 2014 onwards. Sue Donaldson explained that it had been partly due to skills shortages nationally and partly due to ward moves. More detail on this was requested to show the figures broken down by staff group and by division.

Clive Hamilton noted that the Trust appeared to be falling behind in relation to risk assessments for manual handling and stress. Sue Donaldson clarified that the Trust had not fallen behind with assessments, but rather with the returns from assessments and Sue was hopeful that the next quarterly report would demonstrate improvement in this area.

David Armstrong referred to the summary scorecard in the Quality and Performance Report, and asked whether the Quality and Outcomes Committee continuously checked that it contained the right information. Alison Ryan, as Chair of the Quality and Outcomes Committee confirmed that it did so on a regular basis. It was:

RESOLVED:
- **That the Board receive the Quality and Performance Report**
- **In relation to workforce, that the Board receive further detail about internal communication of actions plans, and that more detail be provided about staff turnover from February 2014 broken down by staff group and by division**

95/09/15 Quality and Outcomes Committee Chair's Report (Item 8)
Alison Ryan presented the report for members of the Board on the business of the Quality and Outcomes Committee meeting held on 28 September 2015.

The Committee had welcomed the Green rating for all dementia indicators. They had also welcomed the fact that despite pressures, more people than ever before were now being seen within 4 hours in A&E.

Consideration had been given to the oversight of workforce performance, and it was agreed that the Finance Committee would provide scrutiny in terms of financial impact and value for money, and the Quality and Outcomes Committee would continue to provide scrutiny in terms of quality and access. It was also agreed that the Committee would examine staff experience in depth twice per year.

Clive Hamilton, Governor Lead of the Governors' Quality Focus Group, welcomed the fact that the Committee Chair's report was now shared with governors. Governors found the format of the report very useful in aiding the governors' understanding of the work of the Non-executive Directors. It was:

RESOLVED:
- **That the Board note the Quality and Outcomes Committee Chair's Report**

96/09/15 Referral to Treatment Times Recovery Trajectories (Item 9)
Deborah Lee introduced this report and explained that the Trust was not currently meeting the original trajectories for patients with an ongoing/incomplete pathways, waiting over 18 weeks for referral-to-treatment at month-end, with variances particularly in cardiology, ophthalmic neurology and dental specialties. The report recommended a proposed revision to those trajectories, in light of additional demand and delays to capacity.

The specialties not meeting the current backlog trajectory had reviewed the opportunities to make more rapid progress in reducing the total number of patients waiting over 18 weeks at each month-end, by changing the relative focus of plans between non-admitted (outpatient) and admitted pathways. The Trust was yet to receive formal feedback from Monitor on the proposals.

Deborah provided some assurance around the deliverability of these objectives. Alison Ryan confirmed that the Quality and Outcomes Committee had discussed the revisions and added that while just one measurement was now required nationally, the Trust would continue to receive both admitted and non-admitted measurements to ensure that there was no gaming of the system to reduce a long-term issue. The committee had also suggested that an analysis of potential increase in demand and scenario planning would be helpful for future planning.

John Moore enquired about the trajectories for neurology which showed no improvement in the coming year. Deborah explained that the Trust had failed to recruit a consultant in this speciality, and had now secured a fellow who would not take up post until February. Measures were therefore necessary to ensure the backlog did not grow but it was unlikely to reduce until next year. It was:

RESOLVED:
- **That the Board approve the revision to the Referral-to-Treatment Times Recovery Trajectories.**

97/09/15 Cancer Waiting Times Improvement Plan submission (Item 10)
Deborah Lee presented the report which briefed the Board on the submission the Trust made on 31 August 2015 on plans to improve 62-day GP cancer waiting times performance. The submission and plans had been approved by the Quality and Outcomes Committee via delegated authority of the Board.

All Trusts were required to meet the 85% standard by March 2016 at the latest. However, many of the drivers of the Trust's poor performance remained outside of the Trust's control. The Trust was therefore highly unlikely to achieve the 85% standard without significant improvements in the timeliness of referrals received from other providers. The analysis was intended to provide assurance that the Trust understood the reasons for its under-performance against the 62-day GP standard and that the action plan submitted by the Quality and Outcomes Committee at the end of August had the right focus.

The following discussion focussed on a table in the report showing the Trust's performance against the 85% standard at tumour-site level for quarter 1 including the national average. Non-executive Directors sought assurance around a number of areas below the national average, and Deborah reiterated that causes usually related to late referrals. Delays by the Trust that were considered avoidable primarily related to cancelled operations and late delivery of diagnostics, but even if these had been avoided, the Trust could not statistically achieve the standards unless there was improved performance in the shared pathways.

Guy Orpen noted that UH Bristol's performance in relation to breast cancer was below the national average and enquired why there was no target. Deborah responded that it may relate to the transfer of breast surgery to North Bristol Trust, but she explore this further to establish why there were no targets set. It was:

RESOLVED:
- **That the Board note the Cancer Waiting Times Improvement Plan submission**

98/09/15 Quarterly Complaints and Patient Experience reports (Item 11)
Carolyn Mills presented the report on patient-reported experience received via the Complaints Team and the Trust's patient survey programme.

In terms of the Patient Experience Report, the feedback had been positive overall. Carolyn referred to the negative outliers in respect of patient reported experience in this period, in particular, the relatively low patient satisfaction on ward A900 among patients with Cystic Fibrosis. The Division had started a wider piece of engagement work with these patients which suggested that the fundamental issue was the need to build relationships between patients and staff, as this patient group were regular or long-term attenders and had recently moved to a new ward location (A900) with a new care team in place. The move had resulted in a loss of trust and confidence in the staff, as the previous staff had built strong relationships with patients before the ward move.

Carolyn reported a small reduction of complaints during the period. Work was ongoing in relation to dissatisfaction with complaints responses. The highest number of complaints fell into the "attitude and communication" and "appointments and admissions" complaints categories.

Julian Dennis referred to the Trust's performance in responding to complaints within the timescales agreed with complainants, which was 84.9% compared with a target of 95%, and enquired whether there was an appropriate level of resource to manage complaints. Carolyn responded that while staff absence had sometimes contributed to a delay, she believed that the resources were adequate. Julian requested assurance that the Divisions were dealing with the investigations with high enough priority, and Deborah explained that it was sometimes necessary to achieve a balance between a quick response and quality clinical input. Deborah also added that back-to-the-floor time had been scheduled in the Bristol Eye Hospital Outpatients Department to improve her understanding of the issues there.

John Moore noted that a third of complaints were due to admissions, appointments and administration errors and the failure to answer telephones, and John requested assurance that letters were routinely checked to ensure that the phone number was correct and that staff received training regarding their telephone manner. John suggested that the patient experience pathway in Bristol Royal Hospital for Children be walked through with senior staff, as from personal experience he had felt it was not as slick as it could be. Robert agreed and gave assurance that work was ongoing to improve patient letters and to improve the outpatient experience.

In relation to Ward A900, Mo Schiller enquired whether the Trust was talking to Cystic Fibrosis patients to find out their suggestions for improvements. Carolyn Mills responded that the lead Clinical Nurse Specialist had met with a group of patients and that a number of actions had already been taken. Mo asked that it be reviewed in 6 months' time. Angelo Micciche, Patient Governor, who had personal experience of care on this ward, added that he had been raising concerns about the ward move and its consultation process since February via the Governors' Log. Angelo felt strongly that the risk analysis process that took place when considering moving a service to a new ward should take into account the value of staff experience. In this case, Angelo felt that many years of experience in a specialised area had been lost. Carolyn assured him that the Trust would learn from the experience and would try to resolve the issues arising from the loss of experience in this case.

Julian Dennis's suggestion that paganism be included in the Trust's list of protected characteristics of patients making a complaint was noted. It was:

RESOLVED:

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

99/09/15 Infection Control Annual Report 2014/15 (Item 12)

Carolyn Mills presented this report on the infection prevention and control activities undertaken in 2014/15 at UH Bristol and progress against performance targets. There were several key issues for the Board to note, but no risks that the Board needed to be aware of. The report had been discussed by the Quality and Outcomes Committee.

Emma Woollett requested assurance on the risks around the states of equipment in the decontamination report. Carolyn provided assurance that these were for information only and were on divisional risk registers or were otherwise known in the organisation. It was:

RESOLVED:

- **That the Board note the Infection Control Annual Report 2014/15.**

100/09/15 Safeguarding Annual Report 2014/15 (Item 13)

Carolyn Mills introduced the report. The report's author, Carol Sawkins, Nurse Consultant, Safeguarding Children/Named Nurse, was also in attendance at the meeting.

The annual report provided evidence that UH Bristol was fulfilling its statutory responsibilities to safeguard adults, children and young people. Carolyn detailed three risks that had been identified in relation to safeguarding adults and children on the Trust Risk Register. Each had been clearly defined with controls and action plans in place to mitigate risk rating where possible.

There was a discussion about risk no.1483, potential risk to a child through the use of multiple sets of notes across Trust hospital sites. This had been a long-standing risk, and Non-executive Directors wished to know when the electronic patient records system that would reduce the impact of the risk would be implemented. Carolyn responded that there was a plan in place to introduce a single electronic patient record starting with St Michaels Hospital within a year. Paul Mapson added that this would roll out to the Bristol Royal Hospital for Children next March initially, but that it could take 1-2 years before all records were electronic. Assurance was provided by Carol Sawkins that the risk had been assessed and while it had been on the risk register for a long time, current processes had been deemed as robust and the risks continued be mitigated as far as possible.

Alison Ryan added that the report had not been discussed at the Quality and Outcomes Committee in full as stated on the executive cover sheet. The Committee did however receive a briefing on Female Genital Mutilation. Alison further enquired whether there were any issues around vulnerable adults at the end of life, and Carolyn responded that this fell under the remit of safeguarding adults generally, which expressed her confidence that there were no issues of concern.

Robert Woolley enquired as to the action taken to address the findings of the Child Death Overview Panel that and referred to the need for more training for professionals involved in the Child Death Review process. Carol offered to seek clarification from the Division.

Robert further enquired how the Trust was handling the loss of the Hospital Social Work team. Carol explained that the number of calls to the Child Protection Nursing Team had increased significantly over the last 12 months as a consequence of the social work teams moving off-site.

Activity continued to be monitored closely and it had been incorporated into the existing team workload at a safe level.

Jill Youds enquired whether the data on investigations and outcomes for safeguarding adults were received at the Quality and Outcomes Committee. Carolyn Mills explained that they were currently received at an operational sub-committee and to report activity outcomes into the Quality and Outcomes Committee would result in duplication of reporting and would fall out-with the remit of the Committee.

In relation to a further question from Jill about improving Essential Training compliance, Carol responded that significant progress had been made but that maintaining compliance on an ongoing basis remained challenging. It was:

RESOLVED:
- **That the Board receive the Safeguarding Annual Report for assurance**
- **That the actions be clarified in relation to the Child Death Review Panel findings regarding support for bereaved families and training for staff in the process**

101/09/15 Quarterly Workforce Report (Item 14)
Sue Donaldson presented this report, which provided a more detailed and wide ranging update on the Workforce and Organisational Development agenda than currently provided in the monthly performance reports.

There was improvement in workforce numbers, sickness absence, Staff Friends and Family Test, Essential Training, Appraisal and junior doctor compliance. There had been little change in the use of Bank and Agency staff and overtime usage. Performance had deteriorated in the quarter in respect of vacancies and turnover.

It was noted that the Quality and Outcomes Committee had discussed the report in detail at the August meeting. In response to a question from Jill Youds about when the Trust would make a decision about whether to pursue international recruitment next year, Sue responded that a decision would be made before the end of December and would be reported back to Board. It was:

RESOLVED:
- **That the Board receive the Quarterly Workforce Report for assurance**

102/09/15 Finance Report (Item 15)
Paul Mapson, Director of Finance and Information, introduced this report. The Trust's reported financial position at the end of August 2015 was a deficit of £0.535m (before technical items). This was a significant deterioration from the surplus of £0.514m reported in July.

The position was driven by the Clinical Divisions, with the greatest concern being with the rate of deterioration in Surgery, Head and Neck and Medicine. Clinical Divisions were now £1.71m adverse to their Operating Plan trajectories, which represented an area of concern. The two key issues were the delivery of clinical activity and the high rate of agency nursing expenditure. Detailed discussions were ongoing within divisions and an improvement was expected in September.

The Trust's risk rating had dropped from 4 to 3, but the plan for the year was still to achieve a break even position and achieve a risk rating of 4. The capital programme had undergone a detailed

review. Cash remained strong at 77m, which included the receipts of Old Building sale which was now completed. The Trust had negotiated an increase in its cash position with commissioners.

New appendices had been included in the report, including workforce metrics where there was an overlap with Finance, particularly on agency spending. It was:

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

103/09/15 Finance Committee Chair's Report (Item 16)
Lisa Gardner presented the report of the business discussed at the meeting of the Finance Committee on 25 September 2015. The committee had expressed concern regarding the significant deterioration of the Trust's financial position in August due to the decrease in activity and increases in nursing spend. Divisional activity and divisional finance reports and the cost improvement programme were discussed in detail. The committee were concerned regarding the risk that the cost improvement programme would run out of steam for the future, and Deborah Lee had given assurance that the Senior Leadership Team would be looking at new ways of driving the programme forward. The Committee had received a very useful report on consultant activity in Ear Nose and Throat. Results would be taken into the division for consultant input.

At the Committee's August meeting, Sue Donaldson had attended for insight into workforce challenges, looking at sickness and staff turnover. Sue would now attend on a quarterly basis to give ongoing assurance, and Deborah would continue to deliver a monthly update on workforce.

Emma Woollett enquired about the reasons for the significant decrease in Surgery Head and Neck activity. Deborah Lee responded that it was partly due to the failure to appoint to key posts, but also due to issues mobilising the existing capacity in relation to workforce deployment and annual leave planning. Deborah would be meeting with the Division to discuss the deterioration of their plan in detail and Deborah noted that the Division had an interim divisional director since July, and the Trust would advertise for a permanent appointment in the coming weeks.

John Moore noted that the Trust was still forecasting a break-even position at year end, and enquired about the current forecast for next year. Paul Mapson responded that it was difficult to predict the requirements at this stage. It was:

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

104/09/15 Clinical Research Network Annual Report 2014/15 and Annual Plan 2015/16 (Item 17)
Sean O'Kelly presented these reports. Both had been approved by the National Institute for Health Research. Dr Steve Falk, Clinical Director, West of England Clinical Research Network (WECRN) & Dr Mary Perkins, Chief Operating Officer of WECRN, were in attendance to introduce the reports.

Dr Falk explained that the Trust, as the host organisation for WECRN, UH Bristol was asked to approve the reports on behalf of the member organisations. Dr Falk asked the Board to note that a collaborative approach had been taken and as a result these papers had also been approved by partners in other organisations in the area.

Julian Dennis sought clarification around the reference in the report to a transition year and its resulting problems. Dr Falk explained that the Clinical Research Network had begun as various small topic networks, but last year it was reformed and restructured into one network, in order to enhance the governance arrangements, and that this had necessitated some changes.

Guy Orpen suggested that as host, UH Bristol should be presented with a risk analysis alongside the annual report. Dr Falk agreed, and Debbie Henderson suggested that this form part of the review of the approval process for next year. It was:

RESOLVED:
- **That the Board note the Clinical Research Network Annual Report 2014/15**
- **That the Board approve the Annual Plan 2015/16**

105/09/15 Audit Committee Chair's Report (Item 18)
John Moore, Chair of the Audit Committee, presented the report from the meeting of the Audit Committee on 9 September.

The committee had covered its normal agenda, and there were no issues to report regarding Counter Fraud, Single Tender Actions, Losses and Compensations, nor were there any exceptions reported by the Finance or Quality and Outcomes Committee Chairs.

There were detailed discussions on some of the Internal Audit reports, in particular the Non-executive Directors challenged the Green ratings given to Medical Staff Leave authorisation and oversight, Patient Experience (Dementia) and Workforce Planning. The Executive Team had subsequently reviewed these and agreed that further assurance was needed. They also agreed that Internal Audit conclusions should align with or reflect current outcome-based reporting.

There was discussion on the Trust's work to strengthen procurement controls and habits, with a particular focus on the Estates department, and also Trust-wide procurement outside the EROS system. Further reports would be brought to the committee over the next 6 months.

The Committee received the Clinical Audit annual report for 2014/15 and the 2015/16 Q1 report. The NEDs sought assurance that the Clinical Audit programme ensured best practice across the Trust and prevents poor clinical practice. It was agreed that this should be a topic for a future Board seminar. It was:

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

106/09/15 Governor Expenses Policy (Item 19)
Debbie Henderson presented the Governor Expenses Policy which had been updated to provide further clarity and guidance to governors with regards to the claiming of expenses in relation to their role. The policy outlined the criteria for submissions, and when to seek guidance from the Trust Secretary and Membership & Governance Team. The policy also outlined the process for claiming and repayment of expenses. It was:

RESOLVED:
- **That the Board approve the Governors' Expenses Policy**

107/09/15 Monitor feedback on the 2014/15 Annual Report and Accounts Process (Item 20)
Robert Woolley referred to correspondence from Monitor informing the Trust of their feedback following the closure of the Annual Report and Accounts process. There were no issues to note for the Trust. It was:

RESOLVED:
- **That the Board note the Monitor feedback on the 2014/15 annual report and accounts process.**

108/09/15 Monitor feedback on Q4 monitoring submission and 2015/16 Annual Plan Review (Item 21)
Robert Woolley referred to Monitor's analysis of the Quarter 4 submission based on the Trust's risk ratings which reflected the Trust's submission of a risk rating of 4 for Continuity of Services and a Green risk rating for Governance. There were no issues to note.

The Trust had submitted an improved Annual Plan for 2015/16 with a break-even target, but Monitor had identified an area of concern regarding the level of Cost Improvement Programmes (CIPs) in the Trust's plan and had asked the Trust to review this. In response to a question from Emma Woollett as to whether Monitor's concern related to the Trust's ambition or about control, Robert explained that Monitor's metrics identified that UH Bristol had set a lower target than other Trusts, but the Board agreed that the importance of setting a realistic target should also be considered. It was:

RESOLVED:
- **That the Board note Monitor feedback on Q4 monitoring submission and 2015/16 Annual Plan Review.**

109/09/15 Monitor feedback on Q1 monitoring submission (Item 22)
Robert Woolley referred to Monitor's analysis of the quarter 1 submission based on the Trust's risk ratings which reflected the Trust submission of a risk rating of 3 for Continuity of Services, and a Green risk rating for Governance. It was:

RESOLVED:
- **That the Board note Monitor feedback on Q1 monitoring submission.**

110/09/15 Governors' Log of Communications (Item 23)
This report provided the Trust Board with an update on governors' questions and responses from Executive Directors. Debbie Henderson explained that due to additional pressures in the governance remit of the Secretariat team, administration of the Log had experienced delays in the last two weeks, but assured governors that this would be resolved once the team was fully staffed by mid-October. It was:

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

111/09/15 Any Other Business
Deborah Lee reported that during the meeting e-mail correspondence had been received confirming that a key recovery action within the admitted trajectory for a paediatric speciality had failed. The Trust had been due to contract with an independent provider for a significant level of activity and the provider was now not able to proceed as planned. Deborah asked the Board to note that the Trust would now not be able to deliver the trajectory as set out earlier in the meeting. This was noted by the Board.

Meeting close and Date and Time of Next Meeting
There being no other business, the Chair declared the meeting closed at 13:35.
The next meeting of the Trust Board of Directors will take place on Friday 30 October 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 September 2015
Action tracker

Outstanding actions following meeting held 30th June 2015					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
	90/09/15	Assurance to be provided to the Board regarding training for staff to deal with unexpected patients presenting to wards/ departments	Director of Workforce & OD	October 2015	Verbal update to be provided at the meeting
3	**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	November 2015	N/A
Completed actions following meeting held 30th July 2015					
1	**81/07/15**	Review residual rating on the Board Assurance Framework relating to achievement of annual objectives for workforce prior to the October submission	Director of Workforce & OD	October 2015	Complete – agenda item 16.
2	**55/06/15**	The car parking business case to be submitted to the Board	Chief Operating Officer/ Deputy CEO	October 2015	Complete – agenda item 7 on Board held in private session
		NO COMPLETED ACTIONS TO NOTE			

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on 30 October 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 – Deborah Lee, Deputy Chief Executive/Chief Operating Officer Sponsor – Robert Woolley, Chief Executive									
Intended Audience									
Board members	√	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team. Key issues to note The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in August and September.									
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 – OCTOBER 2015

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in October 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 2 to be the Referral to Treatment Incomplete/Ongoing pathways standard, the Accident and Emergency 4-hour standard, the 62-day GP and 62-day Screening cancer standards. The planned ongoing failure of the Referral to Treatment standards as part of the agreed trajectory should be flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-day GP standards and the Accident and Emergency 4-hour standard, as part of the narrative accompanying the declaration.

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

The group **noted** the Quarter 2 update on Corporate Quality Objectives and noted their concern regarding a number of the flow related objectives. Deborah Lee gave an overview of actions to address.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the Business Planning process for 2016 to 2018 and the ongoing work to develop the Trust's Strategic Implementation Plan. They welcomed the focus on engaging with partners to ensure better alignment of plans.

The group received the Outline Business Case for the development of a multi-storey car park on the Trust site and **supported** the recommendation in the paper for onward submission to the Trust Board for approval.

The group **approved** the making of a UH Bristol film which would succinctly and powerfully demonstrate the Trust's caring staff and range of services, funded by Above and Beyond Charity. It would be used to promote the Trust both internally, through things like staff induction but also externally when opportunities arose. The Senior Leadership Team asked that the design of the film be used as a means of engaging staff, through their involvement.

4. RISK, FINANCE AND GOVERNANCE

The group **received** an update on the status of the transfer of Cellular Pathology to North Bristol Trust and noted continued uncertainty regarding the timing for the review. Good progress was noted in respect of the work on clinical models though two areas remain unresolved and work was on-going.

The group **received** the Board Assurance Framework 2015/2016 Quarter 2 update prior to onward submission to the Trust Board.

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

The group received and **noted** the Quarter 2 2015/2016 Serious Incident Report.

The group **approved** the 2014 National Children's Inpatient and Day Case Survey results for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **received** the Children's Annual Report reflecting the period April 2014 to September 2015, for onward submission to the Trust Board. This was the first report of this nature to be produced and was very well received.

Reports from subsidiary management groups were **noted,** including updates on the Transforming Care Programme.

The group **noted** the update on outstanding Internal Audit Recommendations. Deborah Lee requested that greater clarity be provided on those recommendations outstanding due to the timing of further audits which had yet to be concluded, as opposed to being overdue due to a lack of management action.

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.

Deborah Lee
Deputy Chief Executive
October 2015

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
06. 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)**
28/10/15					

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

October 2015

Executive Summary

Although system pressures have continued to be evident this month, progress continues to be made in improving patient access to the Trust's services. This includes achievement again of the national standard of at least 99% of patients waiting less than 6 weeks for a diagnostic test, and a further reduction in the total number of patients waiting over 18 weeks from Referral to Treatment (RTT), with the number of patients waiting over 18 weeks for admitted treatment now being at the lowest level since December 2013. Whilst challenges remain in achieving the 85% standard for treating patients within 62 days of referral by the GP with a suspected cancer, the Trust is expecting to report a greater than 4% improvement in performance against the standard relative to quarter 1 this year. 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.

Performance against the A&E 4-hour standard was heavily impacted by the continued slow rate of discharge of patients out of the BRI in September, despite actions being taken to improve flow. As in the previous month circa 70 medically fit patients were awaiting discharge from the BRI at any point in time in September and peaked at 85, which represents one and a half additional wards' worth of patients occupying BRI beds relative to the 'normal' levels of delayed discharges seen at the start of 2015/16. The increase in delayed discharges is primarily a result of the recommissioning of domiciliary care packages, with the new providers still to come up to full capacity, the acute shortage of social workers and an increase in those requiring social care as a result of increased admissions. This was previously flagged as a risk to 4-hour achievement to the Trust Board and Monitor. As can be seen in the Assurance & Leading Indicators section of this report, bed occupancy has continued to increase, for this reason, which has resulted in an increase in the number of patients waiting longer than 4 hours in the BRI Emergency Department and also a number of the flow related Trust Quality Objectives being failed in the period. The Bristol Children's Hospital continued to experience heightened levels of emergency demand, also impacted on 4-hour performance, and in combination with the BRI challenges led to the 95% national standard not being achieved for the month, and the quarter as a whole.

Patient feedback through the internally designed surveys, and Friends & Family scores, continues to provide good assurance of a positive experience of the services delivered by the Trust both in an inpatient and outpatient setting, despite the inevitable challenges of high levels of demand. Continuing the improvement in Friends & Family response rates remains a priority, along with our timeliness of response to complaints. Performance against the wide ranging patient safety metrics that the Trust monitors also remains strong, even in the face of long stays for our more elderly and vulnerable patients, including sustainment of a green rating for a number of months for pressure ulcers and inpatient falls per 1000 bed-days, along with venous thromboembolism risk assessment and prophylaxis . Particularly noteworthy this month is 100% compliance with the WHO checklist compliance in theatres for a second consecutive month, and zero medication errors resulting in moderate or severe harm, with non purposeful omitted doses of a critical medication also retaining its green rating for a fourth consecutive month.

System pressures continue to provide context to the current workforce challenges, especially bank and agency spend. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand ahead of the seasonal winter peaks. We also continue to work in partnership with other organisations within the community to mitigate these system risks, and improve 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) – **as reported last month**

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

Current scoring

Risks

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)

Elevated risks:

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
STM	3.5 stars	OK	✓	✓	OK	OK
BRI	4 stars	OK	✓	OK	OK	OK
BDH	4 stars	OK	✓	Not avail	OK	Not avail
BEH	4 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.
Please note – there have been no changes in ratings since last month's report

Monitor's Risk Assessment Framework

For quarter 2 as a whole the Trust achieved all except three 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 3.0[1] against Monitor's Risk Assessment Framework. Monitor restored the Trust to a GREEN risk rating last quarter, following its review of actions being taken to recover performance against the RTT, Cancer 62-day GP and A&E 4-hour standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

Monitor's Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework: Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16*	Q2 Draft Actual	Notes	Q2 Draft Risk Assessment Risk rating
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	3	✓	✓	✓	✓	TBC**	✓	Limit to the end of Q2 = 23 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	99.1%	✓	✓	✓	✓	98.6%	✓		Achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	95.7%	✓	✓	✓	✓	95.6%	✓		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	96.9%	✓	✓	✓	✓	96.8%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	79.2%	✗	✗	✗	✗	81.5%	✗	Half the 62-day screening standard breaches outside of the control of the Trust.	Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	76.5%	✓	✗	✗	✗	79.5%	✗		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	90.5%	Not achieved	Not achieved	Not achieved	Not achieved	90.4%	✗		Not achieved (see notes)
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	96.8%	✓	✓	✓	✓	96.6%	✓		Achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	95.4%	✓	✓	✓	✓	96.5%	✓		Achieved
6b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
7	A&E Total time in A&E 4 hours	1.0	95%	94.3%	✗	✗	✗	✗	94.0%	✗		Not achieved
8	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	Triggers further investigation	Triggers further investigation	GREEN	GREEN	To be confirmed	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.

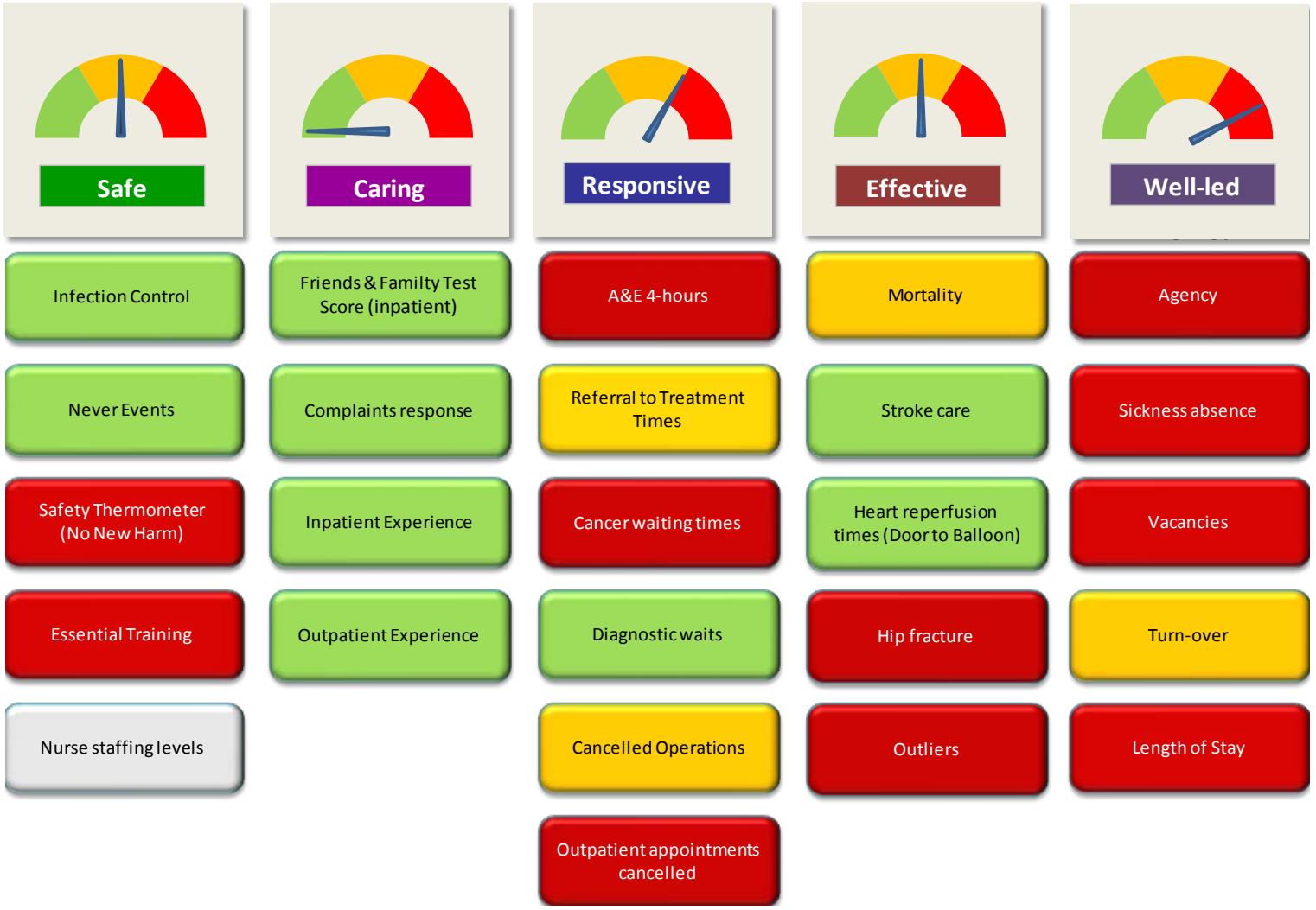
***Q2 Cancer figures based upon confirmed figures for July and August, and draft for September.**
**** C. diff cases from August onwards still subject to commissioner review, but well within limit**

3.0
To be confirmed (see narrative)

[1] **Please note** that in the newly revised Monitor Risk Assessment Framework (August 2015) performance against the admitted and non-admitted RTT standards are no longer scored.

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 (RED, AMBER, GREEN) 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:
- Infection Control
- Never Events

RED to AMBER:
- Referral to Treatment Times

AMBER to GREEN:
- Diagnostic waits

AMBER to RED:
- A&E 4-hours

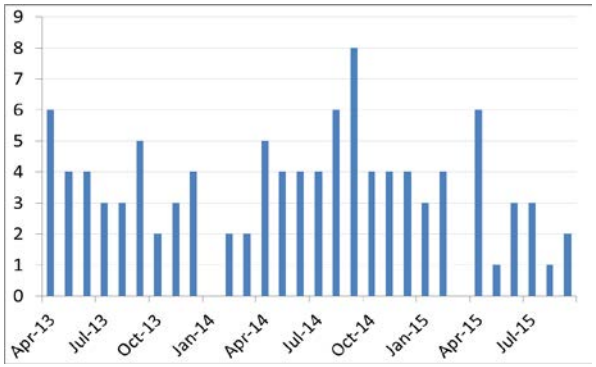
GREEN to AMBER:
- Cancelled operations
- Mortality

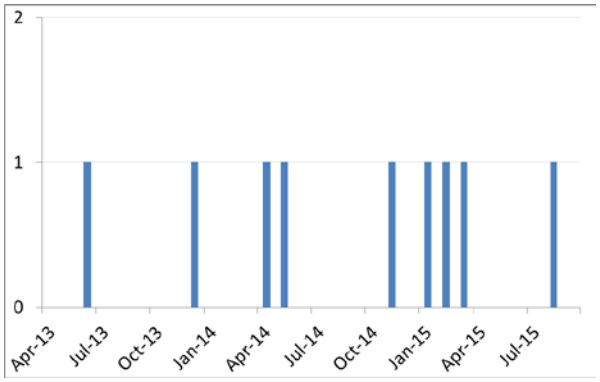
Please note: The RAG rating for Sickness absence has be left as RED rated, although data for the current month isn't yet available.

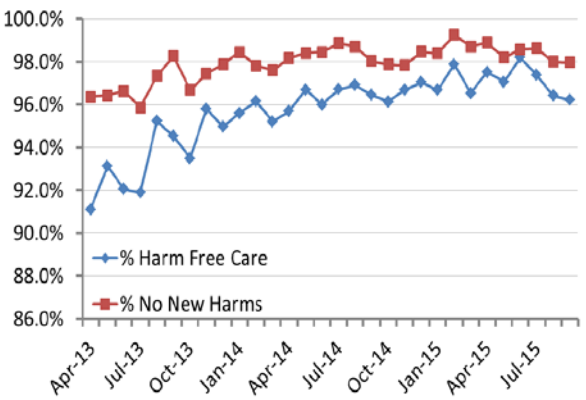
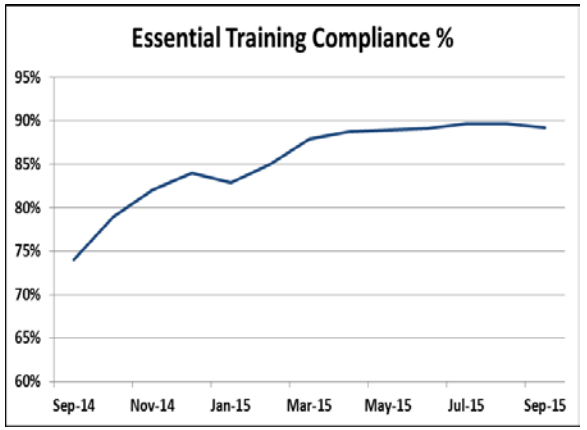
Overview

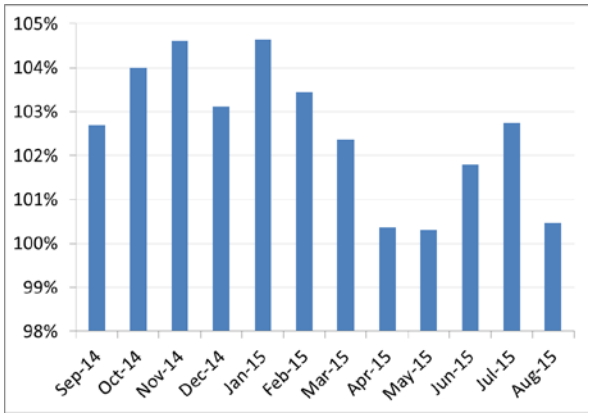
The following summarises the key successes in September 2015, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 3 2015/16

Successes	Priorities
• Additional investment has been agreed to support staff development in key turnover hot spots, which is anticipated to have a direct and demonstrable impact on reducing staff turnover during 2015/16; • No further MRSA bacteraemias in September 2015; • WHO surgical checklist compliance 100% in theatres; • Zero medication errors resulting in moderate or severe harm; • Timely management of patient safety alerts (CAS alerts); • Increase in spontaneous vaginal deliveries; • Achievement of the maximum 6-week wait for diagnostics tests for 99% of patients; • Ideal timescale 62-day pathway for upper GI oesophago-gastric cancers now live; • Further reduction in the number of patients waiting over 18 weeks from Referral to Treatment (RTT), in line with the revised trajectories.	• Increasing outpatient and elective activity to deliver revised trajectories for the reductions in numbers of patients waiting over 18 weeks RTT; • Continued implementation of ideal timescale pathways for high volume cancer tumour sites, with lung planned to go live by the end of October; • Improving staff experience and staff retention; • Sustained nursing and theatre recruitment through national campaigns; • Reducing sickness absence; • Improvement in time to theatre and ortho-geriatrician review for fractured neck of femur patients; • Improvement of complaints response timescales.
Opportunities	**Risks & Threats**
• A schedule of advertising activity has been developed utilising the agreed funding for 2015/16. Activity includes local campaigns through media such as radio and buses and the use of social media. • Continued improvement in Friends & Family Test coverage, Emergency Department and Inpatients.	• In addition to the generic risk of increasing demand, the specific risk of the closure of some services in other areas (e.g. Clinical Genetics in Taunton), and the temporary closure of the eReferrals system ahead of the go-live at North Bristol Trust of their new Patient Administration System, could lead to more outpatient referrals coming to UH Bristol and a risk to sustained reduction of backlogs; • Continuing high levels of Green To Go patients represent an ongoing threat to achievement of the quality objectives and A&E 4-hour standard, although some signs the position is starting to improve with recent interventions; • Risk of not achieving target annual reduction in staff turnover, agreed during Operating Planning Process.

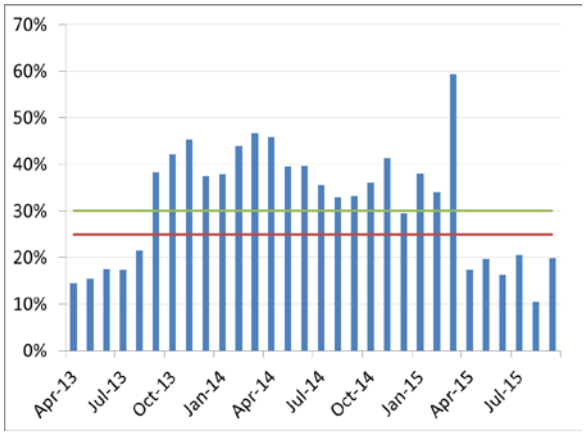
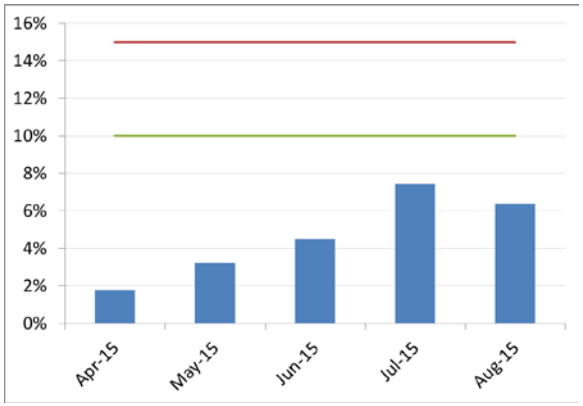
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections and the number of MRSA (Meticillin Resistant Staphylococcus aureus) bacteraemias. The Trust limit for 2015/16 is 45 avoidable cases of clostridium difficile and zero cases of MRSA.</td>
<td>Two cases of clostridium difficile (C. diff) were reported in September 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 avoidable cases for the period.
<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>0</td><td>0</td></tr>
<tr><td>Women’s & Children’s</td><td>1</td><td>0</td></tr>
</table>
There were no cases of MRSA bacteraemias reported in the period.</td>
<td>Total number of C. diff cases
 

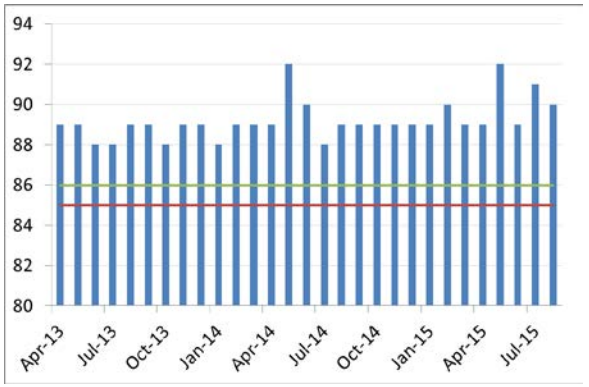
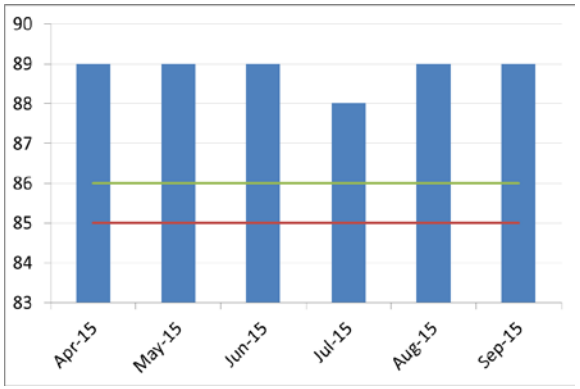
A total of 16 cases (unavoidable + avoidable) have been reported in the year to date (April to September). The limit for avoidable cases for the end of Quarter 2 (September) is 23.</td>
<td>The multidisciplinary Post Infection Review meeting with commissioners, for the two cases of C. diff which occurred in September, is yet to be held. 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 September 2015, one for quarter 2 as a whole.</td>
<td>Number of never events per month
 
</td>
<td>Proactive never events risk assessment work and mitigating action continues across all applicable specialities.
National Safety Standards for Invasive Procedures have been recently published by NHS England and is being incorporated into the Peri-Operative Work Stream of our Sign up to Safety Improvement Programme.</td>
</tr>
</table>

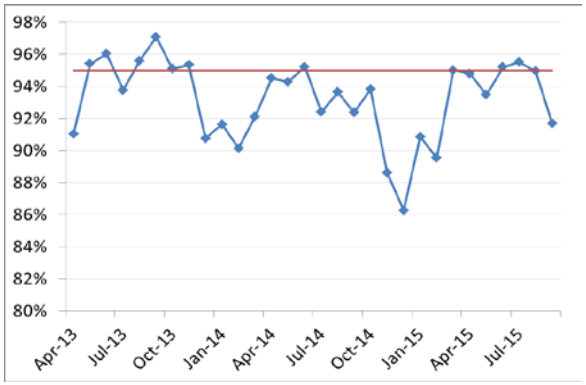
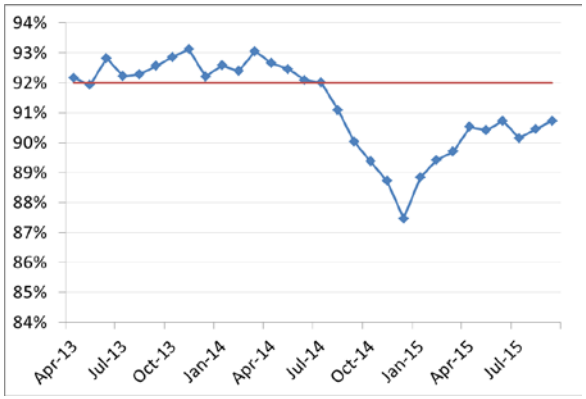
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.</td>
<td>In September 2015, the percentage of patients with no new harms was 98.0 %, against an upper quartile target of 98.26% (GREEN threshold) of the NHS England Patient Safety peer group of trusts. This is the same level of performance as reported in August 2015.</td>
<td>The percentage of patients surveyed showing No New Harm each month
 
</td>
<td>There were four patients with reported new venous thrombo-emboli in September across two divisions, which is more than the usual 1 or 2 in recent months.
(Action 1)
Following last month’s report of 8 catheter associated urinary tract infections, the number for September was 3, suggesting there is no upward trend.</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 September was 89.2% against the 90% threshold for core Essential Training. Three Divisions achieved the 90% target this month.
<table>
<tr><th>September 2015</th><th>Compliance Rate</th></tr>
<tr><td>UH Bristol</td><td>89.2%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>87.7%</td></tr>
<tr><td>Medicine</td><td>89.8%</td></tr>
<tr><td>Specialised Services</td><td>91.5%</td></tr>
<tr><td>Surgery Head & Neck</td><td>90.8%</td></tr>
<tr><td>Women's & Children's</td><td>85.2%</td></tr>
<tr><td>Trust Services</td><td>91.8%</td></tr>
<tr><td>Facilities And Estates</td><td>94.9%</td></tr>
</table></td>
<td>The percentage of core Essential Training completed by month
 
</td>
<td>Compliance exceeded 89% for the fourth consecutive month. There has been continued improvement in Safeguarding Adults/Children with adult safeguarding level 1 and child protection level 1 achieving over 90% (see Appendix 2). Resus and other safeguarding levels continue to be below target, but have detailed plans in place to achieve 90% (Action 2).</td>
</tr>
</table>

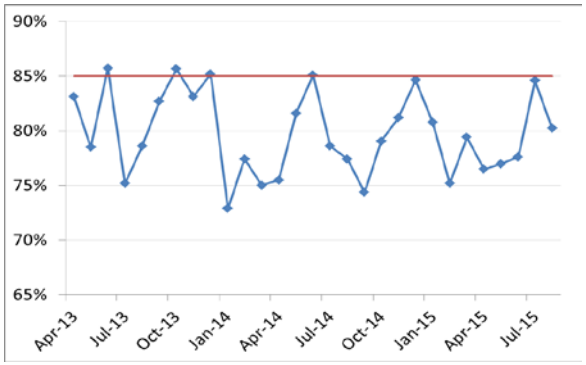
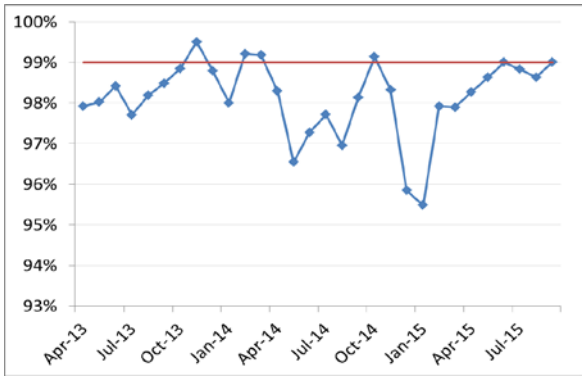
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in September the Trust had rostered 206,924 expected nursing hours, with the number of actual hours worked of 213,254. This gave an overall fill rate of 103.1%.
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>65917</td><td>60656</td><td>+5261</td></tr>
<tr><td>Specialised Services</td><td>39078</td><td>38837</td><td>+241</td></tr>
<tr><td>Surgery Head & Neck</td><td>44034</td><td>41310</td><td>+2724</td></tr>
<tr><td>Women’s & Children’s</td><td>64224*</td><td>66121</td><td>-1896</td></tr>
<tr><td>Trust - overall</td><td>213254</td><td>206924</td><td>+6329</td></tr>
</table>
* there was a reduction on overall acuity in the Children’s Hospital requiring less Registered Nurses</td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>There was an overall deficit of hours due to vacancies particularly in Women’s & Children’s Division and there was reduced acuity in Wards 30 and 33 in the Children’s Hospital and also St Michael’s Hospital. Robust plans have been developed to mitigate the current shortfall (Action 3), which is assessed on a daily basis by the senior nurse team.

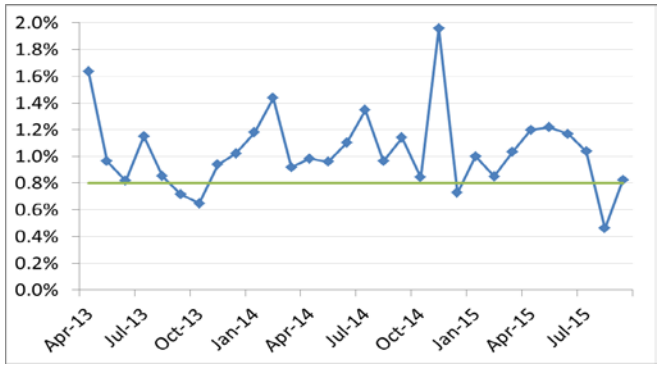
Further detail can be found in the detailed monthly report presented to Quality and Outcomes Committee and Trust Board.</td>
</tr>
</table>

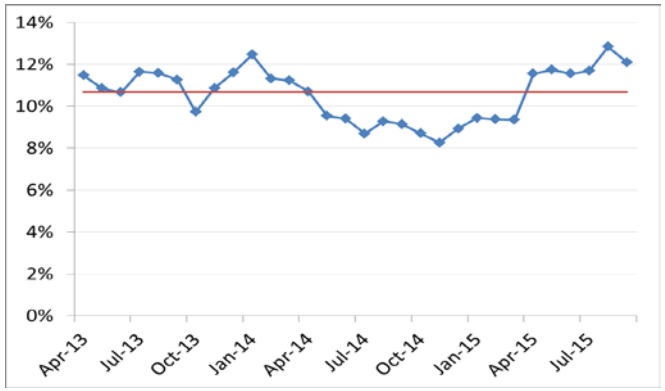
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for September 2015 was 96.2%. This metric combines Friends and Family Test scores from inpatient and daycase areas of the Trust, for both adult and paediatric services. A breakdown of the scores by division is shown below: 2015/16 Quarter 1 / Quarter 2 Medicine: 94% / 94% Specialised Services: 96% / 99% Surgery, Head & Neck: 97% / 98% Women's & Children's (excl. maternity): 95% / 96% Maternity wards: 85% / 94%	**Inpatient Friends & Family scores each month** 	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 received to their friends and family. These results are shared with ward staff and are displayed publically on the wards.
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.	For the month of August 2015, performance was 6.4%. The first milestone is to reach and sustain below 10% in the first six months of 2015/16. In August, we sent out 47 responses to complaints. By the 14th October we had received 3 responses back from complainants indicating they were dissatisfied with the Trust's response = 6.4%. Two of these cases related to responses from the Division of Surgery Head & Neck and one from the Division of Women & Children.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Improving the quality of 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 (Actions 4A and 4B).

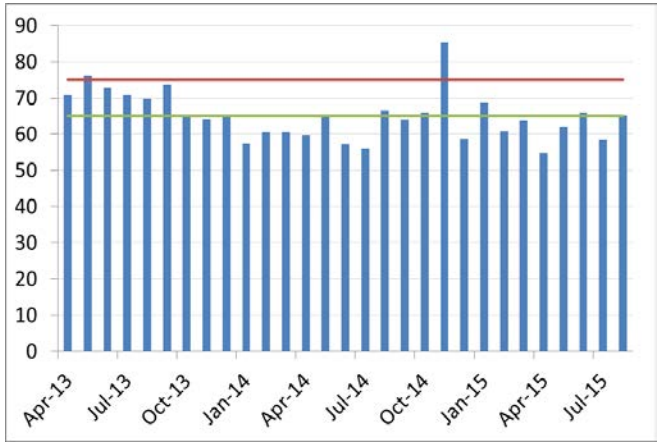
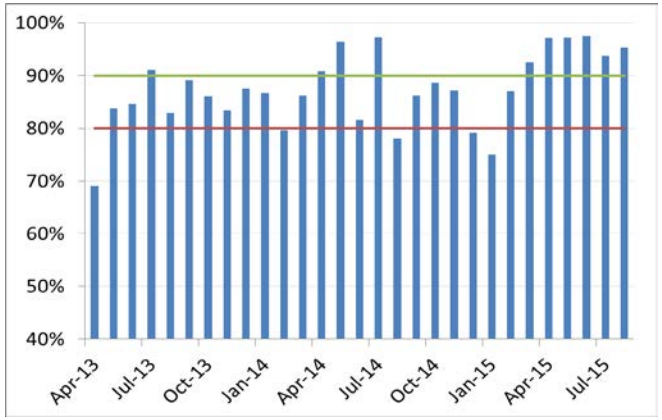
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of August 2015, the score was 90 out of a possible score of 100.
Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.</td>
<td>Inpatient patient experience scores (maximum score 100) each month
 
</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.</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 September 2015, the rolling quarterly score was 89 out of a possible score of 100.
<table>
<tr><th></th><th>Quarter 1</th><th>Sept 2015 (Quarter 2)</th></tr>
<tr><td>Trust</td><td>89</td><td>89</td></tr>
<tr><td>Division of Medicine</td><td>89</td><td>88</td></tr>
<tr><td>Division of Surgery, Head & Neck</td><td>88</td><td>88</td></tr>
<tr><td>Division of Specialised Services</td><td>88</td><td>87</td></tr>
<tr><td>Women's & Children's Division (Bristol Royal Hospital for Children)</td><td>83</td><td>85</td></tr>
<tr><td>Diagnostics and Therapies Division</td><td>92</td><td>94</td></tr>
</table></td>
<td>Outpatient Experience Scores (maximum score 100) each month
 
</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 2. This result will be analysed in detail and an update provided in routine Patient Experience reports to the Board.</td>
</tr>
</table>

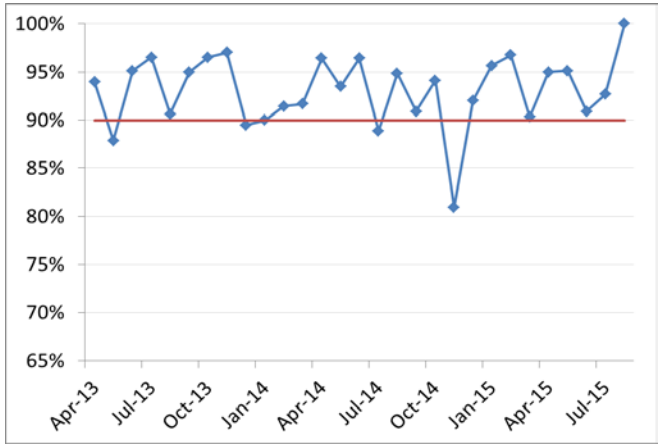
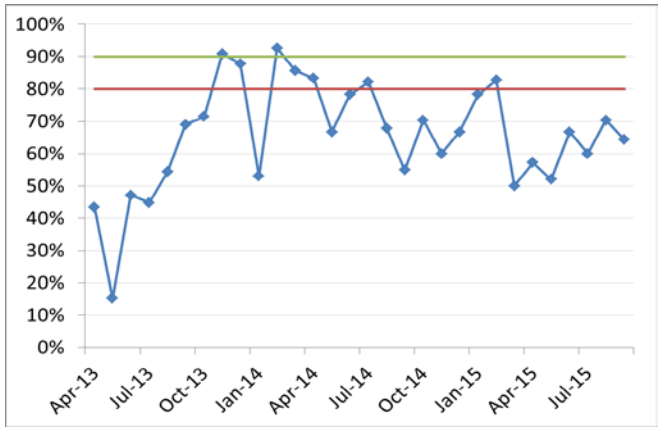
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in September, with performance for the Trust as a whole reported at 91.7%. Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Sep 2014</th><th>Aug 2015</th><th>Sep 2015</th></tr>
<tr><td>Attendances</td><td>5628</td><td>5529</td><td>5363</td></tr>
<tr><td>Emergency Admissions</td><td>1803</td><td>1702</td><td>1795</td></tr>
<tr><td>Patients managed < 4 hours</td><td>4952
88.0%</td><td>5166
93.4%</td><td>4706
87.8%</td></tr>
<tr><th>BCH</th><th>Sep 2014</th><th>Aug 2015</th><th>Sep 2015</th></tr>
<tr><td>Attendances</td><td>2918</td><td>2547</td><td>3200</td></tr>
<tr><td>Emergency Admissions</td><td>769</td><td>718</td><td>835</td></tr>
<tr><td>Patients managed < 4 hours</td><td>2824
96.8%</td><td>2419
95.0%</td><td>3002
93.8%</td></tr>
</table>
</td>
<td>Performance against the A&E 4-hour standard
 
</td>
<td>Performance for the quarter was 94.0% and hence below the trajectory forecast. Levels of emergency admissions into the Bristol Children's Hospital (BCH) in September were 8.6% above the levels seen during the same period last year (Action 5A). The number of Green to Go patients averaged 70 in September, due to domiciliary care package and social worker related delays. Actions continue to be taken to manage demand into the BCH and reduce delayed discharges (Actions 5B and 5C).</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 total number of patients waiting over 18 weeks at the end of September was lower than the revised backlog trajectory, for both the admitted and non-admitted pathways (see Appendix 3). The admitted backlog is now the lowest it has been since December 2013.
There was also a decrease in the number of patients waiting over 40 weeks RTT at month-end against trajectory (in brackets). One 52-week waiters was reported, due to a missed listing for treatment.
<table>
<tr><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>45
(35)</td><td>38
(15)</td><td>28
(6)</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0
(0)</td><td>0
(0)</td><td>1
(0)</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 
</td>
<td>Delivery of the revised trajectories is monitored weekly, with any significant variances from plan escalated to Divisional Director level. The weekly RTT Operational Group continues to oversee the management of waiting lists and booking of longest waiting patients (Action 6).</td>
</tr>
</table>

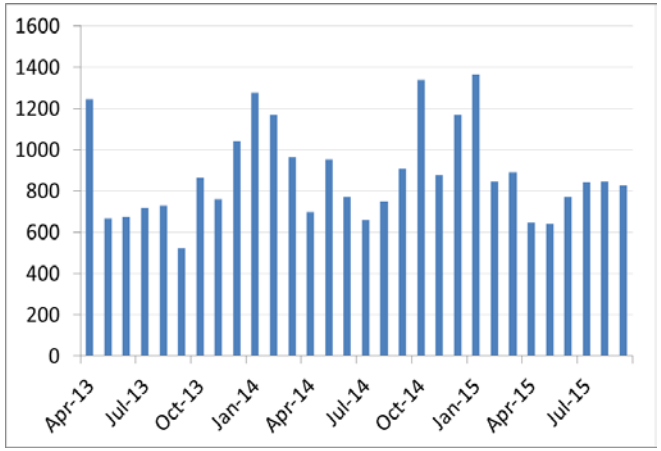
Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	Performance against the 85% 62-day GP standard was 80.2% in August and above the agreed trajectory for the month of 77.0%. Performance against the 90% 62-day screening standard was 70.0%. The main reasons for failure to achieve the 85% national 62-day GP standard were as shown below. **Breach reason** / **August** Late referral by other provider: 4.0 Medical deferral/clinical complexity: 3.5 Insufficient surgical capacity: 3.0 Delayed admitted diagnostic test: 3.0 Delayed outpatient appointment: 2.5 Other (no significant themes): 2.5 **TOTAL**: **18.5**	**Percentage of patients treated within 62 days of GP referral**  The 1.5 x 62-day screening pathway breaches in the period were due to insufficient surgical capacity and breach at other provider following timely referral.	The Internal priority for improving performance against the 62-day GP cancer standard is the implementation of implementation of ideal timescale pathways (Action 7). The upper GI pathway went live at the beginning of October. A network-wide meeting was held on the 29th September, at which milestones for timely referral were agreed in principle with other providers. The above areas of focus are part of wide ranging action plan, as signed-off by the Board.
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 99% national standard was achieved again end of September as forecast. The number and percentage of over 6-week waiters at month-end, is shown in the table below: **Diagnostic test** / **Jul** / **Aug** / **Sep** MRI: 1 / 15 / 2 Echo: 51 / 38 / 30 Ultrasound: 8 / 1 / 0 Endoscopies: 21 / 33 / 32 Other: 2 / 3 / 5 **TOTAL**: **83** / **90** / **69** Percentage: **98.8%** / **98.6%** / **99.0%** Trajectory: 99.0% / 97.0% / 99.0%	**Percentage of patients waiting under 6 weeks at month-end**  Forecast performance for October = 99.0%.	Work continues to reduce the number of patients waiting over 6 weeks for a stress echo following departures within the team. There was a forecast rise in the number of patients waiting over 6 weeks for a routine adult gastro-intestinal (GI) endoscopy due to a short-term loss of capacity. The number of routine over 6 week waiters for paediatric GI endoscopies remains above plan, with actions in progress to eliminate the backlog by the end of December (Action 8).

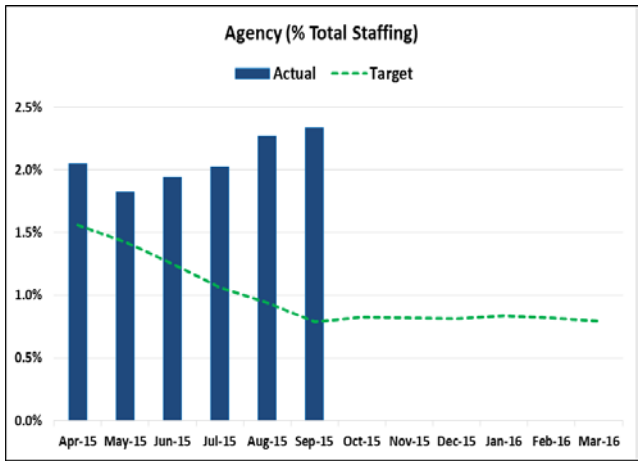
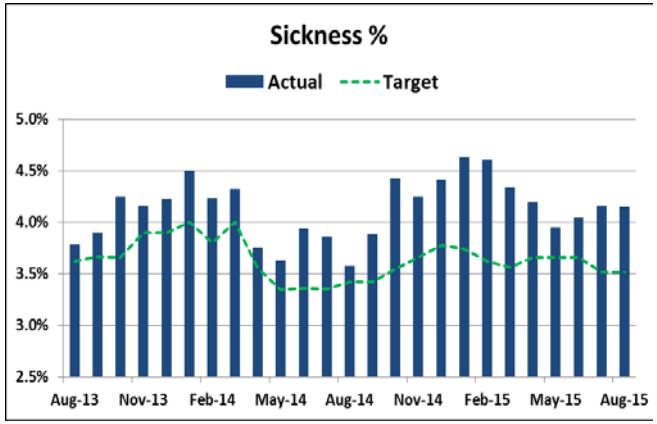
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In September, the Trust cancelled 0.83% of operations at last-minute for non-clinical reasons, narrowly missing the 0.8% national standard. This KPI has an AMBER rating, due to the quality objective being achieved for the month. There were 50 last minute cancellations, the reasons for which are shown below:
<table>
<tr><th>Cancellation reason</th><th>Number/ percentage</th></tr>
<tr><td>No ward bed</td><td>15 (30%)</td></tr>
<tr><td>No ITU/HDU bed</td><td>8 (16%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>7 (14%)</td></tr>
<tr><td>Other causes (12 different breach reasons - no themes)</td><td>20 (40%)</td></tr>
</table>
</td>
<td>Percentage of operations cancelled at last-minute
 

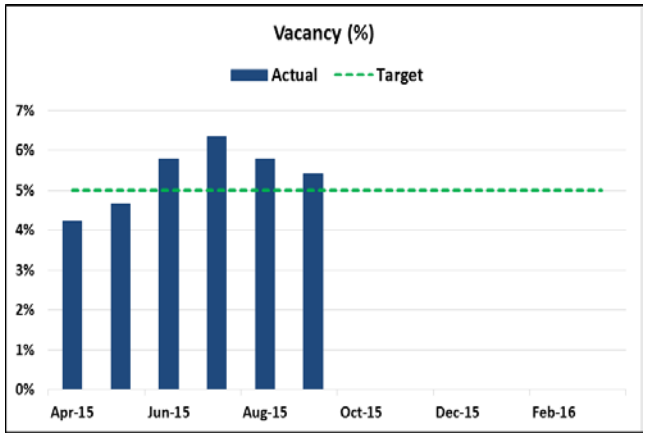
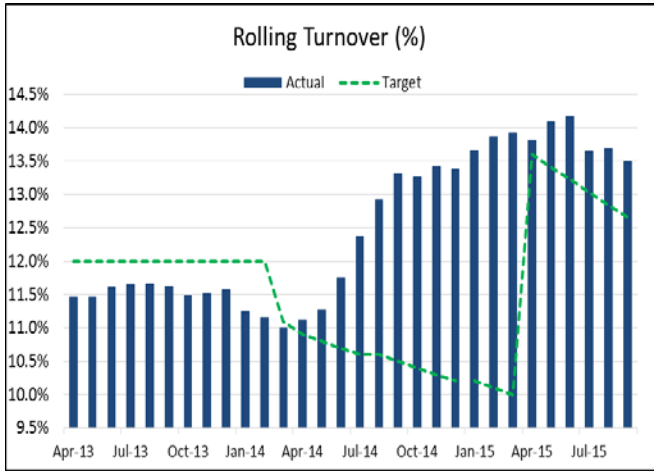
Two patients cancelled in August were readmitted in September, outside of the required 28 days. This equates to 92.0% of cancellations being readmitted within 28 days. The patients failed to be readmitted on time due to more urgent patients taking priority.</td>
<td>There was an increase in the number of last-minute cancellations in the month. This was mainly attributable to the pressure on ward beds due to delayed discharges in the BRI, and high volumes of emergency admissions into the BCH in the period. The number of cancellations due to a lack of an ITU or HDU bed also increased in September, relative to the low levels seen in August, but was not by itself the cause of the failure to meet the 0.8% national standard. (Actions 9A and 9B).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a 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 September 12.1% of outpatient appointments were cancelled by the hospital. This is reduction on the level reported in August (12.8%).
It is thought that the higher level of hospital cancellation of outpatient appointments continues to be due to a high proportion of patients' appointments being brought forward when booked too far ahead. However, further analysis is being undertaken to confirm this.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</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 improvement work overseen by the Outpatients Steering Group (Action 10).</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 August 2015 was 65.1 against an internally set target of 65. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter (i.e. lower and upper confidence intervals greater than 100). No patterns of causes for concern have been identified.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	This is a high level indicator of the effectiveness of the care and treatment we provide. Although August's performance is marginally above our internally set GREEN threshold, our performance continues to indicate 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 September 2015 was 95.3% (latest data) against a target of 90%. There were 43 patients discharged in September, of which 41 had spent at least 90% of their stay on the stroke unit. The year to date performance for this measure is 96.3% (180/187 patients) compared to 86.4% last year.	**The percentage of stroke patients spending 90% of their stay on a stroke unit by month** 	Reasons regarding the two patients for whom we did not achieve the target this month were: One patient, who was appropriately identified as a having a stroke, was admitted to the Acute Medical Unit first due to bed capacity. One patient was transferred to a cubicle (there wasn't one available on the stroke ward) for end of life care.

<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 August (latest data), 25 out of 25 patients (100%) were treated within 90 minutes of arrival in the hospital, meeting the 90% standard.</td>
<td>Percentage of patients with a Door to Balloon Time < 90 minutes by month
 
</td>
<td>Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues. The 90% standard continues to be met for the year 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 September we achieved 64.3% overall performance in Best Practice Tariff. There were 28 patients eligible for Best Practice Tariff in the period, care for 10 of which did not meet all eight standards. Five patients were not operated on within 36 hours. Five patients were 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>Required further diagnostics/ specialist review</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>2</td></tr>
</table></td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>A locum Ortho-geriatrician started on 14th September 2015.
Two patients that breached due to theatre capacity: One was prioritised below another patient with a complex hip fracture, the other was due to theatre overrun. The average time to theatre for the 5 patients was 48 hours.
The actions shown in the improvement plan focus on two key areas: 1) improving access to theatres and 2) reducing delays to Ortho-geriatrician review (Actions 11A and 11B).</td>
</tr>
</table>

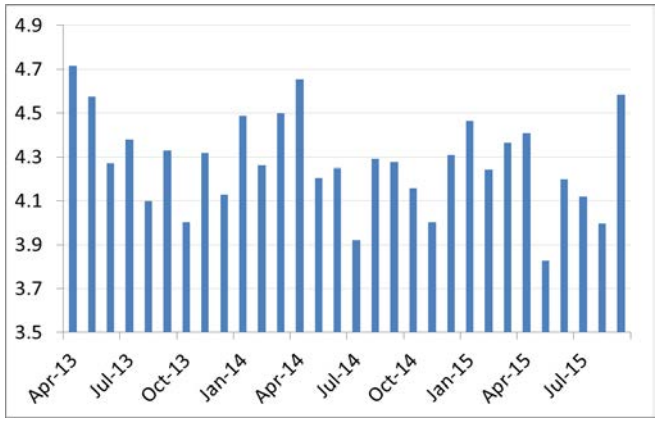
Description	Current Performance	Trend	Comments
Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.	In September there were 824 outlier bed-days against a Q2 monthly target of 563. **Outlier bed-days** / **Sept 2015** Division of Medicine: 381 Division of Surgery, Head & Neck: 317 Division of Specialised Services: 101 Women's & Children's Division: 25 Total: 824 The Trust was in black escalation on a number of days in September.	**Number of days patients spent outlying from their specialty wards** 	The number of outliers increased by 102 bed-days in the Division of Medicine and almost doubled in the Division of Specialised Services, which is a reflection of significant emergency medical admissions and a number of delayed patients awaiting discharge (The Green to Go list averaged 70 patients each day in September). Actions being taken to improve are described in the actions section of this report (Actions 12A and 12B)

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>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.</td>
<td>Agency usage increased by 7.9 FTE. The largest increases were in vacancy cover (8.6FTE), and Registered Mental nursing requirements (7.4FTE). There were small reductions across a range of other reasons, including sickness absence cover (0.8 WTE).
<table>
<tr><th>September 2015</th><th>FTE</th><th>Actual %</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>193.1</td><td>2.3%</td><td>0.8%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>10.4</td><td>1.1%</td><td>0.6%</td></tr>
<tr><td>Medicine</td><td>53.7</td><td>4.2%</td><td>0.8%</td></tr>
<tr><td>Specialised Services</td><td>25.3</td><td>2.9 %</td><td>1.9%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>35.3</td><td>2.0%</td><td>0.6%</td></tr>
<tr><td>Women’s & Children’s</td><td>35.5</td><td>1.9%</td><td>0.5%</td></tr>
<tr><td>Trust Services</td><td>14.0</td><td>2.1%</td><td>0.7%</td></tr>
<tr><td>Facilities & Estates</td><td>19.0</td><td>2.4%</td><td>1.0%</td></tr>
</table>
</td>
<td>Agency usage as a percentage of total staffing by month
 
</td>
<td>The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 13).</td>
</tr>
<tr>
<td>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.</td>
<td>Sickness absence data is not yet available for September, due to the timing of payroll closure, and will be included in the performance report next month. The indicator has been left RED rated (as per August’s rating).</td>
<td>Sickness absence as a as a percentage of full time equivalents by month
 
</td>
<td>Action 14 describes the ongoing programme of work to address sickness absence.</td>
</tr>
</table>

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 reduced from 5.8% (465.1 FTE) to 5.4% (436 FTE) against a target of 5%. Registered Nursing vacancies reduced by 22.4 FTE to 6.9%. Nursing vacancies reduced in Women's & Children's by 24.6 FTE and in Specialised Services by 9.0 FTE, but increased in Surgery Head & Neck by 11.8 FTE and in Medicine by 9.6 FTE.	**Vacancies rate by month** 	Ongoing recruitment plans are described in the improvement plan (Action 15).
Turnover 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 reduced from 13.7% to 13.5% and registered nurse turnover from 13.3% to 12.8%. There were reductions in Women's & Children's, Specialised Services and Surgery Head & Neck, but increases in the other Divisions.	**Staff turnover rate by month** 	Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 16).

September 2015	Rate
UH Bristol	**5.4%**
Diagnostics & Therapies	3.0%
Medicine	7.7%
Specialised Services	6.4%
Surgery, Head & Neck	4.8%
Women's & Children's	2.5%
Trust Services	7.8%
Facilities & Estates	9.5%

September 2015	Actual	Target
UH Bristol	**13.5%**	**12.7%**
Diagnostics & Therap.	12.5%	11.2%
Medicine	12.4%	13.2%
Specialised Services	16.1%	14.5%
Surgery, Head & Neck	14.4%	13.8%
Women's & Children's	11.4%	10.9%
Trust Services	15.6%	12.8%
Facilities & Estates	14.7%	13.2%

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 September the average length of stay for inpatients was 4.58 days. This is an increase on the previous month, when patients stayed an average of 4.00 days. Length of Stay remains above plan, and for this reason is RED rated. 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 this, the percentage of patients discharged in September that had stayed 28 days or more was 3.2% (the highest figure since April 2014). The level of delayed discharges has resulted in more patients staying over 28 days in hospital in Q2 15/16, than in any other period in the last three years, and 11% more than in Q2 2014/15.	**Average length of stay (days)** 	During September the number of delayed discharges has varied considerably, with a high volume of long stay being discharged in the month, but further patients being added to the delayed list. This is primarily a result of the change in providers of domiciliary care packages and an acute shortage of social workers. The number of surgical outliers and long stay patients has increased in recent weeks (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					
Safety Thermometer: New Harms 98.2% against a target of 98.26%	1	Matrons for the wards concerned to review the cases and identify if there is any learning. If so, this will be disseminated via the local safety brief.	31st October 2015	Outcome of Matrons review of cases and local safety brief records.	Small numbers will be subject to normal variation. Plan to achieve no established upward trend of numbers of new venous thrombo-emboli in subsequent months in 2015/16.
Essential Training	2	Continue to drive compliance of core topics, including increasing e-learning Detailed plans focus on improving the compliance of Safeguarding and Resuscitation	Ongoing Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group Oversight of safeguarding training compliance by Safeguarding Board	Trajectory linked to action plans to achieve compliance and sustain 90%.
Monthly Staffing levels	3	Beds closed onwards 31 and 34 in the Children's Hospital	October 2015	Future staffing reports.	Plans to re-open beds once recruited staff (many newly qualified) are in post and inducted.
Caring					
Dissatisfied Complainants	4A	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.
	4B	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the caseworker handling the complaint, then by the Patient Support & Complaints	On-going	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns	As above.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Manager. The Head of Quality for Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.		over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	
Responsive					
A&E 4-hours	5A	Analysis of the causes of the unexpected rise in emergency admissions into the BCH. Work with commissioners to mitigate expected winter rise in admissions.	Completed. Ongoing	Urgent Care Board	Achievement of recovery trajectory over winter, when emergency admissions increase as a result of respiratory viruses.
	5B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of Q3 recovery trajectory.
	5C	Working with partners to mitigate any impact of planned recommissioning of domiciliary care packages providers and bed closures in other acute trusts See also actions 12A to 12C relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of Q3 recovery trajectory.
Referral to Treatment Time (RTT)	6	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. 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 as per revised trajectories.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Cancer waiting times	7	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways, and reduced waits for 2-week wait appointments (copy of plan provided to the Quality & Outcomes Committee as a separate paper in August; and Trust Board in September)	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 (already achieved in Q2). Achieve 85% across shared and internal pathways combined by March 2016.
Diagnostic waits	8	Weekly monitoring of waiting list to inform capacity planning, with particular focus on cardiac stress echo, paediatric and adult gastrointestinal endoscopy long waiters.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Forecast for 99% standard to be restored from the end of September (achieved).
Last minute cancelled operations	9A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited but now in pipeline before starting.	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a reduction in cancellations for this reason (as seen in August and September). Ongoing achievement of quality objective on a quarterly basis, with achievement of national standard of 0.8% in quarter 4 2015/16.
	9B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
Outpatient appointments cancelled by hospital	10A	Reductions in cancellation rates to be realised through improvements in booking practices and appointment slot management	March	Oversight of programme of work, which this is a core part, by the Outpatients Steering Group.	Green target level achieved.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	10B	Analyse percentage of appointments cancelled by hospital which are a result of appointments being brought forward.	November	Information to be reviewed by the Outpatient Steering Group and Quality & Outcomes Committee.	Not applicable.
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	11A	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.	
	11B	Review of all Ward Processes on Trauma and Orthopaedic Wards. Project to review fractured neck of femur direct admission process and reduced length of stay.	November 2015	Future reports to the Board.	Improve in overall fractured neck of femur pathway
Ward Outliers	12A	<u>Reduce demand on beds to support optimal occupancy.</u> Range of initiatives in place to reduce demand for acute services. Limited impact to date and further significant initiative now being pursued – community virtual ward. Discussions between potential provider, Trust, CCG in hand.	Ongoing Working to bring on line for Q4 (subject to reaching agreement)	Oversight in monthly Urgent Care Working Group Fortnightly Director led escalation meeting established this month in response to lack of impact of ongoing initiatives	Maintain modelled occupancy of 90%
	12B	<u>Reduce number of patients whose discharge from hospital is delayed</u>		Weekly multi-agency patient progress meeting held, chaired	'Green to go' trajectory or no more than 30 patients.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Implement Discharge to Assess pathways, to move the patient from hospital to a community bed for assessment to take place. Spot purchase beds as appropriate directly by Bristol CCG. Extra Social Work support to be commissioned for the BRI by Bristol city Council. Mobilise new domiciliary care contract providers to increase access Roll out "Ward Processes" bundle across all wards.	Commenced but not yet scaled (and impacting) due to issues with domiciliary care procurement. Ongoing with limited impact in month. Complete with evidence of impact on assessment delays. Commenced but limited impact due to pace of rollout. Roll out commenced in all Divisions but additional pace and scale required	by the Divisional Director for Medicine. Daily ALAMAC calls with acute and community partners to escalate relevant issues and enhance communication. Fortnightly Director led escalation meeting established this month in response to lack of impact of ongoing initiatives	Length of stay reduction to meet bed model by 31st August 2016 Ward Processes bundle being used in all wards within BHI, BRI and BHOC.
	12C	<u>Right bed, first time</u> Reset bed base between medicine and surgery to reflect modelled demand for beds; Protect dedicated beds for stroke and #neck of femur other than in	Complete Complete	Compliance reviewed through daily Flow Meetings and Silver meetings when convened.	Achieve target outlier bed days in Q3.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		extremis; Introduce 24 hour repatriation standard for non-medical patients on Acute Medical Unit and non-surgical patients on Surgical & Trauma Assessment Unit.	Complete		
Well led					
Agency Usage	13	Key actions driven corporately for Agency are: <u>Nursing and midwifery</u> • Disseminate FAQs on pay arrangements and bank processes; • Close working with wards to maximise the functionality of Rosterpro to support booking and payment processes for bank staff; • A "real time" staffing dashboard is being developed to enable cross-trust review of staffing levels supporting the movement of staff across divisions as an alternative to filling shifts using bank and agency; • A direct booking process based at ward level for temporary staff, commencing September 2015 is being rolled out to all areas to allow greater control over staffing at ward level and	October 2015 Ongoing January 2016 October – December 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 at Divisional level at mid-year review for all workforce KPIs and will be included in the quarterly workforce report.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		maximise the availability to bank staff; • A cross-community Group has been established to share and develop collaborative approaches to reducing agency spend. <u>Medical agency usage</u> • Reduce costs by agreed locum rates and procurement of a Master Vend supplier for locums – contract awarded, go live October; • Rolling out the Envoy Texting system (currently used by the Temporary Staffing Bureau) in the Division of Medicine to improve the speed and efficiency of seeking internal locum solutions; • Work is being undertaken to develop an internal locum bank. Feasibility study of appropriate systems; • There is a continued Divisional focus on filling vacancies and gaps, which are the main reasons for medical agency. <u>Administrative/clerical and ancillary agency usage</u> • Bank processes for administrative/clerical staff are under review and changes,	Ongoing October to December 2015 October to December 2015 Review commences October 2015 Ongoing November 2015		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		which will impact by November 2015, are anticipated to improve the bank fill rate.			
Sickness Absence	14	Detailed plans with timescales for the work programmes agreed with Senior Leadership Team have been developed and will be implemented during the next quarter. • Self-certification for absences of less than four days; • Audit and raise the profile of return to work interviews; • Contacting employees who are taking sickness absence on the 1st, 3rd and 7th day of absence, phased roll-out; • Managers in "hot spots" to receive coaching; • Occupational health triage service to be promoted; • Extension of system to alert managers to sickness stages, currently used in Diagnostic and Therapies. The above areas will form part of a more wide ranging sickness absence audit. Continued implementation of the Staff Health and Well Being action plan: <u>Stress, anxiety and depression</u>	September to December 2015 October 2015 to February 2016.	Oversight by Workforce and OD Group via the Staff Health and Well Being Sub Group	Sickness absence data is not yet available for September, due to the timing of payroll closure, and will be included in the performance report next month. The trajectory has therefore not been updated from the projected out turn reported last month of 3.9%.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• The Resilience Building Programme providing tools and techniques to build resilience and prevent absence for psychological reasons. <u>Musculo-skeletal</u> • Review of Occupational Health to Physiotherapy Bristol Royal Infirmary pathway to improve the focus on prevention and keeping staff at work. • Continued targeted intervention by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team. <u>Colds and flu</u> • The seasonal flu vaccination campaign for all Trust staff commenced on 5 October 2015. The Trust is aiming to achieve the 75% target coverage set by NHS England.	August 2015 to June 2016 November 2015 Ongoing October 2015 to end February 2015	Flu Steering Group	
Vacancies	15	Recruitment action plan includes the following ongoing activities: • A schedule of advertising activity has been developed utilising the agreed funding for 2015/16 to target the national market for hard to fill posts including nursing and midwifery. Activity includes the use of local radio, Bristol buses	September 2015 to March 2016	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. Recruitment is currently below trajectory for nursing and midwifery.

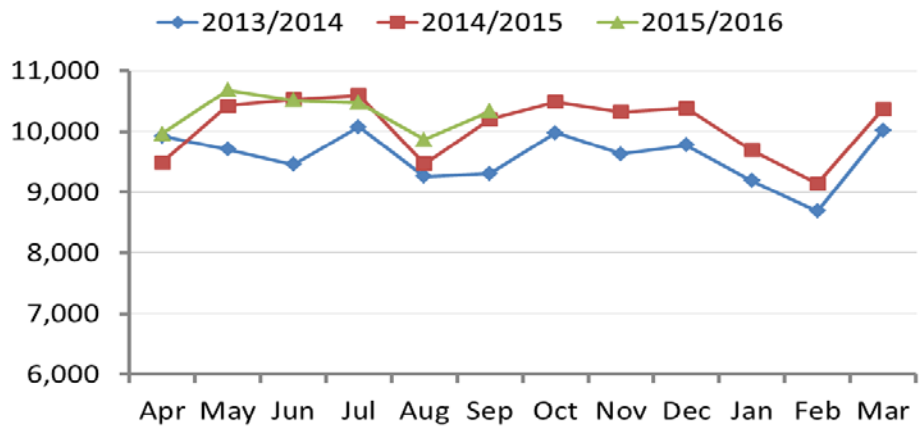
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		and social media. • Service level agreements and KPIs for recruitment will be developed when the TRAC recruitment system has been implemented for three months. This will measure performance and support improvement of conversion to hire rates and benefits realisation. • Newly appointed Recruitment and Retention lead for Facilities will aim to reduce vacancies.	October 2015 October 2015		
Turnover	16	Key corporate and divisional actions include: • 4 staff experience workshops have taken place, with more planned, to agree how we improve communications between managers and teams with an outcome of improving staff experience. A full report will be made to Senior Leadership Team in November; • Pilot preceptorship programmes to support newly qualified nurses in their transition from student to registered nurses; • Stock-take by Divisional Finance Managers of training and development resources; • Additional investment for	July to November 2015 September 2015/ February 2016 October 2015 September 2015 –	Oversight of Staff Experience Programme by Transformation Board. Oversight by Workforce and Organisational Development Group Education Group Senior Leadership	The current trajectory indicates that the annual target will be exceeded, with an anticipated out turn of 14.4%, assuming that the numbers of monthly leavers continue at the present level.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		divisional hot spots including innovative training and development programme for theatres and critical care staff ; • Role competency and career frameworks to be embedded within the revised appraisal process to improve the quality and application of staff appraisals.	March 2016 End of June 2016	Team/Workforce and Organisational Development Group /Divisional Boards Workforce and Organisational Development Group	
Length of stay	17	See actions described under Outlier bed-days (Actions 12A to 12C), focusing on Surgery Length of Stay and Delayed Discharges.			

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.

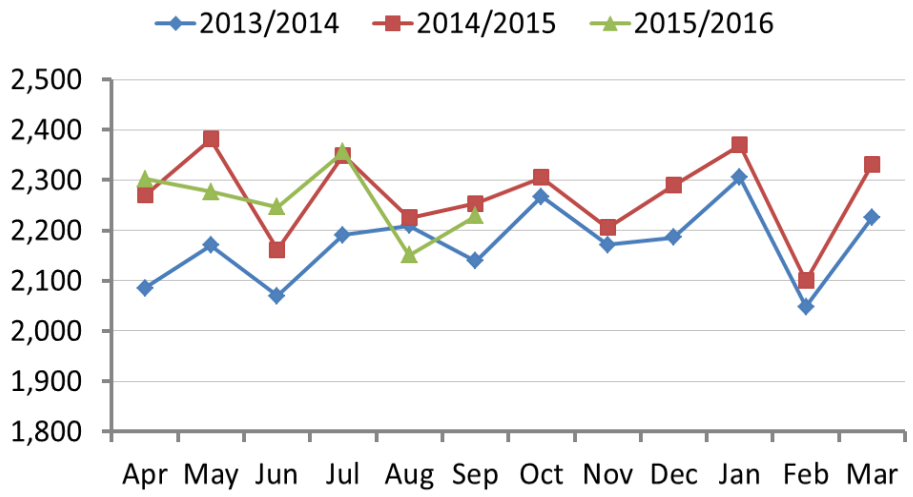
A&E attendances



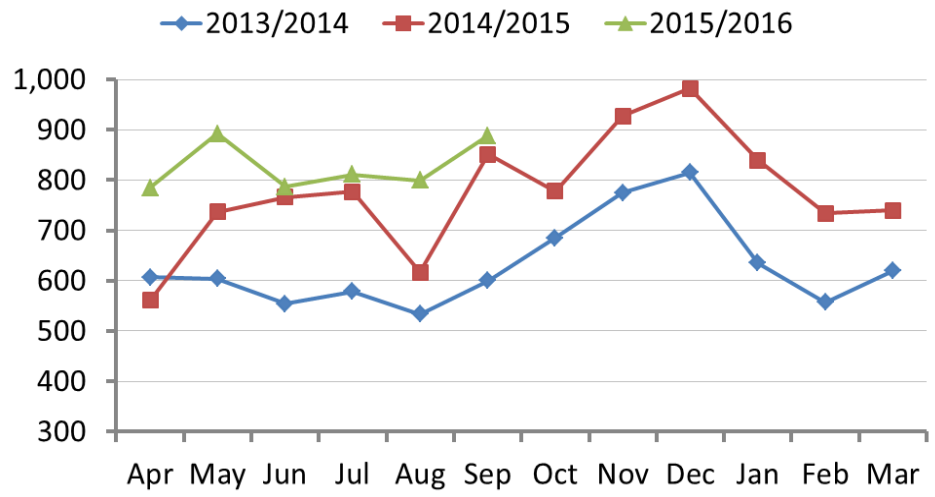
Summary points:

- The level of emergency admissions into the BRI remains consistent with the seasonal norms; the level of emergency admissions into the BCH is above the same period last year;
- Levels of elective admissions is above seasonal norms; as will be seen in the Assurance and Leading Indicators summary, consistent with this, there has been a decrease in the number of patients on elective waiting list, and in the numbers of patients waiting over 18 weeks from referral to treatment;
- Levels of new outpatient attendances have remained at seasonal norm (i.e. at a high level), resulting in a reduction in the total number of patients on the outpatient waiting list.

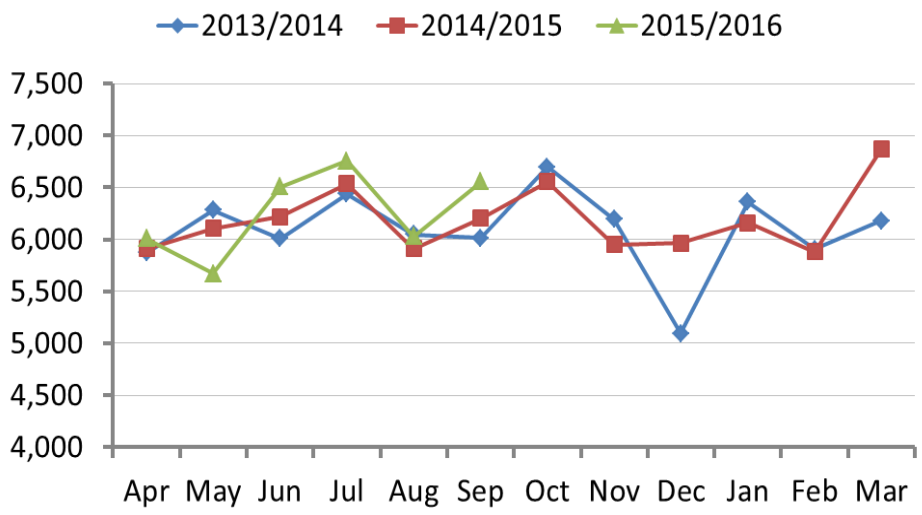
Emergency admissions (BRI)



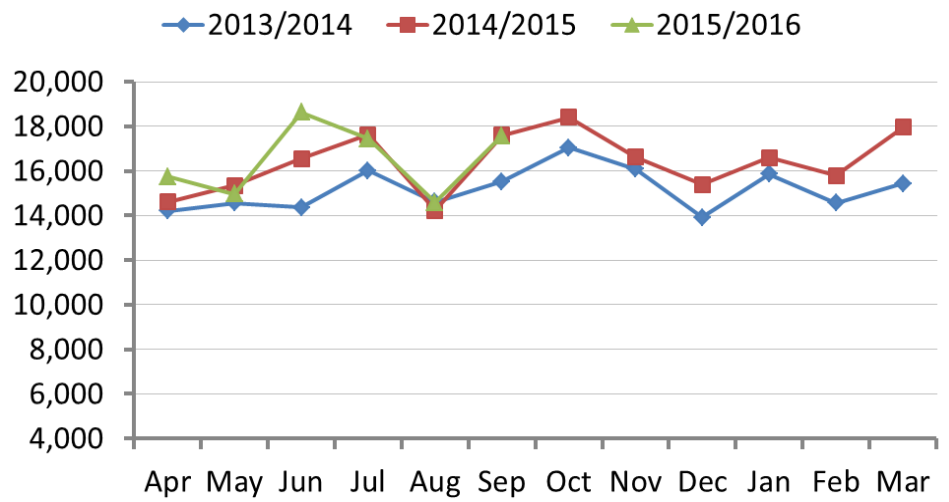
Emergency admissions (BCH)



Elective admissions



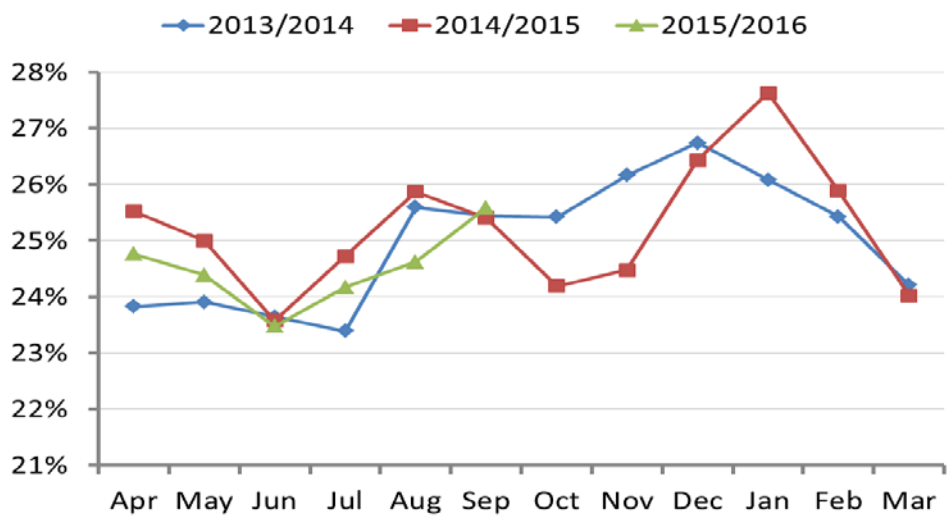
New outpatient attendances



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.

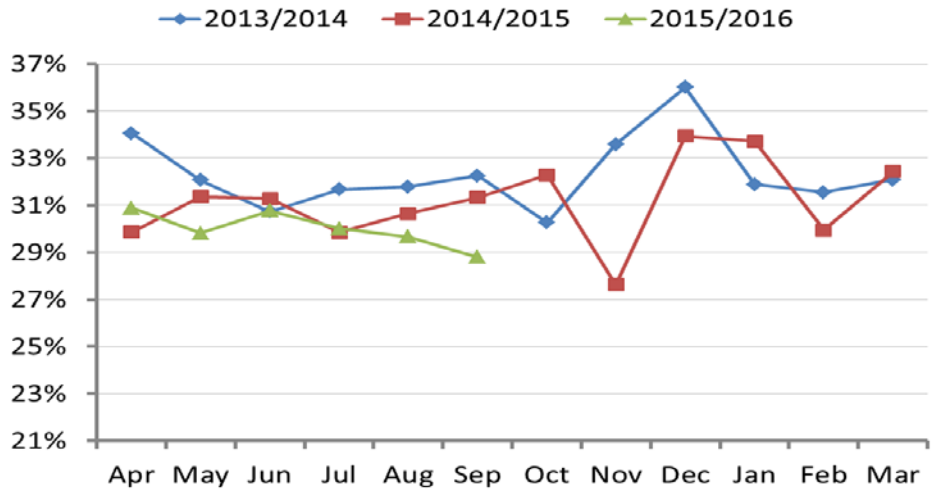
Percentage ED attendances resulting in admission



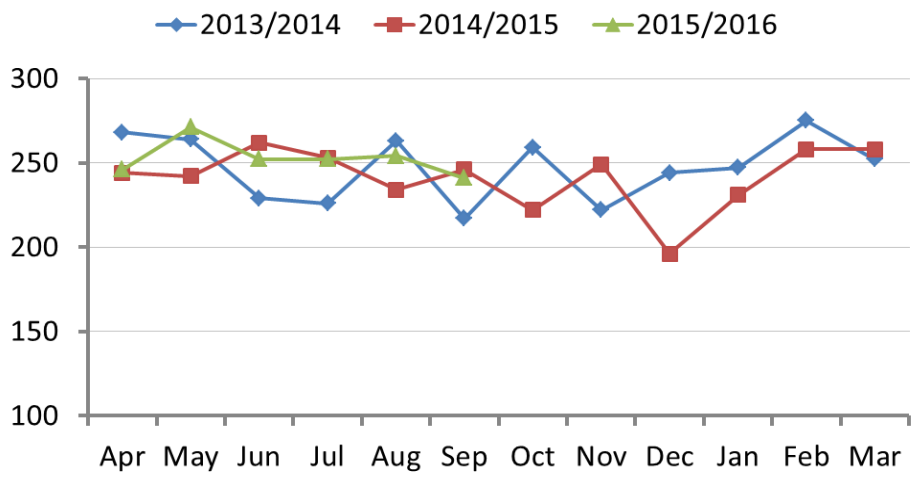
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission was consistent with the seasonal norm in September; in contrast, the percentage of patients admitted aged 75 years and over, was below the seasonal norm;
- BRI bed occupancy has continued to increase, and delayed discharges have remained high, with significant peaks observed in-month;
- The number of patients on the elective and outpatient waiting lists have continued to reduce, which is consistent with the higher than normal number of 18 week clock (treatment) stops in the period, and the reduction in the number of RTT patients waiting over 18 weeks;
- Numbers of patients being referred by their GP with a suspected cancer dropped in the month, which should in two months' time lead to a reduction in the number of patients treated on 62-day pathways, which is currently high.

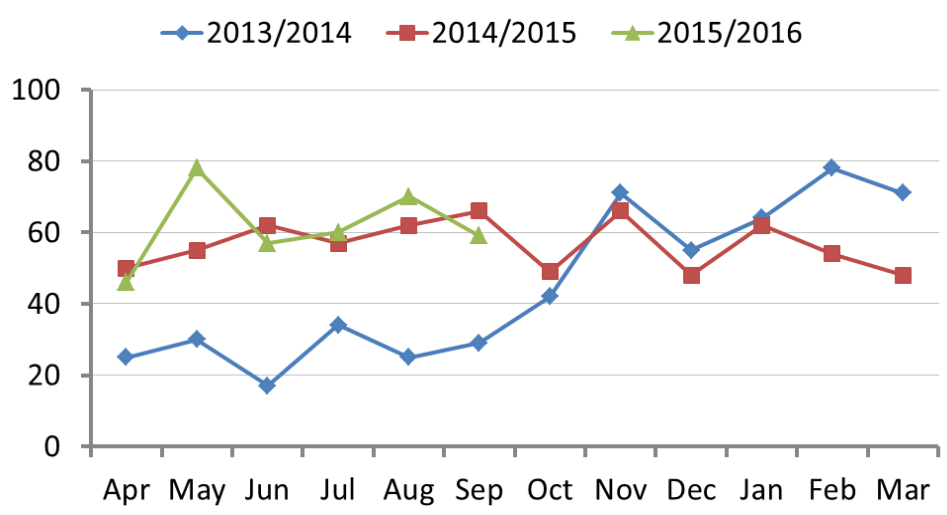
Percentage of Emergency BRI spells patients aged 75 years and over



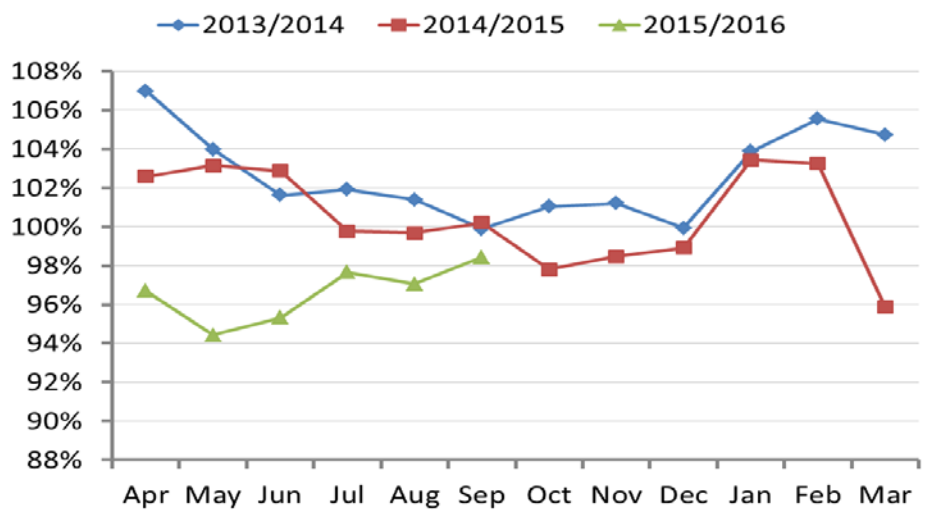
Over 14 day stays



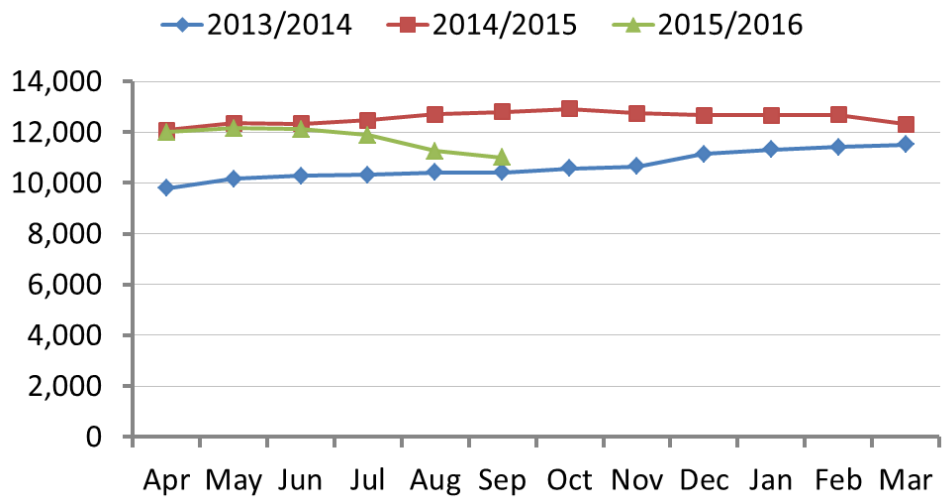
Delayed discharges



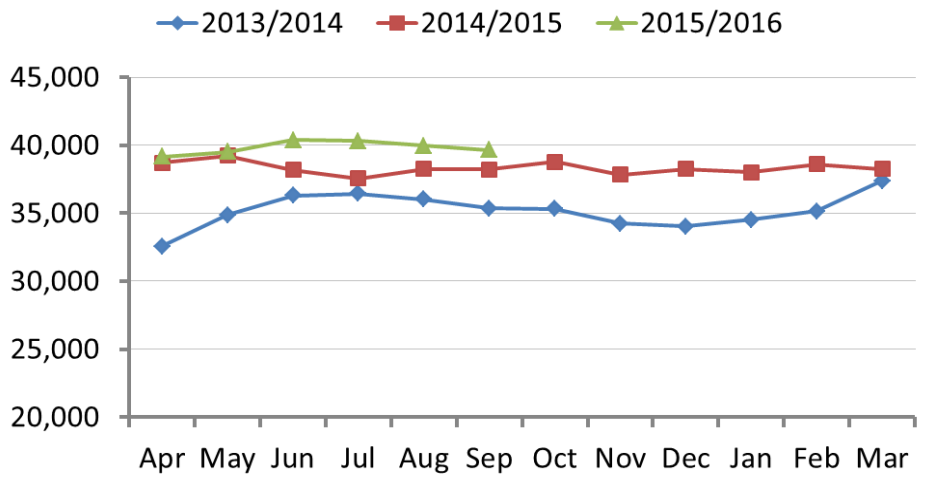
BRI Bed Occupancy



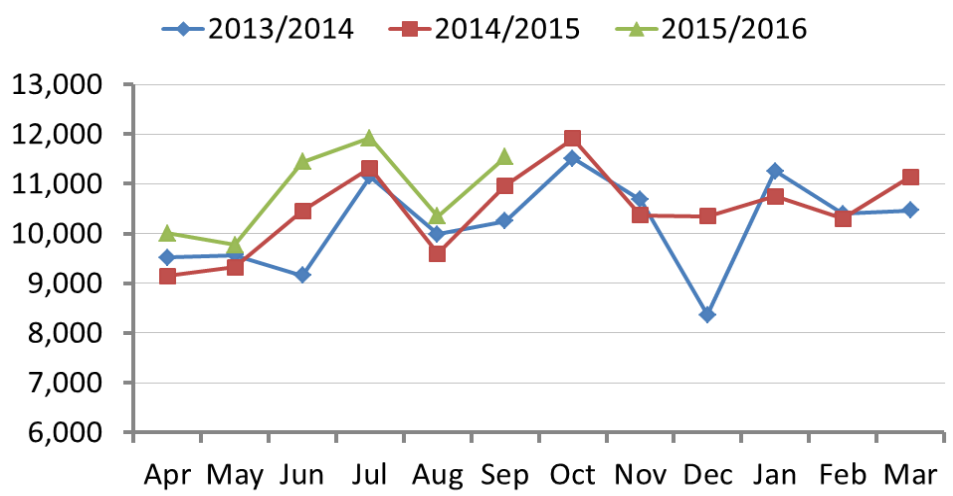
Elective waiting list size



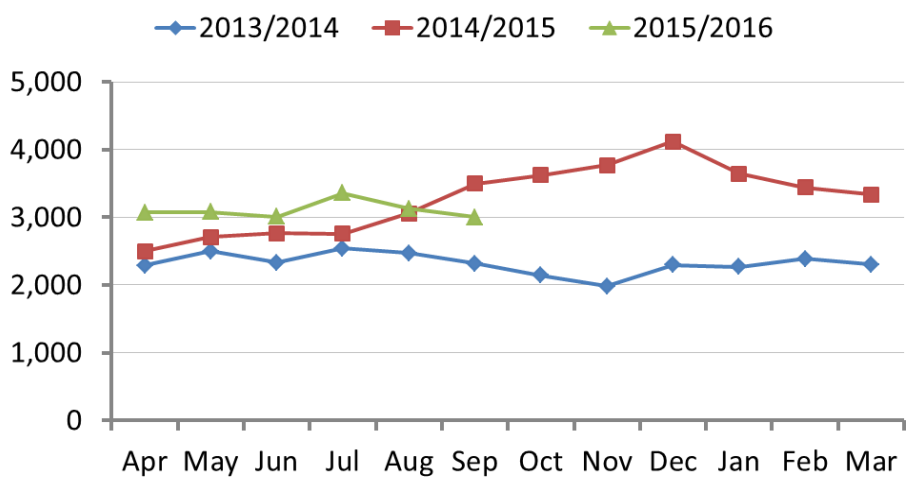
Outpatient waiting list size



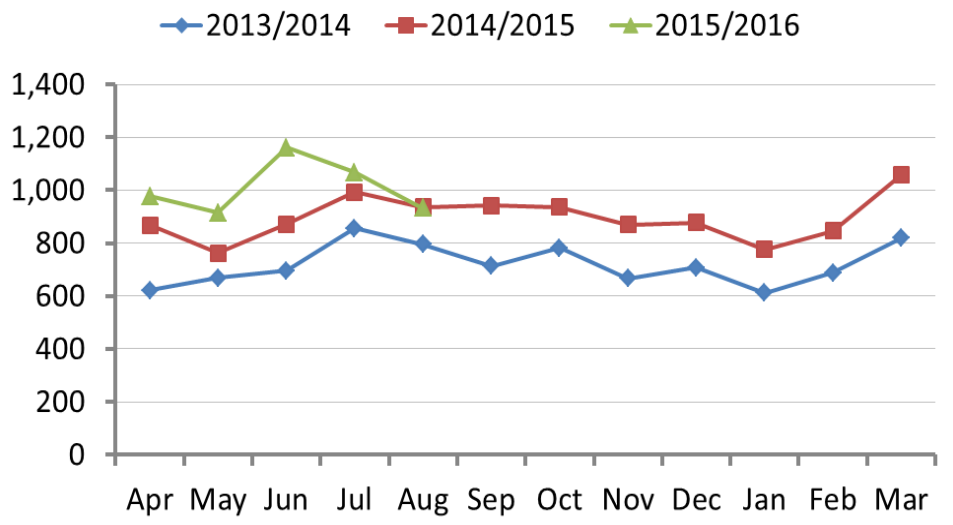
Number of RTT pathways stopped (i.e. treatments)



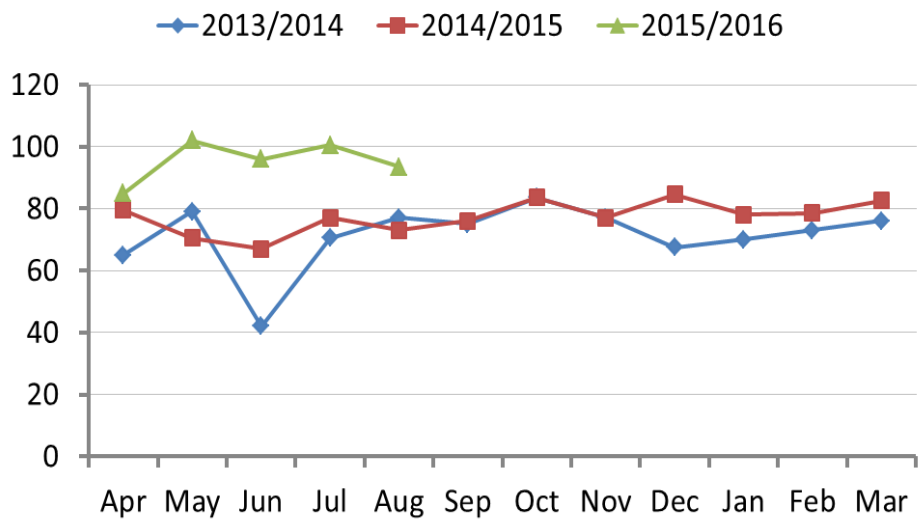
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

QUALITY

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	5	3	3	3	4	4	5	5	1	1	2	2	3	3	4	5	2	3
	DA01	MRSA Bloodstream Cases - Monthly Totals	5	3	0	0	1	0	1	0	1	0	1	0	1	0	1	1	2	1
	DA03	C.Diff Cases - Monthly Totals	50	16	4	4	4	3	4	0	6	1	3	3	1	2	12	7	10	6
	DA02	MSSA Cases - Monthly Totals	33	16	1	3	4	3	2	4	4	1	4	2	3	2	8	9	9	7
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	6	6	6	7	8	8	2	2	3	3	-	-	6	8	3	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.2%	97.5%	96.3%	97.2%	97.6%	97.1%	97.4%	97.6%	97%	96.9%	97.6%	97.7%	97.7%	97.9%	97%	97.4%	97.2%	97.8%
	DB02	Antibiotic Compliance	89.3%	89.6%	90.3%	91.2%	89.1%	90.6%	88.8%	88.8%	90.7%	90.9%	88.9%	88.3%	-	-	90.3%	89.4%	90.1%	88.3%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	94%	95%	96%	96%	96%	95%	95%	93%	95%	93%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	98%	98%	98%	98%	98%	98%	98%	98%	97%	96%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	96%	95%	95%	96%	96%	97%	97%	95%	94%	93%	94%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	78	30	10	6	8	7	4	6	6	6	4	3	8	3	24	17	16	14
	S02a	Number of Confirmed Serious Incidents	71	9	9	5	8	5	4	6	4	3	2	-	-	-	22	15	9	-
	S02b	Number of Serious Incidents Still Open	2	19	-	-	-	2	0	0	1	2	2	3	8	3	-	2	5	14
	S03	Serious Incidents Reported Within 48 Hours	88.5%	80%	80%	83.3%	100%	100%	100%	83.3%	100%	100%	25%	100%	62.5%	100%	87.5%	94.1%	81.3%	78.6%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	73.3%	81%	50%	66.7%	37.5%	80%	66.7%	100%	75%	85.7%	66.7%	100%	100%	66.7%	46.7%	76.2%	78.6%	85.7%
Never Events	S01	Total Never Events	6	1	0	1	0	1	1	1	0	0	0	0	1	0	1	3	0	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	12712	5418	1151	1028	1073	1017	1022	1124	1087	1139	1216	1023	953	-	3252	3163	3442	1976
	S06b	Patient Safety Incidents Per 1000 Beddays	41.32	41.85	44.91	40.6	41.66	37.64	41.85	43.14	42.65	43.43	47.3	39.07	36.85	-	42.4	40.81	44.46	37.97
	S07	Number of Patient Safety Incidents - Severe Harm	89	103	3	12	6	12	7	6	7	5	5	23	63	-	21	25	17	86
Patient Falls	AB01	Falls Per 1,000 Beddays	4.8	4.04	5.23	4.5	5.59	4.89	4.91	4.53	3.61	4.46	3.81	3.82	4.6	3.9	5.11	4.77	3.97	4.11
	AB06a	Total Number of Patient Falls Resulting in Harm	28	7	2	4	1	2	1	2	2	2	0	3	0	0	7	5	4	3
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.387	0.285	0.312	0.553	0.388	0.37	0.45	0.269	0.353	0.267	0.311	0.229	0.232	0.318	0.417	0.361	0.31	0.259
	DE02	Pressure Ulcers - Grade 2	110	39	8	13	8	9	10	5	9	7	7	5	4	7	29	24	23	16
	DE03	Pressure Ulcers - Grade 3	9	5	0	1	2	1	1	2	0	0	1	1	2	1	3	4	1	4
	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%	98.7%	99%	99%	99.1%	99.4%	99.2%	99.1%	99.3%	99.1%	99.4%	99.3%	99%	98.9%	99.2%	99.2%	99.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.4%	94.8%	92.6%	92.3%	96.7%	92.4%	92.9%	96%	93.9%	93%	94.3%	96.6%	95.2%	95.1%	93.8%	93.8%	93.8%	95.7%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	88.9%	89.5%	88.3%	87.2%	87.8%	87.4%	88.4%	87.9%	86.8%	93%	92.3%	90.7%	86.6%	86.5%	87.8%	87.9%	90.9%	87.9%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.9%	99.7%	99.6%	99.4%	100%	100%	100%	100%	99.7%	100%	100%	100%	100%	99.6%	100%	99.9%	100%

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Patient Safety																				
Medicines	WA01	Medication Errors Resulting in Harm	0.45%	0.12%	0%	0.57%	0%	0%	0%	0.54%	0%	0.56%	0%	0%	0%	-	0.2%	0.21%	0.18%	0%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	1.01%	0.87%	1.21%	0.86%	0.37%	1.55%	1.54%	0.52%	0.63%	1.43%	0.96%	0.83%	0.73%	0.75%	0.84%	1.23%	0.96%	0.77%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	96.6%	97.1%	96.1%	96.7%	97%	96.7%	97.9%	96.5%	97.5%	97.1%	98.2%	97.4%	96.4%	96.2%	96.6%	97%	97.6%	96.7%
	AK04	Safety Thermometer - No New Harms	98.4%	98.4%	97.9%	97.8%	98.5%	98.4%	99.3%	98.7%	98.9%	98.2%	98.6%	98.6%	98%	98%	98.1%	98.8%	98.6%	98.2%
Deteriorating Patient	AR03	Early Warning Scores (EWS) Acted Upon	89%	93%	88%	86%	83%	92%	96%	88%	90%	96%	91%	98%	90%	92%	85%	91%	92%	94%
Out of Hours	TD05	Out of Hours Departures	10.4%	11%	9.3%	8.5%	9.5%	10.7%	9%	10.4%	9%	11.7%	11.6%	10.1%	11.7%	11.7%	9.1%	10.1%	10.8%	11.2%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	19.5%	19.3%	18.9%	16.9%	19%	18.5%	22.3%	20.6%	20.4%	19%	18.6%	19.9%	17.8%	19.8%	18.3%	20.4%	19.3%	19.2%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9862	4933	829	726	800	809	877	873	845	838	789	879	738	844	2355	2559	2472	2461
CAS Alerts	CS01	CAS Alerts Completed Within Timescale	97.9%	100%	85.7%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	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	0
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.6%	101.5%	104%	104.6%	103.1%	104.6%	103.4%	102.4%	100.4%	100.3%	101.8%	102.8%	100.5%	103.1%	103.9%	103.5%	100.8%	102.1%
Clinical Effectiveness																				
Mortality	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deat	64.1	61.2	65.9	85.4	58.5	68.6	60.8	63.9	54.8	62	66	58.4	65.1	-	68.7	64.8	60.9	61.6
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	96.5	-	-	-	97.8	-	-	-	-	-	-	-	-	-	97.8	-	-	-
	X06	Risk Adjusted Mortality Indicator (RAMI) 2013 Baseline	68.3	62.4	70.4	89.7	63.3	70.3	57.8	68.6	56.6	70.9	64.7	56.4	64.5	-	73.1	66.1	63.8	60.3
Readmissions	C01	Emergency Readmissions Percentage	2.82%	2.93%	2.45%	2.39%	2.99%	3.06%	2.83%	2.96%	2.89%	3.55%	2.69%	2.72%	2.84%	-	2.61%	2.95%	3.04%	2.78%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	61.5%	61.8%	58.9%	65.5%	59.6%	60%	59.8%	57.9%	60.9%	63.4%	64.1%	57.3%	62.6%	62.4%	61.3%	59.3%	62.8%	60.7%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	76%	75.6%	77.8%	73.3%	70%	78.3%	89.7%	72.7%	71.4%	72%	66.7%	76%	81.5%	85.7%	73.6%	81.1%	70.2%	81.3%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	93.4%	79.9%	88.9%	86.7%	93.3%	95.7%	93.1%	86.4%	77.1%	68%	91.7%	80%	85.2%	78.6%	90.3%	91.9%	78.6%	81.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	70.1%	61.6%	70.4%	60%	66.7%	78.3%	82.8%	50%	57.1%	52%	66.7%	60%	70.4%	64.3%	66.7%	71.6%	58.3%	65%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	40.5	41.3	57.5	45.5	37	47.5	45.5	56.2	55.8	46.7	40.2	39.4	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	56.5%	60.8%	62.8%	59%	62.8%	55%	66.7%	60%	68.6%	65.7%	56.1%	43.8%	67.4%	-	61.6%	61.2%	63.1%	57.3%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	86.4%	96.3%	88.6%	87.2%	79.1%	75%	87%	92.5%	97.1%	97.2%	97.6%	93.8%	95.3%	-	84.9%	85.1%	97.3%	94.7%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.2%	66.7%	58.8%	73.3%	64.7%	50%	57.1%	50%	69.2%	83.3%	30.8%	58.8%	100%	75%	65.3%	52.8%	60.5%	73.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	65%	86.9%	61.4%	63.7%	62.9%	78.3%	77.3%	81.6%	83.9%	88.4%	82.7%	83.3%	92.5%	91.1%	62.6%	79.3%	84.9%	88.8%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	84.1%	94.6%	87.1%	92.2%	82.2%	90.7%	88.5%	94.2%	98.6%	100%	92.8%	90%	92.3%	93.2%	86.3%	91.7%	97%	91.8%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	58.5%	90.5%	78.3%	73.3%	68%	82.4%	81.3%	90.5%	90%	92.3%	92.9%	80%	100%	88.9%	74.3%	85.2%	91.5%	88.9%
	AC04	Percentage of Dementia Carers Feeling Supported	75.2%	87.7%	80%	88.9%	64.3%	87.5%	81.8%	-	90.9%	100%	93.3%	92.3%	76.9%	70%	78.7%	85.2%	94.6%	80.6%
Outliers	J05	Ward Outliers - Beddays	11216	4564	1338	876	1169	1364	847	889	647	638	769	841	845	824	3383	3100	2054	2510

QUALITY (continued)

Topic	ID	Title	Annual 14/15	Annual 15/16 YTD	Monthly Totals Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Quarterly Totals 14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	89	89	89	89	90	89	89	92	89	91	90	-	89	89	90	90
	P01g	Patient Survey - Kindness and Understanding	-	-	93	93	94	93	93	93	94	96	93	93	95	-	93	93	94	94
	P01h	Patient Survey - Outpatient Tracker Score	-	-	-	-	-	-	-	-	89	89	89	88	89	89	-	-	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	38.7%	17.4%	36.1%	41.3%	29.5%	37.9%	33.9%	59.3%	17.4%	19.7%	16.2%	20.5%	10.4%	19.8%	35.5%	44%	17.7%	17.1%
	P03b	Friends and Family Test ED Coverage	20.8%	10.8%	20.2%	14.9%	16%	17.3%	22.5%	37.1%	6.6%	6.7%	7%	12.3%	14.7%	17.8%	17.1%	26.1%	6.7%	14.9%
	P03c	Friends and Family Test MAT Coverage	28.9%	22.3%	18.9%	54.3%	29.2%	26.9%	22.5%	35%	23.9%	33.7%	20.1%	22.1%	18.3%	14.6%	33.7%	28.2%	26.1%	18.5%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	94.9%	96.4%	94.3%	94%	96.3%	95.9%	93.3%	95.5%	96.1%	95.5%	96.3%	97.2%	97.2%	96.2%	94.7%	95.1%	96%	96.8%
	P04b	Friends and Family Test Score - ED	92.7%	75.6%	90.5%	92.4%	92.1%	93.4%	89.9%	93.5%	80.7%	66.3%	70.4%	78.1%	77.3%	76.6%	91.5%	92.5%	72.2%	77.2%
	P04c	Friends and Family Test Score - Maternity	94.2%	96.4%	97.1%	95.8%	92%	97.1%	97.1%	91.5%	97.3%	93.3%	97.8%	98.7%	97.1%	96.3%	95%	94.9%	95.6%	97.6%
Patient Complaints	T01	Number of Patient Complaints	1883	1019	148	140	133	165	171	181	158	147	154	207	168	185	421	517	459	560
	T01a	Patient Complaints as a Proportion of Activity	0.261%	0.274%	0.224%	0.251%	0.224%	0.267%	0.291%	0.273%	0.266%	0.25%	0.231%	0.315%	0.302%	0.279%	0.232%	0.277%	0.249%	0.298%
	T03a	Complaints Responded To Within Trust Timeframe	85.9%	84.5%	84.4%	82.9%	82.9%	84.8%	83.7%	85.3%	89.5%	83.9%	82.1%	87%	80.9%	83.3%	83.4%	84.7%	84.9%	83.9%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	94.3%	77.9%	78.6%	87.1%	87.9%	81.4%	92.6%	93%	91.9%	94%	98.1%	93.6%	95.8%	81.1%	88.1%	93%	96%
	T04c	Percentage of Responses where Complainant is Dissatisfied	-	4.53%	-	-	-	-	-	-	1.75%	3.23%	4.48%	7.41%	6.38%	-	-	-	3.23%	6.93%
Ward Moves	J06	Average Number of Ward Stays	2.32	2.25	2.32	2.37	2.25	2.24	2.28	2.24	2.31	2.18	2.19	2.25	2.28	2.28	2.31	2.25	2.22	2.27
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.08%	0.98%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	0.83%	1.16%	0.97%	1.19%	0.78%
	F01a	Number of Last Minute Cancelled Operations	749	336	52	108	41	58	46	66	66	63	70	62	25	50	201	170	199	137

ACCESS

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	14/15	15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Referral to Treatment (RTT)	A01	Referral To Treatment Admitted Under 18 Weeks	90%	90%	84.9%	82.3%	85.2%	83.1%	84.3%	80.5%	80.4%	80.5%	79.9%	81%	80.4%	84.2%	85.1%	82.5%	84.3%	80.5%	80.4%	84%
	A02	Referral To Treatment Non Admitted Under 18 Weeks	95%	95%	90.3%	89.8%	89.2%	88.8%	89.9%	88.9%	89.3%	90%	90.2%	91.4%	90.7%	89.2%	88.9%	88.7%	89.3%	89.4%	90.8%	89%
	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	90.4%	90.5%	89.4%	88.7%	87.5%	88.8%	89.4%	89.7%	90.5%	90.4%	90.7%	90.2%	90.5%	90.7%	88.5%	89.3%	90.6%	90.4%
Referral to Treatment (RTT) Ongoing Volumes	A03A	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3622	3766	4117	3641	3440	3339	3069	3078	3010	3357	3128	3004	-	-	-	-
	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	59	6	6	8	13	9	11	4	4	1	0	0	0	1	27	24	5	1
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	1842	354	140	117	177	160	161	119	116	89	38	45	38	28	434	440	243	111
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.5%	95.4%	94.7%	96.3%	97.5%	94.3%	95.8%	93.1%	94.2%	94.9%	95.3%	97.3%	95.4%	-	96.1%	94.3%	94.8%	96.4%
	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%	96.8%	95.7%	94%	98.5%	97.9%	98.4%	97%	95.8%	99.5%	95.3%	96.7%	96.6%	-	96.2%	97.7%	96.9%	96.7%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	99.6%	99.1%	100%	98.9%	100%	99%	98.1%	100%	100%	97.8%	100%	99.1%	98.1%	-	99.6%	99%	99.3%	98.6%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	94.9%	95.7%	96.4%	92.3%	95%	95.6%	94.4%	95.9%	94.1%	97.4%	97.9%	88.9%	100%	-	94.8%	95.4%	96.4%	94.6%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.6%	96.9%	98.2%	99.5%	97.2%	96.5%	97.7%	97.2%	97.5%	98.1%	94.7%	96.1%	98.4%	-	98.3%	97.1%	96.7%	97.2%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	79.3%	79.2%	79%	81.2%	84.6%	80.8%	75.2%	79.4%	76.5%	77%	77.6%	84.6%	80.2%	-	81.6%	78.5%	77%	82.5%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	89%	76.5%	73.3%	100%	90.9%	71.4%	60%	100%	100%	81.3%	62.5%	76.9%	70%	-	84.4%	80.6%	78.6%	73.9%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	90.1%	85.3%	85.7%	100%	90.5%	84.4%	94.4%	87.2%	100%	83.3%	76.9%	83.3%	87.5%	-	90.4%	88.8%	85.2%	85.5%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	1.5%	1.08%	0.98%	0.84%	1.96%	0.73%	1%	0.85%	1.03%	1.2%	1.22%	1.17%	1.04%	0.46%	0.83%	1.16%	0.97%	1.19%	0.78%
	F02c	Number of LMCs Not Re-admitted Within 28 Days	36	36	75	47	10	5	14	7	3	3	10	12	12	7	4	2	29	13	34	13
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	79.7%	78.1%	79.4%	73.8%	80%	78.3%	87.1%	83.9%	77.5%	80.5%	86.4%	73.2%	76%	-	77.2%	82.4%	80.6%	74.2%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	92.4%	94.7%	94.1%	81%	92%	95.7%	96.8%	90.3%	95%	95.1%	90.9%	92.7%	100%	-	88.1%	94.4%	94.2%	95.5%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	97.47%	98.74%	99.14%	98.32%	95.85%	95.48%	97.92%	97.9%	98.27%	98.63%	99%	98.83%	98.63%	99.01%	97.8%	97.11%	98.64%	98.83%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	9.2%	11.9%	8.7%	8.3%	8.9%	9.4%	9.4%	9.4%	11.6%	11.7%	11.6%	11.7%	12.8%	12.1%	8.6%	9.4%	11.6%	12.2%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	44	59	43	49	43	39	30	58	51	41	59	48	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	5	7	5	13	11	9	16	20	6	19	11	11	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.7	3.7	4.26	4.19	4.16	4	4.31	4.46	4.24	4.36	4.41	3.83	4.2	4.12	4	4.58	4.16	4.36	4.14	4.23

ACCESS (continued)

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	14/15	15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Emergency Department Indicators																						
Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	92.23%	94.26%	93.81%	88.62%	86.27%	90.87%	89.53%	95.01%	94.81%	93.47%	95.2%	95.51%	94.95%	91.69%	89.59%	91.92%	94.48%	94.04%
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	10	0	0	0	0	10	0	0	0	0	0	0	0	0	0	10	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95%	95%	97.2%	89.4%	100%	99%	87.8%	99.7%	99.8%	87.9%	87.9%	88.3%	89.3%	92.1%	92%	87.1%	95.6%	95.1%	88.5%	90.3%
	B02a	ED Time to Initial Assessment - 95th Percentile	15	15	14	28	12	12	38	14	14	29	30	30.4	28	23	21	32	15	15	30	26
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	78.3%	92.6%	78.4%	71.9%	70.3%	77.7%	76.1%	94.5%	93.2%	92.2%	92.3%	93.4%	91.6%	92.8%	73.5%	83%	92.6%	92.6%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	55.4%	55.9%	58.1%	50.9%	53%	60.6%	59.6%	56.3%	57.2%	53.5%	53.9%	57.5%	60.4%	53.2%	54%	58.8%	54.8%	57%
	B03a	ED Time to Start of Treatment - Median	60	60	54	53	51	59	57	48	50	53	51	56	56	52	48	56	55	50	54	52
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	99.3%	99%	99.3%	99%	99.3%	99.5%	99.5%	99.3%	99.3%	99.1%	98.5%	99.1%	99.2%	98.7%	99.2%	99.4%	99%	99%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.3%	2.8%	2.5%	2.6%	2.4%	2.7%	2.5%	2.5%	2.7%	3%	2.6%	2.9%	2.5%	2.9%	2.5%	2.6%	2.8%	2.8%
	B05	ED Left Without Being Seen Rate	5%	5%	1.8%	2.3%	1.5%	2.3%	1.6%	1.6%	1.5%	1.6%	1.9%	2.4%	2.9%	2.3%	2%	2.3%	1.8%	1.6%	2.4%	2.2%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	1032	1032	1287	287	77	131	168	119	78	49	46	46	29	38	36	92	376	246	121	166

WORKFORCE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			14/15	15/16 YTD	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2
Sickness	AF02	Sickness Rate	4.2%	4.1%	4.5%	4.4%	4.5%	4.7%	4.6%	4.3%	4.2%	4%	4.1%	4.2%	3.9%	4.2%	4.5%	4.5%	4.1%	4.1%
Staffing Numbers	AF08	Funded Establishment FTE	-	-	7775.8	7833.6	7872.4	7927.2	7912.4	7958.8	7976.8	8011.6	8088.3	8096.3	8110.8	8128.9	-	-	-	-
	AF09A	Actual Staff FTE (Including Bank & Agency)	-	-	7859.9	7910.8	8022.7	8004.1	8088.6	8130.6	8080.5	8123.2	8114.4	8069.3	8149.2	8253.7	-	-	-	-
	AF13	Percentage Over Funded Establishment	-	-	1.1%	1%	1.9%	1%	2.2%	2.2%	1.3%	1.4%	0.3%	-0.3%	0.5%	1.5%	-	-	-	-
Bank Usage	AF04	Workforce Bank Usage	-	-	407.1	392.6	489.6	373.9	432.2	416.2	368.6	424.2	423.5	395	399.2	446.2	-	-	-	-
	AF11A	Percentage Bank Usage	-	-	5.2%	5%	6.1%	4.7%	5.3%	5.1%	4.6%	5.2%	5.2%	4.9%	4.9%	5.4%	-	-	-	-
	Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive)																			
Agency Usage	AF05	Workforce Agency Usage	-	-	120.7	165.9	144.5	138.9	157.3	170.3	165.8	148.3	157.3	163.5	185.2	193.1	-	-	-	-
	AF11B	Percentage Agency Usage	-	-	1.5%	2.1%	1.8%	1.7%	1.9%	2.1%	2.1%	1.8%	1.9%	2%	2.3%	2.3%	-	-	-	-
	Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive)																			
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	-	-	443.7	481.3	483.9	435.8	413.3	414.7	333.2	368.5	463.6	507.9	465.1	436	-	-	-	-
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	-	-	5.7%	6.1%	6.1%	5.5%	5.2%	5.2%	4.2%	4.7%	5.8%	6.3%	5.8%	5.4%	-	-	-	-
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	2415	1217	133	154	147	162	239	199	121	174	156	147	398	221	434	600	451	766
	AF10	Workforce Turnover Rate			13.2%	13.4%	13.5%	13.7%	13.8%	13.9%	13.8%	14.1%	14.1%	13.7%	13.7%	13.5%				
	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	AF20	Essential Training Compliance	-	-	79%	82%	84%	83%	85%	88%	89%	89%	89%	90%	90%	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
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit

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 for September 2015

Safeguarding Adults:

Level 1: 90.6% (previous month 90.1%)
Level 2: 82.2% (previous month 81.5%)

Safeguarding Children:

Level 1: 90.7% (previous month 90.1%)
Level 2: 89.5% (previous month 88.5%)
Level 3: 76.2% (core) (previous month 81.7%)
Level 3: 77.2% (specialist) (previous month 79.6%)

Resuscitation: 75.0% (previous month 75.5%)

Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for August 2015, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Breast	75%	-	96.2%
Gynaecology	94.7%	85%	78.7%
Haematology (excluding acute leukaemia)*	77.8%	85%	79.4%
Head and Neck	82.4%	79%	69.3%
Lower Gastrointestinal	60.0%	79%	71.9%
Lung	65.2%	79%	76.2%
Other*	100%	-	73.4%
Sarcoma*	0%	-	73.7%
Skin	100%	96%	96.0%
Upper Gastrointestinal	76.0%	79%	73.1%
Urology*	33.3%	-	75.1%
Total (all tumour sites)	**80.2%**		**82.5%**
Monthly trajectory target	**77.0%**		

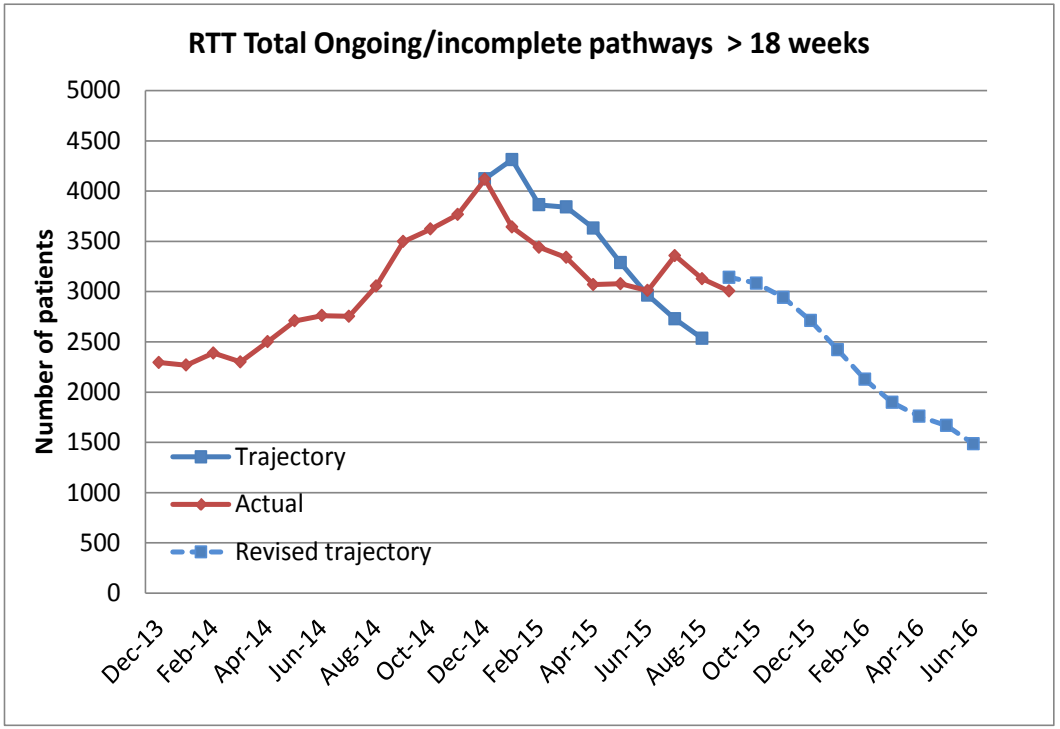
*= 5 or fewer patients treated in accountability terms

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 in September 2015

RTT Specialty	Ongoing Pathways Over 18 weeks	Ongoing Pathways	Ongoing Performance
Cardiology	376	2,246	83.3%
Cardiothoracic Surgery	16	290	94.5%
Dermatology	99	1,796	94.5%
E.N.T.	41	2,303	98.2%
Gastroenterology	43	499	91.4%
General Medicine	3	70	95.7%
Geriatric Medicine	0	164	100.0%
Gynaecology	42	1,223	96.6%
Neurology	84	345	75.7%
Ophthalmology	171	4,281	96.0%
Oral Surgery	129	2,639	95.1%
Other	1,943	14,668	86.8%
Rheumatology	5	380	98.7%
Thoracic Medicine	9	634	98.6%
Trauma & Orthopaedics	43	867	95.0%
Urology	0	2	100.0%
Grand Total	**3,004**	**32,407**	**90.7%**



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Non-admitted pathways (target/actual)	1977/1963	1911	1811	1689	1498	1313	1190
Admitted pathways (target/actual)	1165/1041	1172	1130	1023	923	814	707
Total pathways (target/actual)	3142/3004						
Target % incomplete < 18 weeks	90.6%	90.9%	91.1%	91.7%	92.4%	93.2%	93.9%
Actual target % incomplete < 18 weeks	90.7%						

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
10. Research & Innovation Quarterly Update Report									
Sponsor and Author(s)									
Sponsor: Sean O'Kelly, Medical Director Author: David Wynick									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To provide a quarterly update on performance against key performance indicators for research to the Trust Board. Key issues to note Performance delivering commercial trials and initiating all NIHR research remains steady. Performance recruiting into trials is below the same time in the previous two years, and is likely to impact on income in 16/17.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
None									
Impact Upon Corporate Risk									
None									
Implications (Regulatory/Legal)									
None									
Equality & Patient Impact									
None									
Resource Implications									
Finance			Information Management & Technology						
Human Resources			Buildings						
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			
Date the paper was presented to previous Committees									

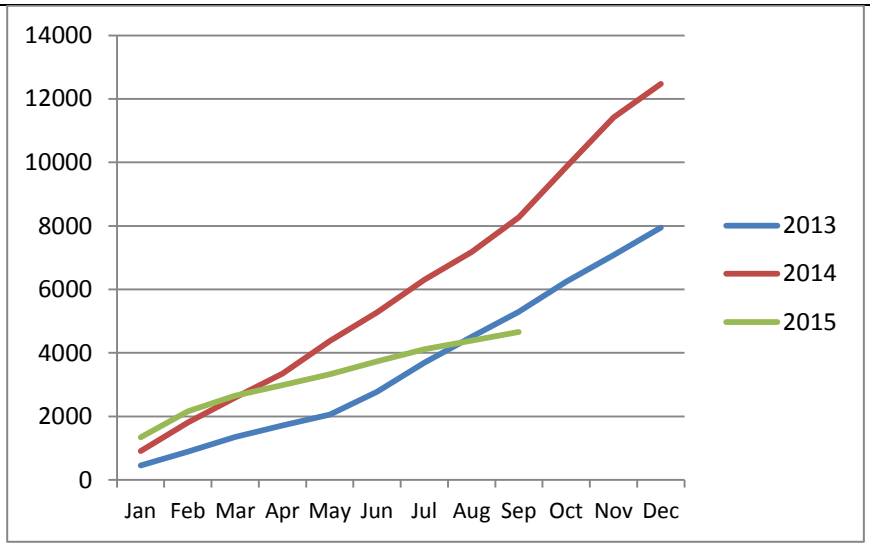
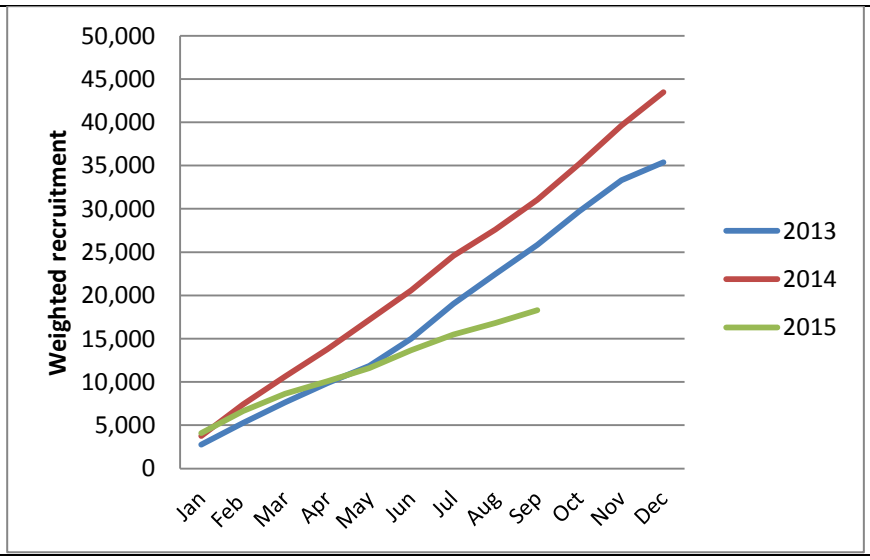
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

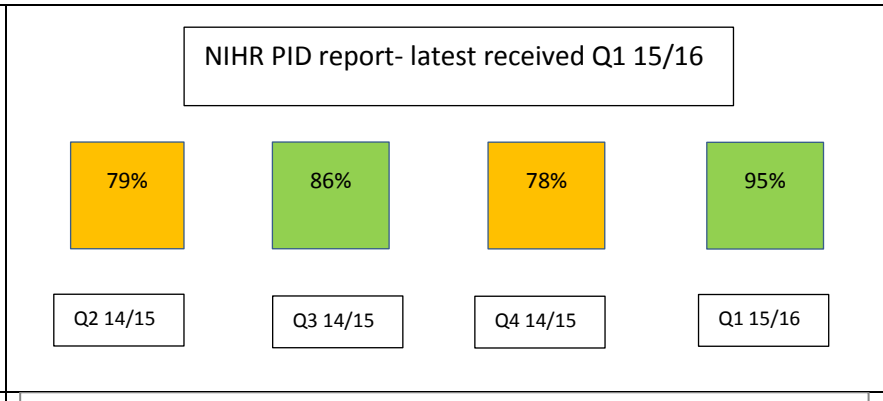
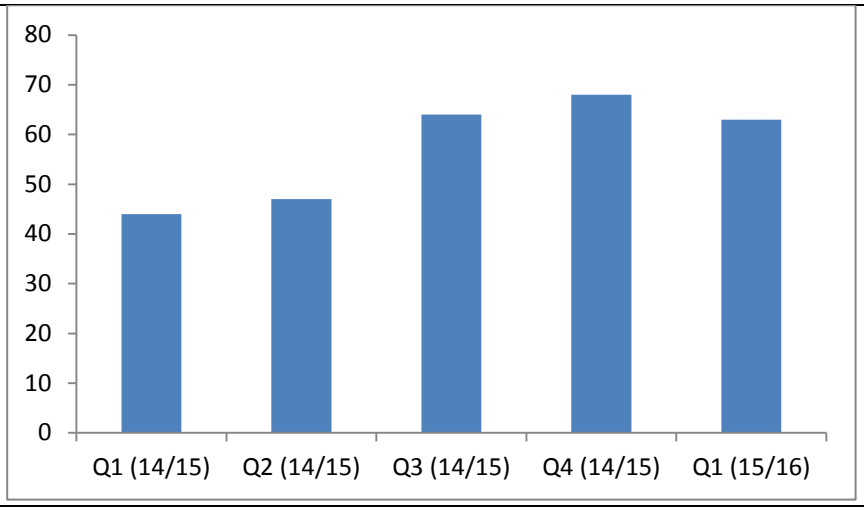
Cumulative number and cumulative weighted recruitment is significantly lower for 2015/16 than in previous years. This is in part due to the closure in 2015 of a high recruiting band 2 study. All research teams have been made aware of the decrease in 2015/16 and a review of the portfolio has been undertaken. Two potentially high recruiting studies have been identified and after initial delays are due to open by end Oct 2015, which will in part mitigate the likely reduction by the end of the financial year. It is however expected that this reduction in cumulative weighted recruitment will result in a decrease in CRN support funds in 2016/17.

We continue to remain in the top half of the league for performance in achieving the 70 day benchmark and have shown improved performance of meeting time to target in commercial clinical trials.

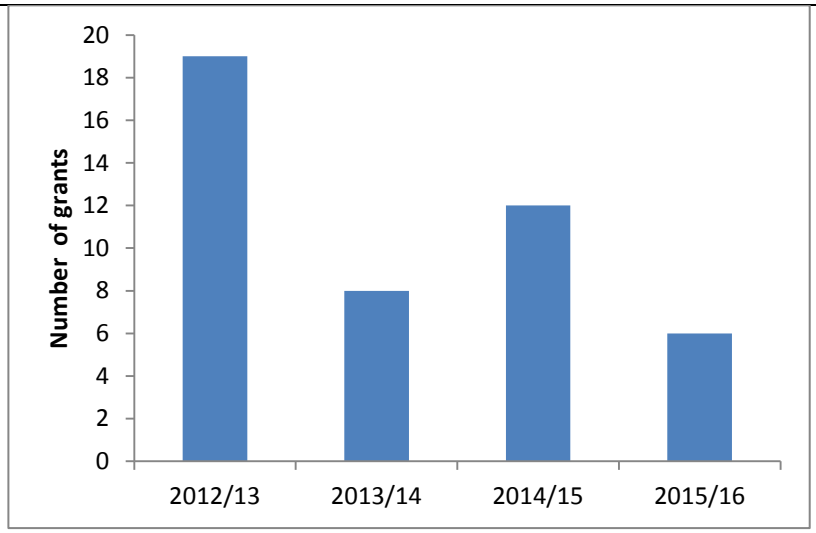
Two grants have been awarded during the quarter with a combined value of £2.8 million.

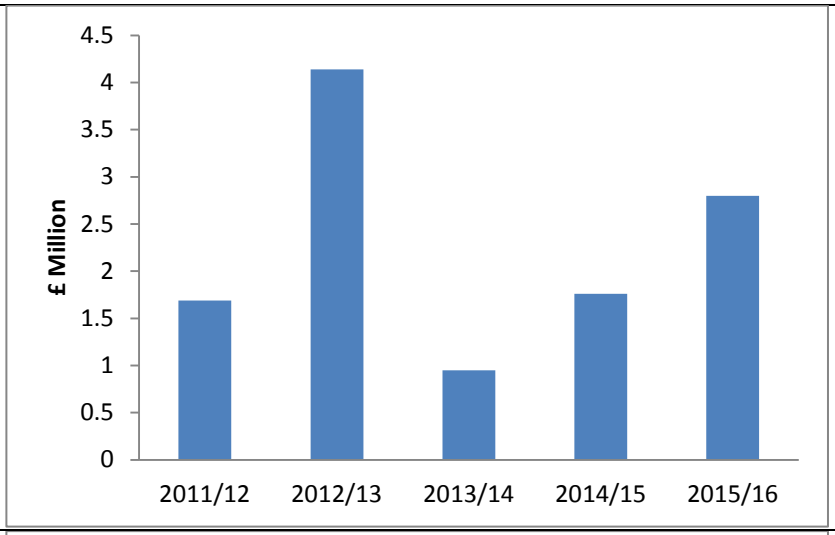
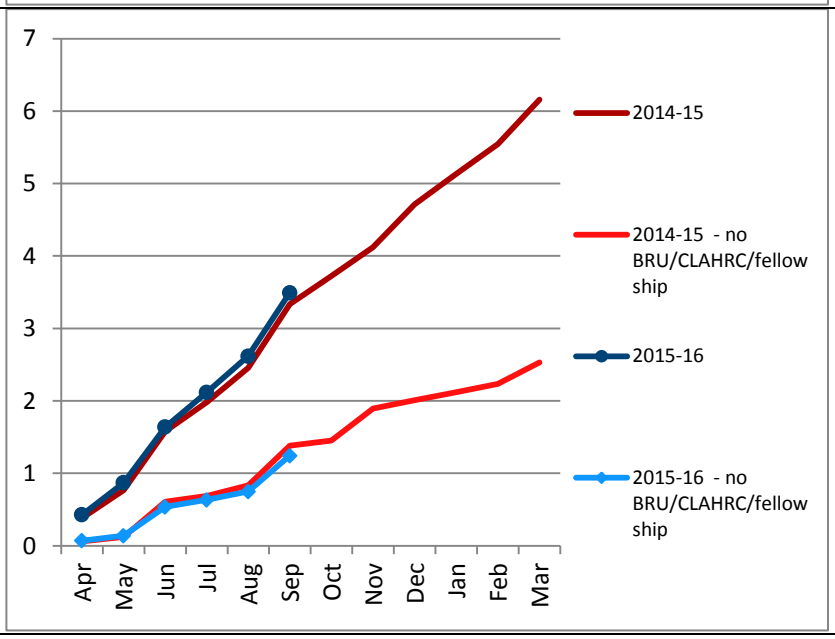
Recruitment Indicators:

	Target for 2015/16	Performance	Progress against target
Cumulative number of patients recruited into NIHR portfolio studies (calendar year) NB. There is a 6 week lag of data from the portfolio.	7,000		
Cumulative weighted recruitment into NIHR portfolio studies (calendar year)	30,000		

Percentage of studies meeting 70 day first-patient first-visit benchmark	Green: >81.4% (Upper Quartile) Red: <70.7% (Median		
Percentage of commercial studies recruiting to time and target	Increase on previous quarter		

Grants Indicators:

	Target		
Number of Grants submitted (15/16 value is 'to date')	No target		N/A

Total value of Grants awarded in year (15/16 value is 'to date')	No target		N/A
Monthly NIHR grant income	No target		N/A

Key:

NIHR	National Institute of Health Research - created by DoH in 2006 to implement the R&D strategy: 'Best Research for Best Health'
Portfolio	The NIHR's list of adopted studies. Studies that are funded through major funders (NIHR, Research Councils, Charities etc) via peer reviewed open national competition are eligible for inclusion on the NIHR Portfolio. Other studies are also adopted on a case by case basis. Funding from CLRNs is provided to support NIHR portfolio adopted studies. Some Commercial research is also adopted but no funding is provided via the CLRNs. UH Bristol falls under the WCLRN who provides funding for delivery of our portfolio studies.
Weighted recruitment	There are 3 different bands of study within the NIHR portfolio- Band 1, 2 and 3. This banding represents the complexities of a study. Patients recruited into a band 1 study are weighted lower than those recruited into a band 2 (observational) study which in turn is weighted lower than those recruited into a band 3 study (interventional). The ratio for the weighting is 1:3:14. The weighted recruitment provides an indicator of the monetary value of our research portfolio and influences the delivery funding supplied by the WCLRN at the end of the year.
70 day benchmark	This benchmark has been set by the NIHR and is 70 days from receipt of a valid research application into Research and Innovation to first patient recruited (consented) by the research team. Our target for approval of each study is 30 days thus allowing 40 days for the research teams to recruit.
Internal delay	Where the 70 day benchmark is not met we are required to supply reasons for this. Some factors influencing whether this benchmark is met is out of our control for example; external sponsors causing delays. However some reasons for not meeting this benchmark is a delay caused by UH Bristol and is thus an 'internal delay'.
Time to target	When an approval application is received into Research & Innovation a target number of patients to be recruited is provided as well as duration of the study. The NIHR requires us to submit quarterly data on whether our commercial studies are meeting their recruitment target and within the timescales of the research study.
Commercial studies	Commercial studies - Research funded AND sponsored (i.e. contracted) by commercial companies e.g. pharmaceutical company; medical device company
Non-commercial studies	Non-commercial - All other research. Funded by a non-commercial organisation such as the NIHR, a research council or charity or local funding. Also includes studies funded by a grant from a commercial company but sponsored by a non-commercial organisation.
R&D approval	Any project that is to be delivered within an NHS trust must be approved by that trusts R&D department before it can start recruiting patients. R&D approval is a process to confirm that a study can be delivered safely and successfully at UH Bristol
RCF	Research capability funding - funding provided by the NIHR for use in developing new grant applications and/or plugging the gaps of NIHR Investigators' salaries in-between grants
CRN WoE	Clinical Research Network - West of England (previous WCLRN) is one of 15 Clinical Research Networks as part of a national research network infrastructure.

University Hospitals Bristol NHS
NHS Foundation Trust

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

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

Executive Summary

Purpose

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

Key issues to note

- Progress towards contract award for King Edward Building works, noting final costs for this scheme are still unknown.
- Delay to the occupation of Wards A524, 525, 528 and the consequential programme pressure on the vacant possession date for the Old Building site.
- Decision to utilise the former Laing O'Rourke site village
- Development of proposals for the signage for the Façade.

Recommendations

The Trust Board is recommended to receive this report as **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

Supports delivery of Strategic Objective 2.1

Impact Upon Corporate Risk

N/A

Implications (Regulatory/Legal)

N/A

Equality & Patient Impact

Continuation of services, from sub-optimal estate, for a further five week 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 October 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 in progress with HMRC to finalise VAT recovery amounts.

BRISTOL ROYAL INFIRMARY Phase 4 and Queens Facade		
1	**Decisions required**	None
2	**Progress**	**Old Building** Sale transaction concluded and funds receipted. On programme to deliver vacant possession as agreed. **Contractors Site Village** It has been agreed to use the former Laing O'Rourke site village as temporary office accommodation, to facilitate exit of the Old Building by 1st Oct 2016 in light of the programme impact caused by pathology service transfer delay. This village accommodation will need some enabling works such as an appropriate IM&T infrastructure and the scheme design is almost complete, due for tender and contract next month with proposed occupation date of March 2016. **BRI Phase 4** The following refurbishment schemes have achieved practical completion • Ward A518 • Ward C808 • Wards A524,525,528 (see below) • Conversion of Old Lecture Theatre Queens level 9/10 The occupation of wards A524, 525 & 528 has been delayed by 5 weeks in order to rectify some material design and construction flaws which has had a knock on effect to the commencement of the works to ward A522 however, overall programme integrity has been maintained. Refurbishment of King Edward Building if the most significant final works package. Cost and programme is being finalised with the recently appointed Scape contractor (Willmott Dixon) following Board approval of this procurement route. A Project Order has been authorised allowing Willmott

		Dixon to fully engage their delivery team and begin the detailed tendering of work packages to determine the final cost and programme. It is anticipated that an enabling works package will commence at the end of October with the final contract agreed and works commenced on site at the end of November, subject to satisfactory conclusion on price. **Queens Façade** 97% of external windows installed and 50% of internal window reveals completed. The final design details of the free standing screen element are being finalised for submission to planners for the final planning condition to be discharged. The lighting installation has commenced and the scheme is on programme for the main façade works to be complete by Christmas with the free standing screen element completing in the New year. The formal contract completion date is June 2016. Work is just commencing to appraise the options for signage.	
3	**Budget**	A total capital allocation of £115.7m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m. The final account has been settled and final submissions made to HMRC to agree VAT recovery amounts The scheme remains within its capital budget pending confirmation of final costs for KEB works which are currently being evaluated.	
4	**Programme**	The phase 4 programme remains on programme to achieve the required vacation date of the Old Building however the slippage on wards A524, 525, 528 are creating some programme pressure in that all programme contingency has now been exhausted and further delays are likely to impact on vacant possession and thus attract financial penalties.	
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 though it should be noted that risks, out with the control of the Trust, have manifested in period and impacted upon cost and programme.

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 20.10.2015

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
12. Capital Investment Policy update
Sponsor and Author(s)
Sponsor: Paul Mapson, Director of Finance & Information Author: Jeremy Spearing, Associate Director of Finance

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

Executive Summary
Purpose The Capital Investment Policy is subject to a full review in May each year. However, the requirement for an imminent capital investment decision, which should be taken in the context of the wider financial environment, means a minor but important change is required. Key issues to note The Trust's current Financial Strategy states that the Trust should plan a net surplus of 1% of turnover each year. This strategy ensures the Trust generates sufficient cash to meet its long term loan debt repayments of £5.8m each year. A surplus of 1% is not the case for 2015/16 and looking ahead, the financial environment remains very challenging meaning that planning a net surplus of 1% to meet the Trust's debt obligations could be potentially unrealistic. In the short term, the Trust's debt repayment obligations will need to be met from the Trust's Medium Term Capital Programme as a first call. The proposed change to the Capital Investment Policy recognises the financial context and now requires, in all capital investment cases, the inclusion of the cost of meeting debt repayment obligations in the financial assessment where loan finance is necessary. Therefore, additional wording to this effect has been added into section 7.1 and is highlighted accordingly.
Recommendations
The Board is asked to receive the report for discussion and **approval.**
Impact Upon Board Assurance Framework
None.
Impact Upon Corporate Risk
None.
Implications (Regulatory/Legal)
None.

Equality & Patient Impact							
None.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	
Date the paper was presented to previous Committees							

Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
	26th October 2015.			21st October 2015.	Capital Programme Steering Group 12th October 2015.

University Hospitals Bristol NHS
NHS Foundation Trust

CAPITAL INVESTMENT POLICY

Owner	Deborah Lee, Director of Strategic Development	
Version 10	12 October 2015	Submitted to Capital Programme Steering Group – 12 October 2015 Submitted to Senior Leadership Team – 21 October 2015 Submitted to Finance Committee – 26 October 2015 Submitted to Trust Board – 30 October 2015
Version 9	11 May 2015	Submitted to Capital Programme Steering Group – 11 May 2015 Submitted to Senior Leadership Team – 20 May 2015 Submitted to Finance Committee – 22 May 2015 Submitted to Trust Board – 27 May 2015
Version 8	12 May 2014	Submitted to Capital Programme Steering Group – 12 May 2014 Submitted to Senior Leadership Team – 21 May 2014 Submitted to Finance Committee – 23 May 2014 Submitted to Trust Board – 28 May 2014
Version 7	25 March 2013	Submitted to Capital Programme Steering Group – 11 February 2013 Submitted to Finance Committee – 25 March 2013
Version 6	03 February 2012	Submitted to and considered by the Trust Management Executive meeting on 15th February. Submitted to and considered by the Finance Committee meeting on 22nd March. To Trust Board for ratification 27 March.
Version 5	04 February 2011	To be submitted to Trust Executive Group 16 February 2011. To be submitted to Finance Committee to be approved for ratification by Trust Board 23 February 2011. To Trust Board for ratification 28 February 2011.
Version 4	15 October 2010	Submitted to Capital Prioritisation Group 19 October 2010. Submitted to Trust Executive Group 15 December 2010 for consideration.
Version 3	7 December 2009	Submitted to Trust Board for approval 22 December 2009
Version 2	18 July 2008	Submitted to Capital Prioritisation Group 16 July to note. Submitted to Trust Executive Group 23 July 2008 to support. Submitted to Trust Board for approval 29 July 2008
Version 1	24 June 2008	Draft considered at Trust Board 1 July 2008

1. PURPOSE

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

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

2. SCOPE

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

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

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

3. INVESTMENT PHILOSOPHY AND OBJECTIVES

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

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

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

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

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

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

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

4. CAPITAL BUDGET-SETTING

4.1 THE MEDIUM TERM CAPITAL PROGRAMME

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

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

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

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

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

4.2 IDENTIFICATION OF MAJOR OR HIGH RISK INVESTMENTS

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

High risk investments are defined as:

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

4.3 BUSINESS CASE REQUIREMENTS

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

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

Table 1: Thresholds for business case requirement

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

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

4.4 PROJECT SPONSOR

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

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

5. FINANCE COMMITTEE

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

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

6. APPROVAL ROUTE

6.1 BOARD OF DIRECTORS

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

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

6.2 FINANCE COMMITTEE

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

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

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

6.3 SENIOR LEADERSHIP TEAM

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

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

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

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

6.4 CAPITAL PROGRAMME STEERING GROUP

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

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

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

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

6.5 SUMMARY

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

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

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

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

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

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

7. EVALUATION

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

7.1 FINANCIAL CRITERIA

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

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

- The cost of loan principal repayments where relevant;
- 3.5% interest charge if internally funded or financed through Public Dividend Capital; or
- at the cost to the Trust, if financed through borrowing.

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

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

7.2 NON-FINANCIAL CRITERIA

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

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

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

Improving Quality – the extent to which the proposed investment delivers UH Bristol's Quality Objectives and improves patient care (Quality objectives are prioritised annually).

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

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

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

Table 4: Thresholds for business case requirement

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

8. RISK MANAGEMENT

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

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

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

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

9. APPENDICES

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

ANNEX 1

THRESHOLDS FOR REPORTING INVESTMENTS OR DIVESTMENTS TO MONITOR

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

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

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

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

Small, Material or Significant Transaction

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

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

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

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

Annex 2

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

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

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

DUE DILIGENCE CHECKLIST TO INFORM RISK ASSESSMENT

Typical due diligence items

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

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

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University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
13. Finance Report

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 September 2015 is £0.311m adverse to plan (before technical items). This position has been achieved by applying one off financial benefits. The Divisions report an overspend of £4.422m compared to £3.461m in August. The run rate in Divisions is of concern and unless this is addressed the break-even forecast for 2015/16 will be compromised and the position in 2016/17 will be a substantial deficit which will compromise the capital investment strategy.

Recommendations
The Board is recommended to receive the report for **assurance.**

Impact Upon Board Assurance Framework
None

Impact Upon Corporate Risk
None

Implications (Regulatory/Legal)
None

Equality & Patient Impact
None

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)**
	26/10/15				

Finance Committee
26th October 2015
Agenda Item 5.1

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a small surplus of £0.052m (before technical items) for the first six months of the financial year. After technical items the surplus increases to £4.855m.

Whilst the overall position may appear acceptable it has been achieved by applying one-off financial benefits (described further below) which then masks a concerning adverse run-rate in Divisions. Unless the run-rate overspend of over £1m per month stops the financial plan will be compromised and the position being taken into 2016/17 will generate a substantial deficit, compromising capital investment plans.

The absolute income and expenditure surplus is in fact an adverse variance of £0.311m against the Monitor Plan due to planned phasing of income in the earlier part of the year.

The Divisions report an overspend of £4.422m compared to £3.461m to August. The rate of overspend in Surgery, Head and Neck (SHN) has slowed but there are deteriorations in Medicine, Specialised Services and Women's and Children's. The adverse variance for Clinical Divisions against the operating plan has now grown from £1.71m to £2.599m. This is of real concern as the main driver now is pay which has not receded from the summer months and in fact has accelerated in September.

The one-off financial benefits now brought into account include the following:

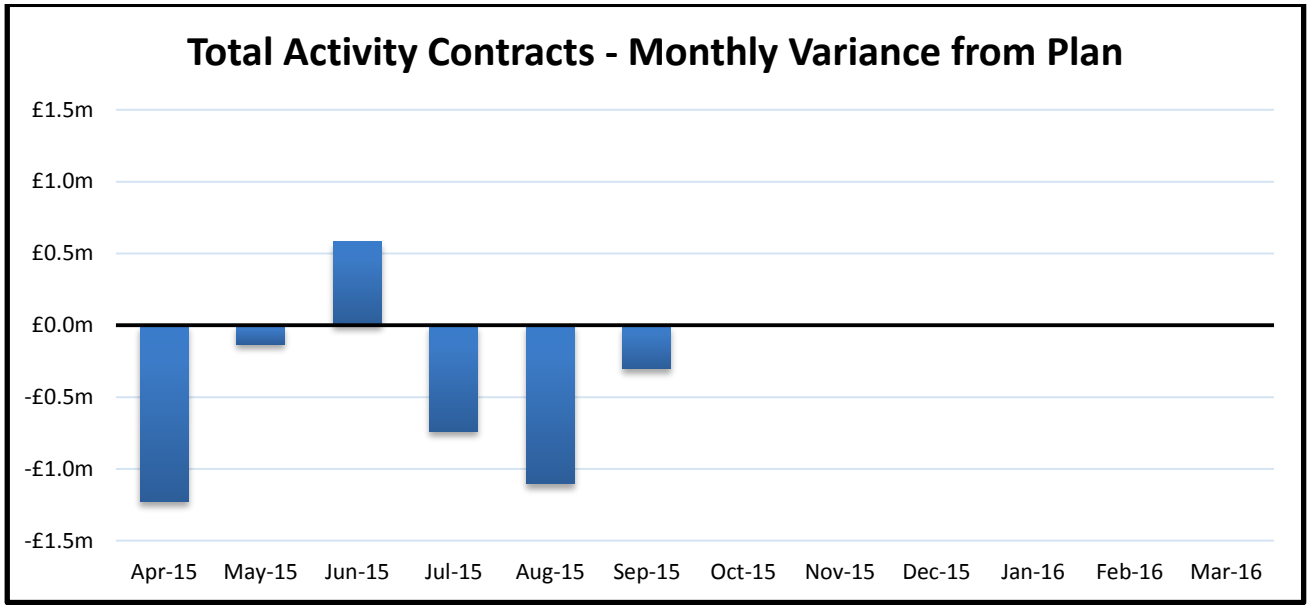
- Incremental drift funding of £1.5m appears not to be required due to turnover of staff;
- Additional Health Education England funding of £0.75m negotiated to mitigate to impact of loss of education tariffs in 2015/16;
- Research and Development surplus are included in 'Other Corporate Services to the value of £0.092m; and
- Other various slippage in commitments e.g. contingency, change costs etc.

Adjusting for savings plans the in month deterioration for Divisions at £0.961m can be attributed as follows:

	(Adverse)/Favourable Variance £m
Pay - Nursing	(0.541)
- Medical	(0.225)
- Other	0.100
Non-pay	0.060
Income (operations & activity)	(0.355)
	(0.961)

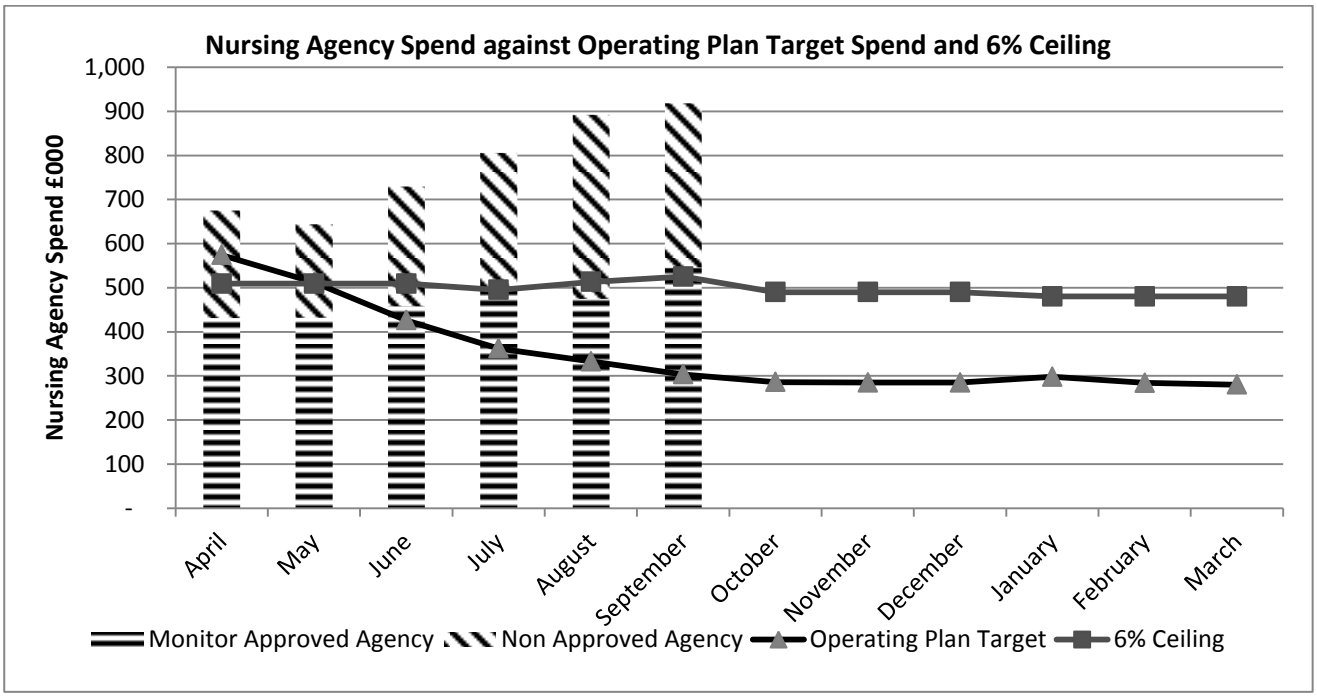
In last month's report two key issues were identified as driving the Divisional position:

- Clinical activity delivery – September was a better month than August. The net SLA under-performance is £0.3m. The bar chart below shows the total activity position (monthly financial variance from plan).



- Nursing Agency Spend – the expected improvement has not materialised with spending rising again in September. The graph below shows the position. A comprehensive plan is being considered by the Trust as well as working with other Trusts from the wider area (including Gloucestershire and Bath) on agency controls. In particular the Trust is a long way from delivering the 6% ceiling set by Monitor and even further away from delivering the Trust's operating plan.

  The main driver for this position is not nursing vacancies but is in fact the monthly over-establishment which is now over 150 whole time equivalents (wtes) for September.



2. Financial Out-turn Assessment

Whilst recognising that the run-rate is of concern a re-assessment of other financial factors has been undertaken. This is performed every quarter and coincides with the Monitor quarterly submission which will undoubtedly attract considerable public attention. In this re-assessment the year end position is also considered.

The position is based on current knowledge and judgements and is shown below:

	←Projected Out-turn→		
Surplus / (deficit)	**Optimistic**	**Realistic**	**Pessimistic**
	£'000	**£'000**	**£'000**
Reserves			
- Inflation - incremental drift	1,500	1,500	1,400
- other	850	800	700
- MPET - new transitional funding	750	750	750
- other	450	450	350
- Histopathology slippage	500	500	500
- Non–recurring provisions	800	700	600
- Contingency reserve	400	300	200
- Pay provisions	1,250	1,000	1,000
Total Reserves	**6,500**	**6,000**	**5,500**
Financing costs	2,200	2,000	1,800
Corporate Income	(800)	(1,000)	(1,500)
Divisions	(6,000)	(7,000)	(8,000)
Trust Total (net surplus/(deficit)	**1,900**	**-**	**(2,200)**

Hence the realistic projected forecast out-turn before technical items is still break-even. It should be noted however, that most of the offsetting reserves surplus is non-recurrent so will not be available in 2016/17. Hence the run-rate must be recovered to avoid the already very difficult position to be faced in 2016/17 not being made much worse resulting in the Trust going from a break-even position in 2015/16 to a substantial deficit in 2016/17 in one step.

The key variances shown above can be explained as follows:

- Inflation – incremental drift – pay budgets are fully funded for increments as at the 1 April 2015. A detailed assessment has been undertaken which shows that there has been no agenda for change staff increase in overall increment drift hence the budget held for this (£1.5m) is available in-year to support the Trust's position. The funding will be required on a recurrent basis though. The level of turnover is the key driver to this position;

- MPET – transitional funding – additional non-repayable funding has been negotiated with Health Education England with regard to mitigating the impact of lower tariffs for 2015/16. Again this is non-recurrent only;

- Histopathology slippage – the net costs of the transfer are not likely to be incurred due to the service transfer being delayed until March/April 2016. The funding budget (£0.5m) is therefore available to support the Trust's overall position on a non-recurrent basis;

- Other provisions – these include under-spending on spend to save, change costs, contingency reserve and a re-assessment of provisions for staff pay which are no longer required;

- Financing costs – slippage on capital plus write-down of asset valuations was originally planned to deliver a £2m surplus in year. This was to offset the divisional planned overspend of £2m;

- Corporate Income – this is the corporate share of income under-performance plus any loss of rewards (CQUINs) or additional fines and penalties. The position is complex and multi-faceted and will be continually reviewed; and

- Divisions – detailed forecast out-turns are not yet available but some element of slowdown in overspending is clearly required.

3. Reporting of Net Income & Expenditure Margin

The definition of what position in the Income and Expenditure account is reported under Monitor arrangements as the net I&E margin has been under discussion for some time. UH Bristol has always reported the following items as technical i.e. below I&E margin:

Donations	- income	- The value of income received for donated assets
	- depreciation	- The depreciation on the donated assets
Impairments	- charge - reversals	- The technical write-down or reversal of write downs of capital assets by the District Valuer

As part of the recent Risk Assessment Framework (RAF) consultation it appeared that Monitor proposed the inclusion of donated income and depreciation above the line i.e. into the I&E margin. UH Bristol wrote to Monitor expressing the view that as these items were associated with the creation of capital assets, including the cash receipt for the purchase of such assets, it did not seem appropriate to include donations in the I&E margin. Monitor are now reporting with donated income and deprecation included.
Therefore reporting in 2015/16 to the UH Bristol Board continues on the existing basis but Monitor will be reporting UH Bristol results differently as follows:

	£'000	£'000
Month 6 (Quarter 2) – Net Surplus reported by UH Bristol		52
add donated income	2,441	
less donated depreciation	(747)	1,694
Net Surplus reported by Monitor		**1,746**

The projected out-turn would then be:

2015/16 Year-end – Net Surplus reported by UH Bristol		0
Add donated income	3,103	
Less donated depreciation	(1,511)	1,592
Net Surplus reported by Monitor		**1,592**

The Finance Committee is asked to note this position. It is proposed that the reporting is kept under review and reconsidered formally for 2016/17.

4. Divisional Financial Position

In total, the Clinical Divisions and Corporate Services overspend against budget increased by £0.961m in September to £4.422m cumulatively. The table below summarises the financial performance in September for each of the Trust's management divisions against the budget and against their September operating plan target. Further analysis of the variances against budget by pay, non-pay and income categories is given at Appendix 2.

	Budget Variance to 31 Aug	Sept Budget Variance	Budget Variance to 30 Sept	Sept Operating Plan Target	Operating Plan Variance
	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000	Fav / (Adv) £'000
Diagnostic & Therapies	(82)	41	(41)	(35)	(6)
Medicine	(700)	(327)	(1,027)	(110)	(917)
Specialised Services	(344)	(180)	(524)	(7)	(517)
Surgery, Head & Neck	(2,266)	(377)	(2,643)	(1,540)	(1,103)
Women's & Children's	(325)	(152)	(477)	(421)	(56)
Estates & Facilities	62	3	65	(13)	78
Trust Services	17	(60)	(43)	(3)	(40)
Other Corporate Services	177	91	268	-	268
Totals	**(3,461)**	**(961)**	**(4,422)**	**(2,129)**	**(2,293)**

Variance to Budget:
The table below shows the Clinical Divisions and Corporate Services budget variances against the four main income and expenditure headings.

Divisional Variances	Variance to 31 Aug	Sept Variance	Variance to 30 Sept
	Fav/(Adv) £'000	Fav/(Adv) £'000	Fav/(Adv) £'000
Pay	(676)	(470)	(1,146)
Non Pay	766	334	1,100
Operating Income	109	74	183
Income from Activities	(1,795)	(483)	(2,278)
Sub Totals	(1,596)	(545)	(2,141)
Savings Programme	(1,865)	(416)	(2,281)
Totals	**(3,461)**	**(961)**	**(4,422)**

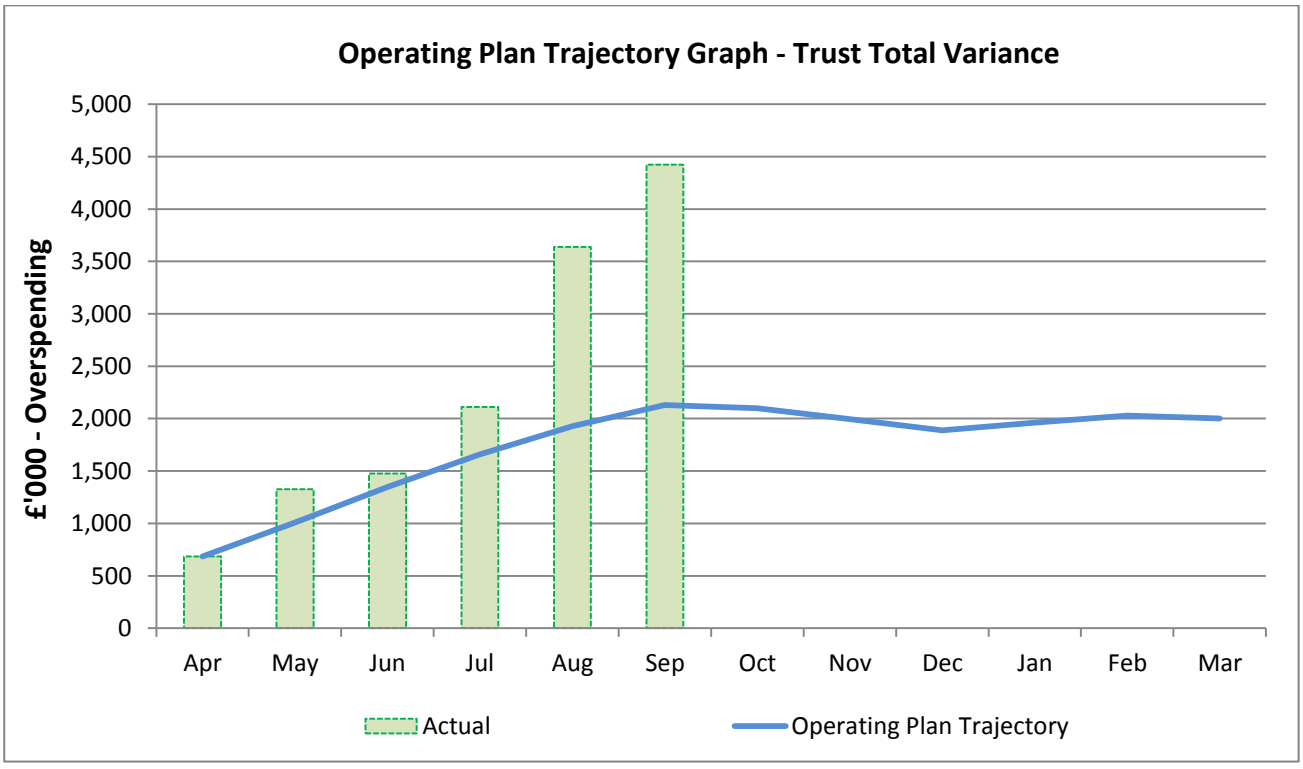
Pay budgets have overspent by £0.470m in the month increasing the cumulative overspend to £1.146m. The principal overspends are within Women's and Children's (£0.864m), Specialised Services (£0.558m), Surgery, Head and Neck (£0.233m) and Medicine (£0.207m). For the Trust as a whole, agency spend is £7.335m to date, an increase of £1.554m in the month. The average monthly spend of £1.222m 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 £0.106m in 2014/15 to £0.252m in 2015/16 and Women's and Children's which increased from £0.154m to £0.257m. Waiting list initiatives costs remain high at £1.685m to date, of which £0.794m is within Surgery, Head and Neck, £0.374m in Women's and Children's and £0.269m in Specialised Services.

N**on-pay budgets** have underspent by £0.334m in the month increasing the cumulative underspend to £1.100m. This relates in the main to divisional support funding and lower activity related expenditure.

Operating Income budgets show a favourable variance of £0.074m for the month to give a cumulative favourable variance of £0.183m.

Income from Activities budgets are adverse in the month by £0.483m increasing the cumulative adverse position to £2.278m. The principal areas of under achievement to date are within Surgery, Head and Neck (£0.806m), Medicine (£0.784m), Specialised Services (£0.673m) and Diagnostics and Therapies (£0.193m) offset by an over achievement in Women's and Children's (£0.205m). The Diagnostic and Therapies position results from the share of the underachievement in other Divisions. The difference between the £0.483m in month deterioration reported here and the £0.310m deterioration reported on SLA income shown in section 6 is accounted for by a deterioration in the variance with regards to private patients £0.090m and other non SLA income from activities, including a deterioration of £0.024m on RTA income along with a minor change with regards to CIP delivery.

Variance to Operating Plan:
Clinical Divisions, Estates and Facilities and Trust Services are £4.422m overspent to date against a combined operating plan trajectory of £2.129m. The September position is £2.293m above trajectory as shown in the graph below.



As can be seen the operating plan trajectories are now unlikely to be delivered.

Further detail is given 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 £7.685m have been realised to date, a shortfall of £2.296m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £1.767m and a further £0.529m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £15k.

The year-end forecast outturn is a shortfall of £2.962m, (a deterioration of £0.081m from last month's forecast shortfall of £2.881m), which represents delivery of 85%. There remains significant risk with achieving this, particularly with regard to schemes relating to income generation and reductions in agency spend.

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

	Savings Programme to 30th Sept 2015			1/12ths Phasing Adj Fav / (Adv) £'000	Total Variance Fav / (Adv) £'000
	Plan £'000	Actual £'000	Variance Fav / (Adv) £'000		
Diagnostics and Therapies	1,034	741	(293)	(38)	(331)
Medicine	1,048	997	(51)	(64)	(115)
Specialised Services	840	947	107	48	155
Surgery, Head and Neck	3,053	1,546	(1,507)	103	(1,404)
Women's and Children's	2,250	1,511	(739)	110	(629)
Estates and Facilities	530	556	26	(16)	10
Trust HQ	155	295	140	(113)	27
Other Services	1,044	1,065	21	(15)	6
Totals	**9,954**	**7,658**	**(2,296)**	**15**	**(2,281)**

5. Divisional Reports

Four Divisions are red rated for their financial performance for the year to date:

Division of Medicine

The Division reports an adverse variance to month 6 of £1.027m; this represents a significant deterioration from month 5 of £0.327m. The Division is £0.917m adverse to its operating plan target to date. In contrast to previous months the savings programme is showing an underachievement to date of £0.115m. The deterioration in CIP performance is due to a reassessment of savings as a consequence of ongoing high levels of nursing spend.

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

- An adverse variance on SLA Income of £0.784m due to the following factors.

  (1) A c.4% adverse financial variance (£520k gross) driven by a 4% under-performance against SLA in volume of emergency admissions. Admissions were 6% lower than SLA in September.

  (2) 3% fewer attendances to the Emergency Department (ED) than at the same time in 2014/15. This, in part, reflects the fact that up to 8 'GP expected' patients per day are

now admitted directly to the Acute Medical Unit (AMU) and bypass the Emergency Department completely;

(3) An adjustment to patient volumes in the Port Cystic Fibrosis database given changes to bandings and deaths within the regional Cystic Fibrosis service of £0.131m. This was an unplanned adjustment and the full year impact must be absorbed within the 2015/16 financial plan;

- A pay overspend of £0.207m due to costs associated with agency nursing and medical staffing. Pay expenditure increased for the second month in a row, a reversal of the trend over the previous two months. This is despite lower recorded levels of activity. The main areas of increased expenditure being with regards to 1:1 cover and the requirements for RMN's.

Actions being taken and mitigation to restore performance include:

- Recruitment to key posts to increase the capacity to deliver outpatient activity.
- Additional outpatient clinics to recover the shortfall on outpatient activity related income, pending successful recruitment.
- A proposal to move to single sex wards within Care of the Elderly is being looked at –the likely consequence of which will be a significant reduction in 1-1 agency shifts as duplication across wards is reduced.
- Continuation of an intensive nurse recruitment programme (using divisional matron resource) and additional resource from Employee Services to address and improve sickness absence rates.

Key risks to delivery of the operating plan include:

- Failure of the recruitment strategy to deliver the required number of posts and hence the planned level of agency expenditure reductions are not achieved.

Division of Specialised Services

The Division reports an adverse variance to month 6 of £0.524m, with a deterioration of £0.180m. The Division is £0.517m adverse to the operating plan target to date; a deterioration from last month of £.0221m.

The savings programme is currently overachieving by £0.155m to date and the non pay budgets are underspending by £0.471m due to the year to date share of support funding and unallocated contract transfer funding as well as a small favourable variance on blood.

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

- Overall the underachievement of income from activities is £0.673m, however it should be noted that the in month deterioration was only £0.062m, this indicates that the adverse variance to date is largely due to the legacy of underperformance in previous months. The year to date performance is due to lower than planned activity in cardiac surgery of £0.566m, cardiac critical care of £0.232m, BMT's £0.189m and radiotherapy of £0.095m, with smaller underachievement's in other specialties. This is offset to some extent by a favourable variance in cardiology £0.129m, clinical haematology/haemophilia £0.213m and private patient income of £0.051m.
  The underperformance 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 available over the period. Actual procedures

performed in month have again been higher than those billed and 7 additional cases will be reflected in next month's position.

- Nursing and midwifery pay overspends of £0.405m, particularly within the BHI. Following two consecutive months of improved performance the nursing financial position has deteriorated significantly in September overspending by £0.130m.

The key reasons for the adverse variance from the operating plan target are:

- Lower than planned cardiac surgery activity £0.299m.
- Higher than planned nursing costs £0.306m.
- BMT activity lower than planned £0.189m.
- Lower than planned Radiotherapy and Gamma Knife activity £0.095m.
- There have been favourable variances offsetting the above with regards to CQUINs, private patients and over performance on activity in cardiology and Haematology.

Actions being taken and mitigation to restore performance include:

- Delivery of Cardiac Surgery activity- A review of scheduling is taking place which informs booking practices based on the patients euro score which is aimed at ensuring that a suitable acuity mix of patients are operated on in order to prevent high volumes of potential long stay patients being treated together, subsequently improving flow through the unit.
- A number of actions have been identified within nursing to maintain a continued focus on this area. These include, the development of a critical care bank, a recruitment and retention programme led by the divisional matron, continued review of lost time including annual leave, review of CICU staffing levels and plans to reduce agency expenditure.
- Additional SLA income opportunities may be possible throughout the year in the areas of Cardiology and Haematology following strong performance year to date. Opportunities with Gamma Knife are also probable in the final quarter of the year.
- Continuing to deliver savings programmes identified and developing new schemes.
- Maintaining controls on non-pay expenditure.

Key risks to delivery of the operating plan include:

- Further loses of Cardiac Surgery activity due to shortages of staff, high acuity of patients or bed pressures during the winter period.
- An inability to recruit to vacant posts in nursing resulting in continued agency expenditure;
- Non recruitment into medical vacancies within the BHOC, particularly for Radiotherapy.
- Continued charges for unused chemotherapy drugs.
- Non delivery of expected savings
- Any reduction in referrals for BMT

Division of Surgery, Head and Neck

The Division reports an adverse variance to month 6 of £2.643m; deterioration from month 5 of £0.377m, this represents a slowing in the run rate. The Division is £1.103m adverse to its operating plan target to date, compared with £0.900m last month.

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

- Underachievement of income from activities of £0.806m due to lower than expected activity primarily in outpatient areas (oral surgery, ophthalmology and ENT) and emergency/ unplanned work in upper GI surgery and T&O – the latter two difficult to recover. A significant element of this is a share of the underperformance on cardiac surgery within Specialised Services (£0.183m), although this run rate has slowed.
- An adverse variance to date on non pay of £0.344m which is an in month deterioration of £24k. Whilst some of this is due to re-profiling and the divisional deficit, there is increased expenditure within theatres which is of significant concern.
- An underachievement of the savings programme, resulting in an adverse variance to date of £1.404m. The majority of which relates to unidentified plans of £1.386m with the balance mainly due to shortfalls on income related schemes. The most significant being 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 key reasons for the adverse variance against operating plan are:

- Underachievement of activity (including the share of cardiac surgery), £0.632m.
- Higher than planned nursing spend £0.452m.
- Higher than planned waiting list payments £0.132m.
- Higher than planned income from operations £0.134m.

Actions being taken and mitigation to restore performance include:

- Implementing a new E-roster reports to support nurse deployment with the aim of reducing bank and agency usage.
- Implementing a revised operating plan to improve utilisation rates within theatres, reducing the number of waiting list initiatives (WLI) required;
- Recruitment of locum posts in endoscopy and anaesthesia to reduce spend on WLI
- Review of classification of critical care patients to ensure staffing skill mix is appropriate, and not higher than required;
- Review of the Enhanced Observation (EO) Policy in T&O wards, with the aim of reducing spend on 1 to 1 nursing and focus on discharge of those Green To Go patients requiring EO.
- Increasing capacity within oral surgery and dental specialities by recruiting to the required levels of nursing and consultant staff.
- Increasing capacity at South Bristol Hospital including the scheduling of additional sessions in the evenings and at weekends.

Key risks to delivery of the operating plan include:

- Continuing high usage of agency nursing if the recruitment strategy fails to deliver.
- Failure to address and recover the underperformance on activity to date.

The Division of Women's and Children's Services

The Division reports an adverse variance to month 6 of £0.477m, this represents a deterioration from month 5 of £0.152m. The Division is £0.056m adverse to the operating plan target to date.

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

- An adverse variance on pay of £0.864m due to higher than planned agency costs within medical staff (NICU cover) and nursing (including 1-1 care). Non clinical staff is overspending by £0.276m driven by requirements such as validating waiting lists and completion of missing outcomes.
- An underperformance on the saving programme, resulting in an adverse variance to date of £0.629m. The majority of which relates to unidentified savings in the plan.
- An overachievement on SLA income of £0.205m including favourable variances in paediatric medical specialties and St Michaels specialties offset by an adverse performance on private patients of £0.106m.
- These adverse variance are offset by a significant favourable variance on non pay which includes the year to date share of support funding , CQUIN funding and a capacity reserve held within the division.

The Division remains broadly in line with its operating plan trajectory.

Actions being taken and mitigation to restore performance include:

- Concerted effort to identify further savings opportunities.
- Minimising agency payments through improved and efficient recruitment and retention.
- Actively managing private patients and commercial research plans.
- Improving cost control and budgetary performance including Profin compliance.

Key risks to delivery of the operating plan include:

- New maintenance contracts for major CSP equipment are due and there is a budget shortfall following project work with MEMO, D&T, Procurement and Trust Finance, now looks likely to be an overspend of £0.046m in year.
- Maintaining elective income though winter, whilst containing winter emergency pressures costs within ORCP envelope.
- Ensuring nurse agency costs reduce significantly in line with recruitment of 107 new starters.

One Division is rated amber/green.

Diagnostic and Therapies Division

The Division reports an adverse variance to month 6 of £0.041m, which represents and improvement from month 5 of £0.041m. The Division is breakeven with regards to the operating plan target to date.

It should be noted that the new DFM has undertaken a detailed review of pharmacy budgets this month which has resulted in a number of budget realignments between pay, non pay and income; this has resulted in changes in variances in these categories this month.

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

- An adverse variance on non-pay of £0.116m relating to radiology maintenance contracts (£0.135m) and the Microbiology Public Health England contract (£0.162m).
- An adverse variance on income from activities of £0.193m which relates to a favourable variance on D&T hosted services of £0.066m off-set by £0.259m adverse on services hosted by other divisions.
- An underachievement of the savings programme, resulting in an adverse variance to date of £0.332m of which £0.167m relates to unidentified plans.
- Vacant posts have contributed to a pay underspend of £0.425m which is offsetting the adverse variances.
- A favourable variance on income from operations of £0.175m within MEMO and Pharmacy also offsets the adverse variances above.

Actions being taken and mitigation to restore performance include:

- Developing the savings programme to address the shortfall.
- Challenging the LIMS costs with NBT.

Key risks to delivery of the operating plan include:

- Other Division's under-performance on contracted activity.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve, such as those linked to the extension of the Roche Managed equipment service for laboratory medicine.
- Employing high cost agency / locums into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as Radiology and Laboratory Medicine.

The remaining two Divisions are rated green.

The Facilities and Estates Division

The Division reports a favourable variance to month 6 of £0.065m, which represents an improvement from month 5 of £3k: the Division is £0.078m favourable to the operating plan target to date.

Trust Headquarters

The Division reports an adverse variance to month 6 of £0.043m, this represents a deterioration from month 5 of £60k; the Division is £40k adverse to the operating plan target to date.

6. Income

Contract income was £0.10m higher than plan in September and £2.63m lower than plan for the year to date. Activity and penalties/rewards were lower than plan whilst pass through payments were higher than plan. The table below summarises the overall position which is described in more detail under agenda item 5.2.

Clinical Income by Worktype	**In Month Variance** Fav/(Adv)	**Year to Date Plan**	**Year to Date Actual**	**Year to Date Variance** Fav/(Adv)
	£'m	£'m	£'m	£'m
Activity Based				
Accident & Emergency	0.03	7.32	7.44	0.13
Emergency Inpatients	0.37	35.99	36.90	0.91
Day Cases	0.04	18.80	18.20	(0.60)
Elective Inpatients	(0.32)	26.48	24.84	(1.65)
Non-Elective Inpatients	(0.03)	7.92	7.36	(0.57)
Excess Bed days	0.20	3.48	4.04	0.56
Outpatients	0.02	39.57	38.43	(1.15)
Bone Marrow Transplants	(0.40)	4.70	4.42	(0.29)
Critical Care Bed days	0.19	20.88	21.20	0.31
Other	(0.41)	46.45	45.87	(0.59)
Sub Totals	**(0.30)**	**211.60**	**208.68**	**(2.92)**
Contract Penalties	(0.05)	(3.04)	(2.86)	0.18
Contract Rewards	(0.18)	4.00	3.82	(0.18)
Pass through payments	0.63	40.08	40.36	0.29
Totals	**0.10**	**252.63**	**250.00**	**(2.63)**

Significant activity underperformance continues within elective inpatients and outpatients. Key areas for the elective inpatient underperformance of £1.65m are cardiac surgery (£0.48m) and upper gastrointestinal surgery (£0.52m), although cardiac surgery has improved in the last two months from £0.69m in July. Ophthalmology outpatient activity is £0.60m lower than plan resulting from reduced capacity whilst recruitment is underway.

Emergency inpatients over performance increased by £0.37m to £0.91m to date, with the over performance to date within the Children's Hospital accounting for £0.90m. Activity this month was high within the Children's Hospital (£0.16m) and the Haematology and Oncology centre (£0.10m).

Contract penalties are £0.18m better than plan. The main driver for this is the specialised services marginal tariff adjustment which is better than expected at £0.30m. Further detail is given at 2.3 in the contract income report.

Contract rewards are £0.18m behind plan. At this relatively early stage, those CQUINs with ≤50% predicted delivery in whole or part relate to "Dementia: Case finding" and "Organisational Patient Safety Culture." These are being monitored closely through the Clinical Quality Group, with relevant SLT sponsors accountable to SLT for delivery.

Pass through payments are £0.29m higher than planned to date, an increase in month of £0.63m. The most significant increase in month was within drugs (£0.40m) due to the implementation of pre-NICE guidance for hepatology. Devices also increased (£0.19m) due to adult cardiology devices.

Performance at Clinical Divisional level is shown at appendix 4a. Activity based contract performance is summarised as follows:

Divisional Variances	**In Month Variance** Fav/(Adv)	**Year to Date Plan**	**Year to Date Actual**	**Year to Date Variance** Fav/(Adv)
	£'m	£'m	£'m	£'m
Diagnostic & Therapies	(0.07)	19.17	18.89	(0.28)
Medicine	(0.13)	24.38	23.75	(0.64)
Specialised Services	(0.02)	27.22	26.37	(0.84)
Surgery, Head and Neck	(0.01)	37.91	36.99	(0.92)
Women's and Children's	(0.04)	49.55	50.02	0.46
Facilities and Estates	(0.00)	1.93	1.90	(0.03)
Corporate	(0.04)	51.43	50.77	(0.66)
Totals	**(0.30)**	**211.60**	**208.68**	**(2.92)**

7. Risk Rating

The following table shows performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the six month period to 30th September 2015, the Trust's achieved an overall FSRR of 3 (actual 3.25) against a plan of 4 (rounded up – actual 3.5). The reduction in the FSRR against plan is due to the Trust's reported net income and expenditure position of £52k surplus (before technical items) against a planned surplus of £363k. The £311k adverse position against plan reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3.

The key risk going forward is the adverse income and expenditure performance run rate against plan and the impact upon the FSRR. Within the FSRR, the income and expenditure performance impacts on the "income and expenditure margin" metric and the "capital servicing capacity" metric. The headroom available until both metrics score a rating of 1 was only £5.1 million. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR capped at 2 for the Trust and potential investigation. A summary of the position is provided in the table below.

		31st August 2015		30 September 2015		31st March 2016	
	Weighting	Plan	Actual	Plan	Actual	Plan	Forecast
Liquidity							
Metric Result – days		6.56	6.58	14.14	15.17	7.16	7.16
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		1.78	1.66	1.86	1.83	1.83	1.83
Metric Rating	25%	3	2	3	3	3	3
Income & expenditure margin							
Metric Result		0.8%	0.5%	0.75%	0.59%	0.5%	0.5%
Metric Rating	25%	3	3	3	3	3	3
Variance in I&E margin							
Metric Result		0.0%	(0.3)%	0.0%	(0.16)%	0.0%	0.0%
Metric Rating	25%	4	3	4	3	4	4
Overall FSRR		**3.5**	**3.0**	**3.5**	**3.25**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**3**	**4**	**3**	**4**	**4**

8. Capital Programme

A summary of income and expenditure for the six months ending 30 September is given in the table below. Expenditure for the period is £9.950m against a revised plan of £10.350m. The revised plan to date and forecast outturn position reflects the conclusion of the re-profiling exercise. The Trust's forecast outturn is £29.992m which is 87% of the original Monitor Annual Plan.

Original Monitor Annual Plan	Revised Annual Plan	Subjective heading	Month ended 30th September 2015			Forecast		
			Plan	Actual	Variance	Outturn	Slippage	Net over / under
£m	£m		£m	£m	£m	£m	£m	£m
		Sources of Funding						
4.558	4.732	Donations	2.599	2.414	(0.185)	3.102	(2.110)	0.480
1.100	14.025	Disposals	14.025	14.025	-	14.025	-	-
0.954	1.130	Grants/Contributions	0.954	1.040	0.086	1.216	-	0.086
		Cash:						
20.814	20.814	Depreciation	10.302	10.237	(0.065)	20.814	-	-
7.043	(0.873)	Cash balances	(17.530)	(17.766)	(0.236)	(9.165)	(7.491)	(0.801)
34.469	**39.828**	**Total Funding**	**10.350**	**9.950**	**(0.400)**	**29.992**	**(9.601)**	**(0.235)**
		Expenditure						
(15.862)	(15.884)	Strategic Schemes	(5.370)	(5.589)	(0.219)	(11.953)	3.931	-
(4.287)	(7.551)	Medical Equipment	(0.929)	(0.823)	0.106	(5.948)	1.418	0.185
(3.171)	(3.230)	Information Technology	(1.070)	(0.736)	0.334	(3.082)	0.183	(0.035)
(2.177)	(2.235)	Estates Replacement	(0.970)	(1.060)	(0.090)	(2.256)	(0.029)	0.008
(8.972)	(10.928)	Operational Capital	(2.011)	(1.742)	0.269	(8.753)	2.098	0.077
(34.469)	**(39.828)**	**Gross Expenditure**	**(10.350)**	**(9.950)**	**0.400**	**(31.992)**	**7.601**	**0.235**
-	-	Planned Slippage	-	-	-	2.000	2.000	-
(34.469)	**(39.828)**	**Net Expenditure**	**(10.350)**	**(9.950)**	**0.400**	**(29.992)**	**9.601**	**0.235**

There have been a number of approved changes to the Trust's Capital Programme since the submission of the Annual Plan in May. The revised break even forecast allowed previously deferred schemes to be brought into the current year programme, and with additional donations and a net movement between capital and revenue the revised annual plan is now £39.828m.

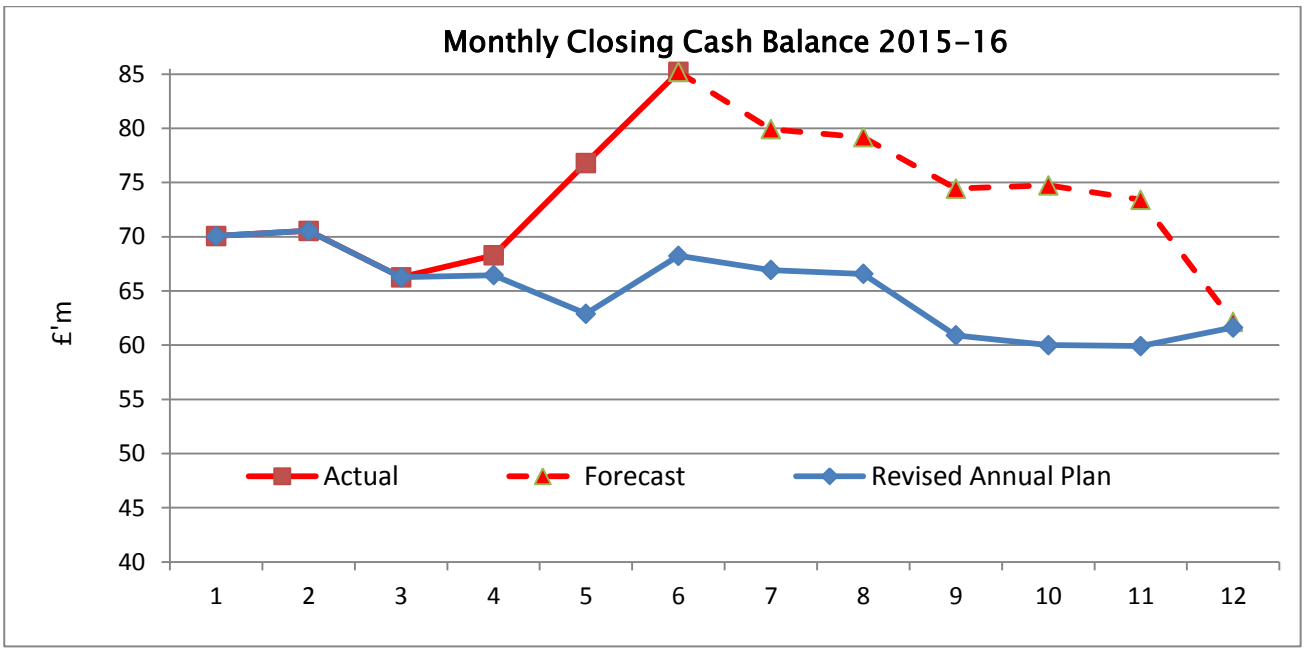
The Finance Committee is provided with further information under agenda item 6.1.

9. Statement of Financial Position and Cashflow

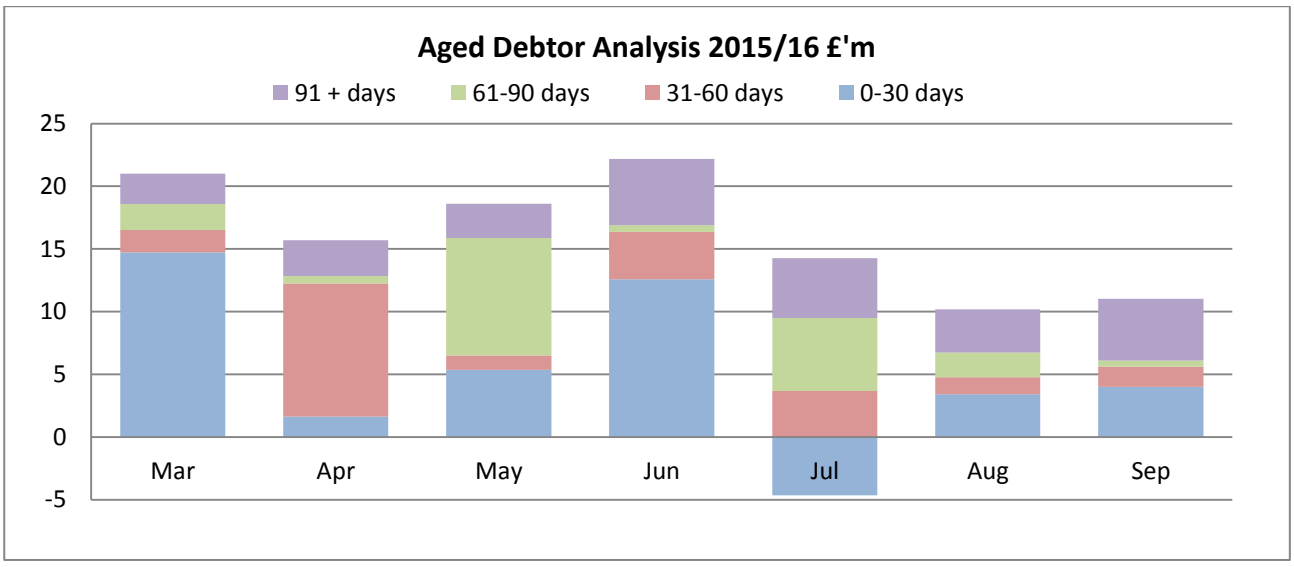
Overall, the Trust has a strong statement of financial position with net current assets of £34.496m as at 30 September 2015 against a plan of £32.908m.

Cash - The Trust held cash and cash equivalents of £85.201m as at 30 September, £16.963m higher than planned primarily due to higher than planned current liabilities of £16.530m. Following a review of forecast capital expenditure and working capital movements, the forecast year end closing cash balance is £62.166m.

The graph below shows the forecast cash balance trajectory for the remainder of the financial year.

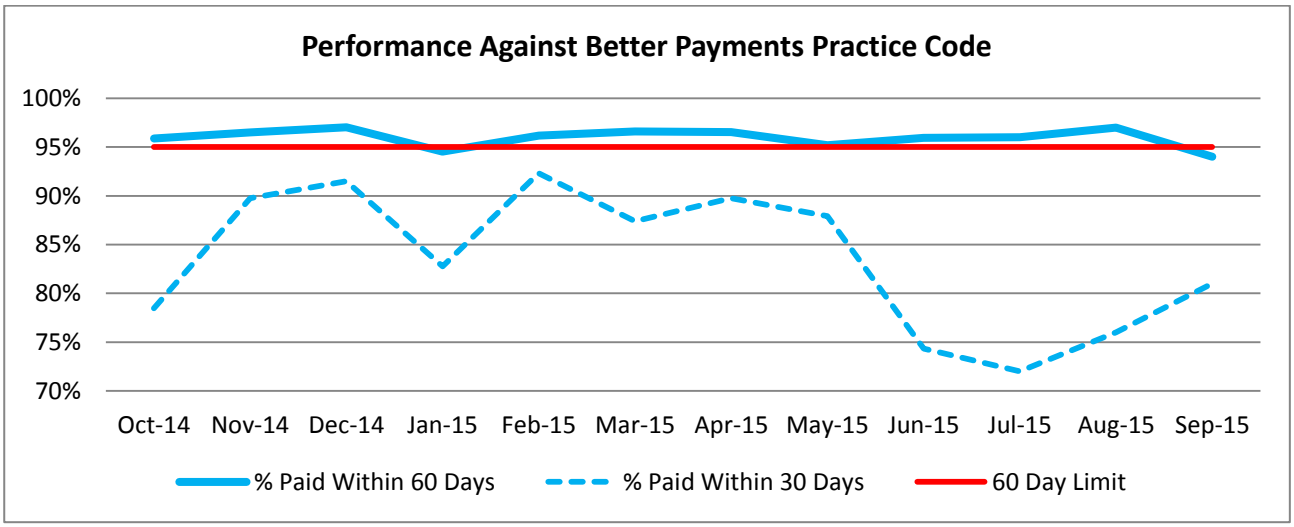


Receivables - The total value of debtors increased by £0.835m to £11.012m in September. SLA debtors increased by £0.287m and non SLA debtors increased by £0.548m. The total value of debtors over 60 days old remained unchanged at £5.399m. Further details are provided in agenda item 7.1.



Accounts Payable Payments – In September, the Trust paid 94% of invoices within 60 days compared with the Prompt Payments Code target of 95%. This reflects the settlement of some old invoices. The number of invoices paid within 30 days increased as the Trust adjusted to the new

system for authorising invoices implemented in August. A summary of performance is provided below.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Financial Sustainability Risk Rating
Appendix 4a – Key Financial Metrics
Appendix 4b – Key Workforce Metrics
Appendix 5 – Financial Risk Matrix
Appendix 6 – Monthly Analysis of Pay Expenditure 2015/16
Appendix 7 - Release of Reserves

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report September 2015- Summary Income & Expenditure Statement

Approved Budget / Plan 2015/16	Heading	Position as at 30th September			Actual to 31st August	Forecast Outturn
		Plan	Actual	Variance Fav / (Adv)		
£'000		£'000	£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)					
504,524	From Activities	253,337	250,211	(3,126)	207,349	505,008
89,690	Other Operating Income	44,362	44,371	9	36,962	91,524
594,214	**Sub totals income**	**297,699**	**294,582**	**(3,117)**	**244,311**	**596,532**
	Expenditure					
(345,756)	Staffing	(174,099)	(175,647)	(1,548)	(145,824)	(354,052)
(202,122)	Supplies and Services	(102,530)	(102,852)	(322)	(85,671)	(210,251)
(547,878)	**Sub totals expenditure**	**(276,629)**	**(278,499)**	**(1,870)**	**(231,495)**	**(564,303)**
(11,836)	Reserves	(3,504)	-	3,504	-	-
34,500	**EBITDA**	**17,566**	**16,083**	**(1,483)**	**12,816**	**32,229**
5.81	**EBITDA Margin - %**		**5.46**		**5.25**	**5.40**
	Financing					
-	Profit/(Loss) on Sale of Asset	-	7	7	7	
(23,054)	Depreciation & Amortisation - Owned	(11,480)	(10,361)	1,119	(8,619)	(20,814)
244	Interest Receivable	122	146	24	119	275
(314)	Interest Payable on Leases	(157)	(160)	(3)	(133)	(314)
(3,192)	Interest Payable on Loans	(1,596)	(1,569)	27	(1,315)	(3,192)
(8,184)	PDC Dividend	(4,092)	(4,094)	(2)	(3,410)	(8,184)
(34,500)	**Sub totals financing**	**(17,203)**	**(16,031)**	**1,172**	**(13,351)**	**(32,229)**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**363**	**52**	**(311)**	**(535)**	**0**
	Technical Items					
4,558	Donations & Grants (PPE/Intangible Assets)	2,599	2,441	(158)	2,399	3,103
(4,719)	Impairments	(1,486)	(1,695)	(209)	(1,285)	(4,616)
500	Reversal of Impairments	-	4,804	4,804	-	3,916
(1,472)	Depreciation & Amortisation - Donated	(736)	(747)	(11)	(621)	(1,511)
(1,133)	**SURPLUS / (DEFICIT) after Technical Items**	**740**	**4,855**	**4,115**	**(42)**	**892**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 2015- Divisional Income & Expenditure Statement

Approved Budget / Plan 2015/16	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st August	Operating Plan Target Year to Date	Variance from Operating Plan Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CRES				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
504,370	Contract Income	252,631	252,631	-	-	4	(4)	-	-	-	-	-
(3,534)	Overheads, Fines & Rewards	(1,766)	(2,332)	-	120	-	(685)	-	(565)	(331)	-	-
38,422	NHSE Income	18,527	18,527	-	-	-	-	-	-	-	-	-
539,258	**Sub Total Corporate Income**	**269,392**	**268,826**	**-**	**120**	**4**	**(689)**	**-**	**(565)**	**(331)**	**-**	**-**
	Clinical Divisions											
(50,870)	Diagnostic & Therapies	(25,622)	(25,664)	425	(116)	175	(193)	(332)	(41)	(82)	(35)	(6)
(71,617)	Medicine	(36,457)	(37,481)	(207)	29	51	(784)	(116)	(1,027)	(700)	(110)	(917)
(91,705)	Specialised Services	(45,756)	(46,282)	(558)	471	81	(673)	155	(524)	(344)	(7)	(517)
(99,890)	Surgery Head & Neck	(50,151)	(52,794)	(233)	(344)	143	(806)	(1,403)	(2,643)	(2,266)	(1,540)	(1,103)
(115,331)	Women's & Children's	(57,767)	(58,243)	(864)	828	(17)	205	(629)	(477)	(325)	(421)	(56)
(429,413)	**Sub Total - Clinical Divisions**	**(215,753)**	**(220,464)**	**(1,437)**	**868**	**433**	**(2,251)**	**(2,325)**	**(4,712)**	**(3,717)**	**(2,113)**	**(2,599)**
	Corporate Services											
(36,058)	Facilities And Estates	(18,274)	(18,208)	(19)	(26)	65	35	10	65	62	(13)	78
(24,566)	Trust Services	(12,187)	(12,235)	347	(358)	(98)	38	28	(43)	17	(3)	(40)
(2,885)	Other	(2,108)	(1,836)	(37)	616	(217)	(100)	6	268	177		268
(63,509)	**Sub Totals - Corporate Services**	**(32,569)**	**(32,279)**	**291**	**232**	**(250)**	**(27)**	**44**	**290**	**256**	**(16)**	**306**
(492,922)	**Sub Total (Clinical Divisions & Corporate Services)**	**(248,322)**	**(252,743)**	**(1,146)**	**1,100**	**183**	**(2,278)**	**(2,281)**	**(4,422)**	**(3,461)**	**(2,129)**	**(2,293)**
(11,836)	Reserves	(3,504)	-	-	3,504	-	-	-	3,504	833	-	-
-	Monitor Plan Profile	0	-	-	-	-	-	-	-	1,048	-	-
(11,836)	**Sub Total Reserves**	**(3,504)**	**-**	**-**	**3,504**	**-**	**-**	**-**	**3,504**	**1,881**	**0**	**-**
34,500	**Trust Totals Unprofiled**	**17,566**	**16,083**	**(1,146)**	**4,724**	**187**	**(2,967)**	**(2,281)**	**(1,483)**	**(1,911)**	**(1,936)**	**(2,293)**
	Financing											
-	(Profit)/Loss on Sale of Asset	-	7	-	7	-	-	-	7	7	-	-
(23,054)	Depreciation & Amortisation - Owned	(11,480)	(10,361)	-	1,119	-	-	-	1,119	461	-	-
244	Interest Receivable	122	146	-	24	-	-	-	24	17	-	-
(314)	Interest Payable on Leases	(157)	(160)	-	(3)	-	-	-	(3)	(2)	-	-
(3,192)	Interest Payable on Loans	(1,596)	(1,569)	-	27	-	-	-	27	15	-	-
(8,184)	PDC Dividend	(4,092)	(4,094)	-	(2)	-	-	-	(2)	494	-	-
(34,500)	**Sub Total Financing**	**(17,203)**	**(16,031)**	**-**	**1,172**	**-**	**-**	**-**	**1,172**	**992**	**0**	**-**
0	**NET SURPLUS / (DEFICIT) before Technical Items**	**363**	**52**	**(1,146)**	**5,896**	**187**	**(2,967)**	**(2,281)**	**(311)**	**(919)**	**(1,936)**	**-**
	Technical Items											
4,558	Donations & Grants (PPE/Intangible Assets)	2,599	2,441	-	-	(158)	-	-	(158)	89	-	-
(4,719)	Impairments	(1,486)	(1,695)	-	(209)	-	-	-	(209)	(214)	-	-
500	Reversal of Impairments	-	4,804	-	4,804	-	-	-	4,804	-	-	-
(1,472)	Depreciation & Amortisation - Donated	(736)	(747)	-	(11)	-	-	-	(11)	(8)	-	-
(1,133)	**Sub Total Technical Items**	**377**	**4,803**	**-**	**4,584**	**(158)**	**-**	**-**	**4,426**	**(133)**	**-**	**-**
(1,133)	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**740**	**4,855**	**(1,146)**	**10,480**	**29**	**(2,967)**	**(2,281)**	**4,115**	**(1,052)**	**(1,936)**	**(2,293)**

Financial Sustainability Risk Rating – September 2015 Performance

The following graphs show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the six month period to 30th September 2015, the Trust's achieved an overall FSRR of 3 (actual 3.25) against a plan of 4 (rounded up – actual 3.5).

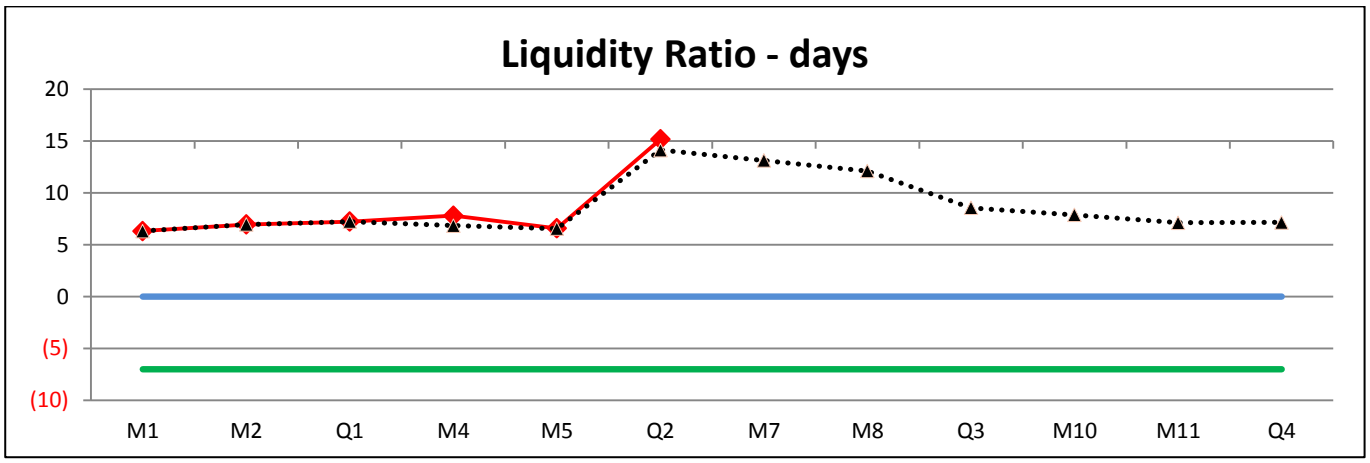
The reduction in the FSRR against plan is due to the Trust's reported net income and expenditure position of £52k surplus (before technical items) against a planned surplus of £363k. The £311k adverse position against plan reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3.

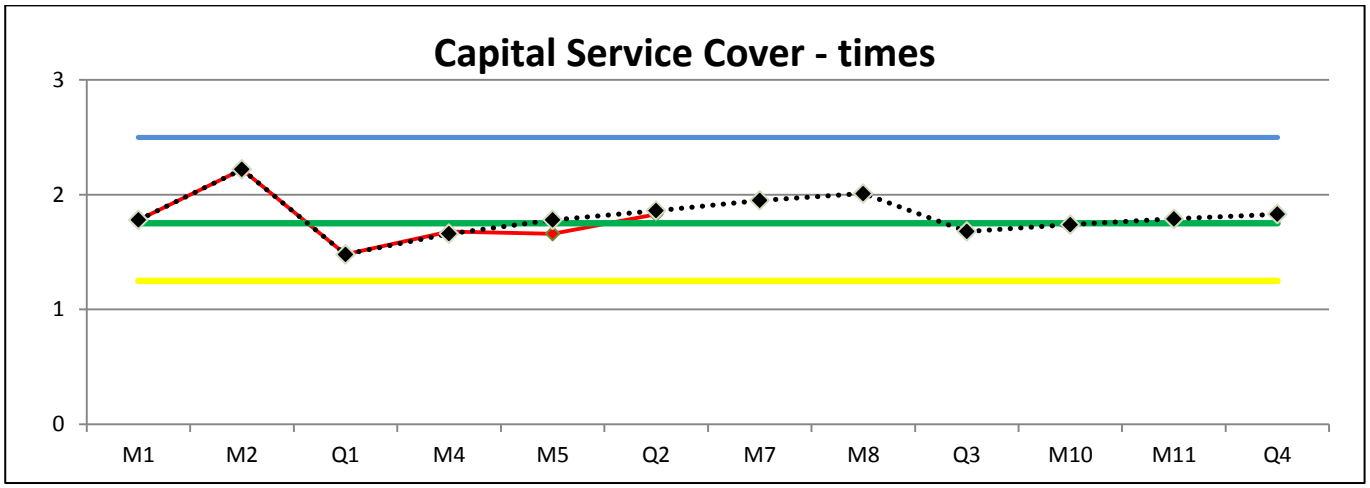
The key risk going forward is the adverse income and expenditure performance against plan and the impact upon the FSRR. Within the FSRR, the income and expenditure performance impacts on the "income and expenditure margin" metric and the "capital servicing capacity" metric. The headroom available until both metrics score a rating of 1 was only £5.1 million. Should any of the four metrics score a metric rating of 1, Monitor will apply an "over-ride" resulting in an overall FSRR capped at 2 for the Trust and potential investigation.

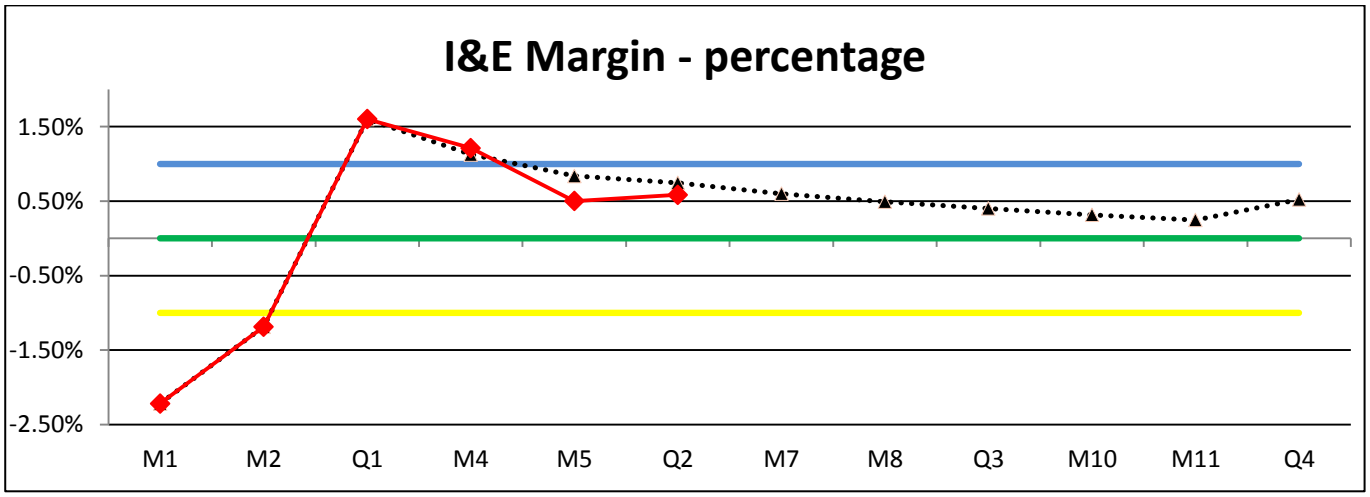
A summary of the position is provided in the table below.

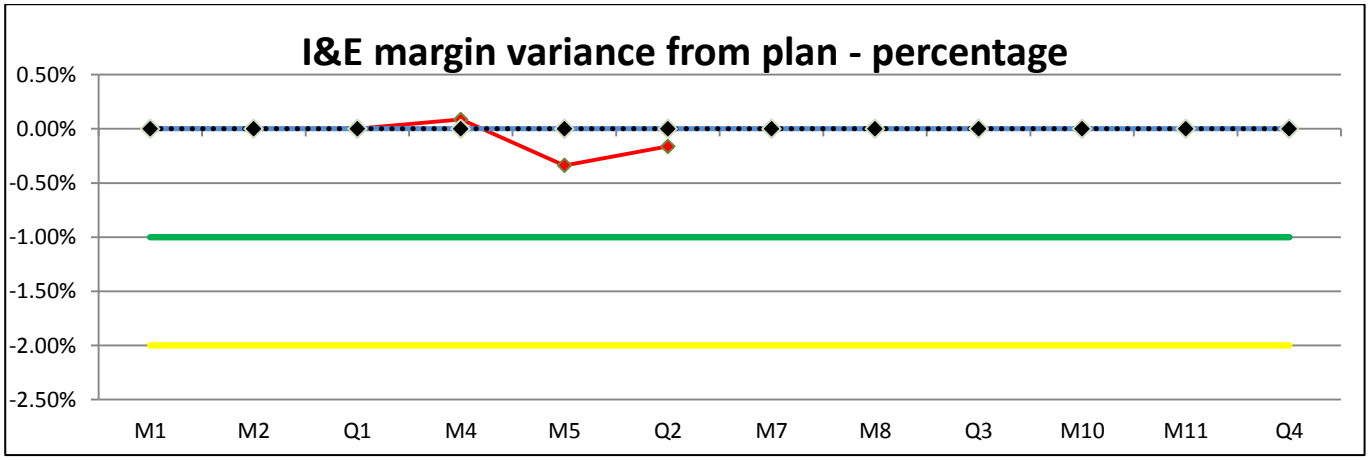
		31st August 2015		30 September 2015		31st March 2016	
	Weighting	Plan	Actual	Plan	Actual	Plan	Forecast
Liquidity							
Metric Result – days		6.56	6.58	14.14	15.17	7.16	7.16
Metric Rating	25%	4	4	4	4	4	4
Capital Servicing Capacity							
Metric Result – times		1.78	1.66	1.86	1.83	1.83	1.83
Metric Rating	25%	3	2	3	3	3	3
Income & expenditure margin							
Metric Result		0.8%	0.5%	0.75%	0.59%	0.5%	0.5%
Metric Rating	25%	3	3	3	3	3	3
Variance in I&E margin							
Metric Result		0.0%	(0.3)%	0.0%	(0.16)%	0.0%	0.0%
Metric Rating	25%	4	3	4	3	4	4
Overall FSRR		**3.5**	**3.0**	**3.5**	**3.25**	**3.5**	**3.5**
Overall FSRR (rounded up)		**4**	**3**	**4**	**3**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The 2015/16 revised Annual Plan submitted to Monitor on 31st July 2015 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.


Liquidity Ratio - days
20
15
10
5
0
(5)
(10)
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


Capital Service Cover - times
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
1.50%
0.50%
-0.50%
-1.50%
-2.50%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E margin variance from plan - percentage
0.50%
0.00%
-0.50%
-1.00%
-1.50%
-2.00%
-2.50%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4

Key Financial Metrics

Appendix 4a

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Activity Based									
Current Month									
Budget	3,273	4,070	4,645	6,445	8,409	328		8,806	35,976
Actual	3,205	3,940	4,629	6,437	8,373	325		8,764	35,673
Variance Fav / (Adv)	(68)	(130)	(16)	(8)	(36)	(3)	0	(42)	(303)
Year to date									
Budget	19,173	24,384	27,216	37,911	49,552	1,933		51,429	211,598
Actual	18,891	23,745	26,373	36,989	50,015	1,899		50,765	208,677
Variance Fav / (Adv)	(282)	(639)	(843)	(922)	463	(34)	0	(664)	(2,921)

Information shows the financial performance against the planned level of activity based service level agreements with Commissioners as per agenda item 5.2

Contract Income - Penalties									
Current Month									
Plan		(28)	(4)	(11)	(3)			(453)	(499)
Actual		(41)	(7)	(6)	3			(494)	(545)
Variance Fav / (Adv)	-	(13)	(3)	5	6	-	-	(41)	(46)
Year to date									
Plan		(173)	(22)	(68)	(18)			(2,761)	(3,042)
Actual		(192)	(28)	(71)	(17)			(2,553)	(2,861)
Variance Fav / (Adv)	-	(19)	(6)	(3)	1	-	-	208	181

Information shows the financial performance against the planned penalties as per agenda item 5.2

Contract Income - Rewards									
Current Month									
Plan								656	656
Actual								474	474
Variance Fav / (Adv)	-	-	-	-	-	-	-	(182)	(182)
Year to date									
Plan								4,001	4,001
Actual								3,819	3,819
Variance Fav / (Adv)	-	-	-	-	-	-	-	(182)	(182)

Information shows the financial performance against the planned rewards as per agenda item 5.2

Cost Improvement Programme									
Current Month									
Plan	173	190	127	505	364	86	27	173	1,645
Actual	110	26	187	379	241	92	28	177	1,240
Variance Fav / (Adv)	(63)	(164)	60	(126)	(123)	6	1	4	(405)
Year to date									
Plan	1,034	1,048	840	3,053	2,250	530	155	1,044	9,954
Actual	741	997	947	1,546	1,511	556	295	1,066	7,659
Variance Fav / (Adv)	(293)	(51)	107	(1,507)	(739)	26	140	22	(2,295)

Key Workforce Metrics

Appendix 4b

Diagnostic & Therapies

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	952	547	106	115	155	116	74	53							619	(72)
Nursing agency expenditure (£'000)	29	17	13	1	1	-	1	0							16	1
Overall																
Sickness (%)	3.00		3.00	2.70	3.10	2.90	2.60	2.80							2.80	
Turnover (%)	11.00		11.80	11.70	12.20	12.00	12.40	12.5							12.50	
Establishment (wte)			968.01	978.45	978.94	981.34	982.24	976.50								
In post (wte)			948.03	943.08	940.05	942.47	961.81	967.64								
Under/(over) establishment (wte)			19.98	35.37	38.89	38.87	20.43	8.86								
Nursing:																
Sickness - registered (%)			0.20	1.90	2.80	4.60	0.20	2.90							2.10	
Sickness - unregistered (%)																
Turnover - registered (%)	15.00		15.70	12.60	11.40	11.00	11.00	10.6							10.60	
Turnover - unregistered (%)																
Starters (wte)			-	-	-	-	-	-								
Leavers (wte)			0.60	-	1.00	-	-	-								
Net starters (wte)			(0.60)	0.00	(1.00)	0	0	0								
Establishment (wte)			16.33	16.33	17.29	17.29	17.88	17.88								
In post - Employed (wte)			16.25	16.42	16.66	15.66	15.57	15.57								
In post - Bank (wte)			1.35	0.42	0.52	0.41	2.10	0.85								
In post - Agency (wte)			2.10	-	-	-	0.70	-								
In post - total (wte)			19.70	16.84	17.18	16.07	18.37	16.42								
Under/(over) establishment (wte)			(3.37)	(0.51)	0.11	1.22	(0.49)	1.46								

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics

Appendix 4b

Medicine

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,732	1,231	324	248	254	226	269	380							1,701	(470)
Nursing agency expenditure (£'000)	1,343	959	279	186	154	184	234	314							1,351	(392)
Overall																
Sickness (%)	4.10		5.10	5.70	5.90	5.50	5.20	5.60							5.50	
Turnover (%)	12.70		13.40	13.50	13.80	12.40	12.30	12.4							12.40	
Establishment (wte)			1,233.42	1,233.54	1,238.01	1,211.24	1,217.72	1,221.40								
In post (wte)			1,267.74	1,282.71	1,255.17	1,236.75	1,257.67	1,285.27								
Under/(over) establishment (wte)			(34.32)	(49.17)	(17.16)	(25.51)	(39.95)	(63.87)								
Nursing:																
Sickness - registered (%)			4.80	5.30	6.20	6.00	5.20	5.30							5.50	
Sickness - unregistered (%)			9.60	10.80	10.40	9.10	10.90	10.40							10.20	
Turnover - registered (%)	13.50		13.00	13.60	14.20	13.30	13.90	14.50							14.50	
Turnover - unregistered (%)	18.50		22.20	21.40	20.40	16.50	16.20	14.80							14.80	
Starters (wte)			18.22	9.24	8.00	7.36	10.07	17.64							70.53	
Leavers (wte)			7.25	10.79	10.54	4.17	17.89	13.90							64.54	
Net starters (wte)			10.97	(1.55)	(2.54)	3.19	(7.82)	3.74							5.99	
Establishment (wte)			787.99	780.39	776.57	758.70	769.84	762.66								
In post - Employed (wte)			674.67	685.88	682.90	677.10	678.05	676.58								
In post - Bank (wte)			100.97	118.33	99.23	96.95	95.94	116.56								
In post - Agency (wte)			47.40	33.86	27.25	31.51	40.08	49.02								
In post - total (wte)			823.04	838.07	809.38	805.56	814.07	842.16								
Under/(over) establishment (wte)			(35.05)	(57.68)	(32.81)	(46.86)	(44.23)	(79.50)								

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics

Appendix 4b

Specialised Services

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	2,136	1,228	205	219	247	236	185	289							1,381	(153)
Nursing agency expenditure (£'000)	633	320	87	121	113	93	68	145							627	(307)
Overall																
Sickness (%)	3.70		3.80	3.50	3.50	3.80	3.80	4.20							3.80	
Turnover (%)	12.40		16.00	16.80	16.40	16.80	16.70	16.10							16.10	
Establishment (wte)			834.39	825.38	851.88	858.86	860.19	859.26								
In post (wte)			870.20	888.79	874.75	874.10	856.84	880.13								
Under/(over) establishment (wte)			(35.81)	(63.41)	(22.87)	(15.24)	3.35	(20.87)								
Nursing:																
Sickness - registered (%)			3.40	3.00	3.80	3.20	3.60	4.30							3.60	
Sickness - unregistered (%)			8.40	6.40	6.20	7.70	9.10	8.40							7.70	
Turnover - registered (%)	14.00		16.20	17.00	17.30	17.10	16.90	15.70							15.70	
Turnover - unregistered (%)	16.20		22.00	20.90	19.00	20.60	17.70	17.50							17.50	
Starters (wte)			4.60	3.46	8.64	1.80	8.00	7.60							34.10	
Leavers (wte)			4.96	10.70	6.94	7.14	6.67	3.87							40.28	
Net starters (wte)			(0.36)	(7.24)	1.70	(5.34)	1.33	3.73							(6.18)	
Establishment (wte)			453.58	449.36	460.69	463.54	463.26	463.26								
In post - Employed (wte)			439.48	439.02	432.60	433.82	427.33	436.39								
In post - Bank (wte)			32.04	37.61	43.55	36.09	33.32	44.75								
In post - Agency (wte)			11.33	13.13	13.01	11.02	9.77	16.08								
In post - total (wte)			482.85	489.76	489.16	480.93	470.42	497.22								
Under/(over) establishment (wte)			(29.27)	(40.40)	(28.47)	(17.39)	(7.16)	(33.96)								

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics **Appendix 4b**

Surgery, Head and Neck

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,387	821	172	190	241	281	320	311							1,515	(694)
Nursing agency expenditure (£'000)	1,019	641	144	144	167	242	276	222							1,195	(554)
Overall																
Sickness (%)	3.50		4.00	3.40	3.60	4.10	4.10	3.90							3.90	
Turnover (%)	12.60		15.40	15.90	16.10	14.60	14.50	14.40							14.40	
Establishment (wte)			1,698.59	1,716.16	1,735.10	1,752.82	1,753.62	1,760.25								
In post (wte)			1,737.89	1,752.24	1,754.64	1,764.87	1,789.03	1787.22								
Under/(over) establishment (wte)			(39.30)	(36.08)	(19.54)	(12.05)	(35.41)	(26.97)								
Nursing:																
Sickness - registered (%)			4.70	3.50	3.80	4.50	4.60	4.80							4.30	
Sickness - unregistered (%)			7.40	6.20	6.80	7.50	7.90	5.20							6.90	
Turnover - registered (%)	13.00		15.10	16.40	16.80	14.90	15.50	15.30							8.30	
Turnover - unregistered (%)	20.10		28.70	27.30	26.90	23.70	22.60	22.20							22.20	
Starters (wte)			10.61	4.00	5.63	1.00	9.00	21.40							51.64	
Leavers (wte)			9.52	8.33	10.64	5.51	22.60	10.97							67.56	
Net starters (wte)			1.09	(4.33)	(5.01)	(4.51)	(13.60)	10.43							(15.93)	
Establishment (wte)			675.98	679.78	689.06	694.06	701.12	701.15								
In post - Employed (wte)			644.20	646.24	650.41	642.90	648.68	636.91								
In post - Bank (wte)			45.02	51.89	55.40	60.48	63.94	67.65								
In post - Agency (wte)			20.66	19.59	27.45	31.41	35.91	29.47								
In post - total (wte)			709.88	717.72	733.26	734.79	748.53	734.03								
Under/(over) establishment (wte)			(33.90)	(37.94)	(44.20)	(40.73)	(47.41)	(32.88)								

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

Key Workforce Metrics

Appendix 4b

Women's and Children's

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,228	281	189	230	284	305	171	365							1,544	(1,263)
Nursing agency expenditure (£'000)	978	177	116	178	225	235	182	248							1,184	(1,007)
Overall																
Sickness (%)	3.90		4.00	3.50	3.40	3.50	3.50	3.80							3.60	
Turnover (%)	9.80		12.30	12.30	12.20	12.30	12.30	11.40							11.40	
Establishment (wte)			1,814.32	1,825.58	1,828.38	1,835.19	1,841.46	1,847.70								
In post (wte)			1,808.92	1,808.69	1,832.69	1,814.52	1,824.23	1877.68								
Under/(over) establishment (wte)			5.40	16.89	(4.31)	20.67	17.23	(29.98)								
Nursing:																
Sickness - registered (%)			4.60	3.90	4.00	401.00	4.20	5.10							4.30	
Sickness - unregistered (%)			5.80	5.40	4.60	4.70	3.70	2.90							4.50	
Turnover - registered (%)	10.00		11.50	11.30	11.00	10.90	10.50	9.50							9.50	
Turnover - unregistered (%)	20.00		22.70	24.60	23.80	23.00	23.50	17.90							17.90	
Starters (wte)			6.94	5.00	6.88	9.23	19.36	57.85							105.26	
Leavers (wte)			13.40	8.23	9.95	10.14	17.03	8.20							66.94	
Net starters (wte)			(6.46)	(3.23)	(3.06)	(0.91)	2.33	49.65							38.32	
Establishment (wte)			1,069.93	1,080.41	1,089.27	1,091.76	1,095.48	1,099.99								
In post - Employed (wte)			1,024.80	1,016.21	1,014.22	1,005.18	1,005.84	1,034.16								
In post - Bank (wte)			39.82	41.71	41.03	37.32	44.22	47.07								
In post - Agency (wte)			15.95	19.81	25.19	24.60	24.19	26.96								
In post - total (wte)			1,080.57	1,077.73	1,080.44	1,067.10	1,074.25	1,108.19								
Under/(over) establishment (wte)			(10.64)	2.68	8.83	24.66	21.23	(8.20)								

Definitions:

Sickness Absence is measured as percentage of available employed Full Time Equivalents (FTEs) absent, calculated on a monthly basis.
Turnover is measured as the total permanent leavers (FTE), taken as a percentage of the average permanent employed staff (excluding fixed term contracts, junior doctors and bank staff) over a rolling 12-month period.

Targets:

There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2016.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2016.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
wte in post for other bank and agency is calculated based on tracker data provided by TSB or the Division or a review of costs processed relating to the current month.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report September 2015 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Risk if no action taken		Action to be taken to mitigate risk	Lead	Residual Risk		Current Risk Score
		Risk Level	Value			Risk Level	Value	
			£'m				£'m	
959	Risk that Divisions do not achieve the required level of cost efficiency savings.	High	7.0	Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes. Trust is working to develop savings plans to meet 2015/16 target.	DL	High	5.0	12
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	High	-	9
872	Risk of non delivery of contracted levels of clinical activity.	High	10.0	Robust approach to capacity planning - demand assessment and supply.	DL	High	6.0	12
951	Risk of national contract mandates financial penalties on under-performance.	High	4.0	Contract signed with NHS England. Trust has also agreed heads of terms with main Commissioners.	DL	High	3.5	9
50	Risk of Commissioner Income challenges	Moderate	3.0	The Trust has strong controls of the SLA management arrangements.	PM	Moderate	2.0	6
408	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	-	3

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	Jul £'000	Aug £'000	Sep £'000	Q2 £'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	3,459	3,447	3,577	10,483	20,841	3,473		3,294	
	Bank	64	91	86	74	315	26	0.8%	26	24	32	82	29	44	36	109	191	32	0.9%	26	0.8%
	Agency	79	184	387	395	1,045	87	2.6%	106	115	155	377	116	74	53	242	618	103	3.0%	28	0.9%
	Waiting List initiative	45	46	65	113	269	22	0.7%	37	34	27	98	8	16	30	54	152	25	0.7%	19	0.6%
	Overtime	101	94	111	99	405	34	1.0%	34	47	65	147	26	34	33	94	240	40	1.2%	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	3,199	3,227	3,222	9,648	19,220	3,203	94.1%	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	3,378	3,394	3,374	10,146	20,422	3,404	100.0%	3,278	100.0%
	Variance Fav / (Adverse)	100	216	(287)	33	62	5		8	14	60	82	81	53	203	337	419	70		16	
Medicine	Pay budget	11,591	11,880	12,506	13,320	49,297	4,108		4,284	4,253	4,304	12,841	4,076	4,211	4,171	12,458	25,299	4,217		3,679	
	Bank	805	870	1,019	872	3,566	297	7.1%	303	329	265	897	252	341	341	935	1,832	305	7.1%	275	6.9%
	Agency	451	630	1,058	1,356	3,495	291	7.0%	324	248	254	826	226	269	380	875	1,701	283	6.6%	196	4.9%
	Waiting List initiative	26	39	34	94	193	16	0.4%	27	15	9	51	12	19	14	45	96	16	0.4%	13	0.3%
	Overtime	36	19	16	20	91	8	0.2%	4	6	6	16	7	6	8	21	37	6	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	3,542	3,725	3,675	10,941	22,153	3,692	85.8%	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	4,040	4,360	4,417	12,817	25,819	4,303	100.0%	3,979	100.0%
	Variance Fav / (Adverse)	(431)	(77)	(209)	(152)	(868)	(72)		(97)	(54)	(10)	(161)	36	(149)	(246)	(359)	(520)	(87)		(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	3,405	3,436	3,409	10,250	20,380	3,397		3,060	
	Bank	309	335	357	292	1,293	108	3.2%	112	127	163	402	120	120	164	404	806	134	3.9%	99	3.1%
	Agency	509	664	677	885	2,735	228	6.7%	205	219	247	671	236	185	289	710	1,381	230	6.6%	157	5.0%
	Waiting List initiative	91	90	133	194	508	42	1.3%	47	30	48	125	51	28	65	144	269	45	1.3%	32	1.0%
	Overtime	55	40	22	30	147	12	0.4%	9	11	9	29	8	10	11	29	58	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	3,074	3,068	3,080	9,222	18,411	3,068	88.0%	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	3,490	3,411	3,609	10,510	20,924	3,487	100.0%	3,142	100.0%
	Variance Fav / (Adverse)	(200)	(369)	(488)	(381)	(1,438)	(120)		(70)	(76)	(139)	(285)	(85)	24	(200)	(260)	(544)	(91)		(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	6,610	6,526	6,533	19,669	39,035	6,506		5,911	
	Bank	463	511	587	463	2,024	169	2.7%	191	178	190	559	218	256	210	683	1,242	207	3.2%	155	2.5%
	Agency	226	327	275	448	1,276	106	1.7%	172	190	241	603	281	320	311	911	1,514	252	3.8%	67	1.1%
	Waiting List initiative	366	456	446	395	1,663	139	2.2%	138	140	129	407	121	132	134	387	794	132	2.0%	116	1.9%
	Overtime	184	114	39	43	380	32	0.5%	11	13	14	38	13	18	17	47	86	14	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	5,959	5,941	5,960	17,860	35,713	5,952	90.8%	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	6,590	6,666	6,631	19,888	39,349	6,558	100.0%	6,145	100.0%
	Variance Fav / (Adverse)	(752)	(783)	(800)	(967)	(3,302)	(275)		(203)	(625)	733	(95)	20	(140)	(98)	(218)	(314)	(52)		(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	Jul £'000	Aug £'000	Sep £'000	Q2 £'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	7,525	7,617	7,686	22,828	45,390	7,565		6,123	
	Bank	530	485	631	528	2,174	181	2.5%	182	180	171	533	171	225	185	582	1,115	186	2.4%	151	2.5%
	Agency	384	397	411	650	1,842	154	2.1%	189	230	284	703	305	171	365	840	1,543	257	3.3%	117	1.9%
	Waiting List initiative	88	87	76	139	390	33	0.5%	69	67	69	205	76	48	45	169	374	62	0.8%	30	0.5%
	Overtime	82	79	95	99	355	30	0.4%	8	7	8	23	9	9	2	19	42	7	0.1%	19	0.3%
	Other pay	19,455	20,428	20,875	20,758	81,516	6,793	94.5%	7,120	7,139	7,232	21,492	7,124	7,219	7,352	21,695	43,187	7,198	93.4%	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	7,685	7,672	7,949	23,305	46,260	7,710	100.0%	6,159	100.0%
	Variance Fav / (Adverse)	(106)	45	(144)	60	(144)	(12)		(190)	3	(207)	(393)	(160)	(55)	(263)	(477)	(870)	(145)		(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	1,686	1,760	1,667	5,113	10,170	1,695		1,536	
	Bank	227	316	271	251	1,065	89	5.5%	80	106	111	296	115	107	98	320	617	103	6.0%	46	3.0%
	Agency	80	115	133	174	502	42	2.6%	47	33	65	145	61	59	66	186	332	55	3.3%	29	1.9%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	244	255	273	193	965	80	5.0%	79	65	82	225	77	90	77	244	469	78	4.6%	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	1,437	1,476	1,459	4,373	8,779	1,463	86.1%	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	1,691	1,732	1,700	5,123	10,196	1,699	100.0%	1,516	100.0%
	Variance Fav / (Adverse)	(23)	101	(20)	101	161	13		30	(8)	(38)	(16)	(5)	28	(33)	(9)	(25)	(4)		20	
(Including R&I and (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	2,211	2,173	2,112	6,496	12,983	2,164		2,458	
	Bank	165	154	189	178	686	57	2.4%	51	67	61	179	72	71	68	211	390	65	3.1%	57	2.4%
	Agency	135	139	154	280	707	59	2.5%	17	34	18	69	35	52	90	177	246	41	1.9%	31	1.3%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	31	27	33	19	110	9	0.4%	7	8	7	22	8	8	7	23	45	8	0.4%	9	0.4%
	Other pay	6,061	6,433	6,362	7,822	26,678	2,223	94.7%	2,022	2,000	2,007	6,029	1,948	2,043	1,976	5,967	11,996	1,999	94.6%	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	2,062	2,174	2,142	6,378	12,677	2,113	100.0%	2,383	100.0%
	Variance Fav / (Adverse)	132	149	520	755	1,557	130		67	(15)	137	188	149	(1)	(29)	118	307	51		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	28,971	29,171	29,156	87,298	174,099	29,016		26,060	
	Bank	2,564	2,762	3,140	2,657	11,124	927	3.3%	945	1,012	992	2,949	978	1,164	1,102	3,244	6,193	1,032	3.5%	809	3.0%
	Agency	1,865	2,455	3,096	4,187	11,603	967	3.4%	1,059	1,070	1,264	3,393	1,259	1,129	1,554	3,941	7,335	1,222	4.2%	625	2.4%
	Waiting List initiative	616	718	754	935	3,023	252	0.9%	318	286	282	886	268	243	288	799	1,685	281	1.0%	210	0.8%
	Overtime	734	628	589	503	2,454	204	0.7%	151	156	191	499	148	175	155	478	977	163	0.6%	201	0.8%
	Other pay	76,378	77,117	78,440	80,436	312,370	26,031	91.7%	26,574	26,484	26,695	79,752	26,282	26,699	26,723	79,705	159,457	26,576	90.8%	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	28,935	29,409	29,822	88,166	175,647	29,274	100.0%	26,603	100.0%
	Variance Fav / (Adverse)	(1,281)	(716)	(1,427)	(546)	(3,970)	(331)		(455)	(762)	537	(680)	37	(238)	(666)	(868)	(1,548)	(258)		(543)	

NOTE: Other Pay includes all employer's oncosts.

In Month 6 a review of central provisions held within support services resulted in a movement of credits between agency and employed staff - this is reflected in this report appropriately in prior months.

	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	(89)	(26)	(529)	-	(334)	(117)	(1,095)	30	162	50	164	320	142	169	58	1,095
July movements	43	(26)	(94)	-	(182)	(7)	(266)	31	26	14	23	14	27	15	116	266
August Movements	44	(26)	(447)		(638)	(11)	(1,078)	165	102	69	196	130	34	656	(274)	1,078
September Movements																
Consultant incremental drift		(176)					(176)	8	20	41	51	56				176
Service developments			(157)				(157)					157				157
EWTD					(112)		(112)	9	24	15	19	42	1	1	1	112
MPET funding					(5)		(5)					78			(73)	5
CQUINs			(49)				(49)		36	5		8				49
BRI redevelopment						(31)	(31)		10				18	3		31
Other	89	(26)			32		95						26	11	(132)	(95)
Month 6 balances	837	2,608	4,057	44	2,539	1,337	11,422	4,099	8,327	5,194	10,392	8,669	1,232	5,930	7,873	51,716

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
15. Monitor Q2 Risk Assessment Framework 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	**X**	Governors		Staff		Public	

Executive Summary

Purpose

All NHS Foundation Trusts require a licence from Monitor stipulating specific conditions that they must meet to operate including financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach and their use of the framework to assess individual FT compliance with two specific aspects of their work: the Continuity of Services and Governance conditions in their provider licences.

The purpose of a Monitor assessment under the framework is to highlight when there is a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or poor governance.

It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk.

Key issues to note

This report provides an analysis of governance risk (Appendix A) and finance 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 2 to be, the RTT Incomplete/Ongoing pathways standard, 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 continues to be flagged to Monitor, along with specific risks to achievement of the 62-day screening and 62-day GP cancer standards, and the A&E 4-hour standard, as part of the narrative that accompanies the declaration.

Recommendations

The Board of Directors are asked to **approve** the following Quarter 2 declaration for submission to the Board of Directors on 30th October 2015:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 2 to be the RTT

Incomplete/Ongoing pathways standard, 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 continues to be flagged to Monitor, as part of the narrative that accompanies the declaration;
- 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)
- Confirmation that the Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months; and
- Confirmation that the Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the forecast in the financial return.

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
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

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
28/10/15	26/10/15				

Appendix A: Monitor Quarter 2 declaration against the 2015/16 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 2 declaration of compliance with the 2015/16 Monitor Risk Assessment Framework by the 31st October 2015.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 2, 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 2 and quarter 3 to be as follows:

	Quarter 2	Quarter 3
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* 62-day GP cancer 62-day Screening cancer
Score	**3.0**	**3.0**

*Please note: these standards are no longer scored under the Risk Assessment Framework

2. Performance in the period

Table 2 shows the performance in quarter 2 against each of the standards in Monitor's Risk Assessment Framework. The following standards were not achieved in the quarter:

- A&E 4-hour standard (1.0)
- 62-day GP and 62-day Screening cancer standard (combined score of 1.0)
- RTT Incomplete/Ongoing pathways standard (score 1.0)

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.

Overall the Trust scores 3.0 against the Risk Assessment Framework, although 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 2 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 performance against the cancer standards is still subject to final national reporting at the beginning of November and therefore the position shown in Table 2 remains draft.

Quarter 3 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 2, along with the key risks to target achievement for quarter 3 2015/16. The mitigating actions that are being taken are also provided, along with the residual risk.

Although the RTT recovery trajectories were not met in July or August, progress continues to be made in reducing the total number of patients waiting over 18 weeks RTT for treatment. The number of patients waiting over 18 weeks for admitted treatment is the lowest it has been since the end of December 2013. The RTT backlog reduction trajectories were revised in September, to reflect the impact of growth in demand into outpatients and additional clinical staff not coming into post when expected. These revised trajectories have been signed-off by the Trust Board and by commissioners, and have also been sent to Monitor. The failure of the RTT Incomplete/Ongoing pathways standard in quarter 2 was forecast, and a necessary part of the recovery plan. In line with the revised recovery trajectories, the Ongoing/Incomplete RTT pathway standard is now also expected to be failed in each month in quarter 3 2015/16. The failure of the admitted and non-admitted RTT standards (but not the Incomplete/Ongoing pathways standard) was declared in the Monitor Annual Plan.

The A&E 4-hour 95% standard was achieved in July (95.5%) and narrowly missed in August (94.95%). However, performance deteriorated sharply in September, in association with the rise in delayed discharges on the BRI site, resulting from new providers of domiciliary care packages not being up to full capacity, and an acute shortage of social workers. In addition, the Children's Hospital experienced a 9% increase in emergency admissions, above levels seen in the same period last year. These system risks continue to be at play in quarter 3.

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 a high proportion of breaches resulting from patient choice and other causes outside of the Trust's control. A total of six patients (four breaches in accountability terms) were not treated within 62 days of referral in quarter 2. The reasons for the breaches were: patient choice (2 patients), late referral to the Trust (1 patient), surgical capacity (1 patient), delayed outpatient appointment (1 patient) and a breach at another provider following timely referral (1 patient). The capacity problems experienced within the colorectal service during quarter 2 are in the process of being fully resolved, but will also impact on quarter 3. 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 3, 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 Quality and Outcomes Committee is to declare the standards failed in quarter 2 2015/16 as being: the RTT Incomplete/Ongoing pathways standard, 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 and the A&E 4-hour standard, for the reasons set-out in section 3 above.

Table 2 Summary of performance in quarter 2 2015/16, and the risks to quarter 3 compliance

Indicator	Score	Achieved in Q2 2015/16?	New risks to Q3 2015/16?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for incomplete pathways	1.0	No – 92% standard failed each month; although backlog reduced over the quarter	Yes – higher levels of demand	- Non admitted RTT treatments difficult to plan because an RTT clock may or may not stop at each outpatient attendance; - Longer than planned waits for first outpatient appointments in dental specialties in particular, due to recruitment challenges and loss of capacity; - Ongoing growth in outpatient demand above planning assumptions; - Higher than predicted paediatric emergency admissions which may result in elective cancellations in Q3; - Additional new outpatient appointments put in place to shorten waiting times for non-admitted pathways, will continue to create a 'bulge' in the elective (admitted pathways) waiting list in the short-term.	- Revised trajectories developed and being implemented, to reflect rising demand and clinician appointments not being made as planned; additional activity being delivered in quarter 3 in line with these trajectories; - Waiting list transfers to other providers (e.g. Independent Sector Treatment Centre) where possible and appropriate; - Validation of long waiters to improve data quality and waiting list management; - 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 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.

A&E Maximum waiting time 4 hours	1.0	No – although 95% standard achieved in July.	No – Ongoing risks from Q2	- Delayed Discharges rose sharply during August due to previously flagged risk related to changes in providers of domiciliary care packages and also an acute shortage of social workers; - Levels of emergency admissions via the Emergency Department into the Bristol Children's Hospital in September 7.9% above same period last year and therefore significantly above plan; - Performance trajectory based upon impact of system-wide actions not forecasting achievement of 95% standard in Q3.	- Escalation of risks relating to delayed discharges to partner organisation Execs; - Continued implementation of wide ranging system-wide Resilience Plan, supported by additional funding; - Further Transformation efforts focused on discharges earlier in the day, and improving flow within the Children's Hospital; - Additional 10 to 18 beds at the BCH now likely to be able to be kept open with improvements in nurse staffing levels following new intake of nurses in September.	High	High
Cancer: 62-day wait for first treatment – GP Referred	1.0	No – although internal pathway performance, and performance, taking account of late referrals, above 85%,	Yes – impact of colorectal capacity shortfall	- High levels of late tertiary referrals - High levels of medical 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	- Cancer Performance Improvement Group overseeing action plan, which includes development and implementation of 'ideal timescale' pathways and offering patients a first appointment within 7 days, wherever possible; - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work; - Patients on the cancer patient	High	High

				cancellations - Awareness raising campaigns likely to continue to increase demand	tracking list continue to be actively managed, with oversight of the waiting list through divisional and Trust-wide weekly meetings, and any delays escalated to Divisional Directors and Chief Operating Officer; - Further focus on staff recruitment and retention of nurses 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% (50% of breaches outside of the control of the Trust)	Yes – impact of colorectal capacity shortfall	- Following the transfer of the Avon Breast Screening Service in quarter 2 2014/15, the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, unlike bowel which nationally performs well below the 90% standard; - All bowel screening pathways originate at the Trust, and capacity constraints at other providers will have a knock-on impact on performance for shared pathways; - Patient choice in bowel screening pathway; - Numbers of cases reported	- Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored; - Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers; - Need for additional elective capacity for colorectal surgery continuously reviewed; - All CT colon scanning and reporting delays escalated, 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; - Capacity and demand review undertaken for colorectal service	High	High

				under this standard are now low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact. - In Q2 some breaches incurred due to a shortfall of colorectal capacity; the impact of this will be felt during Q3.	to inform medium-term business plan whilst additional sessions are put in place in the short-term to meet demand.		
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 colorectal and hepatobiliary services - 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 wait for subsequent treatment - subsequent radiotherapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day	1.0	Yes	No	- Peaks in demand from	- Book dates for surgery at least 7	Moderate	Low

wait for first definitive treatment				emergencies for ITU/HDU beds, resulting in cancellations of surgery - Current shortfall in colorectal surgical capacity, in the process of being addressed	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.		
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 by the commissioners to be potentially avoidable.	No	- Flat profiling of annual target continues to be imposed by Monitor; - Bristol community is an outlier for antibiotic prescribing	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application has been implemented - Use of Fidaxomicin to treat patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any	Low	Low

					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

Appendix 1 – Learning Disability Access Criteria

Criteria	Trust evidence
1. Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• The Trust has a clinical alert system which has approximately 3,000 patients registered and is managed by the learning disabilities Nurse/team. This system has proven to be an effective way of identifying known patients with learning disabilities when accessing both inpatient and outpatient services • The Trust has an informative learning disabilities internal web page which includes referral pathways and documentation tools to support assessments, implementation and reasonable adjustments. The learning disabilities risk assessment gives opportunity for staff teams to record all reasonable adjustments made against the identified needs • When individuals with learning disabilities are referred to the learning disabilities team from carers or external providers (local authority), the team is able to support pre-planned admissions and make reasonable adjustments according to identified needs. As a Trust we are able to provide multiple procedures under one general anaesthetic, bringing diverse teams together as required for treatment and/or investigations
2. Does the NHS foundation trust provide readily available and comprehensive information to patients with learning disabilities about the following criteria: - Treatment options - Complaints and procedures and - Appointments?	• The Trust has a series of `Easy Read' leaflets. Easy Read uses pictures to support the meaning of text. It can be used by a carer/staff teams in support of the decision making process regarding treatment and care • The Trust 'Easy Read' range includes: ➢ Healthcare and treatment options ➢ Consent ➢ How to contact patient support and complaints team ➢ Going into hospital and what happens ➢ Learning disabilities liaison nurse ➢ Being discharged from hospital • The Trust has various appointment letters to support individuals individual needs
3. Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• The trust has a `Welcome pack' which profiles the Trust providing a range of information around admission and orientation when visiting • The learning disabilities risk assessment has a section to identify the needs of family and carers to ensure reasonable adjustments are made for them as well

	as the individual receiving direct care • The learning disabilities team provide support to all carers identified for individuals accessing both inpatient and outpatient services and continues from preadmission through to discharge planning. • The Trust has a Carers' Strategy and Carer support worker to support the needs of carers
4. Does the NHS foundation trust have protocols in place to routinely include training on providing health care to patients with learning disabilities for all staff?	• The Trust `essential training' programme including at Trust induction learning disabilities awareness training for non-clinical and clinical staff and includes medical staff • The LD nurse delivers custom made training to meet the needs of existing staff groups as required • Annual training events are hosted for link nurses to support their knowledge and skills in caring for patients with learning disabilities
5. Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• The Trust consults with Learning Disability user groups when strategies and Easy Read materials are in draft format for comments • The Trust provides annual training events whereby users groups attend and receive training around health needs, procedures and support systems available when accessing acute services
6. Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	• The Trust has a Learning Disabilities Strategy that informs the work plan for the Steering Group and sets the standards • Service delivery and outcomes are captured by the learning disabilities team and are incorporated into Trust and divisional objectives • The learning disabilities team monitor monthly the risk assessment and reasonable adjustment compliance to deliver the CQUIN and ensure best care • The Learning Disability Steering Group reports to the Patient Experience Group

Appendix 2 – Draft declaration

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.

Key:
must complete
may need to complete

Target or Indicator (per Risk Assessment Framework)		Annual Plan				Quarter 2			
		Threshold or target YTD	Scoring Per Risk Assessment Framework	Risk declared	Scoring Per Risk Assessment Framework	Performance	Declaration	Comments / explanations	Scoring Per Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	i	92%	1.0	Yes	1	90.2%	Not met	Averag for quarter 90.4%	1
A&E Clinical Quality - Total Time in A&E under 4 hours	i	95%	1.0	Yes	1	94.0%	Not met	Achieved 95.5% in July	1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	i	85%	1.0	Yes	1	81.5%	Not met	Subj to national reporting	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	i	90%	1.0	Yes		79.5%	Not met	Subj to national reporting	1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation	i					81.5%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation	i					79.5%			
Cancer 31 day wait for second or subsequent treatment - surgery	i	94%	1.0	No		95.6%	Achieved	Subj to national reporting	
Cancer 31 day wait for second or subsequent treatment - drug treatments	i	98%	1.0	No	0	98.6%	Achieved	Subj to national reporting	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	i	94%	1.0	No		96.8%	Achieved	Subj to national reporting	0
Cancer 31 day wait from diagnosis to first treatment	i	96%	1.0	No	0	96.6%	Achieved	Subj to national reporting	0
Cancer 2 week (all cancers)	i	93%	1.0	No		96.5%	Achieved	Subj to national reporting	
Cancer 2 week (breast symptoms)	i	93%	1.0	N/A	0		Not relevant		0
C.Diff due to lapses in care (YTD)	i	22.5	1.0	No	0	3	Achieved		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)	i					16			
C.Diff cases under review	i					3			
Compliance with requirements regarding access to healthcare for people with a learning disability	i	N/A	1.0	No	0	N/A	Achieved		0
Risk of, or actual, failure to deliver Commissioner Requested Services		N/A	Report by Exception	N/A			No		
Date of last CQC inspection	i	N/A		N/A			08/09/2014		
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)	i	N/A		N/A			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		N/A			No		
Overall rating from CQC inspection (as at time of submission)	i	N/A		N/A			Requires improvement		
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		

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A There are three targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 2. These are: the A&E 4-hour standard, the RTT Incomplete pathways standards, and the combined 62-day GP and 62-day screening cancer standards.

The Trust performed at 94.0% against the A&E 4-hour standard in the period, against the recovery trajectory for the quarter of 95.0%, having achieved the 95% national standard for the month of July. Two factors affected performance against the standard in the month of September, which resulted in the 95% standard being failed for the quarter as a whole. These were 1) the increase in emergency admissions into the Children's Hospital in the period, at 9% 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 peaking at 80 during the period, as a result of insufficient domiciliary care packages and an acute shortage of social workers. The risks associated with the re-commissioning of domiciliary care packages within the community, from 51 to 4 providers, was flagged to Monitor in the Q1 declaration and in routinely monthly reporting. 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, with additional actions being taken to address delayed discharges and improve the ability of partner organisations to respond to demand.

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. 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 continued to implement its backlog reduction plans, with trajectories having been revised in September to take account of unexpected delays in clinical appointments and heightened growth in outpatient referrals. The admitted over 18-week backlog is now at the lowest level it has been since December 2013. A further period of planned failure of the standards during quarter 3 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) and tumour site case-mix. 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 of 2014/15 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 2 a total of 4 breaches of standard in accountability terms were incurred, taking performance below the 90% standard. Breach analysis demonstrates half of the screening breaches were for reasons outside of the control of the Trust, including patient choice, late referral and breach at another provider following timely referral. There were also breaches attributable to an unforeseen increase in demand, at the time of a period of extended unplanned leave by one of the clinicians. A capacity and demand review has been undertaken and plans are being implemented to increase the service capacity in the short and medium term.

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board
30th October 2015
Agenda Item 15

QUARTER 2 MONITOR SUBMISSION – FINANCIAL COMMENTARY

Director of Finance
October 2015

1. EXECUTIVE SUMMARY

The Trust reports an EBITDA surplus of £16.083m for the period, £0.329m lower than plan. The income and expenditure statement shows a net surplus of £4.855m after technical items, £4.116m higher than plan. This is primarily due to an impairment reversal of £4.394m in the month relating to the disposal of the BRI Old Building in September. Before technical items, (donation income £2.441m, net impairment reversal £3.109m and donated asset depreciation £0.747m), the Trust reports a surplus of £0.052m for the period to date against a planned surplus of £0.363m.

The Financial Sustainability Risk Rating (FSRR) for the period is 3 (actual 3.25) against the planned FSRR of 4 (rounded up, 3.5 actual). The reduction in the FSRR against plan is due to the Trust's reported net income and expenditure position of £0.052m surplus (before technical items) against a planned surplus of £0.363m. The £0.311m adverse position against plan reduces the "variance in I&E margin" metric rating from a planned metric rating of 4 to an actual rating of 3.

		30 September 2015	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		14.14	15.17
Metric Rating	25%	4	4
Capital Servicing Capacity			
Metric Result – times		1.86	1.83
Metric Rating	25%	3	3
Income & expenditure margin			
Metric Result		0.75%	0.59%
Metric Rating	25%	3	3
Variance in I&E margin			
Metric Result		0.0%	(0.16)%
Metric Rating	25%	4	3
Overall FSRR		**3.5**	**3.25**
Overall FSRR (rounded up)		**4**	**3**

2. NHS CLINICAL INCOME

NHS Clinical Income is £0.089 higher than the plan at £246.564m. NHS Clinical Income includes income from NHS Commissioners and Territorial Bodies.

Performance by Point of Delivery

Point of Delivery	YTD Plan £m	YTD Actual £m	YTD Variance £m
Elective Inpatients	25.945	24.832	(1.113)
Day Cases	18.586	18.192	(0.394)
Non-Elective Inpatients	43.529	43.553	0.024
Outpatients	36.978	36.180	(0.798)
Accident & Emergency	7.406	7.442	0.036
Pass Through Costs	37.100	42.878	5.778
Other NHS Clinical Income	77.021	73.577	(3.444)
Totals	246.565	246.654	0.089

i. Elective Inpatients

Elective Inpatients are £1.113m below plan. Adult Cardiac Surgery is lower than plan due to availability of critical care beds in this area. There has also been a reduction in referrals for major oesophagastric cancer cases reflected in lower than plan activity in Upper Gastrointestinal Surgery. Paediatric Cardiac Surgery is lower than plan due to delays in creating 5 day operating capacity to undertake planned growth. A change in case-mix within adult Cardiology has resulted in lower than planned performance, offset by over-performance within Day cases.

ii. Day Cases

Day Cases are £0.394m below the plan to date of £18.586m. Paediatric Surgery is lower than plan but this if offset by higher than planned activity in other specialties. Capacity issues have suppressed Endoscopy volumes, and recruitment challenges have reduced capacity within Ophthalmology.

iii. Non-Elective Inpatients

Non-Elective inpatients are broadly in line with.

iv. Outpatients

Outpatient income at £36.180m is £0.798 behind plan. Significant areas include Ophthalmology and Oral Surgery where planned growth has been delayed by slower than expected recruitment.

v. Accident & Emergency

Accident & Emergency income at £7.442m is broadly in line with plan.

vi. Pass Through Costs

Pass Through Costs are £5.788m higher than the plan to date of £37.100m. This reflects a correction in reporting of the Cancer Drugs Fund as pass through costs and an expected over-performance due to the implementation of pre-NICE guidance for Hepatology drugs

vii. Other NHS Clinical Income

Other NHS activity includes Direct Access, Radiotherapy, Critical Care, Contract Penalties, CQUINs and specialised services such as Bone Marrow Transplants (BMTs). This category is £3.444m behind the plan to date of £77.021m, reflecting the correction of Cancer Drug Fund income now shown as pass through costs.

Performance by Commissioner

The table below summarises the cumulative NHS Clinical Income variances by commissioner.

Commissioner	YTD Plan £m	YTD Actual £m	YTD Variance £m
Bristol CCG	76.163	74.127	(2.036)
North Somerset CCG	19.735	19.677	(0.058)
South Gloucestershire CCG	14.415	14.157	(0.258)
NHS England	110.355	114.918	4.563
Other South West Commissioners	15.053	15.119	0.066
Welsh Commissioners	4.691	4.382	(0.309)
Variable Estimates	(0.166)	(0.184)	(0.018)
Provider Trusts	1.021	1.009	(0.012)
Prior Year Income	0.723	2.170	1.447
Other Commissioners	4.575	1.280	(3.295)
Totals	246.565	246.654	0.089

3. NON-NHS CLINICAL INCOME

Private Patient Revenue

Private Patient Revenue is £0.415m below plan.

Other Clinical Revenue

Other Clinical Revenue at £2.739m is broadly in line with plan.

4. NON CLINICAL INCOME

Overall, non clinical income is £0.846m higher than plan primarily due to additional research grant income.

5. EXPENDITURE

Overall operating costs of £278.499m for the period to date are £0.778m or 0.3% higher than plan. Trust pay costs are £1.391m or 0.8% higher than plan and non pay costs are £0.612m or 0.6% lower than plan.

5.1 Pay Costs

Pay costs at £175.647m to date are £1.391m higher than plan. Agency costs are £2.671m higher than plan and other pay costs are lower than plan by £1.280m mainly due to vacancies.

5.2 Drugs

Drug costs at £33.374m are higher than plan by £1.582m due to activity mix and increased usage of at cost drugs.

5.3 Clinical supplies and services (excluding pass-through costs)

Clinical supplies and services costs at £20.537m are broadly in line with plan.

5.4 Supplies and Services General

Supplies and services general at £3.835m are marginally below the plan to date by £0.287m.

5.5 Other Non Pay Expenses

Other costs are £2.387m lower than plan to date. £0.351m relates to a decrease in impairment of receivables. Pass-through costs were also lower than plan by £0.491m and premises and fixed plant costs were lower than plan by £0.271m.

6. CAPITAL

The Trust recently completed a full re-profiling exercise of capital expenditure for the remainder of 2015/16. Consequently, the Trust's capital programme has been updated since the submission of the

Annual Plan in May. The re-profiling exercise has revised the 2015/16 forecast expenditure to £29.992m, which is 87.0% of May's Annual Plan of £34.469m.

The table provided below shows a comparison of the Trust's current plan with actual expenditure to date.

	6 months to 30th September 2015		
	Plan	Actual	Variance
	£m	£m	£m
Sources of Funding			
Donations	2.599	2.414	(0.185)
Disposals	14.025	14.025	-
Grants/Contributions	0.954	1.040	0.086
Cash:			
Depreciation	10.302	10.237	(0.065)
Cash balances	(17.530)	(17.766)	(0.236)
Total Funding	**10.350**	**9.950**	**(0.400)**
Expenditure			
Strategic Schemes	(5.370)	(5.589)	(0.219)
Medical Equipment	(0.929)	(0.823)	0.106
Information Technology	(1.070)	(0.736)	0.334
Estates Replacement	(0.970)	(1.060)	(0.090)
Operational / Other	(2.011)	(1.742)	0.269
Total Expenditure	**(10.350)**	**(9.950)**	**0.400**

7. STATEMENT OF FINANCIAL POSITION

The significant balance movements and variances are explained below.

7.1 Non Current Assets

The balance of £376.669m at the end of September is £10.096m lower than plan. This partly reflects the capital expenditure position but also the earlier than planned disposal of the Old building assets.

7.2 Inventories

The value of inventories held totalled £11.029m. This is £0.058m lower than plan due to earlier than expected consumption of stock and closer management of stock levels.

7.3 Trade and Other Receivables

The balance of trade and other receivables including accrued income but excluding prepayments totals £20.345m which is £0.663m above plan. The decrease in receivables, offset by an increase in accrued income, reflects the timing of raising invoices for activity.

7.4 Prepayments

The prepayment balance at the end of the six months is £3.422m. This is mainly due to payments for equipment maintenance contracts and CNST premiums.

7.5 Trade and Other Payables

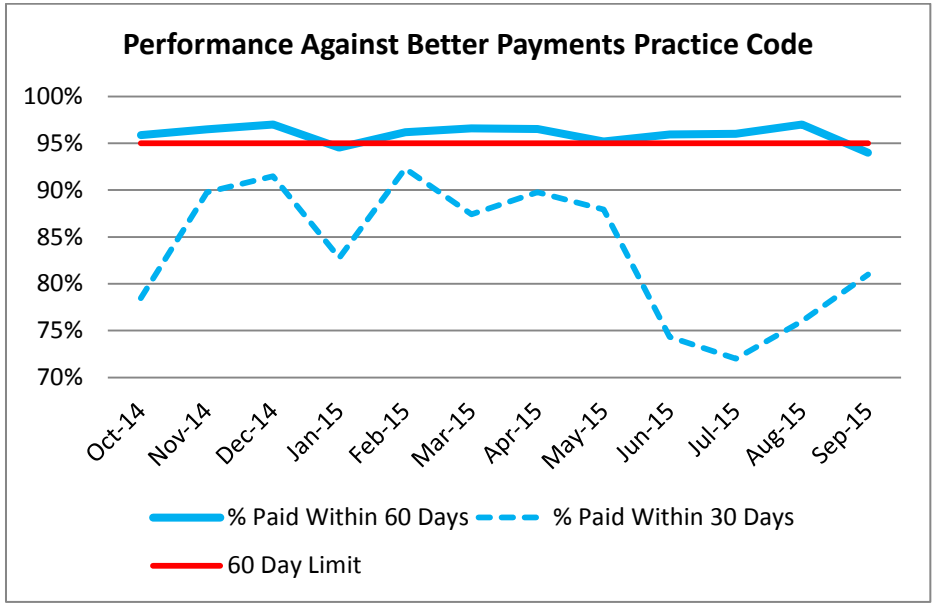
Including expenditure accruals these liabilities total £69.960m at the end of month six. This is £17.449m higher than the plan of £52.511m largely down to inter NHS trade liabilities and expenditure accruals.

7.6 Other Liabilities, Current

The balance for deferred income at £2.987m is £0.951m lower than the plan of £3.938m. This represents monies which have been received but will not be recognised as income until the appropriate conditions for expenditure have been met.

7.7 Prompt Payments Code

The Trust is a signatory of the Prompt Payments Code (PPC) requiring the payment signatories should pay 95% of invoices within 60 days and aim to move towards 30 days as a norm. In September the Trust paid 94% of invoices within the 60 day limit.



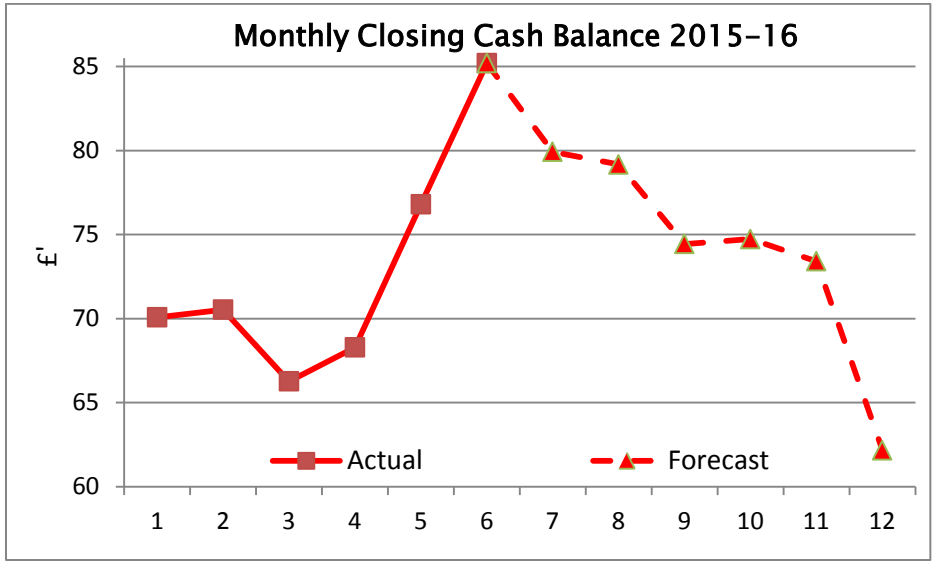
8. Summary Statement of Financial Position

A summary statement is given below showing the balances as at 30th September together with comparative information taken from the Trust's revised Annual Plan.

	Position as at 30th September 2015		
	Plan £'m	Actual £'m	Variance £'m
Non current assets total	**386.765**	**376.669**	**(10.096)**
Inventories	11.087	11.029	(0.058)
Trade, Other Receivables	19.682	20.345	0.663
Other Financial Assets	0.104	0.104	-
Prepayments	2.872	3.422	0.550
Cash & Cash Equivalents	68.238	85.201	16.963
Current assets total	**101.983**	**120.101**	**18.118**
Total assets	**488.748**	**496.770**	**8.022**
Trade and other payables	(52.511)	(69.960)	(17.449)
Short term borrowings	(6.109)	(6.108)	0.001
Other financial liabilities	(6.318)	(6.318)	-
Other liabilities incl provisions	(4.137)	(3.219)	0.918
Current liabilities total	**(69.075)**	**(85.605)**	**(16.530)**
Net current assets	**32.908**	**34.496**	**1.588**
Long term borrowings & provisions	(90.313)	(90.300)	0.013
Total assets employed	**329.360**	**320.865**	**(8.495)**
Public Dividend Capital	194.125	194.125	-
Retained Earnings	67.554	78.155	10.601
Revaluation Reserve	67.596	48.500	(19.096)
Other Reserves	0.085	0.085	-
Total Taxpayers Equity	**329.360**	**320.865**	**(8.495)**

9. Cash

The Trust held cash and cash equivalents of £85.201m at the end of September. This is £16.963m higher than the plan of £68.238m. This is primarily due to lower than planned capital expenditure and higher than planned current liabilities. The forecast year end closing cash balance is £62.166m. The graph below provides a forecast trajectory of month end cash balances.



10. 2015/16 Forecast Outturn

The Trust's projected forecast outturn remains in line with the 2015/16 revised plan submission made on the 31st July 2015 i.e. break-even before technical items. After technical items, the forecast net income and expenditure position is a surplus of £0.892, an improvement of £2.025m. This is primarily driven by the forecast increase in impairment reversals of £3.416m arising from the sale of the BRI Old Building offset by a forecast reduction in donation income of £1.455m.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
16. Board Assurance Framework – Quarter 2 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

To provide assurance that the organisation is on track to achieve its objectives for the current year.

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 details 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, 15 Amber rated objectives and 1 Red rated objective relating to organisational support with regard to the Better Care Fund.

Recommendations
The Board is asked to receive the Board Assurance Framework for assurance
Impact Upon Board Assurance Framework
Not applicable
Impact Upon Corporate Risk
Not applicable
Implications (Regulatory/Legal)
Not applicable
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**	**Risk Management Group**
				21/10/15	14/10/15

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
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 and our work with system partners.	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 including roll out of Ward Processes to all wards 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 events 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 bedded in but further opportunities exist and review being established. Progress is being on related Quality Objectives, though rated AMBER due to ongoing risks. Discharge to assess capacity established in very limited capacity due to issues with domicilary care supply. Flow transformation project ongoing, with evidence of impact. Ward Processes bundle delivering early benefit and roll out underway in Surgery Head and Neck division and BHI. Terms of Reference for review of critical care in development paused to allow for impact of a fully recruited unit to be felt. Breaking the Cycle concluded and a further Emergency Department Perfect week undertaken.	Risk that system partners do not sustain their focus on UH Bristol pathways and flow. Risk of a reduction in bed base of NBT, RUH and Clevedon during summer months. Risk relating to the recommissioning of large volume of homecare providers and significant shortfall in hospital based social work.	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	Unschedule Care & Discharge Group 23/9/15
		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	25% - 50%	New contract has been agreed with the following ongoing derogations: - Paediatric Medicine: Gastroenterology, Hepatology and Nutrition - Specialised Endocrinology - Paediatric Intensive Care Retrieval (Transport) Achievement of compliance is due in year and monitored through contract monitoring meetings.	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	Not currently applicable	DS&T	SLT via Clinical Strategy Group	23/09/2015
		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	25% - 50%	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 (end of August 2015), 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), three are amber rated (reducing appointment delays in outpatients and keep patients better informed about delays; reducing cancelled operations; and improving the management of Sepsis) and two are red-rated (minimising inappropriate patient moves between wards; and improving patient discharge). Awaiting National Standards from NHS England with regard to Paediatric Cardiac Services. The Trust are not aware of any services which are not compliant with accepted national standards.	Risk of non-acheivement of patient flow objectives.	Cancelled operations 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: CQC intelligence monitoring on a quarterly basis; and Commissioners quality meeting	A	Not currently applicable	MD / CN	SLT and CQG for CQUINs Clinical Quality Group for quality objectives;	SLT 23/9/15 Clinical Quality Group 1/10/15
		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	25% - 50%	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, medium and longer term results.	Risk of funding not being 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.	All media coverage is monitored and classified (positive/negative/neutral). Communications report to SLT on a monthly basis.	A	869	Deputy CEO	Senior Leadership Team	23/09/2015
		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.	Risk of a delay in launch of the patient safety programme due to vacancies in the central patient safety team. Risk of the failure to identify and implement effective actions and reduce harm. Risk of a lack of 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	Not currently applicable	MD	Senior Leadership Team	22/07/2015

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2	We will ensure a safe, friendly and modern environment for our patients and our staff	**2.1.** To successfully complete phase 4 of the BRI Redevelopment	Complete the ward re-furbishments in Queens Building. Complete the refurbishment of the outpatient departments in the King Edward Building. Staff Restaurant opened Q1. Identify and implement solution for office accommodation, aligned to vacation of Old Building Successfully deliver Queen's Building Façade Project	25% - 50%	Good progress being maintained on majority of schemes, however delay of transfer of pathology services to Southmead had impacted on forward programme. Delay to one three ward scheme impacting on operational performance due to slippage but not impacting on the overall 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.	Risk of failure to successfully mobilise contingency plan for clearing Old Building of all services. Risk of further delay to service transfers. Risk of the failure to address budget constraints associated with KEB work programme.	Redevelopment Board continues to have oversight of all Phase 4 risks, and is responsible for developing actions to adequately mitigate.	Project Risk Register presented to RB on monthly basis. External Gateway Review GREEN rated, providing assurance re approach to project and risk management.	G	2476 & 759	COO	BRI Redevelopment Group	02/10/2015
		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). Embed and test for revised Major Incident Plan.	25% - 50%	The Terms of reference for the Civil contingencies steering group were reviewed and amended following the Civil Contingencies steering group meeting in September 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.	Risk of a lack of input from divisions and clinical teams during periods of operational pressure.	New resilience Manager in post work programme agreed. Development of overarching EPRR strategy to bring together all aspects of this agenda. EPRR self-assessment submitted.	EPRR annual assurance process underway. Self-assessment completed and visits due for October and November 2015.	G	Not currently applicable	COO	Senior Leadership Team	Due 21/10/15
		2.3. Set out the future direction for the Trust's Estate	Agree and implement approach to future of Old Building Site	75% - 100%	Sale agreed and completed with all funds received. Vacant possession date agreed as 1st October 2015	Risk that planning permissions is not secured, for planned use. Risk of inability 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	Not currently applicable	COO	Senior Leadership Team	23/09/2015
			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 following on from pilot. 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	25% - 50%	The new leadership programme is in place and has been evaluated. As part of this review existing frontline manager training is being revised in response to feedback from staff engagement listening events. 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.	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 and is due for review end of October 2015.	Risks are managed through the Workforce & OD group and Transformation Board	A	Not currently applicable	DWOD	Senior Leadership Team 23/9/15	Transformation Board 3/8/15, Staff Enagement & Leadership sub-group 26/8/15, Workforce & OD Group 25/9/15
		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 Conducted a full census staff survey. Carry out 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. 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. Four staff engagement events have been held to date with more planned at various locations. The themes from these events have been extracted and worked upon by SLT sub-group. In September, full census survey distributed across the Trust. Quarter 4 FFT response has shown a slight improvement in staff engagement scores.	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	Not currently applicable	DWOD	SLT 5/8/15 and 2/9/15	Workforce & OD Group September 2015
		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 Procure and implement a recruitment management system which delivers the required efficiencies within the recruitment process and deliver improved management information and performance monitoring.		Areas for improvement to create efficiency were identified through the rapid improvement programme - optimising the speed of staff recruitment. The new recruitment system went live at the end of June 2015. Over 300 appointing managers have been trained. Work remains ongoing to roll out the 'vacancy authorisation end' of the system across all divisions. Work continues to identify improvements in processes and systems within the TSB. Benchmarking is underway, evaluating results from a recent survey on staff benefits, the outcomes of	Risk that the Trust fails to recruit and retain staff key staff groups due to national shortages; timeliness of recruitment and failing to address high turnover. At mid-year point, the risk appears greater around the turnover KPI than the Trust's vacancy KPI.	Recruitment group overseeing detailed plan to ensure we achieve staff numbers with OPP. WFOD Group overseeing retention/staff engagement plan. The WFOD Group escalated to SLT given the level of risk.	The Recruitment Sub-group of the Workforce and OD Group and the Workforce and OD Group.	A	2841	DWOD	Senior Leadership Team 23/9/15	Recruitment sub-group 22/9/15, Workforce & OD Group 25/9/15

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			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.	25 - 50%	which will ensure the framework is responsive and improves retention. Retention plan £200,000 for divisions to bid against development opportunities.								
			For existing staff, develop retention and reward initiatives, informed by the exit data, FFT and staff survey, including mobilisation of staff engagement plans.										
			Improve exit data to understand key reasons for leaving.										
			Develop a strong identity through innovative branded advertising solutions.										
	We will strive to employ the best and help all our staff fulfil their individual potential.	**3.4** Reward and Performance Management: Improve the quality and application of staff appraisal	Clarify role, responsibilities and objectives for all individuals and teams	25% - 50%	The Trust is working with Kallidus (IT system provider) to understand the capacity to record appraisal information including objectives and scoring; initial draft appraisal paperwork completed to inform IT design; Staff Health appraisals included in Ward Health and Safety Audits. Competencies developed for nursing roles bands 5 - 7. All of these activities will shape the work required to ensure that all staff have clarity of their role, responsibilities and clear objectives.	Risk that a reduction in the quality of appraisals are not increased due to the lack of engagement/messenging that appraisal is a continuous process, not a one-off event.	Develop better understanding of the new appraisal approach including IT capability, targetting training and coaching resources to jave maximum impact.	Risks reviewed by the Workforce & OD group	A	Not currently applicable	DWOD	Senior Leadership Team 23/9/15	Staff Engagement and Leadership Group 26/8/15
			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	25% - 50%	Aston pilot on effective team working (including team objectives) underway. Two cohorts received training on team coaching and are currently working with teams across the Trust. 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 completed and using results from a recent survey on staff benefits, an initial draft Benefits framework is currently being reviewed. It is anticipated that this work will support and improve 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	50% - 75%	Strategy signed off by Senior Leadership Team and Trust Board. New governance via Education Group and Learning & Development group in place. Work commenced to strengthen partnerships with HESW, University of Bristol and UWE.	Risk of limited external places for learners will impact on delivery of the Education Strategy	Engaged with HESW to ensure allocation of UH Bristol places for learners is increased for future intakes.	Risks reviewed by the Education Group and the Workforce & OD Group	A	Not currently applicable	DWOD	Senior Leadership Team 23/9/15	Education Group 23/8/15
			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. Divisions were able to bid against £200,000 to support development activities in clinical areas.								
			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 and will be extended to cover all aspects of this strategy. We will review the approach to ensure equity of access during 2015/16. A review of existing funding across the Trust and divisions is due to be complete by the end of the October 2015.								
		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 needs	50% - 75%	Building on training from early 2015, a pilot is planned for Diagnostic and Therapies division to share workforce planning skills, together with a Masterclass for Nurses in December 2015. Improved templates/tools for supporting operating plans 2016/17 are being developed including a joint finance/HR template. Additional tools and benchmarking sources added to HR web. Review of age profiles/trajectories within divisions highlighting gaps within groups/specialist areas.	Risk to developing workforce KPIs for vacancy, turnover and agency due to national nursing recruitment challenges.	The mid-year review in October will provide a robust assessment of risks. Mitigations including agency action plan, being led by the Chief Nurse, and recruitment action plans, being overseen by the Workforce & OD Group.	Risks reviewed by Workforce & OD Group 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.										

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4	We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**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. Start to work up and agree CSIP plans for the next phase	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	Risk that 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	Not currently applicable	DoF	Information Management and Technology Group	02/09/2015
		4.2. We will maintain our performance in initiating and delivering high quality clinical trials, demonstrated by remaining within the upper quartile of trusts within our league (as reported to Department of Health via NIHR)maintain our performance in initiating research) and remaining the top recruiting trust within the West of England Clinical Research Network and within the top 10% of Trusts nationally (published annually by NIHR)	(a) 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. (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.	25% - 50%	Overall levels of recruitment this financial year are well below levels in comparison to previous years, in part due to burden of follow up for studies initiated in 2014/15. Priority is towards effective delivery of open studies and use staffing efficiently: (a) Project identifying reasons for not meeting time and target now complete. Identified that most effective first steps are to focus on data quality for non commercial research, mirroring work already done (with good outcome) with commercial trials. Scope of first phase is non commercial research sponsored by UH Bristol. Scope to extend to non commercial research sponsored by other organisations following that. Imminent staffing pressures require moderate replanning of timelines. (b)Pending completion of (a) (c) Plan of work is ongoing; all data collected and report prepared and under review. On track.	(a) (b) Risk of competing priorities for fixed resource. R&I staffing currently under pressure; lead for the project will be leaving and there is some additional sickness absence expected to last through October. (c) Risk of a lack of high levels of expert resource required to support implementation of change, with strong buy-in from divisional management team. Absence of this will put implementation at risk.	(a) & (b) Plan to be adjusted to account for reduction in staffing; vacancy to be advertised. (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.	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	Not currently applicable	MD	Trust Research Group	July-15 - no further meetings have taken place
		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.	25% - 50%	(a) Progress update presented to BHP Executive in October 2015; incremental changes to processes across organisations taking place; small improvements in performance being seen within UHBristol. (b) High level agreement reached following stakeholder meeting in September 2015 regarding approach to BRU/BRC call when it is released. Potential themes and theme leads identified.	(a) Risk that NIHR reduces the Research Capability funding. (b) Risk that BRU/BRC call is not in the form or scale expected, particularly following comprehensive spending review.	(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. (b) Agile and flexible bid team will develop alternative strategies in parallel. Use of key contacts to develop intelligence. 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	Not currently applicable	MD	Trust Research Group	July-15 - no further meetings have taken place
		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)	25% - 50%	(a) Ongoing. Links with library service made to support activity in this area, particularly in compiling and disseminating information. (b) Ongoing engagement with band 7 research nurses to draw this information out. (c) Significant contribution made to NHS England policy making process as the result of research findings during October, expected to result in release of new policy and prescribing advice.	(a) Risk that completion rates of locally led grants is low, making momentum difficult to maintain. Staffing issues draw activity to other areas. (b) Risk that the tangible benefit difficult to quantify, reducing the likelihood of impacts being identified and reported. (c) Risk of 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. Collaboration with library services. (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	Not currently applicable	MD	Trust Research Group	Jul-15 - no further meetings have taken place
		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.		Our Operating Model programmes have established new ways of working across our hospitals; In unscheduled care we have established the Integrated Discharge hub and designed new Discharge to Asses pathways with our partners. In Planned Care we have extended the new scheduling processes and in the BHI and BHRC, and designed new pathways for emergency surgical patients to help all surgical patients get treated in the right	Risk of not fully understanding and evidencing the underlying causes and issues which require addressing. Risk of operational demands causing progress to drift. Risk of operational demands adversly	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		Not currently applicable	DS&T	Transformation Board	Transformation Board Risks reviewed on 5/10/2015

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			Deliver a theatre transformation programme to drive more efficient use of theatres, better patient and staff experience	25-50%	location. We are working with IM&T to get real time data visible in clinical areas. We have begun the roll out of a package of work with clinical teams on wards to establish best practice ward processes in day to day routines. The focus of work now is ensuring we derive measurable improvement from these changes.. The Theatres programme has engaged teams in each suite to make improvement within a Trust wide set of standards which has led to changes such as new portering arrangements and automatic patient sending to reduce start of day delays, and projects to reduce turnaround times between procedures.	affecting staff engagement and therefore improved performance is not sustained.			G				
5	We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	5.1. We will play an active roll in the urgent system with the aim of consistently achieving timely flow through our hospitals	Participate in the Better Care Fund governance to ensure programmes and projects are impacting as predicted. 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 due to issues of supply of social work and community based social care.	Risk that community partners do not engage with objectives of BCF programme. Risk of 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.	R	Not currently applicable	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	Not currently applicable	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	Not currently applicable	MD	Senior Leadership Team	22/07/2015
		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	Not currently applicable	MD	Senior Leadership Team	22/07/2015
6		**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. Performance to end of August 2015 is £0.919m adverse to plan.	Risk of failure of under performance of activity Risk of under delivery of CIPS Risk of failure to deliver performance Risk of failure to recruit and retain staff, manage staff absence resulting in high agency expenditure	Monthly Operational and Finance reviews with divisions. Finance Committee Board of Directors	Oversight by operational planning core group, monthly operational and finance reviews with divisions	G	50 872 959	DoF	Finance Committee	25/09/2015
		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 to inform strategic and business planning	50% - 75%	Quarter 4 - 2014/15 position published by October 2015.	Risk of failure to retain of staff	Finance Department staff development and succession planning.	Director of Finance oversight	G	Not currently applicable	DoF	Finance Committee	Due 26/10/15
		6.3. Deliver minimum cash balance	Maintain a liquidity metric of at least 0 days thus achieving Monitor's Risk Assessment Framework liquidity metric of rating of 4. Maintain a cash balance of no less than £15 million.	100%	Cash balance as at 31st August 2015 was £76.8 million. The revised planned year end cash balance as at 31st March 2016 is £61.6 million.	Risk of failing to deliver financial plan	Monthly cash flow projections and liquidity performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Monthly reporting to Monitor.	G	Not currently applicable	DoF	Finance Committee	Due 26/10/15
		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.		Focus of work programme reviewed and Savings Board being "reinvigorated". Workstream Terms of Reference clarified	Risk of 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 Reports to Savings Board and Finance Committee.			COO	Savings Board	21/09/2015

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
	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		Develop robust CIP plans to ensure annual CIP is delivered in 15/16 in addition to carry forward shortfalls from 14/15 and ensure plans for 16/17 are developed in a timely way.	25% - 50%	Work started. Terms of reference clarified. Renewed focus on CIP pipeline at Divisional level on an ongoing basis.		there in. Monthly Divisional CIP Review meetings to monitor progress of current plan and ensure recovery actions if required.	Annual Internal Audit Report External benchmarking to provide assurance on Trust approach taken.	A	741 959			
		6.5. Ensure 2015-16 Operating Plans addresses risks to sustainability	Ensure 15/16 Operating Plans are robust and subsequently reviewed at Quarterly Reviews where risks are identifed at an early stage and plans to mitigate and/or recover developed.	25% - 50%	Monthly and Quarterly Divisional review format, function, and paperwork recently revised, changes evaluating well.	Risk that plans are unable to be implemented due to factors outside Trust control such as failure to recruit.	Monthly and quarterly operational and finance reviews flag early warning to risks to delivery, which in turn require recovery plans to be developed for review and implementation.	Deloitte Well Led Governance Review provided external assurance on this objective. Reports to monthly operational and finance reviews.	G	Not currently applicable	COO	Senior Leadership Team	23/09/2015
		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.	25% - 50%	Well Led Governance review task and finish activity defined and in train to ensure effective strategy governance. Phased programme of strategic activity agreed. Current phase of CIP activity on target to deliver by 31st October 2015. Individual strategic initiatives/opportunities being evaluated as presenting (CAMHS, SBCH, Acute Services Model of care, Education & Research and innovation strategies through the Strategic Implementation Planning work). Clinical Strategy Group being re-launched to cover the full scope of the Trust strategy.	Risk of lack of capacity across the Bristol Health and Well Being System to collaborate in strategic activity for the benefit of Bristol patients.	Review our partnership activity as part of routine monitoring and reporting; proposals in development to increase the impact of this work.	Senior Leadership Team	G	Not currently applicable	DS&T	Senior Leadership Team	23/09/2015
		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.	25% - 50%	Joint project underway with Finance Team to review controls around overseas and private patients. PP post held pending outcome of review.	Risk of a lack of resilience in this area until review completed and post recruited into.	Development of post which is attractive to potential candidates	Progress reports to SDG and Finance Committee.	A	Not currently applicable	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, Capital Servicing Capacity, Income and Expenditure margin, and variance in income and expenditure margin metrics in line with the 2015/16 revised plan.	50% - 75%	FSRR at 31st August 2015 is 3. The current forecast outturn for 2015/16 is a FSRR of 4.	Risk of not succeeding in the delivery of CIP plans, a reduction in premium cost services. Improvement in workforce retention, recruitment and management of absence is a pre-requisite to delivering a reduction in agency expenditure and delivering contracted clinical activity to secure income in line with Commissioners SLAs and the Trust's 2015/16 planned income.	Monthly Operational and Financial Reviews chaired by COO with Exec Director support. Monthly FSRR performance reported monthly to Finance Committee.	Monthly reports to Finance Committee and Trust Board. Monthly reporting to Monitor via Finance Committee and Trust Board.	G	50 872 959	DoF	Finance Committee	25/09/2015
		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	25% - 50%	A&E trajectory not achieved in Q1 or Q2, although performance above 95% for two consecutive months (June and July). 62 day cancer standard remains at risk, but performance improving by quarter and internal performance above 85% for Q2. RTT admitted backlog continues to improve, but non-admitted backlog reduction has stalled due to increases in referrals and delayed appointments (outside of the control of the Trust). RTT medway migration plan being actively managed, although recent refresh to timeline for implementation due to scale of task to update historic pathways and need for further enhancement to Medway to facilitate RTT pathway management.	Risk that activity exceeds plans and 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	801	COO	Senior Leadership Team	23/09/2015
	We will ensure we are soundly governed and are compliant with the requirements of our regulators	**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.	25% - 50%	Final report received for Board review in July. Board seminar work undertaken to identify key themes for action and improvement. Board level task and finish groups, led by a Non-Executive and Executive lead, established to monitor actions and outcomes. Regular reporting to the Board in progress with a view to incorporating outcomes into 'business as usual' by 1st April 2016.	Risk of a lack of commitment due to other priorities to push forward trust wide change and improvement. Risk of a lack of resource to support the required actions.	Establishment of task and finish groups led by Neds and Execs and with support from senior managers. Implementation of actions and accountability at the lowest level of possible to ensure resource is effective.	Regular updates to Trust Board	A	1854/ 2619	Deputy CEO	Board of Directors for Well Led Review oversight Risk Management Group for DMS oversight	30/9/15 Due 14/10/15
			To agree direction of travel for Trust Document Management System and agree plan for forward approach.	0% - 25%	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.	Risk that the infrastructure for the new Document Management System and Procedural Document Framework remains not fit for purpose, or is not complete before the end of the year.	DMS Administrator in post and reviewing all documentation in the interim prior to transfer. DMS working group established, reporting to Risk Management Group. 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.	Quarterly Updates to Risk Management Group					

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
		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) Implement the revised CQC compliance assurance process and ensure ongoing compliance	75% - 100%	Inspection plans have been closed with agreement of Senior Leadership Team and Quality and Outcomes Committee. Remaining actions have been subsumed into 'business as usual' (for UH Bristol and for Bristol Urgent Care Working Group) and will be reviewed in March 2016. An internal audit is currently testing robustness of assurances that resulted in consensus to close. Clinical Quality Group is routinely monitoring compliance with CQC fundamental standards; each month, the group receives a detailed report on one standard and exception reports for all others.	Risks that assurances which led to the closure of inspection action plans were not sufficiently robust. Risk that governance arrangements are not robust to facilitate adequate oversight of ongoing compliance.	Fundamental standards assurance is monitored monthly by Clinical Quality Group.	Fundamental standards assurance is monitored monthly by Clinical Quality Group	G	Not currently applicable	CN	Clinical Quality Group Quality & Outcomes Committee	CQG 1/10/15 QoC 28/7/15
		7.5. Agree clear recovery plans by specialty to delivery RTT performance for admitted, non-admitted and on-going pathways	To achieve compliance with the national RTT standard of 92% of patients on an on-going pathway waiting less than 18 weeks, from January 2016 and maintain thereafter.	25% - 50%	At the end of August 2015 the Trust had reduced the backlog of over 18 week admitted waiters down from 1450 to 1155. The non-admitted backlog has however grown (from 1619 to 1973), due to an increase in outpatient referrals and additional capacity not able to be put in place due to delayed appointments. For this reason the RTT backlog trajectories have been revised for the year, with achievement of the ongoing standard moved from September 2015 to January 2016.	Risk of continued increase in outpatient referrals, as recently evidenced. Difficulties in 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 challenges in recruitment.	Divisions review options for increasing/restoring capacity, which has fed into the recent review of trajectories. 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	1051	COO	Senior Leadership Team	23/09/2015
		7.6. Improve cancer performance to ensure delivery of all key cancer targets	Delivery of Internal milestones within the Cancer Improvement Plan and Trust recovery trajectory for performance. To work through the Tripartite to agree and implement a pan-BNSSG Cancer Performance Improvement Plan.	50% - 75%	Action plan in place and on track. Performance ahead of trajectory.	Risk of late referrals from other providers remains the leading cause of breaches in the 62 day GP standard. Medical deferral and clinical complexity are also increasing and result in a high proportion of breaches. Critical care capacity and temporary shortfalls in operating capacity also impact on performance.	Leading on work to redesign cancer pathways, sharing this with other providers to support agreement of timely referral milestones. The BNSSG Cancer Working Group is in place and meets regularly. The Trust is well represented and an active member. Plan to improve critical care recruitment and retention in place. Actions also being taken to identify co-morbidites earlier in the pathway.	Weekly cancer performance assurance meeting chaired by the Associate Director of Performance. Performance Improvement Plan managed through Cancer Performance Improvement Group (CPIG) with escalation to the Cancer Steering Group and SLT.	G	1412	COO	Senior Leadership Team	23/09/2015

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

Report Title									
17. Corporate Risk Register									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive Author: Debbie Henderson, Trust Secretary and Sarah Wright, Risk Manager									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The CRR contains all risks which attract a current risk score of 12 or greater. This is a change to the former arrangements whereby only those risks of 15 or greater were included in the CRR. The risks reflect Divisional risks which continue to attract a score of 12 or greater, following reassessment in a corporate context.

Key issues to note

There are 13 risks on the Corporate Risk Register as follows:

New Corporate Risks:

- 423 Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy;
- 674 Risk of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff;
- 793 Risk of work related stress affecting staff across the organisation;
- 801 Risk that the Trust does not maintain a GREEN Monitor Governance Rating;
- 872 Risk of non-delivery of contracted levels of clinical activity;
- 888 Risk of failure to deliver the agreed recovery trajectories for all RTT standards;
- 919 Risk that the Trust does not meet the national standard for cancelled operations;
- 959 Risk that Divisions do not achieve the required level of cost efficiency savings;
- 961 Risk of harm to patients awaiting discharge, once medically fit;
- 964 Risk of non-compliance with Department of Health Alert related to window restriction; and
- 1145 Risk that patients' requiring domiciliary care may have a delay in their discharge due to reduced service capacity

Amendments to Corporate Risks

- 423 Risk amended to ‘Quality’ domain from ‘Business’ and Moderate x Likely (12) from Major x Possible (12);
- 932 Risk domain amended to ‘Statutory’ from ‘Quality';
- 959 Risk amended to Major x Likely (16) from Major x Possible (12); and

- 1145 Risk amended to Moderate x Almost Certain (15) from Moderate x Likely (12)

The Trust operates within a high overall range of risks broken down into the following domains in line with the National Patient Safety Agency model:

Domain	Definition
Safety	Impact on the safety of patients, staff or public
Quality	Impact on the quality of our services (includes complaints and audits)
Workforce	Impact upon our workforce (excluding safety), organisational development, staffing levels and competence and training
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections
Reputation	Impact upon our reputation through adverse publicity
Business	Impact upon our business and project objectives (service and business interruption)
Finance	Impact upon our finances
Environmental	Impact upon our environment, including chemical spills, building on green field sites, and our carbon footprint

The Trust's lowest risk appetite is for safety risks. This means that reducing these risks in so far as is reasonably practicable will take priority over meeting our other business and strategic objectives. Therefore, the Trust has a lower willingness to accept risks which sit within the safety domain therefore the majority of risks detailed on the Corporate Risk Register will relate to safety risks.

Recommendations

The Board are asked to review the content of the Corporate Risk Register and receive the document for assurance.

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	**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)
28/10/15				21/10/15	14/10/15

Corporate Risk Register 20/10/2015

							Inherent				Controls		Current				Actions Summary		Target					Review
ID	Division	Risk Domain	Manager	Executive Lead	Title	Description	C	L	S	Risk level	Controls in place	Adequacy	C	L	S	Risk level	Action	Due date	C	L	S	Risk level	Review date	
423	Trust Services	Quality	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Chief Operating Officer	Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy	Risk that length of stay does not reduce in line with plans resulting in increased occupancy that impacts on flow, ED performance, staff workload and patient experience. Links to following risks: 766 - Delays in discharge or transfer to community services; 759 - Redevelopment Programme not to time; 2168 - CSP; 1798 - Emergency admissions above bed capacity.	Major	Likely	16	Very High Risk	- Constant work with system partners to support timely discharge of patients who are medically fit for discharge - transformation programme to support effective and timely discharge -Board rounds, enhanced recovery, day of admission initiatives, improved day surgery rates, accelerated discharge, TTAs, access to pathology, order comms, review of ED rota, review of medical model of care for general medicine take. Whole system approach to be developed through Urgent Care Board. Drive to reduce Length of Stay and improve bed efficiency. Weekly system wide operational group, Acute Services Transfers - city wide group, Daily monitoring of activity levels throughout the Frenchay move (using SPC charting)	Inadequate	Moderate	Likely	12	High Risk	Continue to work with partners to improve timeliness of discharge from hospital (see risk 766) Simon Chamberlin: Work with partners through the Urgent Care Group on an agreed integrated action plan to deliver system wide improvement. Within this, deliver the internal Unscheduled Care Operating Model project scope to improve flow through our wards.	31/07/2015 31/10/2015	Moderate	Unlikely	6	Moderate Risk	29/01/2016
674	Trust Services	Workforce	Donaldson, Sue - Director of Workforce and OD	Director of Workforce & Organisational Development	Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff	A risk of increased costs for recruitment, agency and bank cover, low staff morale and staffing levels due to an increase in turnover and inability to fill vacancies without staffing gap. Turnover is considerably above the benchmark and are continuing to increase and recruitment into many areas is challenging.	Moderate	Likely	12	High Risk	Review at Workforce and OD Group, Divisional Reviews, QOC, Trust Board. Identification of reasons for leaving through exit process Engagement Action Plan Retention Action Plan to Workforce and OD Group 25 September 2015 Improve the Trust's recruitment branding and benefits package with a particular focus on areas which are difficult to recruit to , 2) Recruit for values as well as skills, 3) Ensure there is a clear understanding of reasons for staff leaving the Trust and taking action where appropriate, 4) Align recruitment with workforce planning to ensure staff are recruited in a timely way, 5) Strengthen the infrastructure within the Recruitment team and locally within Divisions to increase the speed of conversion to hire, 6) Establish rigour in reporting real-time vacancy positions for each staff group in each Division, 7) Strengthen supply of temporary staff from the Bank, 8) Annual review of age profile across professions as part of the Divisional Operating plan cycle	Inadequate	Moderate	Likely	12	High Risk	Rebecca Ridsdale: Understanding reasons for leaving Develop a range of retention incentives as part of an overall work programme Helen Morgan: Pre and post Induction Support Jo Witherstone: Career Progression for nursing roles.	31/01/2015 31/01/2015 30/09/2015 30/09/2015	Minor	Possible	6	Moderate Risk	11/01/2016
793	Trust Services	Health & Safety	Donaldson, Sue - Director of Workforce and OD	Director of Workforce & Organisational Development	Risk of work related stress affecting staff across the organisation	Our staff are at risk of work related stress with evidence from staff surveys and occupational health information that this is affecting a wide range of different staff. Impact is on both individual and service, when staff are not able to work fully or at all.	Moderate	Almost certain	15	Very High Risk	Annual audits are conducted to check that each ward or dept. has conducted the stress check list and proceeded to a risk assessment as required by law, All dept. managers where stress is recognised as a risk are advised to implement the HSE management standards and proceed to the HSE questionnaire process, facilitated by the Safety Dept., The annually completed Staff attitude survey looks at 10% of the workforce and includes work related stress as part of the question set. An action plan is then formulated at Trust and Divisional level, Conflict resolution training is delivered to all clinical staff described in the NHS protect target audience and offered to those that are non clinical dependant on role/ location	Inadequate	Moderate	Likely	12	High Risk	Safety dept team to continue to facilitate HSE process as felt by those completing to be worthwhile. Action plan is produced and where possible the ward/ dept. manager takes actions forward Resilience building utilising two extended modules from the 5 module Lighten up programme, namely Making changes and Identifying and managing stress being rolled out to a maximum of 300 staff - 150 places per module. This will be followed by full evaluation and consideration of further opportunity to deliver in the next financial year	31/12/2015 01/07/2015	Moderate	Possible	9	High Risk	30/04/2016
801	Trust Services	Statutory	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Deputy Chief Executive	Risk that the Trust does not mainain a GREEN Monitor Governance Rating	Prolonged failure of one of the following performance indicators, or concurrent failure of 4 or more indicators leading to loss of green status in Monitor Governance risk rating: Referral to Treatment Time Standards Cancer Standards ED Standards (A&E 4-hours) Healthcare Acquired Infections	Major	Likely	16	Very High Risk	RTT Steering Group (monthly and weekly), Cancer Steering Group, Project plans for new Operating Model 2014/15 being overseen via the Senior Leadership Team (SLT). Weekly reporting against performance indicators and escalation to Steering Groups, Service Delivery Group and Senior Leadership Team as appropriate. Oversight of A&E performance and recovery within Emergency Care Access Steering Group	Inadequate	Major	Possible	12	High Risk	Engage in joint work with Monitor Improvement Directorate on cancer 62 day standard Develop action plan from Deloitte Well Led Governance Review and submit to Monitor Undertake Monthly monitoring calls with Monitor	30/09/2015 30/09/2015 31/03/2016	Major	Rare	4	Moderate Risk	04/11/2015

Corporate Risk Register 20/10/2015

							Inherent				Controls		Current				Actions Summary		Target					Review
ID	Division	Risk Domain	Manager	Executive Lead	Title	Description	C	L	S	Risk level	Controls in place	Adequacy	C	L	S	Risk level	Action	Due date	C	L	S	Risk level	Review date
872	Trust Services	Financial	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Chief Operating Officer	Risk of non-delivery of contracted levels of clinical activity	There is a risk that activity is not delivered in line with the contracted levels, which has the potential to impact upon delivery of access standards, income recovery against plan and patient experience.	Major	Likely	16	Very High Risk	Monthly contract activity reviews, Monthly Divisional Performance Reviews.	Inadequate	Major	Possible	12	High Risk	Sarah Nadin: Develop recovery plans for underperforming specialities	31/07/2015	Moderate	Possible	9	High Risk	23/12/2015
888	Trust Services	Quality	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Chief Operating Officer	Risk of failure to deliver the agreed recovery trajectories for all RTT standards	Risk to the delivery of agreed recovery trajectory and thus trust performance as a result of potential increased demand, or reduction in capacity or resources. Issues include lack of sub-specialty operating capacity, increase in the volume of ongoing pathways since the introduction of Medway, change in process of applying RTT events since introduction of Medway and volume of long waiting patients transferred to the Trust in Head and Neck specialties increasing outpatient waiting times.	Major	Likely	16	Very High Risk	-Weekly review of patients waiting 13 weeks and over, paused patients and planned over-due via RTT Operational Group; Divisions to report back with progress and action plans for dating all patients -Validation of patients approaching and over 18-weeks by clinical divisions, Validation team in post to provide additional support to Divisions, but also identify data quality issues that can be fed-back to Divisions -Delivery plans in place for under-performing specialties, based upon outputs of IMAS capacity & demand modelling, Correct level of activity commissioned, to enable backlog to be cleared in 2015/16 -Migration Plan developed to move to direct reporting of RTT pathways from Medway, which will improve Divisions' access to real-time pathway data and reduce burden of validation, Monthly RTT Steering Group reviewing progress with enacting recovery plans, and considering strategic options for managing RTT in the future -Roll-out of RTT training Trust-wide, to improve understanding around the RTT rules application, and management of RTT pathways -Weekly specialty-level monitoring of RTT backlogs against trajectory, with escalation to monthly Divisional Review meetings	Inadequate	Major	Possible	12	High Risk	Move to direct reporting of RTT performance from Medway. Centralisation of Outpatient Administration Train Staff in RTT Management, Data Capture and Access Policy Develop data quality metrics as part of the migration to Medway direct RTT reporting.	31/12/2015 31/12/2015 31/10/2015 31/10/2015	Major	Unlikely	8	High Risk	31/12/2015
919	Trust Services	Quality	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Chief Operating Officer	Risk that the Trust does not meet the national standard for cancelled operations	Risk that the Trust does not meet the national standard for cancelled operations resulting in poor patient and staff experience, adverse impact on access standaards and contractual penalties.Risk of cancelled operations arisies from multiple sources including lack of ward beds, critical care beds, booking errors, theatre over runs.	Moderate	Likely	12	High Risk	Twice monthly monitoring at the EA-PIG and the SDG meeting monthly. Reported monthly to the Trust Board and reviewed at monthly performance monitoring meetings., Three times daily patient flow meetings supporting proactive management of cancellations with review of all elective admissions on a daily basis. Weekly operational meetings to validate cancellations and review action plan., Productive theatre initiative successfulyl brings on additional controls over theatre utlisation increaidng capacity and reducing canclations, Protocol for use of intensive care between cardiac and surgical teams resulting in immediate reduction of canclaations of cases due to shortage of bed Protocol agreed with medical director for priority use of ITU beds and embedded from 23/12/2010, Additional ITU capacity planed for 2011 with interim capaity in 2010, Programme of work to improve patient flow in the Trust will reduce the risk of cancellations due to lack of beds. Paper presented to Service Development Group on cancelled ops and all divisions developing a plan to tackle., All Division have implemented a new escalation process such that LMCs can only be approved by a DM, HoD or HoN.	Inadequate	Moderate	Likely	12	High Risk	Children;s Flow Programme to improve planning, communication and decision making to reduce LMCs	30/11/2015	Minor	Rare	2	Low Risk	04/11/2015
932	Trust Services	Statutory	Whittaker, Xanthe - Associate Director of Performance/ Deputy Chief Operating Officer	Chief Operating Officer	Risk of failure to deliver care that meets National Cancer Waiting Time Standards	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.	Major	Almost certain	20	Very High Risk	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., Cancer performance action plan in place and reviewed at fortnightly Cancer Performance Improvement Group, with new actions identified and added regularly., Ongoing efforts to engage other providers and commissioners in performance improvement, for example by leading on pathway timescale development.	Inadequate	Major	Likely	16	Very High Risk	Manage response to new NICE guidance together with BNSSG colleagues 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. Ongoing close patient level management of cancer PTL, including a weekly cross-divisional review meeting	31/03/2016 31/03/2016 31/03/2016	Major	Unlikely	8	High Risk	07/01/2016

Corporate Risk Register 20/10/2015

							Inherent				Controls		Current				Actions Summary		Target					Review
ID	Division	Risk Domain	Manager	Executive Lead	Title	Description	C	L	S	Risk level	Controls in place	Adequacy	C	L	S	Risk level	Action	Due date	C	L	S	Risk level	Review date	
959	Trust Services	Financial	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Chief Operating Officer	Risk that Divisions do not achieve the required level of cost efficiency savings	Risk of Plans under achieving and impacting on trust annual and planned outturn. Savings are not identified, are duplicated or double counted, slippage in delivery, activity growth consumes benefit, in year cost pressure or competing priorities eliminate gains.	Major	Likely	16	Very High Risk	-Monthly Divisional CIP reviews, Monthly Divisional Performance reviews , Quarterly reviews, Monthly review by CIP Programme Steering Group, monthly updated at a glance reports, Benefits tracking systems - all schemes are tracked based on actual savings to specific budget line and this is monthly reviewed and end of year forecast risk assessed, Divisional control of vacancies and procurement monitored at monthly performance meetings. -Those Divisions who have challenges meeting the target are given additional external and internal support to assist in managing the recovery. -Regular Reporting to the Finance Committee and Trust Board, Risk is partially mitigated by slippage on reserves.	Inadequate	Major	Likely	16	Very High Risk	Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes. Trust is working to develop savings plans to meet 2015/16 target.	31/12/2015 31/12/2015	Minor	Unlikely	4	Moderate Risk	23/12/2015
961	Medicine	Patient Safety	Green, Rowena - Divisional Director - Medicine	Chief Operating Officer	Risk of harm to patients awaiting discharge, once medically fit	There is evidence of harm to patients who are awaiting discharge - classified as Green To Go Patients - this includes falls resulting in fracture, pressure ulcers and hospital acquired infection. These have occurred on at least a monthly basis. These risks are regularly reported to partners and formal reporting is to be established from Q3 onwards.	Major	Likely	16	Very High Risk	-Enhanced Observation of patients at risk in place across all wards -Standard Operating Procedure in place and compliance regularly monitored -All incidents investigated and any learning, to prevent future incidents, acted upon. -Weekly Patient Progress Meetings with partners -Fortnightly Unscheduled Care and Discharge Steering Group -Three month project in which there is an enhanced REACT service which will cover OPAU and MAU in addition to the Emergency Department. -A Social care Practitioner has been seconded to the team to assist in the rapid turnaround of appropriate patients. -A clinical alert system is being established to alert the Hospital Discharge Team when identified patients re-present in the emergency department. -New Fast Track nurse assessor posts are now in place facilitating earlier discharge for end of life patients.	Inadequate	Major	Possible	12	High Risk	Discharge to Assess Pathways to be agreed and delivered Develop weekly Patient Progress meeting to provide a seperate meeting for Surgery. Integrated Discharge Project actions in progress following workshops held in July 2014. Monitored weekly and reporting to the Unscheduled care and Discharge Steering Group. This project is being overseen by the Transformation Team at UHB with individual projects led by senior staff from UHB, Bristol CCG and Bristol city Council. Monitor performance standards for Social Services Pathways required for bariatric patients	24/08/2015 12/08/2015 30/09/2015 30/09/2015 30/09/2015	Moderate	Possible	9	High Risk	28/10/2015
964	Trust Services	Statutory	Donaldson, Sue - Director of Workforce and OD	Director of Workforce & Organisational Development	Risk of non-compliance with Department of Health Safety Alert related to window restriction.	Not all window restrictors are compliant with national guidance and as such may be inadequate in preventing a determined effort to force a window open beyond the 100mm restriction as per guidance on the installation, use and maintenance of window restrictors, e.g. HTM 55 and advice from HSE. There is a rolling programme to address and to date there have been NO incidents as a result of this non-compliance.	Major	Possible	12	High Risk	-Monthly checks by wards and departments -Regular inspections by estates/facilities/modern matrons/H&S adviser. -Site inspections by Specialist Advisers includes checking of circulation routes for window restrictors, Door closures - swipe card access two way wherever possible -Audits undertaken 2011, 2013, 2014.	Inadequate	Major	Possible	12	High Risk	annual audit as a reminder for monthly checks to take place has shown increased coverage, report taken to Risk Management Group and Health & Safety Committee re other trust where lessons can be learnt Estates contracted out a window survey which looks at glazing specification and window restrictors throughout patient facing areas in the trust	16/10/2015 31/08/2015	Negligible	Rare	1	Low Risk	13/10/2015
991	Womens & Childrens	Quality	Hernandez, Judith - Deputy Divisional Manager - W&C	Chief Operating Officer	Risk to quality of care, due to failure of pneumatic chute	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). Ths risk will be eliminated by the end of October when the tube will have been replaced.	Moderate	Almost certain	15	Very High Risk	-Samples and blood and blood products can be transported by staff member, taxi or NICU ambulance transport staff, when tube is out of service. -Discussion with laboratory to expedite analysis (when tube has delayed transport) or inform clinical teams that repeat samples are needed.	Inadequate	Moderate	Almost certain	15	Very High Risk	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. 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. Business case and planning for new chute 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. New Estates project to fix the long term issues that prevent the chute from working are now in progress. Testing of robustness of pod delivery is underway with further work to be done under this scheme to review the ventilation in order to prevent samples from overheating en route. Business case and planning for new chute	28/11/2014 30/01/2015 19/06/2015 30/10/2015 15/01/2016 30/09/2015	Minor	Unlikely	4	Low Risk	09/12/2015

Corporate Risk Register 20/10/2015							Inherent				Controls		Current				Actions Summary		Target					Review
ID	Division	Risk Domain	Manager	Executive Lead	Title	Description	C	L	S	Risk level	Controls in place	Adequacy	C	L	S	Risk level	Action	Due date	C	L	S	Risk level	Review date	
1145	Trust Services	Quality	Lee, Deborah - Chief Operating Officer / Deputy Chief Executive	Chief Operating Officer	Risk that patients' requiring domiciliary care may have a delay in their discharge due to reduced service capacity	Bristol City Council are currently re-tendering their domiciliary care contracts and have awarded contracts to 4 providers, from 41 previously. This is a signifcant change and has the potential to impact upon service capacity over the period of transition, which in turn could impact upon timely discharge from hospital, in turn impacting upon occupancy and flow.	Moderate	Almost certain	15	Very High Risk	Monitoring of Green to Go list through daily patient flow meetings gives early indication of changes in volume of delayed patients, Structured meetings with BCC at a number of levels to maintain an understanding of current pressures. SRG has oversight of the current changes in service	Uncontroiled	Moderate	Almost certain	15	Very High Risk			Minor	Unlikely	4	Moderate Risk	31/12/2015	

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title									
18. 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. The log is distributed to all Board members, including Non-Executive Directors when new items are received and when new responses have been provided. Key issues to note: Since the last report was noted at Board, a further 2 new items have been added to the log. 4 Items have been updated with a response, and at the time of issuing the report 1 item is outstanding but not overdue.									
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 15/10/2015

ID **Governor Name**

137 **Mo Schiller** ***Theme:*** Dermatology Services ***Source:*** Governor Direct

Query **22/10/2015**

I understand that Weston dermatology has now transferred to UHB. In view of the increase in numbers of skin cancers coming to us now from there are the trust considering setting up nurse led PDT [photodynamic therapy] centre at UHB.This is proven treatment without surgical excision. The nearest centres for patients to access this are Cardiff and Bath.

Division: Medicine ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/10/2015

Response

Pending Executive response.

Status: *Assigned to Executive Lead*

136 **Mo Schiller** ***Theme:*** Workforce ***Source:*** Governor Direct

Query **30/09/2015**

Staff participated in a consultation regarding 12-13 hour shifts this year.Recent reports appear to show increased stress levels,sickness and burn out nationally.Did the UHB survey have any similar findings and if so what is being done to address the matter.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:*** 30/09/2015

Response **14/10/2015**

From December 2014 to February 2015 a variety of methods were used to gather staff views regarding 12 hour shift patterns. These included, an online survey monkey which saw 253 responses and a series of focus groups open to all staff, run at different times of the day and in different locations. The data was triangulated together with information from the most recent staff surveys and stress audits.

The consensus view emerging from the shift review processes were that the majority of staff taking part felt positive about working a twelve hour shift pattern, in respect of the impact on their work-life balance and childcare/dependent responsibilities. Some staff did identify that working a twelve hour shift pattern could have a negative impact on their health and well-being.

From the survey results there was no indication of a need to review undertaking a complete review of the current shift patterns that staff work.

The feedback also indicated that work in a number of areas would potentially reduce the negative health impact of the current shift patterns. These include:

• Review the e–rostering rules to ensure that the necessary controls are in place to avoid rostering of more than two consecutive long days/nights and an adequate time off is rostered. (unless this is a personal request) – this should reduce fatigue.
• There is a re-communication that there is an option available for staff to work half twelve hours shifts. (NB this is only possible if two members of staff want to work shorter shifts in one area so may necessitate staff moving area to accommodate these requirements)
• The importance of taking allocated breaks is re-enforced with all staff and managers
• Review options to identify and flag staff working excess hours using e-roster so that impact on these staff can be assessed.
• Issues of health and well-being of staff undertaking a 24/7 shift pattern are reviewed as appropriate in the context of their shift patterns.

A number of these actions have already been implemented

Status: *Closed*

ID **Governor Name**

135 **Mo Schiller** ***Theme:*** CF Ward ***Source:*** Governor Direct

Query **18/09/2015**

Ref 114 submitted 10.2.15 Angelo Micciche

I participated in the Face to face interviews last week speaking with CF patients on Ward A900. In view of the comments I received I referred to log item 114 submitted in February of this year by Angelo. Despite reassurance in the response that concerns had been rectified I feel I need to check on concerns given by CF patients to me last week.The initial consultation process would appear to have looked at different patients being on the new ward to those who are now there.

They cannot understand why there are not more trained CF nurses on the ward. They identified problems of confidence in carrying out tasks, i.e. one nurse had to call in help from another ward at night as she was not competent to give IV antibiotics into an IV long line. There was also feedback about less time spent supporting patients compared with the old ward. Patients expected the nursing staff to have more knowledge of CF problems. Housekeeping and physio were satisfactory.

There are obviously still concerns despite reassurance from the origianl exec response ,it is now 6 months since the log question so initial concerns should have settled, they appear to still be ongoing.

Division: Medicine ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/09/2015

Response **14/10/2015**

The outcomes of the face to face work and feedback through other sources, formal and informal tell us that patients like the new physical environment and that there are a number of areas where the actions detailed in my previous response have led to improved patient experience. The key ongoing issue of concern for patients is their lack of confidence in the staff's expert knowledge related to their condition. The patients miss knowing all of the staff and the continuity and confidence that this provides them when they are admitted as an inpatient. It would be fair to say that the transition to a new ward environment has been more difficult both for patients and staff than was anticipated.

Training within the current team on care of CF patients continues, as does the increased support from the clinical nurse specialist team. The level of vacancies in team on Ward A900 has meant that some shifts are being covered by temporary staff, bank and agency, who may not be as familiar with the Trust's/wards ways of working and may not have an expert knowledge of CF. This has been identified as a specific areas of concern by some patients. Recruitment to these vacancies means that the level of temporary staff usage is reducing. Training has been planned for the new staff on the specialities that the ward covers CF and gastroenterology. This should start to develop an increased level of expert knowledge within the team and improve the continuity of carers for the CF patients.

Status: *Awaiting Governor Response*

134 **Pam Yabsley** ***Theme:*** Inpatient Care ***Source:*** From Constituency/ Members

Query **18/09/2015**

Recently I have heard about a patient being discharged from UHB following a six week stay. He suffers from dementia and was cared for on the appropriate ward. Whilst in the care of UHB he developed a pressure ulcer and furthermore his bottom set of dentures were lost. Regardless of the reasons for the issues in this patient's case, this to me reflects poor nursing care. Unfortunately he will end his life in a very uncomfortable situation which is distressing for his family members. What assurances can be given that care for these patients is good.

Division: Medicine ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/09/2015

Response **14/10/2015**

There are a number of assurances which the Trust Board and Governors received regularly via the monthly performance report related to both the care of patients with dementia and care of patients at risk of developing a pressure ulcer. The Governors quality group recently had a presentation, at their request, related to the provision of dementia care within UHBristol from the lead consultant and specialist practitioners, this included information on national dementia standards and how the Trust performs against these.

Sometimes people do develop pressure ulcers which are generally a reflection of a breakdown in the process of risk assessment and/or care deliver, I agree this does not reflect a high enough standard of care. Occasionally pressure ulcers can develop as a result of patient non-compliance with planned care. High quality care provided by UHBristol staff has played a significant part in reducing new pressure ulcers. The efforts of healthcare colleagues across the Trust has seen the proportion of patients with new grade 2, 3 or 4 pressure ulcers reduce year on year. In 2013/14, we also set an internal Trust target to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1,000 bed days (based on a percentage reduction of a previous NPSA benchmark): we achieved a rate of 0.656 per 1,000 bed days. This compares with a rate of 1.264 in 2012/13. . The ambition to eliminate hospital acquired grade 3 and 4 avoidable pressure ulcers continues to be a clear quality priority for UHBristol.

Status: *Awaiting Governor Response*

ID	Governor Name		
133	Graham Briscoe	***Theme:*** Outpatient Services	***Source:*** Governor Direct

Query **21/08/2015**

There appear to be two telephone number pathways into the Outpatient Appointment Service for the Bristol Eye Hospital, but staff manning these lines do not seem to have access to the same booking system information.

Also, the main UHB Outpatient Appointment Service situated at the Main Entrance in the Welcome Centre does not delay with Eye Hospital Outpatient bookings.

From experience this caused issue when trying to change an appointment and confirm the location of the clinic for the appointment. Please can further detail regarding the structure and running of BEH Outpatient services, including the BEH A&E Clinic, be provided.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 18/09/2015

Response **24/09/2015**

The Trust is aware that patients are encountering issues when attempting to telephone the Bristol Eye Hospital Accident & Emergency Department. There are two telephone lines to reach the services at the Eye Hospital, one is a dedicated administrative call centre for outpatient appointments at the Eye Hospital and the other is a line into the Eye Accident and Emergency Department. The phone number indicated on the patient letter is dictated by whether the clinic is held in outpatients or in the Accident and Emergency department. Whilst both lines are answered by teams who do have access to the same trust wide booking system, they are in practice more likely to respond only on matters related to the clinics that they arrange and are held in each respective department because they will have local knowledge about them.

With regard to the line in the Accident and Emergency department, this is also used for direct clinical referrals from GPs and other patients requiring advice, which means it would not be possible to redirect this entirely to the local call centre. The department has recently lost approximately 20% of its experienced nurse practitioners, to retirement and new opportunities. Whilst we have replaced these posts the new staff do not yet have the experience to manage the telephone triage to the level required which has also impacted on our ability to respond to calls in a timely way.

To alleviate the issue in the short-term, additional administrative resource has been allocated to the Accident & Emergency department to ensure the telephones are answered in a timely manner.

The long term solution is to fund a dedicated triage telephone line manned by a nurse practitioner who is able to help and support patients with a view to reducing hospital attendances wherever possible, this will free up the administration lines for patients with appointment queries. The Division of Surgery Head and Neck is currently working up a business case to develop this further.

Currently the BRI Main Appointment Centre only manages a portion of our general outpatient specialities and at this time this does not include the services at the Bristol Eye Hospital. Any patient presenting with a clinic query outside of these specialties would be redirected as the team there would be unable to help. As part of wider improvements to the Outpatient Services it is intended to review the remit and function of this team.

The Trust has convened an Outpatients Steering Group which commenced in July 2015. This group consists of senior staff from all divisions, the transformation team and the Trust patient experience lead. This steering group has identified a programme of work that will improve standards across all our outpatient areas. A project plan and associated work streams have been produced and agreed, which includes development of the BRI Appointment Centre and telephone line enquiries.

We understand that patient's letters in some areas need to be revised and improved to ensure patients have the correct information for attending their appointment and the ability to contact the correct department in the hospital in a timely manner. We have identified this as a quality objective for this year and created a Patient Letters Group to deliver the required improvements.

Supplementary update:
Why cannot any outpatient clinic in the Eye Hospital Accident & Emergency Department be handled by the Team that handles the normal outpatient appointment bookings. Why is it required to even mention the Eye Hospitals Accident & Emergency department when handling outpatient appointment bookings ?

The nature of the outpatient services in the two areas with BEH are distinct. The clinics which operate in the A&E area are for those patients who have been referred by their GP for an urgent opinion or were originally seen in the A&E department and require follow up. Yhe main outpatient area is dedicated to providing clinics for patients who have been routinely referred by their GP or optician or are in long term follow up for conditions such as glaucoma. This approach ensures that there is an appropriate supply of "A&E" outpatient appointments for those that need them urgently and it allows the A&E administrative staff to keep track of this group of patients, pull their notes and manage the outpatient capacity so it is line with the needs of the A&E service.

Registering at the main reception is not part of the pathway for A&E outpatient attenders and I can only assume that the member of staff you came into contact with, was not familiar with the processes for which I apologise.

Status: *Closed*

ID	Governor Name		
132	Mo Schiller	***Theme:*** Staff engagement	***Source:*** Governor Direct

Query **17/08/2015**

Following on from the recent report in Newsbeat; Robert's visit to the eye hospital theatres. The fact that the Chief Exec dons scrubs and spends time with the team provides support and encouragement and must have been appreciated. Does the Executive team consider going back to the floor in all areas and that spending time with the teams should be a regular occurrence? I appreciate the walk-arounds give an opportunity for Executives to be seen but actually participating in a working day/part day with all members of the workforce could be a valuable exercise?

Division: Trust-wide ***Executive Lead:*** *Chief Executive* ***Response requested:*** 18/08/2015

Response **04/09/2015**

Although all Executives do this periodically and the Chief Nurse on a regular basis, a formal 'back to the floor' programme is not currently in operation across the Trust. However, it is something we will be considering as part of the programme following feedback from the recent listening events with staff. We will update you again once further discussion have taken place with the Senior Leadership Team in October.

Status: *Closed*

131	Bob Bennett	***Theme:***	***Source:*** Governor Direct

Query **14/08/2015**

Following recent media coverage, can the Board confirm that no senior member of staff is involved in obtaining financial remuneration from any pharmaceutical company.

Division: Trust-wide ***Executive Lead:*** *Trust Secretary* ***Response requested:*** 17/08/2015

Response **14/10/2015**

In line with other NHS Teaching Trusts, there are a small number of Medical Consultants who participate as ‘expert advisors’ on Advisory Boards of Pharmaceutical Companies. These are not statutory boards of directors and do not have authority over the governance of an organisation. An advisory board provides support and expert insight, and are not responsible for decision-making. These Consultants may be in receipt of remuneration, the declaration of which is required under Trust policy. With regard to ‘senior managers’, I can confirm that no member of the Board of Directors are in receipt of financial remuneration from any pharmaceutical company.

Status: *Awaiting Governor Response*

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 **23/09/2015**

The Trust is very mindful of the distress which can be caused to family when a deceased former patient is sent correspondence from the Trust. The Trust has two specific “routines” it runs on our information system to ensure that this does not happen. Firstly, when a patients dies in our care, this is documented promptly on the patient administration system (Medway) and a programme runs 5-6 per day where this deceased status results in the automatic cancellation of any outstanding appointments, admissions or letters recorded on the patient administration system. For patients who die outside of the Trust, these deaths are entered onto a national “spine” linked to GP records and the Trust receives an upload from the spine every two weeks. The Trust This relies upon the timely recording of death on the GP system. There remains an unavoidable risk that deceased patients may receive correspondence from the Trust in the period between GP registration of death and Trust reconciliation with the national spine though there is no evidence to suggest this is happens on a regular basis.

Status: *Closed*

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
19. 2014 National children's inpatient and day case survey
Sponsor and Author(s)
Sponsor: Carolyn Mills, Chief Nurse Authors: Paul Lewis, Patient Experience Lead (analysis); Hazel Moon, Head of Nursing Women's and Children's Division (actions / response)

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

Executive Summary

Purpose

To provide the Quality and Outcomes Committee with a summary of the Trust's performance in this national survey.

Key issues to note

This was the first time that a mandatory paediatric patient experience survey had been carried out as part of the Care Quality Commission's national programme. The participants comprised a random sample of 0-15 year olds who had attended as an inpatient or day case during August 2014. The survey was designed to capture the views of parents of children aged 0-15, along with the views of patients themselves if they were aged 8-15.

Two reports are provided:

- A local analysis of the results from UH Bristol's Patient Experience and Involvement Team, incorporating a response / actions from the Women's and Children's Division.
- The Care Quality Commission's "benchmark report" for UH Bristol

The headline results from this survey are that:

- UH Bristol had one score that was better than the national average (whether parents were told what would happen to their child in hospital)
- All other UH Bristol scores were in line with the national average

Recommendations
It is requested that the Trust Board discuss the outcomes of this survey and the actions being taken in response to it.
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)**		
28/10/15				21/10/2015			

2014 National children's inpatient and day case survey results: Local Analysis Report

1. Summary

This report provides an analysis of UH Bristol's performance in the 2014 national children's inpatient and day case survey, and presents a response to the key issues identified. The headline results from the accompanying Care Quality Commission benchmark report are:

- UH Bristol had one score that was better than the national average (whether parents were told what would happen to their child in hospital)
- All other UH Bristol scores were in line with the national average

2. Background

This was the first time that a mandatory national paediatric patient experience survey had been carried out as part of the Care Quality Commission's national survey programme. Patients were eligible to receive a questionnaire if they were aged 0-15 years old and had attended UH Bristol as an inpatient or day case patient during August 2014[1]. From this group of patients, 850 were selected at random to receive a questionnaire by post. The survey had a relatively complicated design, with parents / carers being sent one of three questionnaires depending on the age of their child:

- One questionnaire was for parents of children aged 0-7 years
- One questionnaire was for children and young people aged 8-11 years, with a section of the questionnaire for their parents to complete
- One questionnaire was for children and young people aged 12-15, with a section for their parents to complete.

These questionnaires were tailored to the group of people completing it and so not all of the questions were the same in each one.

The mail out sizes and response rates are summarised in Table 1. Mail outs (including up to two reminders to non-respondents) were sent out between October 2014 and January 2015. The overall UH Bristol response rate was 31% compared to 27% nationally.

Table 1: mail out numbers and response rates per survey

Age group (years)	Sample size[2]	Responses	Response rate
0-7 (parent / carer)	558	162	29%
8-15 (parent / carer and child)	283	95	34%

The vast majority (89%) of the sample was from the Bristol Royal Hospital for Children, with most of the remainder (10%) being day cases from the Bristol Dental Hospital. Due to the relatively small numbers it is not possible to split the response data by site. It should also be noted that the Bristol Royal Hospital for Children treats younger people over the age of 16, and so the national children's

[1] Patients / parents were not sent a questionnaire if the patient had died or were currently in hospital.
[2] These rates exclude patients who died during the course of the survey and where the questionnaire mail out was returned undelivered by Royal Mail.

survey doesn't provide a comprehensive view of the care provided at that hospital. It does however provide a useful benchmark of the hospital experiences of younger children and their parents. There are no plans to repeat the survey during the 2015/16 financial year. UH Bristol collects regular survey feedback from parents and young people via the monthly postal survey programme and Friends and Family Test.

3. Care Quality Commission benchmark report: headline results

This local analysis report is accompanied by the Care Quality Commission's (CQC's) benchmark report, which shows UH Bristol's score on each survey question relative to other English trusts[3]. The benchmark report presents the data for three cohorts: all parent responses, parents of 0-7 year olds specifically, and the child respondents to the survey (aged 8-15). The headline results for UH Bristol are as follows:

- Of the 13 survey questions answered by children aged 8-15 years, all of UH Bristol's scores were in line with the national average.
- Of the 24 survey questions answered by all parents, one UH Bristol score was better than the national average and the remaining scores were in line with this benchmark:
    - Hospital staff told the parent / carer what would happen to their child in hospital (better than the national average).
- Of the 15 survey questions answered specifically by parents of 0-7 year olds, all of UH Bristol's scores were in line with the national average.

4. UH Bristol local analysis

The following "local analysis" was carried out by the Trust's Patient Experience and Involvement Team. To aid interpretation of the results and to improve the accuracy of the data, it reduces the analysis down to two groups: parents and children. Chart 1 (over) presents an indication of UH Bristol's overall position relative to the national average in each of the national patient experience surveys[4]. It should be noted that this is a relatively simplistic analysis that does not take account of margins of error in the data. Nevertheless, the broad position that UH Bristol occupies for the children's survey (i.e. between the national average and top quintile) is typical of the Trust's performance in national surveys. Charts 2-5 adopts a similar analysis to show UH Bristol's position against all participating trusts in the national children's survey, including a cohort of similar ("peer") hospitals[5]. Whilst it should be emphasised that these charts are a guide rather than an absolute measurement, it can be seen that UH Bristol scores positively relative to peer trusts - particularly in respect of the children's responses (Chart 5).

[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] For each participating trust, a mean (average) is taken across all of the survey question scores. These means are then used to calculate national averages / quintiles. Please note that for the children's data (ages 8-15), trusts are not included if they data for less than half of the question scores. The NICU survey was a voluntary survey that not all trusts participated in.

[5] This cohort was derived by CHKS healthcare intelligence.

Chart 1: Comparison of UH Bristol's national patient experience survey results relative to the national average (the nearest quintile threshold to UH Bristol is shown against each score)

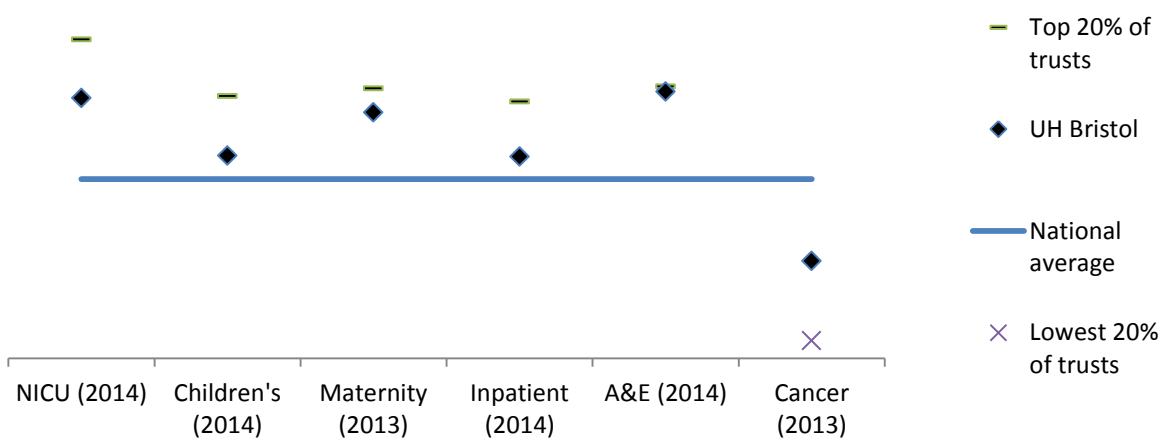


Chart 2: mean score across all survey questions for each participating trust (parent responses) - with national average and top 20% threshold shown

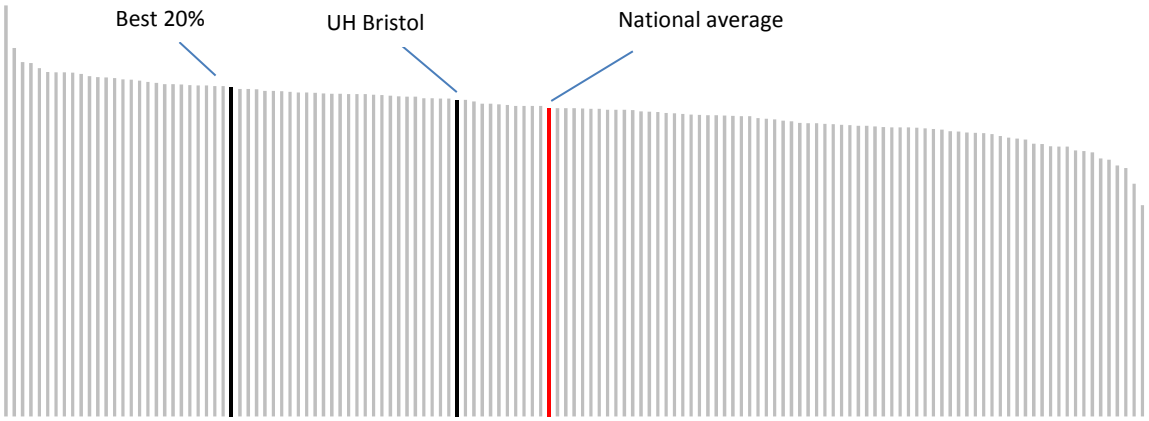


Chart 3: mean score across all survey questions for each participating trust (responses for 8-15 year olds)

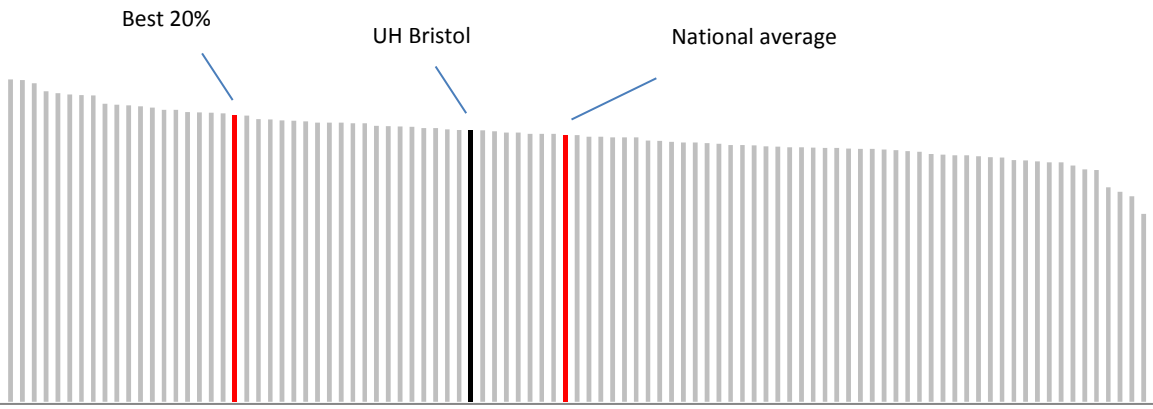


Chart 4: mean score across all survey questions for Bristol Royal Hospital for Children peer hospitals (parent responses) - with national average and national best 20% threshold shown

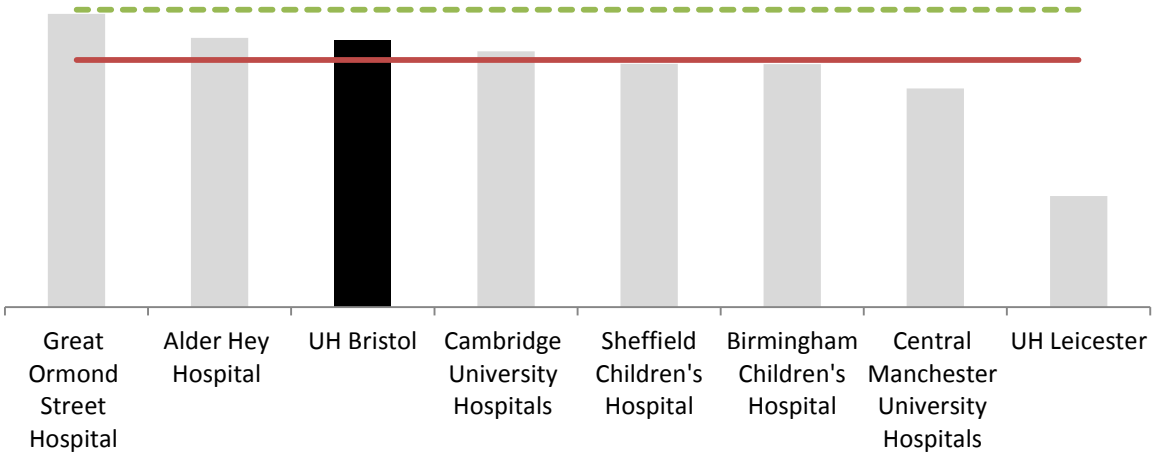
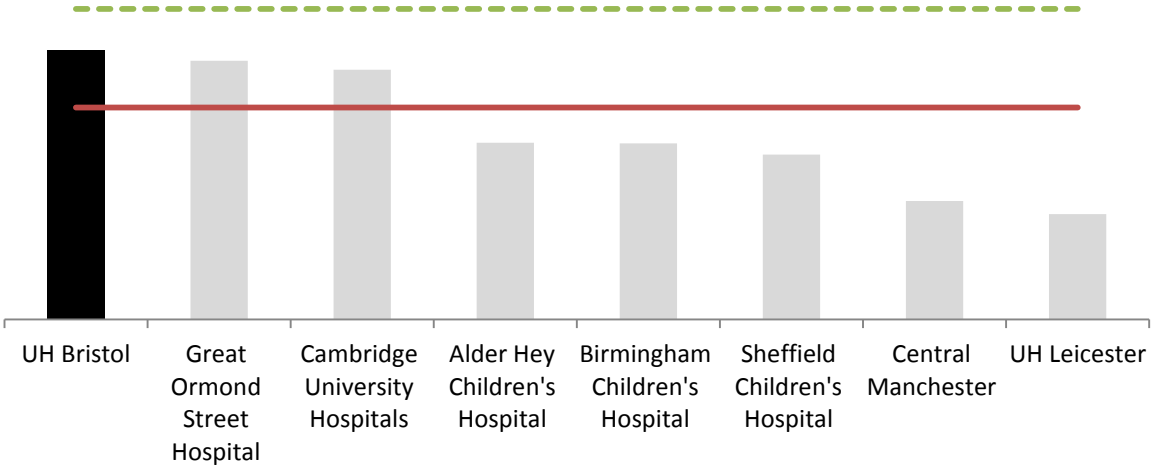


Chart 5: mean score across all survey questions for Bristol Royal Hospital for Children peer hospitals (8-15 year old responses) - with national average and national best 20% threshold shown



5. Best UH Bristol scores

UH Bristol's highest (best) survey scores are shown in Table 2. The top scores for parents were mainly around communication about the child's medical condition. The best scores from 8-15 year olds were broadly around making the child feel safe and valued (e.g. by staff being friendly and explaining aspects of their care to them).

Table 2: Best UH Bristol scores with scores (out of 10)

Parent / Carer of children aged 0-15	
Before the operation or procedure, did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.5
Were you given enough information about how your child should use the medicine(s) (eg when to take it, or whether it should be taken with food)?	9.4
Before the operation or procedure, did a member of staff explain to you what would be done during the operation or procedure?	9.4
How clean do you think the hospital room or ward was that your child was in?	9.2
Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	9.1
After the operation or procedure, did someone explain to you how the operation or procedure had gone in a way you could understand?	9.0
Child (aged 8-15)	
Do you feel that the people looking after you were friendly?	9.5
Before the operation or procedure, did hospital staff tell you what would be done?	9.5
Did hospital staff tell you how they were going to care for you, in a way you could understand?	9.2
Did you feel safe on the hospital ward?	9.2
Do you think the hospital staff did everything they could to help your pain?	9.1

6. Improvement themes / actions

The following scores provide the basis of UH Bristol's response to national patient surveys:

- Any UH Bristol scores that are below the national average (not applicable in the national children's survey)
- The lowest scores for UH Bristol[6]
- The UH Bristol scores that are furthest away from the best trust score nationally

The same scores often fall into both of these latter two categories (Table 3 - over) with some consistent themes emerging:

- Facilities for parents (overnight stays and access to hot drink facilities) and whether children like the hospital food.
- Involving parents in decisions about their child's care and treatment (which may impact positively on whether parents feel that the clinical team are aware of their child's medical history)
- Ensuring parents / children are given clear information and advice about post-hospital care.

[6] Given the relative number of questions in the parent survey (which had 24 questions) and child surveys (which only had 13 questions), the bottom 5 scores are taken from the parent survey and bottom 3 from the child survey.

Table 3: identifying service improvements

		UH Bristol score (national average in brackets)	Among lowest UH Bristol scores	Among furthest from the best Trust score (best trust score in brackets)
Parents of 0-15 year olds	Were you encouraged to be involved in decisions about your child's care and treatment?	8.2 (7.9)	x	
	Were the different members of staff caring for and treating your child aware of their medical history?	7.6 (7.6)	x	x (9.2)
	Did you have access to hot drinks facilities in the hospital?	8.1 (8.8)	x	x (9.9)
	How would you rate the facilities for parents or carers staying overnight?	6.9 (7.2)	x	x (8.7)
	Did a member of staff tell you what would happen next after your child left hospital?	8.3 (8.1)	x	x (9.9)
	Did a member of staff give you advice about caring for your child after you went home?	8.4 (8.5)		x (9.8)
Children aged 8-15	Afterwards, did someone from the hospital explain to you how the operation or procedure had gone in a way you could understand?	8.4 (8.2)	x	x (9.5)
	Did someone from the hospital tell you what to do or who to talk to if you were worried about anything when you got home?	8.3 (8.2)	x	x (9.3)
	Did you like the hospital food?	6.2 (6.3)	x	x (9.3)

7. Response / actions

Ensuring parents / children are given clear information and advice about post-hospital care.

Although the Trust's scores were in line with the national average, and the scores in themselves were not low, the survey suggests that there is room for improvement in this aspect of information provision for parents and patients. On discharge from hospital, parents and children should always be given clear information regarding their ongoing care and be advised who to contact if they have any concerns. Initially, the ward teams will be reminded of the importance of this. An exploration of existing survey data will also be carried to identify any particular "hotspots" within the Bristol Royal Hospital for Children. Any wards identified via this analysis will be the subject of targeted improvement work around discharge information. If necessary, interviews will take place with parents / children to confirm exactly what information they would like to receive at discharge from hospital.

Action 1: Share the survey results with the ward teams, highlighting the importance of information provision at discharge from hospital.

Date: November 2015

Owner: Hazel Moon, Head of Nursing, Women's and Children's Division.

Action 2: Analysis of monthly postal survey results to break down responses from parents/children relating to information and advice given on discharge to identify 'hotspots' for targeted improvement

Date: November 2015

Owners: Paul Lewis, Patient Experience Lead (surveys and evaluation); Hazel Moon, Head of Nursing Women's and Children's Division.

Action 3: Parent / child interviews to discuss information provision at discharge from hospital

Date: January 2016 (extension of Action 2, if necessary)

Owners: Sara Reynolds, Younger Persons Involvement Worker; Lisa Smith, LIAISE

Facilities for parents (overnight stays and access to hot drink facilities) and whether children like the hospital food.

There is some accommodation available for parents / carers of children being cared for at UH Bristol (e.g. Ronald MacDonald House, Sam's House, and Cots for Tots). In addition there are parent rooms on site and pull down beds next to each child's bed space. However, UH Bristol recognises the need to increase the availability of parental accommodation, particularly in light of the centralisation of specialist paediatrics to the Trust in May 2014. Plans are in place to expand the provision of accommodation, with support from the Grand Appeal. The project team are currently identifying appropriate sites where this accommodation could be located.

For those parents who remain at the hospital overnight, the majority of wards have a kitchen where parents can make hot drinks, snacks and heat food (the wards without kitchens do not have the physical space for this). However, there have been instances of poor maintenance of the kitchen environment / facilities within it, and we will therefore improve the quality checking process in this respect.

The monthly postal survey results show polarised opinions around hospital food (both in adult and children's services). 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, undertaken quarterly, and the annual PLACE inspections (parent/child led inspections of the care environment) which have consistently produced favourable results in respect of UH Bristol's food provision.

Action 4: Continue working with the Grand Appeal to expand parental accommodation (next key phase: identifying a suitable site / location).

Date: To be confirmed (estimate: during 2016)

Owners: Ian Barrington, Divisional Director, Women's and Children's Division

Action 5: Improve the onsite parents rooms by undertaking regular inspections to ensure provision adequate e.g. availability of kitchen equipment and ensure any repairs are actioned promptly

Date: November 2015

Owner: Gary Moreton, Hotel Services Manager, Facilities Department

Action 6: All wards to provide insulated cups with lids to enable parents to have hot drinks safely in ward areas

Date: November 2015

Owners: Ward Sisters, Bristol Royal Hospital for Children

Action7: Mattresses for parents pull down beds to be inspected and replaced as required

Date: November 2015

Owners: Ward Sisters, Bristol Royal Hospital for Children; Lisa Smith, LIAISE Manager

Action 8: Re-design / launch of food satisfaction patient questionnaire, in conjunction with the Youth Council members and undertake survey monthly rather than quarterly

Date: December 2015

Owner: Gary Moreton, Hotel Services Manager, Facilities Department; Sara Reynolds, Young Person's Involvement worker

Involving parents in decisions about their child's care and treatment

Where investigations are carried out into a child's unexpected deterioration, parents often say that they had 'known' or 'felt' that their child's symptoms were worse than the medical staff believed. There is a strong Policy drive to involve parents in their children's care, including from the Government's 2010 white paper "Equity and Excellence: Liberating the NHS", which stated that no decision should be made about a child's healthcare without the input of the parent and child.

The Bristol Royal Hospital for Children (BRHC) has sought to address this need by developing a practical framework to enable staff to involve parents more purposefully in their child's care, and to

help with the earlier identification of any deterioration in their condition. As a result the hospital now has a "Listening Standard Operating Procedure" in place, and have updated the 'Listening Leaflets' and poster campaign which informs parents how to feedback in real time any concerns relevant to their child's care and condition.

The "appropriate" level of involvement takes many forms and is most effective when it is integral to clinical practice throughout the patient journey. The clinical teams recognise that young people and their families want differing levels of involvement in the care process and require information / discussion in different forms at different times. It is however important that we continue to try and understand exactly how these important principles can be applied in practice. To help this, the Bristol Royal Hospital for Children have developed a new approach to engaging families in feeding-back their experiences of services. For example, Family Support and Communication events have been undertaken to better understand this aspect of care. There have also been a number of key developments with regard to family support and communication, including additional psychology support and additional hours within the LIAISE service to support the clinical teams.

Action 9: Continue to monitor "involvement" scores in the Trust's monthly inpatient survey

Date: Monthly through the Quality and Patient Safety Team and quarterly at the Divisions' Quality Assurance Committee

Owner: Paul Lewis, Patient Experience Lead (surveys and evaluation); Hazel Moon, Head of Nursing, Women's and Children's Division.

Action 10: Family listening events

Date: Ongoing

Owner: Sara Reynolds, Younger Persons Involvement Worker; Lisa Smith, LIAISE

Whether parents felt that members of their child's care team were aware of the patient's medical history

This is an ongoing issue for many parents (particularly if their child has complex healthcare needs), who often report that they have to repeat their child's past medical history to new members of the team who may need to become involved with their child's care and treatment. In 2013, the Children's Hospital Passport was launched at the Bristol Royal Hospital for Children. This is completed by the parents (either online or a paper record) and remains with the child throughout their stay. The Passport has improved communication to healthcare teams, but the national survey suggests that this remains an issue both locally and nationally. The first action will therefore be to contact the best performing trusts on this question, to identify best practice. We will also carry out a review of the Children's Hospital Passport with a view to updating this if necessary. We will also raise awareness of this issue by inviting staff to submit their ideas for improving this aspect of care, with a small prize for any ideas that can be adopted in practice.

Action 11: Contact the best performing trust nationally to identify best practice, taking the leaning and implementing in practice

Date: November 2015

Owner: Hazel Moon, Head of Nursing, Women's and Children's Division.

Action 12: Review / evaluate current "hospital passport"

Date: January 2016

Owner: Hazel Moon, Head of Nursing, Women's and Children's Division.

Appendix A: 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 B: 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 inpatients (or parents of younger patients), 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 C: Publication Timeline

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

23 June 2015	Data released to trusts under embargo
24 June 2015	Email summary of results to Executive Directors, Divisional Chairs / Managers, and Heads of Nursing
1 July 2015	Data released publically
27 August 2015	Results and local analysis report reviewed at Patient Experience Group
4 September 2015	Women's & Children's Divisional Management Board
21 October 2015	Senior Leadership Team
28 October 2015	Quality and Outcomes Committee of the Trust Board
30 October 2015	Trust Board

Patient survey report 2014

National children's inpatient and day case survey 2014

University Hospitals Bristol NHS Foundation Trust

National NHS patient survey programme
National children's inpatient and day case survey 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.

National children's inpatient and day case survey 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 local health services to tell us about their experiences.

This survey focused on young patients who were admitted to hospital as inpatients or for treatment as day case patients. One hundred and thirty seven acute and specialist NHS trusts across England participated. We received feedback about the care of nearly 19,000 young patients, which is a response rate of 27%. Young patients were eligible to take part in the survey if they were:

- aged between 0-15 years
- not staying in hospital at the time patients were sampled
- not 'well babies' i.e. newborn babies where the mother is the primary patient
- were admitted to hospital in August 2014 (some trusts also sampled patients who were admitted in July or September also)

Questionnaires and reminders were sent to patients between October 2014 and January 2014.

The children's survey is part of a wider programme of NHS patient surveys, which covers a range of services including acute adult inpatients, A&E, maternity services and community mental health services. To find out more about our programme and the results from previous surveys, please see the links 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 assessments as part of their Oversight Model for NHS Trusts.

Interpreting the report

This report shows how a trust scored for each evaluative question in the survey, compared with other trusts. 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.

Throughout the report, results are presented for two main groups of respondents: children and young people, and their parents or carers. Each of these groups used different questionnaires although both focused on the care provided to the young patient. In this report, results are

presented using feedback from the following groups:

- children and young people aged 8-15 years
- parents and carers of patients aged 0-15 years
- parents and carers of patients aged 0-7 years (where questions were only asked of this group)

Responses from parents and carers are divided into these two groups because children under 8 years of age were not asked any questions. Parents and carers of these children were therefore asked more questions than the parents and carers of older children.

This report shows the same data as published on the CQC website available at the following link: www.cqc.org.uk/childrenssurvey

Standardisation

Trusts have differing profiles of people who use their services. For example, one trust may have more younger patients than another trust. This can potentially affect the results because carers or parents may answer questions in different ways, depending on certain characteristics of their children. For example, the parents of older children may report more positive experiences than those of younger respondents. 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 in different ways for the different groups that took part in this survey. The data provided by children aged 8-15 has been standardised by route of admission (whether a patient was admitted as an emergency or their admission was planned) and the type of stay (day case or inpatient). The data provided by parents or carers of children aged 0-15 has been standardised by the same two variables plus survey age group (whether the child was aged 0-7 or 8-15). This helps to ensure that each trust's profile reflects the national distribution (based on all of the respondents to the survey). It 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 in any way, for example, they may be may be 'routing questions' designed to filter out respondents to whom following questions do not apply.

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 clearly 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.
Graphs are presented based upon themes, under each theme will be both the data from adults and from children/young patients.

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, the response rate for your trust and background information about the young people and their parents and carers that responded.

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/childrenssurvey

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/769

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

More information on CQC's hospital intelligent monitoring system is available on the CQC website:
http://www.cqc.org.uk/public/hospital-intelligent-monitoring

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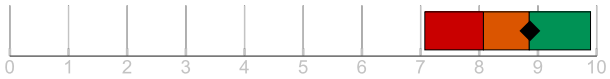
Going to hospital

Children and young people said:

When arriving at the hospital, they were told what would happen to them whilst there

All parents and carers said:

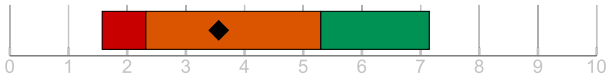
Hospital staff told them what would happen to their child in hospital



Better

Parents and carers of 0 to 7 year olds said:

The hospital gave them a choice of admission dates



The hospital did not change the admission date

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		

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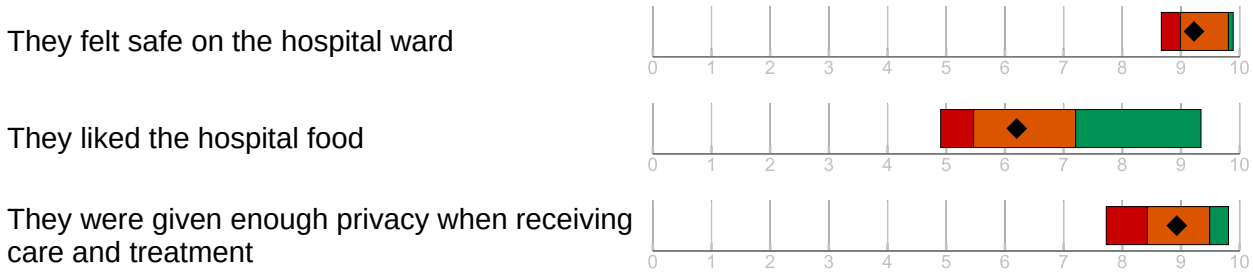
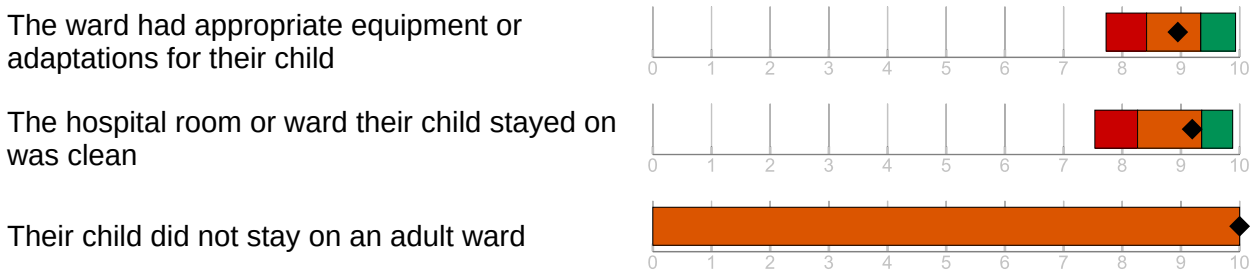
The hospital ward

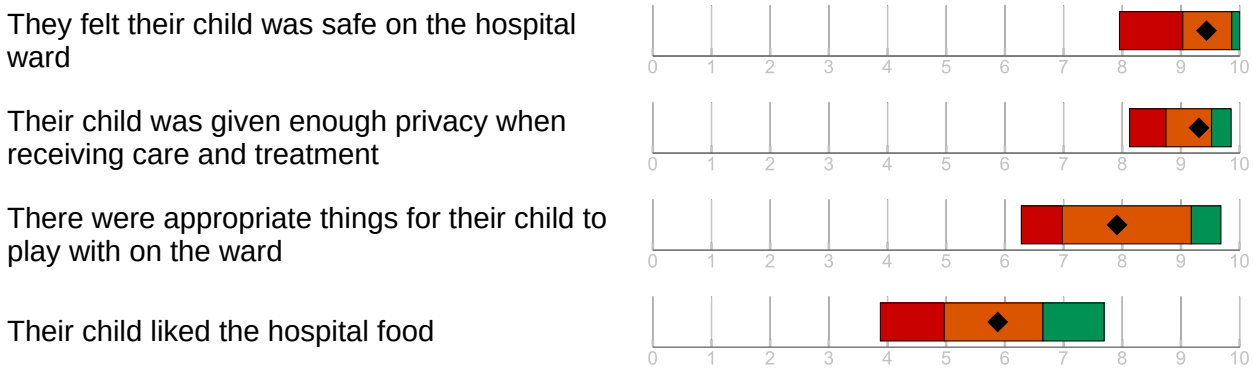
Children and young people said:



All parents and carers said:



Parents and carers of 0 to 7 year olds said:



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

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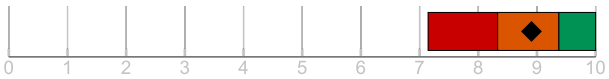
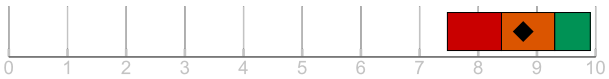
Hospital staff

All parents and carers said:

A member of staff agreed a plan with them for the child's care

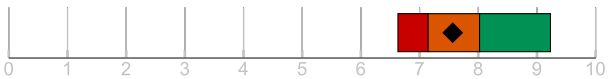


They had confidence and trust in the members of staff treating their child

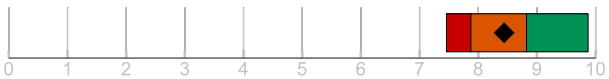


They were encouraged to be involved in decisions about the child's care and treatment

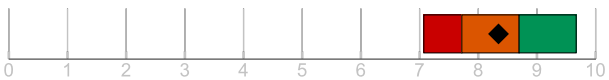
Members of staff were aware of the child's medical history



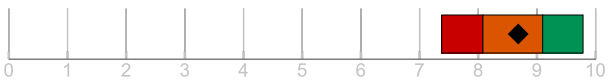
Staff knew how to care for the child's individual or special needs



Staff were available when their child needed attention

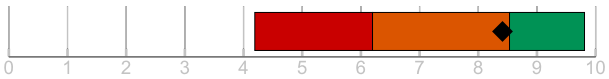


Members of staff caring for their child worked well together



Parents and carers of 0 to 7 year olds said:

The hospital staff played with their child while they were in hospital



Their child was well looked after by hospital staff

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		

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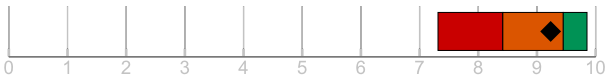
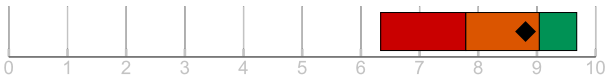
Speaking with patients and providing information

Children and young people said:

Staff talked to them in a way they could understand



Someone at the hospital talked to them about any worries they had



The people looking after them listened to them

The people looking after them were friendly

All parents and carers said:

Staff gave them information about the child's condition and treatment in a way they could understand

Hospital staff kept them informed about what was happening whilst the child was in hospital

Staff asked if they had any questions about their child's care

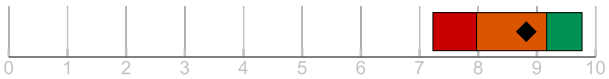
Parents and carers of 0 to 7 year olds said:

New members of staff treating the child introduced themselves

Members of staff communicated with the child in a way they could understand

They were not told different things by different people, which left them feeling confused

The people looking after their child listened to them



The people looking after their child were friendly

Staff treated them with respect and dignity

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		

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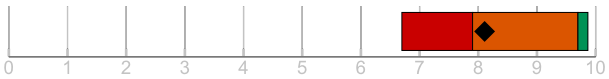
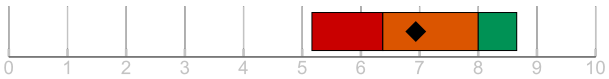
Facilities for parents and carers

All parents and carers said:	
They had access to hot drinks facilities at the hospital	
The facilities for staying overnight for parents and carers were good	

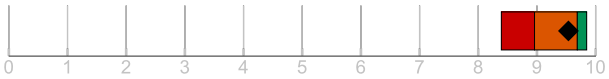
Pain

Children and young people said:	
Hospital staff did everything they could to help their pain	

All parents and carers said:	
Hospital staff did everything they could to ease the child's pain	

Operations and procedures

Children and young people said:	
Someone told them what would be done, before the operation or procedure	
Someone from the hospital explained how the operation or procedure went, in a way they could understand	

All parents and carers said:	
Staff explained to parents and carers what would be done during the operation or procedure	
Staff answered their questions about the operation or procedure, in a way they could understand	
Someone from the hospital explained how the operation or procedure had gone, in a way they could understand	

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		

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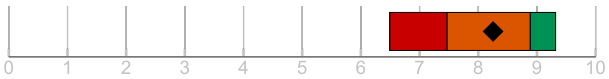
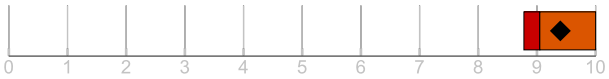
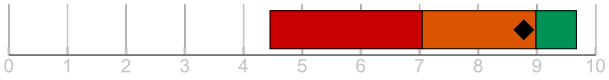
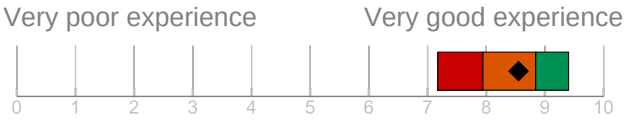
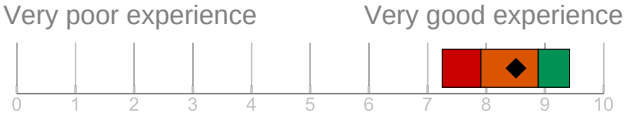
Being prepared to leave hospital

Children and young people said:	
Hospital staff told them what to do or who to talk to if worried about anything when home	
All parents and carers said:	
They were given enough information on how their child should use and take any new medicine	
They were given advice on how to care for the child when home	
They were told what would happen next after the child left hospital	
They were given written information about the child's condition or treatment to take home	
Parents and carers of 0 to 7 year olds said:	
They were told what to do or who to talk to, if worried about their child when home	

Overall experience

Children and young people said:	
They had a good overall experience of care in the hospital	
All parents and carers said:	
They felt their child had a good experience of care in the hospital, overall	

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

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	Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Going to hospital				
Children and young people said:				
When arriving at the hospital, they were told what would happen to them whilst there	9.0	7.3	9.7	88
All parents and carers said:				
Hospital staff told them what would happen to their child in hospital	8.9	7.1	9.9	254
Parents and carers of 0 to 7 year olds said:				
The hospital gave them a choice of admission dates	3.6	1.6	7.1	91
The hospital did not change the admission date	8.6	7.6	9.9	96
The hospital ward				
Children and young people said:				
They felt safe on the hospital ward	9.2	8.7	9.9	94
They liked the hospital food	6.2	4.9	9.3	72
They were given enough privacy when receiving care and treatment	8.9	7.7	9.8	93
All parents and carers said:				
The ward had appropriate equipment or adaptations for their child	8.9	7.7	9.9	228
The hospital room or ward their child stayed on was clean	9.2	7.5	9.9	254
Their child did not stay on an adult ward	10.0	8.6	10.0	248
Parents and carers of 0 to 7 year olds said:				
They felt their child was safe on the hospital ward	9.4	8.0	10.0	161
Their child was given enough privacy when receiving care and treatment	9.3	8.1	9.9	161
There were appropriate things for their child to play with on the ward	7.9	6.3	9.7	147
Their child liked the hospital food	5.9	3.9	7.7	91

National children's inpatient and day case survey 2014
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	Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Hospital staff				
All parents and carers said:				
A member of staff agreed a plan with them for the child's care	8.9	7.1	10.0	240
They had confidence and trust in the members of staff treating their child	8.8	7.5	9.9	254
They were encouraged to be involved in decisions about the child's care and treatment	8.2	6.7	9.0	253
Members of staff were aware of the child's medical history	7.6	6.6	9.2	239
Staff knew how to care for the child's individual or special needs	8.4	7.5	9.9	251
Staff were available when their child needed attention	8.3	7.1	9.7	253
Members of staff caring for their child worked well together	8.7	7.4	9.8	252
Parents and carers of 0 to 7 year olds said:				
The hospital staff played with their child while they were in hospital	8.4	4.2	9.8	80
Their child was well looked after by hospital staff	9.0	7.9	10.0	162
Speaking with patients and providing information				
Children and young people said:				
Staff talked to them in a way they could understand	9.2	7.3	9.9	90
Someone at the hospital talked to them about any worries they had	8.8	6.3	9.7	72
The people looking after them listened to them	9.0	7.3	9.6	94
The people looking after them were friendly	9.5	8.3	10.0	94
All parents and carers said:				
Staff gave them information about the child's condition and treatment in a way they could understand	9.1	8.1	10.0	253
Hospital staff kept them informed about what was happening whilst the child was in hospital	8.4	7.1	9.4	252
Staff asked if they had any questions about their child's care	8.4	6.6	9.7	242
Parents and carers of 0 to 7 year olds said:				
New members of staff treating the child introduced themselves	8.6	7.4	9.5	157
Members of staff communicated with the child in a way they could understand	7.9	6.5	9.3	150
They were not told different things by different people, which left them feeling confused	8.2	6.7	10.0	160
The people looking after their child listened to them	8.8	7.2	9.8	162
The people looking after their child were friendly	9.0	7.7	9.8	161
Staff treated them with respect and dignity	9.2	8.1	10.0	162

National children's inpatient and day case survey 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)
Facilities for parents and carers				
All parents and carers said:				
They had access to hot drinks facilities at the hospital	8.1	6.7	9.9	246
The facilities for staying overnight for parents and carers were good	6.9	5.2	8.7	136
Pain				
Children and young people said:				
Hospital staff did everything they could to help their pain	9.1	7.3	9.6	64
All parents and carers said:				
Hospital staff did everything they could to ease the child's pain	8.7	7.4	9.8	155
Operations and procedures				
Children and young people said:				
Someone told them what would be done, before the operation or procedure	9.5	8.1	9.9	70
Someone from the hospital explained how the operation or procedure went, in a way they could understand	8.4	6.6	9.5	71
All parents and carers said:				
Staff explained to parents and carers what would be done during the operation or procedure	9.4	8.3	10.0	186
Staff answered their questions about the operation or procedure, in a way they could understand	9.5	8.4	9.8	179
Someone from the hospital explained how the operation or procedure had gone, in a way they could understand	9.0	7.6	9.8	187
Being prepared to leave hospital				
Children and young people said:				
Hospital staff told them what to do or who to talk to if worried about anything when home	8.3	6.5	9.3	85
All parents and carers said:				
They were given enough information on how their child should use and take any new medicine	9.4	8.8	10.0	104
They were given advice on how to care for the child when home	8.4	7.5	9.8	235
They were told what would happen next after the child left hospital	8.3	6.8	9.9	233
They were given written information about the child's condition or treatment to take home	8.8	4.5	9.7	183
Parents and carers of 0 to 7 year olds said:				
They were told what to do or who to talk to, if worried about their child when home	8.7	7.1	9.9	148

National children's inpatient and day case survey 2014
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	Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)
Overall experience				
Children and young people said:				
They had a good overall experience of care in the hospital	8.5	7.2	9.4	93
All parents and carers said:				
They felt their child had a good experience of care in the hospital, overall	8.5	7.3	9.4	251

National children's inpatient and day case survey 2014
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Background information

The sample	This trust	All trusts
Number of respondents	257	18736
Response Rate (percentage)	31	27

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	55	56
Female	45	44
Ethnic group (percentage)	(%)	(%)
White	88	79
Multiple ethnic group	4	5
Asian or Asian British	4	8
Black or Black British	3	3
Arab or other ethnic group	0	1
Not known	2	4