University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Council of Governors meeting to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough St, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda	Chairman	
3. Minutes from the Previous Meeting To consider the minutes of the meeting of the Council of Governors on 29 January 2016 for **approval**	Chairman	3
4. Matters Arising (Action Log) To consider the status of Actions from previous meetings	Chairman	13
5. Nominations and Appointments Committee report • To receive and **note** this report • To **approve** the Committee's Terms of Reference	Chairman	14
6. Governor Development Seminar report To receive and **note** this report.	Head of Membership and Governance	23
7. Governor Groups reports To receive and **note** the following reports: a) Governors' Strategy Group b) Quality Focus Group c) Constitution Focus Group	Governor Group Leads	25
8. Membership and Governor Engagement To receive the update reports on a) Membership Engagement, and b) Governor Activity to **note**. To receive and note a verbal report from the NHS Providers Governor Conference (Bill Payne)	Head of Membership and Governance	30
9. Governor Elections 2016 To **note** an update on the 2016 Governor Elections	Head of Membership and Governance	39
10. Lead Governor Election 2016 To approve the appointment of a Lead Governor for the Council of Governors for 2016/17	Head of Membership and Governance	44

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11. Council of Governors Meetings Forward Planner for 2016/17 To receive the forward planner for 2016/17 for Council of Governors meeting business to **note**.	Head of Membership and Governance	45
12. External Auditors – Extension of Contract To receive the recommendation from the Audit Committee to re-appoint PriceWaterhouseCoopers for a further 12 months from 1 July 2016 - 30 June 2017.	Chairman	verbal
13. Review of Governor Compliance To **note** the review of governor compliance To receive the Council of Governors' Register of Business Interests to **note**.	Head of Membership and Governance	47
14. Governors' Log of Communications To **note** the current position of the Governors' Log of Communications	Chairman	52
15. Performance Update and Strategic Outlook a) **Chief Executive's report** To receive and **note** a verbal update from the Chief Executive b) **Quarterly Patient Experience and Complaints Reports** To receive and **note** these reports c) **NHS Improvement 2016/17 Operational Plan submission** To **note** the final Operational Plan document 2016/17 previously approved at the Governors Strategy Group	Chief Executive Chief Nurse Director of Finance and Information	 65 122
16. Governors' Questions arising from the meeting of the Trust Board of Directors To respond to questions arising from matters of business discussed at the preceding meeting of the Trust Board of Directors, including quality and performance	Chairman	
17. Any Other Business To **note** any other relevant matters	Chairman	
18. Foundation Trust Members' Questions To **receive** questions from Foundation Trust members and members of the public present (preferably notified in advance of the meeting)	Chairman	
Meeting Close and Date of Next Meeting The next meeting of the Council of Governors will be held at 14:00 on Thursday 28 July 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.		

University Hospitals Bristol NHS
NHS Foundation Trust

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Minutes of the Council of Governors Meeting held on 29 January 2016 at 2:00pm in the Conference Room, Trust Headquarters, Marlborough Street, BS1 3NU

Present:
John Savage – Chairman
Ben Trumper – Lead Governor and Staff Governor
Pauline Beddoes – Public Governor
Clive Hamilton – Public Governor
Mo Schiller – Public Governor
Sue Silvey – Public Governor
Brenda Rowe – Public Governor
Graham Briscoe – Public Governor
Bob Bennett – Public Governor
Sylvia Townsend – Public Governor
Ray Phipps – Patient Governor
Angelo Micciche – Patient Governor
John Steeds – Patient Governor
Anne Skinner – Patient Governor
Pam Yabsley – Patient Governor
Edmund Brooks – Patient Governor
Wendy Gregory – Patient/Carer Governor
Lorna Watson – Patient/Carer Governor
Philip Mackie – Patient/Carer Governor
Sue Milestone – Patient/Carer Governor
Karen Stevens – Staff Governor
Florene Jordan – Staff Governor
Jeanette Jones – Appointed Governor
Sue Hall – Appointed Governor

In Attendance:
Robert Woolley – Chief Executive
Deborah Lee – Deputy Chief Executive and Chief Operating Officer
Sean O'Kelly – Medical Director
Sue Donaldson – Director of Workforce and Organisational Development
Carolyn Mills – Chief Nurse
Alison Ryan – Non-executive Director
Guy Orpen – Non-executive Director
Julian Dennis – Non-executive Director
Lisa Gardner – Non-executive Director
Jeremy Spearing – Associate Director of Finance
Debbie Henderson – Trust Secretary
Amanda Saunders – Head of Membership and Governance
Sarah Murch – Membership and Governance Administrator (minutes)
Sophie Jenkins, Vice-Chair of Joint Union Committee
Mary Royce – Foundation Trust member
Gail Bragg – Foundation Trust member
Bob Skinner, Foundation Trust member
Mr AR Joomun – Foundation Trust member
Mrs Joomun – Member of the public

52/01/16 Chairman's Introduction and Apologies (Item 1)
The Chairman, John Savage, welcomed everyone to the meeting. Apologies had been received from Tim Peters –Appointed Governor, Tony Rance – Public Governor, Jill Youds – Non-executive Director, John Moore – Non-executive Director, and David Armstrong – Non-executive Director.

53/01/16 Declarations of Interest (Item 2)
In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the meeting agenda. There were no declarations of interest.

54/01/16 Minutes from Previous Meeting (Item 3)
Governors considered the minutes of the meeting of the Council of Governors on 30 October 2015 and approved them as an accurate record of the meetings.

Wendy Gregory, Patient/Carer Governor referred to her question at the last meeting about the process for the appointment of Senior Independent Director, and noted that a written response had not been provided. Debbie Henderson, Trust Secretary, explained that a verbal response had been provided to the Nominations and Appointments Committee at their December meeting, and she briefly outlined the process for appointment– the Chairman would make a recommendation to the Nominations and Appointments Committee, the committee would make a recommendation to the Council of Governors, and the final decision would rest with the Council of Governors. This would take place on an annual basis. The Nomination Committee also highlighted the risk of Emma Woollett holding both the position of Vice-Chair and Senior Independent Director. It was acknowledged that the appointment of the Senior Independent Director would be reviewed in line with Emma's annual review in May 2016. It was:

RESOLVED:
- **That the minutes of the Council of Governors meeting held on 30 October 2015 be approved as an accurate record of proceedings**

55//01/16 Matters Arising/Action Log (Item 4)
The Action Log was noted.

56/01/16 Nominations and Appointments Committee report (Item 5)
Lisa Gardner, Non-executive Director, left the meeting for this item.
John Savage introduced the report of the committee meeting held on 18 December 2015. There was a recommendation that required the approval of the Council of Governors: to continue Lisa Gardner's appointment as Non-executive Director for a third term of office subject to annual review as outlined in Monitor's Code of Governance.
Jeanette Jones, Appointed Governor, added that the Committee had engaged in an open and frank discussion, and governors had been pleased to endorse Lisa's continuing appointment, particularly appreciating her challenging questions, for example on issues such as the Trust's performance in relation to Fractured Neck of Femur targets. It was:

RESOLVED:
- **That the Council of Governors receive the report for approval**
- **That the Council of Governors approve the Committee's recommendation to continue Lisa Gardner's appointment as Non-executive Director for a third term of office subject to annual review as outlined in Monitor's Code of Governance.**

57/01/16 Governor Development Seminar report (Item 6)
Amanda Saunders, Head of Membership and Governance, introduced the report of the Governor Development Seminar on 14 January. It had been a full-day training session run by external trainers from Governwell/NHS Providers and at the governors' request it had covered the topics of effective questioning and holding Non-executive Directors to account.

Philip Mackie, Patient/Carer Governor, added that he had found the session of great benefit – the speakers were knowledgeable and had presented the session very effectively. Graham Briscoe, Public Governor, enquired whether NHS Providers could provide anything similar for new governors when they joined the Trust, and Amanda responded that there were plans to incorporate some of the materials provided into the induction process for new governors. Debbie Henderson asked that the training programme for other Governwell courses be circulated to governors for information.

The next seminar would be held on 8 April and would include a follow-up on governors' personal objectives as well as internal updates from the Trust. It was:

RESOLVED:
- **That the Council of Governors receive the Governor Development Seminar report for information**
- **That the Governwell training programme be circulated to governors.**

58/01/16 Governor Groups Meeting reports (Item 7)
Written reports had been circulated for all groups.

a) Governors' Strategy Group
Wendy Gregory, Chair of the Governors' Strategy Group, introduced the report of the group's meeting on 3 December 2015. The group had spent part of the session taking a close look at what strategy was, which they had found very helpful. Governors had provided useful input in terms of ideas for future topics and objectives.

As the Trust's Interim Director of Strategy and Transformation, Anita Randon, had left this week, Clive Hamilton, Public Governor, enquired as to who would attend the meeting in her place in the future. Amanda Saunders responded that Sarah Nadin, Head of Strategy and Business Planning, would continue to be the nominated Executive Lead for the group, and this would be reviewed once the new Director of Strategy & Transformation, Paula Clarke, was in place at the start of April.

Wendy Gregory took an opportunity to thank Anita during her time with the Trust and noted the fresh approach to strategic development which Anita had introduced. In response to a question from Wendy regarding the risk regarding continuity arrangements in this regard, Robert Woolley explained that the Trust's entire approach to strategy was currently under review, and consideration would be given as to how best to use the governors' strategy group as part of this. Clive Hamilton enquired whether this would impact on the Trust's duty to involve governors in the production of the Annual Plan. Robert responded that while the Trust was committed to involving governors, national requirements had significantly curtailed the planning period and the Trust was now required to produce a draft plan by 8 February. Governors would therefore be involved in the next stage of the planning before the final version was submitted at the end of March.

Amanda Saunders added that as a result of the deadline change, the next Governors' Strategy Group meeting scheduled for 9 February would be cancelled, and governors would instead discuss the

Annual Plan at their following meeting on 15 March. She assured governors that she was working with the relevant leads to ensure that governors received the Annual Plan in a timely fashion.

b) Quality Focus Group

Clive Hamilton, Lead Governor for the Quality Focus Group, introduced a report of meetings held on 5 November 2015 and12 January 2016. The group had received presentations on staffing issues and had been particularly pleased to note that the staff appraisal system was being reviewed and improved. They had received reports from the Board's Quality and Outcomes Committee and had discussed the Board's Quality and Performance reports. The group had noted that the Trust was still generally in a good position but could see that seasonal pressures were affecting waiting times and some quality metrics. Particular issues were noted in the 62-day GP waiting time target for Lower Gastrointestinal and, to some extent, lung tumour sites.

Cancelled operations and other issues in Cardiac Surgery had been highlighted as a particular cause for concern. Deborah Lee, Chief Operating Officer and Deputy Chief Executive, offered to respond more fully to governors' concerns in this area via the Governors' Log of Communications, but meanwhile provided reassurance to governors that any decisions to cancel operations were taken very seriously and were driven by clinical priority. Robert Woolley further explained that winter pressures meant that the Bristol Royal Infirmary and the Bristol Royal Hospital for Children were struggling to find the capacity to meet emergency demand. He reiterated that any decisions to defer planned work were clinically-informed and necessary to meet this demand. Non-executive Directors also assured governors that they were sighted on this issue through their Quality and Outcomes Committee.

Edmund Brooks, Patient Governor, enquired how the Quality Focus Group ensured that it had sight of the full range of different ways of capturing patient experience and raised concern that the Quality Focus Group did not have a bigger focus on this area. Amanda Saunders responded that she was currently working with the Trust's patient experience leads to look at ways in which patient experience could be more effectively brought into the group. Clive Hamilton added that Tony Watkin, Patient Experience Lead (Engagement and Involvement) attended the group's meetings periodically to report back on the Trust's latest patient experience initiatives and findings. Governors also brought patient experience into the group themselves: from personal experience, anecdotal evidence, and from the various Trust groups that they attended, as well as from Board reports. Debbie Henderson agreed that the increased focus on patient experience was a relatively new introduction into the remit of the Quality Focus Group and governor representatives on the group were committed to this piece of work going forward. Wendy Gregory took an opportunity to challenge the concern and noted that the group had introduced a significant focus on this area over the past few months.

It was announced that Marc Griffiths, Appointed Governor, would take over from Clive as Group Chair in June. The group's next meeting would take place on 10 March at 12.30-14.30 and all governors were welcome to attend.

c) Constitution Focus Group

Sue Silvey, Lead Governor for the Constitution Focus Group, introduced the report of the meeting held on 3 December 2015. It had included discussion on the forthcoming governor elections. It had also been agreed that Angelo Micciche, Patient Governor, would take over from Sue as chair of the group in June. It was:

RESOLVED:

- **That the Council of Governors receive the following updates to note:**
  - **Governors' Strategy Group**
  - **Quality Focus Group**
  - **Constitution Focus Group**

59/01/16 Membership and Governance Engagement (Item 8)
Amanda Saunders, Head of Membership and Governance, introduced the reports on Membership and Governor activity in the period 30 October 2015-29 January 2016.

The Trust had held a very successful Health Matters Event for members in November, which had been attended by around 120 people. The main speaker, Dr Shane Clarke, had given an excellent presentation on Osteoporosis, and the National Osteoporosis Society had spoken about their support services. Attendees had been asked for feedback on the event and ideas for future events, and their feedback was now informing planning for events over the coming year. A new focus for 2016 is to consider how these events could be used not only to enable members and the public to ask their questions on the health topic, but also to bring feedback on Trust services back into the organisation. The first theme was likely to be End-of-Life care, and work was going on to link with consultants to see how the agenda might be shaped to be both informative and also to contribute in a useful way to their ongoing programme of work.

While it appeared that membership numbers had increased, Amanda explained that this was due to an increase in staff numbers, and that more still needed to be done to improve the public and patient focus. With this in mind, the team was trialling regular membership recruitment stands in public areas of the hospitals to talk about the benefits of membership and to give governors the opportunity to talk to patients and staff. The next quarter would also have a particular focus on governor elections. This month's Voices magazine would be sent out to all members and would focus on the theme of carers as well as governor elections.

Amanda acknowledged and welcomed governor input and support in the period on the membership agenda, particularly for their help with governor election materials, such as the information pack for prospective governors. Among examples of governors going above and beyond in their duties in this period, she noted that Graham Briscoe, Public Governor, had volunteered to assist the Trust's Big Green Scheme with the judging of their award entries. It was:

RESOLVED:
- **That the Council of Governors receive the report on membership and governor engagement to note**

60/01/16 Governors Elections 2016 (Item 9)
Amanda Saunders introduced a report on the planning for the 2016 governor elections. A letter from the Chairman had been sent to members who had been active within the past year, and had resulted in more than 20 enquiries, with some interested people attending today's Council of Governors meeting. Information events had been scheduled and an information pack for potential candidates would be printed and distributed next week. The next steps would be to promote the vacancies among staff and UH Bristol's partner organisations.

She reported that consideration had been given to appropriate ways to recruit governors in the 'Rest of England and Wales' constituency, and it had been decided to target those areas from which UH Bristol received most of its activity locally, such as Bath and Taunton. Information stalls were planned at libraries out of area to widen our reach. It was:

RESOLVED:
- **That the Council of Governors receive the report on Governor Elections 2016 to note**

61/01/16 Review of Governor Compliance (Item 10)
Amanda Saunders introduced the report on governor compliance. She reported that some progress had been made concerning the two governors with outstanding Disclosure & Barring Service checks. She informed governors that Jim Petter, Appointed Governor for South Western Ambulance Service NHS Foundation Trust, no longer felt he had the time to devote to the role of governor, and was helping to secure a new appointment from his organisation.

Graham Briscoe enquired whether the Trust was aware of its duties under the Prevent strategy and Channel programme (government strategy focussing on providing support at an early stage to people identified as being vulnerable to being drawn into terrorism). Sue Donaldson, Director of Workforce and Organisational Development, provided assurance that the Trust was aware and involved. Following a suggestion that a presentation for governors on the wider aspects of Prevent and its implications might be useful, Alison Ryan, Non-executive Director, provided assurance that these issues were also covered in the reports as part of the safeguarding reports to the Quality and Outcomes Committee, and under the new alignment with the Quality Focus Group, this would be reported to Governors as part of the Chair's update in future It was:

RESOLVED:
- **That the Council of Governors receive the review of governor compliance to note**

62/01/16 Governors' Log of Communications (Item 11)
Governors received an updated report of the questions that governors had asked directors via the Governors' Log of Communications. Florene Jordan, Staff Governor, expressed disappointment that she had not yet received a response to the Log item that she had submitted in December. John Savage apologised and Carolyn Mills, Chief Nurse, confirmed that work was ongoing and a response would be circulated as soon as possible.

Clive Hamilton commented that some of the responses provided for Log items referenced work in progress, and issues would therefore need to be revisited at a later date. John Savage reminded him that issues could be raised at Board meetings, and Debbie Henderson suggested that help would be given to governors to identify any themes arising from the Log as part of the governors' development structure. It was:

RESOLVED:
- **That the Council of Governors receive the Governors' Log of Communications report to note**

63/01/16 Performance Update and Strategic Outlook (Item 12)

Item 12a) – Chief Executive's Report
Robert Woolley, Chief Executive, gave a verbal update on the Trust's performance and its strategic outlook.

Performance at UH Bristol: Performance was broadly positive in terms of quality indicators and access indicators; however, the Trust was experiencing significant difficulties around winter pressures, particularly emergency demand and the impact on A&E waiting times. This was unsurprising given that the entire Bristol, North Somerset and South Gloucestershire system had been

in escalation over recent weeks. Trust staff were doing their best to provide good care to patients under significant unrelenting pressures and were being supported to do so.

Workforce indicators were disappointing, with higher turnover and sickness absence than planned. A range of options to improve this and to make the Trust an attractive place to work and stay were under consideration. These were particularly necessary given the national mandate to reduce the amount of money that the Trust was spending on its agency staff.

In relation to finances, the Trust was projecting a small surplus for the year, which was positive compared with the vast majority of trusts around the country; however, this masked an underlying pressure particularly in the clinical divisions, as it was propped up by non-recurrent measures to control expenditure which would not be available to the same extent next year.

The Independent Review of Children's Congenital Heart Services was ongoing. Interviews with Trust staff had started and would continue through February. The target date for the production of a report was still understood to be Spring 2016. Governors would be kept updated.

Robert informed governors of an allegation which had recently gained a significant amount of media attention in relation to the death of a baby in paediatric intensive care. The parents had alleged that there had been deception regarding the information they had been given about the cause of the baby's death and had made allegations regarding staff conduct. Although the Trust had investigated these issues, the family remained concerned regarding staff conduct. In order to address the issues about the probity of the Trust's management response, Robert confirmed that the Board had now commissioned an independent enquiry from specialist investigations agency Verita, who were due to start their investigations next week and would interview the family and staff involved.

Strategic Outlook: With reference to the 2016/17 Annual Plan, Robert advised that deadlines had been brought forward to a point before negotiations with commissioners about contracts for next year would be complete, which presented some challenges. In addition to the Trust's Annual Plan, national guidance now also required a 5-year Sustainability and Transformation Plan (STP) to be prepared on a place-based-basis by the whole local health and care system (including local government). This had to be agreed and submitted by the end of June and was a system plan for delivering the goals in NHS England's 5-year forward view in relation to joining up health and social care, moving care out of the hospitals and into the community, and public health and self-care. It was a very significant agenda and would be discussed by the System Leadership Group for Bristol, North Somerset and South Gloucestershire at a meeting next week. Robert attended this group on behalf of UH Bristol, and he confirmed that the Trust was taking a proactive and positive role in discussions and implementation. It was understood that access to certain national monies would be entirely dependent on the robustness of that system plan and the extent of the ambition with acute providers, community providers, commissioners, mental health providers, social services and others in delivering that plan. Governors would be kept informed with its progress and its impact on Trust strategy.

In relation to the future of Weston General Hospital, Robert reported that the Trust was represented at the Weston Sustainability Board, which involved all health and social care partners across the area. Strategic opportunities were being identified to arrive at a model for the configuration for services at the hospital that would be clinically and financially sustainable. The output from that work was expected by the end of March, and there was also a commitment to go to full public consultation on any changes. This would also affect the system-wide Sustainability and Transformation Plan.

Edmund Brooks, Patient Governor, enquired whether the cancellation of operations had a financial impact on the Trust. Robert responded that there was an income implication as the Trust would not

be paid for work that had not been carried out, but also the Trust could be fined by commissioners if it was not hitting certain targets around planned care. Arrangements had been made in the contract for this year to mitigate that risk, but he acknowledged that there was a risk to income.

Item 12b – Quarterly Patient Experience and Complaints Reports

Carolyn Mills introduced these reports, which had been provided to governors for information. She explained that the reports were presented together to enable the identification of any links between patient experience and patient complaints, however, no tangible links had been identified in this quarter. Patient Experience was generally positive, with areas highlighted for improvement including the response rate for Friends & Family tests, and the issues around the transition of ward A900, where work was ongoing to mitigate the lack of continuity for patients due to staff changes that had happened as part of a ward move. The complaints report had revealed a mixed performance, with key themes relating to appointments, telephones not being answered, and the quality of complaints letters.

In response to a question from Edmund Brooks as to how the decision was made as to which wards and departments to focus on for patient interviews, Carolyn explained there were various routes: some areas had been identified by patient experience data, or conversations with wards and governor feedback, and some were related to key corporate projects and improvement work-streams. In response to a further request from Edmund for an update from Tony Watkin, Patient Experience Lead (Engagement and Involvement) on his reflections on the feedback that he received from patient interviews, Amanda explained that Tony attended Quality Focus Group periodically to share this with governors. Jeanette Jones added that Tony Watkin also occasionally invited governors to take part in patient interviews, and this was fed back to other governors at the governors' informal sessions. It was:

RESOLVED:

- **That the Council of Governors receive the Quarterly Patient Experience and Complaints Reports to note**

64/01/16 General Discussion (including Governors' Questions arising from the meeting of the Trust Board of Directors) (Item 13)

a) John Steeds, Patient Governor, enquired about the Trust's plans for the future of South Bristol Community Hospital (SBCH). Robert Woolley responded that UH Bristol was currently in discussion with Bristol Clinical Commissioning Group (CCG), as its contract as lead provider was due to expire in March 2017. The Trust had put a proposal to the CCG that it would be sensible to extend the contract by a year to allow a plan to be prepared for the future of SBCH. UH Bristol was also proposing that the CCG extend the contract longer than five years, so that the Trust could more effectively invest in South Bristol to improve its utilisation. The proposals had been received positively but discussions were still ongoing. More details would be provided to governors in the coming months.

b) John Steeds referred to the occasions when the Trust's breaches of the 62-day referral-to-treatment cancer standard were due to late referrals, and asked what steps the Trust was taking to raise the issue with referring organisations. Deborah Lee, Chief Operating Officer, responded that the Trust had written to leaders of organisations, had met with their senior leadership, and had also raised the subject with regulators and commissioners who might be able to incentivise other organisations. Of particular note was the Trust's part in engaging the clinical body in the work around 'perfect pathways' or 'timed pathways' – where UH Bristol and its partner organisations had reached agreement on how the best pathways should look, and could therefore hold each other to account on whether they delivered on their own part of the pathway. All Boards,

including UH Bristol's, had now agreed to report in the public domain not only the breaches that occurred in their Trust but also in other Trusts where their late referrals were a contributory factor.

c) In relation to the Trust's improved financial outlook, Angelo Micciche, Patient Governor, cautioned the Board that the news that the Trust was now set to make a small surplus this year might be received negatively from staff who had requested, and been denied certain small investments for service developments in their own areas due to budgetary constraints. John Savage clarified that the surplus was money that the Trust was obliged to make in order for it to pay back the construction costs for the redevelopment of the buildings over recent years. It was suggested that perhaps the issue raised by Angelo related instead to how requests from staff for small investments were tracked, and Robert Woolley offered to pursue this outwith the meeting if necessary. It was also acknowledged that the messaging with regard to the surplus be clear and easy to understand by all staff in the Trust.

d) With reference to the Trust Board's Quality and Performance Report, Wendy Gregory, Patient/Carer Governor, expressed concern about the indicators for the well-led area with regard to staffing. She asked the Non-executive Directors whether they were confident that they had the assurance that the four red-rated indicators (turnover, sickness, vacancies and agency) were likely to improve and whether there was a clear timeline. Alison Ryan, Non-executive Director, expressed doubt that any hospital currently had assurance on this as there were serious national issues on the supply and demand of hospital staff. They had therefore not received assurance from the Executive team on these indicators; however, they were assured that there was a close focus on it and that work in this area was ongoing.

e) Clive Hamilton, Public Governor, referred to the overspend in the Surgery, Head & Neck Division and asked whether it was due to excessive outsourcing and insufficient in-house work. Robert clarified that the outsourcing that had been referenced (waiting list initiatives etc) was not work given to the private sector, but rather a model of incentivising the Trust's own staff to deliver more out-of-hours activity. The financial problems in the Division related to the underachievement of savings over many years which had accumulated and rolled forward. He provided reassurance that the Trust was now actively considering how to deal with this and give the division a realistic target to achieve in the coming year. Amanda Saunders reminded governors that they been provided with an update on this at their November Governors' Informal Meeting, and added that Deborah Lee would be attending their February informal meeting to outline Glanso arrangements and could provide further updates if necessary.

f) Clive Hamilton requested assurance that the national mandate to reduce agency spend would not affect quality of care. Robert assured him that the Trust would not allow it to compromise safety: there was a procedure in place that allowed requests to be escalated and permission would be granted for agency staff where necessary.

g) Florene Jordan, Staff Governor, requested that a staff engagement session be organised specifically for theatre staff, as many of them had been unable to get time off work to take part in the Trust-wide sessions, and that more engagement sessions be offered to staff in their local areas, when they may be able to attend meetings and events. She also suggested that a Staff Experience Story be reported to Trust Board meetings alongside as the Patient Story. Sue Donaldson, Director of Workforce and Organisational Development, agreed to consider these requests.

h) Florene requested that posters with photos of the Trust Board and Council of Governors be visible in all public areas of the hospital areas. Philip Mackie, Patient/Carer Governor, asked that

governors' contact details be reinstated in Bristol Royal Hospital for Children. Amanda Saunders agreed to look into this.

i) Sue Silvey, Public Governor, expressed appreciation for the expertise provided by Debbie Henderson and Amanda Saunders over the past year, which had greatly benefited governors. With Debbie leaving the Trust in March, and Amanda on maternity leave from May, she asked for assurance that appropriate cover arrangements were in place to support the significant programme of work ahead. Debbie Henderson responded that interviews for the substantive Trust Secretary post were being held next week, and while there was likely to be a need for an interim arrangement, the interim would be given a very specific role to hopefully enable stability to be maintained in relation to membership and governance. Amanda Saunders informed governors that there was already some interest in the maternity cover role and that she would leave them with a comprehensive plan for the year. Debbie undertook to keep governors updated as and when cover arrangements were finalised. John Savage added his commitment that the Board was concerned that there should be no deterioration in support for this function.

65/01/16 Any Other Business (Item 14)

- Governors were invited to a Charity Ball by Philip Mackie, Patient/Carer Governor, in aid of Little Bridge House Children's Hospice.
- John Savage reminded governors that it was Debbie Henderson's last Council of Governors meeting, and he led governors and Board in warmly acknowledging the significant contribution that she had made in the role of Trust Secretary over the past year.

It was:

RESOLVED:

- **To consider requests for staff engagement sessions specifically aimed at theatre staff, and for the Trust Board meetings to consider a staff experience story as well as a patient experience story.**
- **To ensure Trust Board photos and governor contact details are visible in appropriate areas of the hospitals.**

66/01/16 Foundation Trust Members' Questions (Item 15)

There were no questions.

Meeting Close and date of next meeting

There being no other business, the Chair declared the meeting **closed**.

The next meeting of the Council of Governors will be held at 14:00 on Thursday 28 April 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Council of Governors meeting
Item 04 - Action tracker

Outstanding actions following meeting held 29 January 2016				
Minute reference	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
64/01/16	To consider requests for staff engagement sessions specifically aimed at theatre staff. For the Trust Board meetings to consider a staff experience story as well as a patient experience story.	Director of Workforce and Organisational Development		Listening events have been held with theatre staff – these were run locally and also with Executive input. The governors' Quality Focus Group will be discussing the staff survey results/staff engagement at their meeting on 5 May. It may be helpful to further explore the idea of a staff story as part of this session.
64/01/16	To ensure Trust Board photos, governor photos and governor contact details are visible in appropriate areas of the hospitals.	Head of Membership & Governance		Review after governor elections.
Completed actions following meeting held 29 January 2016				
57/01/16	That the Governwell training programme be circulated to governors.	Head of Membership & Governance	1/2/16	Governwell training programme was included in the Governor Focus newsletter that was circulated to all governors on 1 Feb.

Nominations and Appointments Committee Report for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 05 - Nominations and Appointments Committee Report

Purpose

The purpose of this report is to provide the Council of Governors with an update on the activities of the Governors' Nominations and Appointments Committee.

Abstract

The Nominations and Appointments Committee is a formal Committee of the Council of Governors established for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Recommendations

The Council of Governors is asked to **note** the report and:

- To **approve** the Committee's terms of reference and current membership.

Report Sponsor or Other Author

Sponsor: Trust Secretary

The Nominations and Appointments Committee has held **one** meeting since the last Council of Governors meeting.

Nominations and Appointments Committee: 26 February 2016

Governors present: Mo Schiller, Sue Silvey, Anne Skinner, Pam Yabsley, Angelo Micciche and Florene Jordan.

Others present or in attendance: John Savage – Chairman, Debbie Henderson – Trust Secretary, and Sarah Murch – Membership & Governance Administrator.

Topics discussed:

- **Appraisal and Annual Review of Non-executive Directors -** The committee noted appraisal papers for Jill Youds and Julian Dennis. The committee voiced their support for Jill and Julian and felt that they made a strong contribution to the Board.
- **Remuneration of Non-executive Directors** – as remuneration of Non-executive Directors had not been reviewed for some time, it was agreed to review it at the next meeting.
- **Committee Terms of Reference and Membership –** it was agreed to recommend to the Council of Governors approval of the Terms of Reference and committee membership with no changes.
  It should however be noted that several committee members will be standing down from the committee at the end of their term of office on 31 May. Vacancies will therefore be advertised to governors in June and appointments to the committee will be approved at the next Council of Governors meeting on 28 July.
- **Committee Forward Planner and Self-assessment** – it was agreed to postpone these items until the next committee meeting.

The next meeting of the Nominations and Appointments Committee will take place on 27 June 2016, 13:30-14:30 in the Conference Room, Trust Headquarters.
Appendix A – Terms of Reference and Committee Membership.

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference - Nominations and Appointment Committee – Council of Governors

Document Data	
Corporate Entity	Nominations and Appointments Committee (Membership Council)
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Trust Secretary
Document Owner	Trust Secretary
Approval Authority	Membership Council
Document Reference	TOR0003
Review Cycle	12 months
Next Review Date	12/02/2015

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
July 2009	1.0	Membership Manager	Major	Version 1.0
27 July 2011	1.1	Membership Manager	Minor	Version 1.1
02 May 2012	2.0	Trust Secretary	Major	Revision to Foundation Trust Constitution to increase Committee membership. Approved by the Membership Council.
12/02/2015	3.0	Interim Head of Membership and Governance	Major	

Table of Contents

1. Constitution and Purpose

1.1 The Nominations and Appointments Committee is a formal Committee of the Council of Governors established in accordance with the NHS Act 2006 [1],) as amended by the Health and Social Care Act 2012 (the 2012 Act), the University Hospitals Bristol NHS Foundation Trust Constitution [2], and the Monitor Foundation Trust Code of Governance[3] for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment removal, remuneration and other terms of service of the Chairman and Non-Executive Directors.

2. Function and Duties

2.1 The Committee shall carry out functions in relation to the following:

Nominations Functions

(a) determine a formal, rigorous and transparent procedure for the selection of the candidates for office as Chairman or Non-Executive Director of the Trust having first consulted with the Board of Directors as to those matters and having regard to such views as may be expressed by the Board of Directors;

(b) seek by way of open advertisement and other means, candidates for office and to assess and select for interview such candidates as are considered appropriate and who meet the *"fit and proper person* "test as set out in the provider license — and in doing so the Committee shall be at liberty to seek advice and assistance from persons other than members of the Committee or of the Council of Governors;

(c) make recommendation to the Council of Governors as to potential candidates for appointment as Chairman or other Non-Executive Director, as the case may be,

(d) consider and make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of the Chairman and other Non-Executive Directors,

(e) on a regular and systematic basis monitor the performance of the Chairman and other Non-Executive Directors and make reports thereon to the Council of Governors from time to time when requested to do so or when, in the opinion of the Committee, the results of such monitoring ought properly to be brought to the attention of the Council of Governors;

(f) To ensure there is a formal and transparent procedure for setting the annual objectives for the Non-Executive Directors, in conjunction with the Chairman, and in conjunction with the Senior Independent Director in the case of the annual objectives for the Trust Chairman

(g) To ensure there is a formal and transparent procedure for the appraisal of the Trust Chairman and Non-Executive Directors' performance

(h) To regularly review, in conjunction with the Board of Directors Nominations and Remuneration Committee, the structure, size and composition of the Board of Directors, including giving full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS Foundation Trust and the skills and expertise required within the Board of Directors to meet them.

Remuneration Functions

(a) To ensure there is a formal and transparent policy on remuneration for the Trust Chairman and Non-Executive Directors;

(b) To set the structure and levels of remuneration of the Trust Chairman and Non-Executive Directors;

(c) To determine and review the terms and conditions of the Trust Chairman and Non-Executive Directors;

(d) To market test/ benchmark the remuneration of the Trust Chairman and Non-Executive Directors at a frequency agreed by the Committee and taking account of any external guidance on recommended frequency and/ or where the Committee is considering recommending large change to that remuneration, drawing on external professional advice

(e) To appoint, if deemed appropriate, independent consultants to advise on Trust Chairman and Non-Executive Director remuneration.

3. Authority

3.1 The Committee is authorised by the Council of Governors to carry out the functions and duties set out in these Terms of Reference.

3.2 All powers and authorities exercisable by the Council of Governors, together with any delegation of such powers or authorities to any Committee or individual, are subject to the limitations imposed by the by the National Health Service Act 2006, the NHS Licence Conditions, Trust Constitution or by other regulatory provisions.

3.3 In discharging the functions and duties set out in these Terms of reference, the Committee is to have due regard for the applicable principles and provisions of the Monitor NHS Foundation Trust Code of Governance.

4. Reporting

4.1 The Committee shall report to the Council of Governors.

4.2 A Chair of the Committee or nominated member of the Committee shall report the proceedings of the Committee to the Council of Governors after each meeting

[1] 17 (1) It is for the Council of Governors at a general meeting to appoint or remove the Chairman and the other non-executive directors.

[2] 10.2 The Council of Governors shall establish a committee of its members to be called the Nominations and Appointments Committee to discharge those functions in relation to the selection of the Chair and Non-Executive Directors.

[3] The NHS Foundation Trust Code of Governance Section B2: Appointments to the Board

4 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.

5. Membership

5.1 Members of the Committee shall be appointed by Council of Governors as set out in the Trust's Constitution and shall be made up of twelve members including:

(a) 8 elected public, patient or carer governors

(b) 2 appointed governor

(c) 2 elected staff governor

5.2 Appointment of governors to the Committee shall be conducted at a general meeting of the Council of Governors. If there are more governor nominees than places on the Committee, the final selection of candidates shall be put to a vote of the Council of Governors.

5.3 Governors shall be appointed to the Committee until their term of office as governor ends as set out in the Trust's Constitution, or they choose to resign from the Committee, which shall be confirmed in writing to the Chair of the Committee. Membership of the Committee will be reviewed on an annual basis

5.4 In the case of the appointment process for the Trust Chairman, the Senior Independent Director (SID) will be co-opted to join the Committee. The SID will attend in an advisory capacity and will not participate in the formal decision making process.

5.6 Chair of the Committee

(a) The Chairman of the Trust will Chair the Nominations and Appointment Committee. In his absence, or when the Committee is to discuss matters in relation to the appraisal, appointment, re-appointment, suspension, removal or remuneration and terms and conditions of the Chairman, the Committee will be chaired by the Senior Independent Director.

5.6 Quorum

(a) The quorum necessary for the transaction of business shall be four governors and the Chairman and/or Senior Independent Director

(b) A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5.7 Attendance at Meetings

(a) Only members of the Committee have the right to attend Committee meetings.

(b) Other individuals, including advisers, may be invited to attend for all or part of any meetings, as and when appropriate. This shall include the Director of Workforce and Organisational Development in an advisory capacity when considering matters of recruitment, appointment and appraisal of the Chairman and Non-executive Directors

(c) The Trust Secretary shall attend meetings of the Committee to advise on matters of corporate governance, procedure and conduct in relation to the NHS Provider Licence Conditions and Trust Constitution.

6. Secretariat

6.1 The Trust Secretariat shall provide Secretariat support to the Committee.

6.2 Notice and Conduct of Meetings

(a) The Trust Secretary shall call meetings of the Committee at the request of the Chairman not less than ten clear days prior to the date of the meeting,

(b) The agenda shall be agreed by the Chair of the Committee in consultation with the Trust Secretary,

(c) Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting,

(d) Supporting materials shall be provided to Committee members and to other attendees as appropriate, at the same time.

6.3 Minutes of Meetings

(a) The Trust Secretary or his nominee shall minute the proceedings and resolutions of the Committee, including the names of members present and others in attendance. Draft minutes shall be distributed to Committee members for approval after each meeting.

6.4 Frequency of Meetings

(a) The Committee shall meet at least twice per annum and at such other times as the Chair of the Committee shall require.

7. Review of Terms of Reference

7.1 At least once a year, the Committee shall review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Council of Governors.

DH/Dec 14

NOMINATIONS AND APPOINTMENTS COMMITTEE

MEMBERS LIST – Feb 2016

NAME	CONSTITUENCY
John Savage	Chairman
Mo Schiller	Public: Bristol
Sue Silvey	Public: Bristol
John Steeds	Patient: Local
Anne Skinner	Patient: Local
Pam Yabsley	Patient: Local
Phil Mackie	Patient: Carer of patient under 16yrs
Wendy Gregory	Patient: Carer of patient 16yrs and over
Angelo Micciche	Patient: Local
Florene Jordan	Staff: Nursing & Midwifery
Ian Davies	Staff: Medical and Dental
Marc Griffiths	Appointed: University of the West of England
Jeanette Jones	Appointed: Joint Union Committee
In attendance	
Debbie Henderson	Trust Secretary
(Alex Nestor	Head of Human Resources)
Sarah Murch	Membership PA/Administrator (minute taker)

University Hospitals Bristol NHS
NHS Foundation Trust

A Governor Development Seminar Report for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – Governor Development Seminar Report

Purpose

To provide the Council of Governors with an update on the governor development programme.

Abstract

The governor development programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Author: Head of Membership and Governance

Report

There has been **one** Governor Development Seminar since the last Council of Governors meeting.

Governor Development Seminar: 8 April 2016

Governors attending: Mo Schiller, Angelo Micciche, Anne Skinner, Sue Silvey (part), Clive Hamilton, John Steeds, Brenda Rowe (part) Florene Jordan (part), Jeanette Jones (part), Tim Peters (part), Pam Yabsley, Pauline Beddoes, Bob Bennett and Ray Phipps (part).

- **Bristol Medical Simulation Centre** – An tour and overview from James Murray, Business Manager and the team at the Bristol Medical Simulation Centre (BMSC), a unique facility delivering expert multidisciplinary healthcare training using a variety of interactive human patient simulators and manikins to give clinicians the opportunity to learn, rehearse and perfect procedures from the simple to the highly complex.
- **Patient Safety Improvement Programme -** An update from Anne Reader, Head of Quality (Patient Safety) on the Trust's Sign up to Safety Programme (a presentation recommended by the Quality & Outcomes Committee).
- **National Maternity Survey 2015 –** An update by Sarah Windfeld, Head of Nursing and Midwifery at St. Michael's Hospital, following the announcement by the CQC that St. Michael's Hospital and UH Bristol are rated the best performing Trust nationally for hospital maternity care.
- **Bristol Health Partners Healthcare Professional of the Year** – Sue Brand, Germ Cell Clinical Nurse Specialist, spoke about winning this award. Sue is based at Bristol Haematology and Oncology Centre. In her role as germ cell cancer specialist she offers advice and support to the hundreds of patients across the South West who are diagnosed with testicular cancers.
- **Monitor Annual Plan Submission** – Further and final update from Paul Mapson, Director of

Finance & Information.

Next session:

The next Governor Development Seminar will be held on Monday 13 June 2016 from 10:00-16:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

It will be an induction and introduction session for new and existing governors. It is hoped that all governors will attend to help give the newly-elected governors a good start in their new role.

University Hospitals Bristol NHS
NHS Foundation Trust

Governors' Strategy Group Meeting Account for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 7a – Governors' Strategy Group Meeting Account

Purpose

To provide the Council of Governors with an update on meetings of the Governors' Strategy Group.

Abstract

The Governors' Strategy Group provides an opportunity for engagement with governors to develop the Monitor Annual Plan and to contribute to the Trust's strategic planning.

The group is chaired by Wendy Gregory, Patient/Carer Governor, and Executive Lead for the group is the Director of Strategy/Head of Business Planning. There are around 6 meetings a year, and they are open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Wendy Gregory, Governor Lead for Strategy Project Focus Group

The Governors' Strategy Group has held **one** meeting since the last Council of Governors meeting.

Governors' Strategy Group: 15 March 2016

Governors attending: Graham Briscoe, Clive Hamilton, Ray Phipps, Wendy Gregory, Jeanette Jones, John Steeds, Pam Yabsley, Mo Schiller, Sue Silvey, Brenda Rowe, Bob Bennett, Flo Jordan and Angelo Micciche.

Others present or in attendance: Paul Mapson – Director of Finance, Jeremy Spearing – Associate Director of Finance, Amanda Saunders – Head of Membership and Governance, Jill Youds, Non-executive Director, Sarah Nadin – Head of Business Planning.

This session provided governors with the opportunity to be consulted on the 2016/17 Monitor Annual Plan submission, and receive a full update on all aspects of Business Planning from the relevant Trust leads. It was agreed at this meeting that governors noted their support for the plan, and would receive a further and final update prior to submission at their Development Seminar on Friday 8th April 2016.

Topics discussed:

- **Business Planning – Internal Planning**
- **Business Planning – Monitor Annual Plan**
- **Business Planning – 5-year Sustainability and Transformation Plan (STP)**

Presentations and update from the Director of Finance, Associate Director of Finance and the Head of Strategy & Business Planning.

The next meeting of the Governors' Strategy Group will be held on Friday 10 June 2016 at 10:30-12:30, in the Board Room, Trust Headquarters.

University Hospitals Bristol NHS
NHS Foundation Trust

Quality Focus Group Meeting Account for a Council of Governors Meeting, to be held at 14:00 on 28 April 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07b- Quality Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Quality Focus Group.

Abstract

The objectives of the Quality Focus Group are to provide:

a) engagement with governors to develop the Board's Annual Quality Report;
b) regular support to enable governors to understand, interpret and raise questions on the Board Quality and Performance Report;
c) regular support to enable governors to understand and interpret reported progress on the Board's Quality Objectives; and,
d) opportunities for input from governors on quality matters.

The group is chaired by Clive Hamilton and includes input from the Chief Nurse and Medical Director. Meetings are held bi-monthly and open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for the Quality Focus Group

The Quality Focus Group has held **one** meeting since the last Council of Governors meeting. There was also an extra Trust Quality Report consultation meeting with governors in February.

Quality Report Consultation Meeting: 26th February 2016

Governors attending: Karen Stevens, Graham Briscoe, Clive Hamilton, Mo Schiller, Sue Silvey, Angelo Micciche, Florene Jordan, Ray Phipps, Bill Payne, Bob Bennett, Anne Skinner, Pam Yabsley, Ben Trumper, Sylvia Townsend, Marc Griffiths, Wendy Gregory.

Also Attending: Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness), Amanda Saunders (Head of Membership and Governance).

Topics Discussed: This was a meeting to support the governor input to the Trust's Quality Report for 2016/17. There were many suggestions and these, together with Executive input and suggestions from a Member focus group meeting on 20th January 2016 were to be the basis for submission to the Trust Board. The governors also put forward observations on their choice for an Audit Indicator.

Quality Focus Group Meeting: 10 March 2016

Governors attending: Clive Hamilton (Lead governor for the group), Mo Schiller, Pam Yabsley, Bob Bennett, Ian Davies, Flo Jordan, Anne Skinner, Graham Briscoe, Sue Milestone, Wendy Gregory, Brenda Rowe, John Steeds, Marc Griffiths, Karen Stevens, Angelo Micciche.

Also attending: Carolyn Mills – Chief Nurse, Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness), Amanda Saunders – Head of Membership and

Governance.

Topics discussed:

Corporate Quality Objectives and 2015/16 Quality Report: Governors received an update on progress with the Trust's Corporate Quality Objectives for 2015/16. Four of these will be carried forward to the coming year together with six new objectives. At least two of last year's objectives will not be met by end of March 2016. It was indicated that Early Warning Scores (suggested by governors) would be the Local Audit Indicator to be checked for 2015/16. The governors would produce a commentary for inclusion in the report based on their monitoring during the year.

Trust Quality Report for 2016/17: The Head of Quality (Patient Experience and Clinical Effectiveness) outlined the conclusions from the Extra Quality Report meeting with Governors on 26th February and listed the ten proposed Corporate Quality Objectives to be included as 2016/17 targets.

Report from Chair of Quality And Outcomes Committee: Governors received the written report which was welcomed for its thoroughness and comprehensive scrutiny of quality issues. The assurance provided was appreciated and governors asked that positive feedback was transmitted to the Committee Chair with their wishes for a speedy recovery.

Quality and Performance Report Summary: The Chair of the Group presented his written report which was based on the data from the Board papers for 29th January and 29th February 2016. It was noted that the Trust is achieving its target for 18 week referral to treatment target and backlog clearance and with achievement of the 62 day G.P. referral to treatment target after a long period of non-achievement. Quality measures such as Falls, Pressure Ulcers, Dementia Care, Management of Sepsis, Nutrition monitoring, Clostridium Difficile incidence and Harm Free Care continued to be above target and these have been consistent successes throughout the year. The governors were particularly impressed with the achievement of a first place rating for Maternity Services awarded by the Care Quality Commission. Increased demand on services had impacted on other measures, especially the 4hour emergency treatment target and delays to ambulance handover. There was a declining trend in some other quality measures which gave cause for concern. These were Venous Thrombo-embolism Assessment, Early Warning Scores, Medicines Safety, Emergency Readmissions, Fractured Neck of Femur Best Practice, Stroke Care, Cancelled Operations and Ward Outliers.

Any Other Business: The Governors Log items were reviewed and there was discussion about the improving situation in ward A900 (Cystic Fibrosis), The health effects for staff on twelve hour shifts, the proposed centralisation of the Cellular Pathology service at North Bristol Trust (1st May 2016) and concerns about the cancelled operation rate in Cardiology together with the GLANSO model.

The next meeting of the Quality Focus Group will be held on Thursday 5 May 2016 at 12:30-14:30 in the Conference Room, Trust Headquarters.

University Hospitals Bristol NHS
NHS Foundation Trust

Constitution Focus Group Meeting Account for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07c – Constitution Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Constitution Focus Group.

Abstract

The objectives of the Constitution Focus Group are to provide:

(i) engagement with governors in drafting Constitutional changes;

(ii) assessing the membership profile; and,

(iii) advice from governors on communications and engagement activities for Foundation Trust members.

The group meets quarterly and is open to all governors. The Chair of the Group is Sue Silvey and the executive lead for the Group is the Trust Secretary.

Recommendations

- The Council of Governors is asked to **note** the update.

Report Sponsor or Other Author

Sponsor: Trust Secretary/Lead Governor for the Constitution Focus Group

The Constitution Focus Group has held **one** meeting since the last Council of Governors meeting.

Constitution Focus Group Meeting: 15 March 2016

Governors attending: Sue Silvey (group Chair), Mo Schiller, Graham Briscoe, Clive Hamilton, John Steeds, Bob Bennett, Ray Phipps, Pam Yabsley, Wendy Gregory, Florene Jordan and Bill Payne.

Others present or in attendance: Amanda Saunders – Head of Membership and Governance, Sarah Murch – Membership and Governance Administrator.

Topics discussed:

- **Governor Elections** – an update was given on the work to promote the governor elections and the current position as to potential candidates.
- **New Governor Induction –** a new governor induction pack will be produced for the 2016 intake of new governors, and governor input on this will be sought in due course.
- **Membership** – There was a report on membership recruitment and governors gave feedback on new membership materials and proposed activities. Governors gave their views on the approach for the next Health Matters Event.
- **Governor Seminars** – Governors were asked for their input into the governor development seminar programme.
- **Lead Governor Election –** governors were informed that an election for lead governor would take place in April and they discussed the nature of the role and what it should involve, based on the revised role description agreed by Council in 2015.
- **Opportunities for governor involvement –** governors wished to explore opportunities to attend events such as the Trust's peer reviews or clinician/divisional away days.
- The group also gave their thanks to **Sue Silvey**, who was chairing the meeting for the last time.

Angelo Micciche will take over as Governor Chair of this group with effect from 1 June.

The next meeting of the Constitution Project Focus Group will be held on **Thurs 23 June 2016 (please note new date)**, at 10:00-12:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Membership Activity Report for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08a- Membership Engagement Report

Purpose

To provide the Council of Governors with current membership details, and a summary of membership engagement since the last Council of Governors meeting on 29 January 2016.

Abstract

The Trust has a formal requirement to maintain a Foundation Trust membership and a responsibility to engage with its membership. Progress against the Membership Engagement and Governor Development Strategy (April 2015) is reported below.

Recommendations

The Council of Governors is recommended to **note** the Membership Activity Report.

Report Sponsor or Other Author

Sponsor: Head of Membership and Governance

Report

Key areas of progress against the Membership Engagement and Governor Development Strategy have included:

- Health Matters Event held in April 2016, with over 60 attendees. In addition to a service update the session incorporated the opportunity for member feedback facilitated via small discussion groups. We worked with Tony Watkins, PPI lead and the Trust End of Life Care Team on the event. Positive feedback received to date.
- Attendance at the Bristol Carers Support Centre event for carers in March 2016 to promote membership and the role of Patient Carer Governor at the Trust.
- Membership engagement stands in Bath and Thornbury.
- Voices mailing to all members, content to include the role of governors in linking with support groups such as carers support groups and promotion of the governor elections.
- General focus on governor elections and promotion of the opportunity to stand for a governor role – including three Prospective Governor Information Events hosted by Chair/ NED, Governors and Membership Team.

Current Membership Numbers:

At **21 April 2016**, Foundation Trust membership stands at 21,511 members (6,377 public members, 4,609 patient members and 10,525 staff members).

This compares with membership at **20 January 2016** of 21,426 members (6,404 public members, 4,650 patient members and 10,372 staff members).

Membership can be broken down as follows:

Member Type Breakdown	Total
Public Constituencies	**6,377**
Out of Trust Area	5
Bristol	3,127
North Somerset	1,249
South Gloucester	1,239
Rest of England and Wales	757
Patient Constituencies	**4,609**
Unspecified	26
Carer of patients 16 years and over	207
Carer of patients 15 years and under	528
Patient - Local	3,848
Staff Classes	**10,525**
Unspecified	0
Medical and Dental	1,327
Nursing and Midwifery	3,000
Other clinical healthcare professionals	2,985
Non Clinical Healthcare Professionals	3,213

Areas of Focus for the next quarter:

- Final stages of governor elections – promoting voting opportunities to relevant member constituent groups.
- Outline options for a joint event with Youth Council, to be co-designed with Youth Council Governors and Sara Reynolds, Young Persons Involvement Worker.
- Voices mailing to all members – May 2016. Feature written by Wendy Gregory, Patient Governor, to update on the progress achieved by the Council and a look ahead to new governors joining the Trust.
- Outline options for summer membership recruitment and engagement programme, final plans to be worked up in conjunction with Constitution Focus Group.

University Hospitals Bristol NHS
NHS Foundation Trust

Governor Activity Report for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08b – Governor Activity Report

Purpose

To report on the ways in which governors have discharged their responsibilities and governor activity in the period 29 January 2016 – 28 April 2016

Abstract

The Council of Governors has responsibilities that are set out in Acts of Parliament such as the National Health Service Act 2006 and more recently new powers within the Health and Social Care Act 2012.

The report below shows how governors have discharged their responsibilities in the areas of:

- Engagement with their members
- Holding Non-executive Directors to account
- Strategic and other responsibilities.

It is followed by a summary of governors' activity in the period.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Appendices

Appendix A – Governor activity Jan-April 2016

Constitution of the Council of Governors:

- As of 18 April 2016 there were 33 governors in post and 3 vacancies.
- There are 15 governor seats up for election in the 2016 governor elections. Of these:
  - Nine governors will be stepping down on 31 May (Tony Tanner, Brenda Rowe, Sylvia Townsend, Tony Rance, John Steeds, Pam Yabsley, Wendy Gregory, Thomas Davies and Ben Trumper).
  - Four are standing for re-election (Flo Jordan, Sue Milestone, Ray Phipps and Pauline Beddoes)
  - Two seats were already vacant (previously Mani Chauhan and Nick Marsh)

Governors' activities in relation to their responsibilities (29 January – 27 April 2016)

Responsibilities of the Council of Governors:	**How governors discharged their duties:**
1. Membership Engagement: • *To represent the interests of the Members of the Trust as a whole and the interests of the public.* • *developing the membership by overseeing the implementation of the Trust's Membership Strategy and by direct engagement with members at events and meetings* • *feed back information about the Trust, its vision and its performance to members, staff, or stakeholder organisation* • *represent the interests of the community, including service users and carers, by ensuring effective communication with Members, feeding back information to the Trust as necessary*	• Governors actively participated in a successful Health Matters event for our members on the topic of End of Life Care on 14 April 2016. • Governors volunteered to man membership recruitment stalls in the main hospital areas in Jan-March 2016. Governors also helped out at a membership stall in Thornbury Library as part of our efforts to reach our South Gloucestershire constituents. • Governors took part in three Governor Election information events for potential governors in Feb-March 2016. • Trust Governors were represented at several external events including the NHS Providers' Governor Focus Conference on 20 April in London, an information-sharing meeting for governors organised by Oxford University Hospitals NHS Foundation Trust on 3 March, Healthwatch Bristol's Open Advisory Group meeting on 8 March, and People in Health West of England's Public and Patient

• *providing a Governor perspective on the efficacy of staff engagement mechanisms*	Involvement in Practice event on 8 February. A UH Bristol governor has also been selected for a place on NHS England's Leading Together Programme, which will take place in April-June supporting health professionals and lay people to develop partnerships that make a difference to their local health organisations and communities. • Governors took part in PLACE visits (Patient-Led Assessments of the Care Environment), a Patient Food Tasting, and the 15-step Challenge (which aims to help patients, staff and Governors work together to identify improvements that will enhance the patient experience.) • Staff governors held the second of their quarterly meetings with Chief Executive Robert Woolley on 17 March. This is a new initiative to enable staff governors to feed back any concerns from their constituents. • Governors were asked for their views on the Happy App – an online application that staff can use to rate their moods and raise issues that are frustrating them at work. • Governors were represented on the panel for judging of the Trust's Nursing & Midwifery Awards and the Big Green Scheme Awards. • The Mar/Apr issue of Voices magazine (staff edition) included governor input. • Governors continued to feed back issues raised by patients and staff at their meetings and through the Governors Log of Communications.
2. Holding Non-executive Directors to account: • *hold the Non-executive Directors individually and collectively to account for the performance of the Board of Directors*	• Governors attended the public meetings of the Trust Board of Directors in January and February to observe the Non-executive Directors. Non-executive Directors also attend Council of Governors

• *receive performance appraisal information regarding the Trust Chairman and Non-executive Directors* • *set the pay and terms & conditions of appointment for the Trust Chairman and Non-executive Directors* • *appoint and (if necessary) remove the Trust Chairman and Non-executive Directors* • *approve the appointment of the Chief Executive - however, the Council of Governors will not appoint the Chief Executive* • *if necessary, inform Monitor, via the Lead Governor, if there are any 'material concerns' about the actions of the Board of Directors which cannot be resolved locally* • *being assured that the Non-executive Directors act so that the Trust does not breach the conditions of its NHS Provider Licence*	meetings. • Non-executive Directors have attended meetings of the Governors' Quality Focus Group and the Strategy Focus Group in this period to provide governors with updates from their committees. • The regular and informal Counsel meetings that governors have with the Chairman and Non-executive Directors are now chaired by a Non-executive Director on a rotational basis. • Governors on the Nominations and Appointments Committee met on 26 February to review the appraisal papers for Non-executive Directors Jill Youds and Julian Dennis.
Strategic Direction: • *give a response when consulted by the Board of Directors on the Trust's Annual Plan* • *satisfy itself that proposals in the Annual Plan (other than those relating to the provision of health services in England) will not significantly interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions* • *approve any proposal to increase by 5% or more the proportion of the Trust's total annual income from activities other than the provision of health services in England.* • *approve any applications for significant transactions*	• The Governors' Strategy Group met on 15 March and discussed the Annual Plan at length. • Governors were given a further update on the progress of the Annual Plan at their Seminar on 8 April. • Governors continue to receive updates on the Trust's strategic outlook from the Chief Executive at Council of Governors meetings. • Deborah Lee, Chief Operating Officer, attended a Chairman's and Non-executive Directors' Counsel meeting on 26 February to provide an update to both governors and Non-executive Directors with regards to Glanso arrangements.

• *approve any applications for mergers, acquisitions, separation or dissolution of the Trust* • *agree, in conjunction with the Board of Directors, changes to the Trust's Constitution* • *supporting the Board of Directors in setting the long-term strategic direction for the Trust* • *promote and support the organisation's strategy*	
Other responsibilities: • *appoint or (if necessary) remove the Trust's external auditors* • *receive the Trust's Annual Report and Accounts, and the Auditor's report* • *select a local audit indicator for inclusion in the Trust's Quality Report.*	• Governors held a meeting on 26 February with the Head of Quality (Patient Experience and Clinical Effectiveness) to give input into the draft corporate quality objectives for 2016/17, and to select a local audit indicator for inclusion in the Quality Report.

Governor Activity 29 Jan 2016-27 April 2016	Public Governors									Public, rest of	Patient Governors						Carers 16+		Carers -16		Staff Governors					Appointed Govs							
Name of Event	Pauline Beddoes	Tony Tanner	Clive Hamilton	Sue Silvey	Mo Schiller	Brenda Rowe	Bob Bennett	Graham Briscoe	Sylvia Townsend	Tony Rance	Anne Skinner	Pam Yabsley	Angelo Micciche	Edmund Brooks	Ray Phipps	John Steeds	Wendy Gregory	Sue Milestone	Philip Mackie	Lorna Watson	Ian Davies	Karen Stevens	Thomas Davies	Florene Jordan	Ben Trumper	Marc Griffiths	Sue Hall	Jim Petter	Tim Peters	Bill Payne	Jeanette Jones	Julia Lee	Isla Phillips
Council of Governors																																
29 Jan 2016	X		X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X		X		X	X		X			X		
Nominations and Appointments Committee (Committee members only)																																
26 Feb 2016				X	X						X	X	X											X								
Governors Development Seminar																																
8 April 2016	X		X	X	X	X	X					X	X		X	X								X				X		X		
Quality Project Focus Group																																
10 Mar 2016			X		X	X	X	X			X	X	X			X	X	X			X	X		X		X						
Governors Strategy Group/Annual Plan Project Focus Group																																
15 Mar 2016			X	X	X	X	X	X				X	X		X	X	X							X						X		
Constitution Project Focus Group																																
15 Mar 2016			X	X	X		X	X				X			X	X	X							X					X			
Chairman's and NEDs' Counsel/Govs Informal Meeting																																
26 Feb 2016			X	X	X		X	X	X		X	X	X		X		X					X		X	X					X		
Public Trust Board meetings																																
26 Jan 2016	X		X	X	X		X	X			X	X	X		X		X	X						X						X		
29 Feb 2016			X										X		X	X								X					X	X		
30 Mar 2016			X			X									X	X	X				X			X								
Chair and Chief Exec Walkrounds (2 governor observers per walkround)																																
23-Feb-16															X		X															
17-Mar-16														X															X			
Members' Events																																
Membership Recruitment Stall - BHI 3/2/16											X	X																				
Membership Recruitment Stall - Oncology 11/2/16																	X													X		
Membership Recruitment Stall - BCH 25/2/16							X																									
Gov Election Information event - 29/2/16											X		X																			
Membership Recruitment Stall - Thornbury Library 11/3/16	X																															
Gov Election Information event -10/3/16																	X							X								
Gov Election Information event - 22/3/16					X		X																									
Health Matters Event - 14/4/2016	X		X	X	X			X			X					X	X													X		

Governor Activity 29 Jan 2016-27 April 2016	Public Governors									Public, rest of	Patient Governors						Carers 16+		Carers -16		Staff Governors					Appointed Govs							
Name of Event	Pauline Beddoes	Tony Tanner	Clive Hamilton	Sue Silvey	Mo Schiller	Brenda Rowe	Bob Bennett	Graham Briscoe	Sylvia Townsend	Tony Rance	Anne Skinner	Pam Yabsley	Angelo Micciche	Edmund Brooks	Ray Phipps	John Steeds	Wendy Gregory	Sue Milestone	Philip Mackie	Lorna Watson	Ian Davies	Karen Stevens	Thomas Davies	Florene Jordan	Ben Trumper	Marc Griffiths	Sue Hall	Jim Petter	Tim Peters	Bill Payne	Jeanette Jones	Julia Lee	Isla Phillips
Other regular meetings or events																																
Governors' Voices Editorial group meeting - 16/2/16					X						X						X					X		X								
Patient-Led Assessments of the Care Environment (PLACE) workshop 10/2/16	X												X																		X	
Patient-Led Assessments of the Care Environment (PLACE) BCH - 2/3/16					X																											
Quarterly Staff Governors meetings with Chief Exec-17/3/16																						X										
Patient-Led Assessments of the Care Environment (PLACE) 30/3/16	X						X				X							X												X		
Ad-hoc meetings/events																																
ED Observation with management trainee 2/2/16													X																			
Trust Secretary Interviews - 4/2/16					X								X																	X		
Patient Food Tasting - 25/2/16				X									X					X														
Nursery & Midwifery Awards Panel mtng 12/4/16											X																					
15-steps workshop - 18/4/16											X																					
UH Bristol Governor Representation at External Events																																
People in Health West of England PPI in practice - 8/2/16											X																					
Oxford UH NHS FT information-sharing event 3/3/16																								X								
Healthwatch Bristol Open Advisory Group meeting 8/3/15								X																								
NHS Providers Governor Focus Conference, London, 20/4/16																														X		
Trust Operational Groups with governor representation																																
Carers' Reference Group - gov rep is Anne Skinner **ATTENDED 24/2/16**											X																					
Nutrition & Hydration Steering Group - gov rep is Anne Skinner											X																					
Decontamination Board/Decontamination Group - gov rep is Florene Jordan																								X								
Patient Experience Group - gov rep is Pam Yabsley **ATTENDED 18/2/16**												X																				
Clinical Ethics Advisory Group - gov rep is Anne Skinner - **ATTENDED 3/3 and 22/3**											X																					
Equality and Diversity Staff Group - gov rep is Florene Jordan																								X								
Carers Strategy Steering Group - gov reps are Wendy and Lorna																	X															

Report for a Council of Governors Meeting to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 09 – Governor Elections 2016 - Update

Purpose

The purpose of this report is to provide the Council with an update on the work being undertaken to support the UH Bristol Governor Elections for 2016.

Recommendations

The Council of Governors is asked to **note** the report.

Report Sponsor or Other Author

Sponsor: Head of Membership & Governance

Report

In 2016, 15 Governor roles will be available for re-election:

- Public Governor for Bristol (2 seats)
- Public Governor for South Gloucestershire (2 seats)
- Public Governor for the Rest of England & Wales (2 seats)
- Patient Governor for the local area (Bristol, North Somerset and South Gloucestershire – 3 seats)
- Patient Governor for Carers of Patients over 16 years of age (2 seats)
- Staff Governors – Non Clinical, Other Clinical, Nursing and Midwifery (4 seats in total)

The 2016 election programme undertook a refreshed approach to the promotion of the governor role, and a comprehensive campaign to generate interest, including;

- Mailing to all 'warm' members – circa 250
- Updated Information Pack
- Promotion across the Trust and in the local area, including coverage in the Evening Post
- 3 Prospective Governor Information Events attended by over 40 members
- Promotion in the Chief Executive all staff briefing and Newsbeat

The nominations closed after a brief extension at 9am on Monday 11th April 2016. The final statement of candidates is attached as Appendix A. The constituencies of Rest of England and Wales, South Gloucestershire, Nursing and Midwifery and Other Clinical Healthcare Professional will be uncontested, resulting in automatic appointment of nominees. The constituencies of Public Bristol, Patient Local and Patient Carer for patient over 16 years will all go to ballot vote.

The key dates for the election process will then run as follows, with support from Electoral Reform Services (ERS):

- 28th April – Voting open, all members sent details of nominees and instruction on how to vote
- 24th May – Voting closes
- 25th May – Declaration of results – ERS/ Membership & Governance team to confirm to nominees and announce results via Trust website, etc.
- 1st June – Official appointment and commencement of Term of Office for new/ re-elected Governors

12th April 2016

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
ELECTION TO THE COUNCIL OF GOVERNORS

STATEMENT OF NOMINATED CANDIDATES

The deadline for nominations for the above election was Noon on Wednesday 6th April 2016.

Constituency Name	Candidate Name	Political Interests	Financial and Other Interests in the Trust
Public: Bristol	Carole Dacombe	None	None
Public: Bristol	Tom Frewin	None	None
Public: Bristol	Susan Mehdevy	None	None
Public: Bristol	Paul Mugford	Liberal Democrats	None
Public: Bristol	Graham Russell Papworth	None	None
Public: Bristol	Maureen Ann Phillips	None	None
Public: Bristol	Bishnu Upadhaya	None	None
Public: Bristol	Gillian Woodman-Smith	None	None
Public: Bristol	Brian Worthington	None	None
Rest of England and Wales	Said Hussein Amiri	None	None
Rest of England and Wales	Jonathan Seymour-Williams	None	None
Public: South Gloucestershire	Pauline Beddoes	None	None

Public: South Gloucestershire	Malcolm Stuart Watson	None	None
Patient: Carer of patients 16 years and over	Anthony Collis	None	None
Patient: Carer of patients 16 years and over	Mike Lyall	Labour	None
Patient: Carer of patients 16 years and over	Sue Milestone	Labour Party	None
Patient: Carer of patients 16 years and over	Garry Williams	Conservative	None
Patient: Local	Kathy Baxter	None	None
Patient: Local	Abdoor Rashid Joomun	None	None
Patient: Local	Ray Orgill	None	None
Patient: Local	Ray Phipps	None	None
Patient: Local	Belinda Sully	None	None
Staff: Non-clinical Healthcare Professional	Michael Maimone	None	None
Staff: Non-clinical Healthcare Professional	Neil Morris	None	None
Staff: Non-clinical Healthcare Professional	Derek Pearce	None	None
Staff: Non-clinical Healthcare Professional	Jane Westhead	Independents for Bristol	None
Staff: Non-clinical Healthcare Professional	Sharmily Yogananth	None	None

Staff: Nursing and Midwifery	Florene "Flo" Jordan	None	None
Staff: Other Clinical Healthcare Professional	Andy Coles-Driver	None	None

The contact address for each of these candidates is C/O The Returning Officer, University Hospitals Bristol NHS Foundation Trust, Electoral Reform Services Limited, The Election Centre, 33 Clarendon Road, London, N8 0NW, or email at jonathan.tait@electoralreform.co.uk.

Should any candidate wish to withdraw their nomination the deadline is Noon on Thursday 14th April 2016.

Jonathan Tait

Returning Officer
On behalf of University Hospitals Bristol NHS Foundation Trust

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Council of Governors Meeting to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Lead Governor Election 2016 -
Purpose
The purpose of this report is to provide the Council with an update on the election of a Lead Governor for the period 1st June 2016 - 31st May 2017.
Recommendations
The Council of Governors is asked to **approve** the nominees.
Report Sponsor or Other Author
Sponsor: Head of Membership & Governance
Report
The role of Lead Governor is one that has received a vote of support previously by the Council and the Constitution Focus Group. At the last meeting of the Constitution Focus Group governors reviewed the role description for the Lead Governor, noting only minor amendments. A call for a new nominee for the Lead Governor role was issued on 24th March 2016 via email to all governors. Following a reminder, two candidates have come forward and subsequently the Council is asked to consider a proposal for a Joint Lead Governor, with the role held by both Angelo Micciche and Mo Schiller. It is proposed that Angelo and Mo would share the responsibilities of the role, and as a result ensure that the Council still receive the benefit of having a Lead Governor. In the event it was ever required by Monitor then Angelo and Mo would both support facilitation between this body and the Council. The Council is asked to approve this proposal.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a report for a Council of Governors Meeting to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 11 – Forward Planner for Council of Governors Meetings 2016-2017
Purpose
The purpose of this report is to note the forward planner for the business of Council of Governors Meetings for 2016-2017.
Recommendations
The Council of Governors is asked to receive the forward planner to **note**.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Forward Planner for Council of Governors Meetings 2016-2017

Council of Governors Reports must be:

To ***Approve*** (Strategy, Policy, Finance, Business Case, Recommended course of action)
To ***Ratify*** (endorse a decision made elsewhere that requires Board approval)
For **Review** (assess status, challenge performance, make recommendations for change)
To ***Note*** (provided for formal awareness)
For ***Information*** (provided for general reading, not formal)

Council Committees may: Approve, Review, Monitor, Audit, Scrutinise, depending on their delegated role and function.

						Council of Governors Public Meeting	Council of Governors Public Meeting	Annual Members' Meeting	Council of Governors Public Meeting	Council of Governors Public Meeting
				Meeting Date		Thurs 28/04/2016	Thurs 28/7/2016	Thurs 15/9/2016	Mon 31/10/2016	Tue 31/1/2017
				Start Time		14:00	14:00	17:00	14:00	14:00
				Location		Conference Room, Trust HQ	Conference Room, Trust HQ	Lecture Theatre 1, Education Centre	Conference Room, Trust HQ	Conference Room, Trust HQ
				Deadline for Inclusion						
			Number of Meetings =>	4	Annual Reporting Data	19	19	9	15	15
Scheduled Reports	**Category**	**Regularity**	**Sponsor**	**Other Author**	**Number of times seen by Council**	**Purpose**	**Purpose**	**Purpose**	**Purpose**	**Purpose**
Chairman's Welcome and Apologies	Corporate Governance	Standing	Chairman	Chairman	5	Note	Note	Note	Note	Note
Declarations of Interest	Corporate Governance	Standing	Chairman	Chairman	4	Note	Note		Note	Note
Minutes and matters arising from previous meetings	Corporate Governance	Standing	Chairman	Chairman	4	Approve	Approve		Approve	Approve
Governors' Log of Communications	Governors' Questions	Standing	Chairman	Governors	4	Review	Review		Review	Review
Nominations & Appointments Committee Report	Statutory and Foundation Trust Constitutional Duties	Standing	Chairman	Chairman	4	Note	Note		Note	Note
Governor Development Seminar Report	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Trust Secretary	4	Note	Note		Note	Note
Governor Groups Report (including reports from Quality Focus Group, Constitution Focus Group, Governors' Strategy Group and any others)	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Trust Secretary	4	Note	Note		Note	Note
Governor Activity Report	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Head of Membership & Governance	4	Note	Note		Note	Note
Governor Compliance Report	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Head of Membership & Governance	4	Review	Review		Review	Review
Chief Executive's Report	Strategic Outlook	Standing	Chief Executive	Chief Executive	4	Note	Note		Note	Note
Membership and Engagement Strategy (including Membership report)	Statutory and Foundation Trust Constitutional Duties	Standing	Trust Secretary	Head of Membership & Governance	5	Approve	Note	Note	Note	Note
Quarterly Patient Experience and Complaints reports	Performance Update and Strategic Outlook	Standing	Chief Nurse		4	Note	Note		Note	Note
Governors' Questions arising from the meeting of the Trust Board of Directors	Governors' Questions	Standing	Chairman	Governors	4	Review	Review		Review	Review
Foundation Trust Members' Questions	Corporate Governance	Standing	Chairman	FT Members	5	Note	Note	Note	Note	Note
Selection of audit indicators for annual Quality Report.	Statutory and Foundation Trust Constitutional Duties	Annual	Chief Nurse	Head of Quality (Chris Swonnell)	1					Delegated to Quality Focus Group
Appointment of Lead Governor	Corporate Governance	Annual	Trust Secretary	Head of Membership & Governance	1	Approve				
Foundation Trust Constitution	Statutory and Foundation Trust Constitutional Duties	Annual	Chairman	Trust Secretary	1		Review / Approve			
Council of Governors Register of Interests	Corporate Governance	Annual	Trust Secretary	Trust Secretary	1	Note				
Election and Appointment of Governors	Statutory and Foundation Trust Constitutional Duties	Annual (July in election years)	Trust Secretary	Head of Membership & Governance	1		Note			
Forward Planner 2016/17	Statutory and Foundation Trust Constitutional Duties	Annual	Trust Secretary	Head of Membership & Governance	1	Approve				
Governors Meeting Dates for 2017/18	Statutory and Foundation Trust Constitutional Duties	Annual	Trust Secretary	Trust Secretary	1				Approve	
Appointment/Re-appointment of the Trust's External Auditors	Statutory and Foundation Trust Constitutional Duties	As required	Trust Secretary	Trust Secretary	2	Approve		Note		
Monitor Annual Plan	Performance Update and Strategic Outlook	Annual	Chief Executive	Chief Executive	1	Approve				
Independent Auditor's Report to the Governors on the Quality Report	Performance Update and Strategic Outlook	Annual	Chief Nurse	Chief Nurse	2		Note	Note		
UH Bristol Quality Report	Performance Update and Strategic Outlook	Annual	Chief Nurse	Chief Nurse	2		Note	Note		
Report on Significant Transactions	Strategic Outlook	Ad hoc	Chairman	Chairman	0					
Report on Integration / Reconfiguration	Strategic Outlook	Ad hoc	Chief Executive	Chief Executive	0					
Report on Major Capital Projects	Strategic Outlook	Ad hoc	Chairman	Chairman	0					
Achievement of Corporate Quality Objectives	Performance Update and Strategic Outlook	Ad hoc	Chief Nurse	Chief Nurse	1		Note			
Presentation of the Annual Report and Accounts	Statutory and Foundation Trust Constitutional Duties	Annual	Chief Executive and Director of Finance	Chief Executive and Director of Finance	1			Note		
Presentation of the External Auditors Opinion on the Annual Report (Annual Audit Letter)	Statutory and Foundation Trust Constitutional Duties	Annual	Chief Executive	Chief Executive	1			Note		
Governors' Annual Report of Governor and Membership Activity	Statutory and Foundation Trust Constitutional Duties	Annual	Lead Governor	Head of Membership & Governance	1			Note		
		Checksum	0	77	77	19	19	9	15	15

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 13 – Review of Governor Compliance
Purpose
To **report** on the ongoing review of compliance to statutory requirements of all governors.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary Author: Head of Membership & Governance
Report
The Trust Secretary and Head of Membership & Governance continue to monitor governor attendance and engagement, as summarised in Appendix A of the Governor Activity Report. In addition to attendance at meetings, we encourage and look for active participation in membership engagement. We continue to seek a replacement appointed governor from South Western Ambulance Service NHS Foundation Trust, and hope to make an appointment in line with the commencement of term of office from 1st June. Sue Hall, Appointed Governor for Avon & Wiltshire Mental Health Partnership, has noted her intention to resign from her role, and so the Membership Office will now also support an appointment to the Appointed Governor for this organisation. There are still 2 DBS checks outstanding. These will now be undertaken if the governors are re-elected, the outstanding DBS checks pose a significant risk to the Trust and the safety of patients, as a precautionary measure governors who do not have a DBS aren't currently permitted to undertake any patient facing activity within the Trust. The Membership Team will link with HR/ Recruitment to ensure all new governors have their DBS checks undertaken within 3 months of their appointment to the role.
Appendix A – Governors' Register of Business Interests – updated April 2016.

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Pauline	Beddoes	Governor -Public, South Gloucestershire	n/a	None	n/a	12/4/2016
Bob	Bennett	Governor - Public, Bristol		Independent Hospital Manager, The Priory Group	Yes - when attending patient reviews.	5/4/2016
Graham	Briscoe	Governor - Public, North Somerset	Nov 15 Mar 16	Independent Lay Member of the Chartered Society of Physiotherapy Charitable Trust Independent Lay Member on the Professional Conduct Committee of the UK Council for Psychotherapy	No No	16/4/2016
Edmund	Brooks	Governor - Patient, Local	n/a	Member of an NIHR research funding panel funded by NHS. Research collaborator for University of Bristol applying for funding from NIHR on GP/Patient relations.		15/4/2016
Ian	Davies	Governor - Staff, Medical and Dental	n/a	None	n/a	5/4/2016
Thomas	Davies	Governor - Staff, Other Clinical Healthcare Professionals	n/a	None	n/a	15/4/2016
Wendy	Gregory	Governor - Patients, Carers (patients 16 years and over)	2012/3 - ongoing	Trustee of the Carers Support Centre Bristol and South Gloucestershire	No	15/4/2016
Marc	Griffiths	Governor - Appointed, University of the West of England		Current employee - University of the West of England	Yes	*20/04/2015*
Sue	Hall	Governor - Appointed, Avon & Wiltshire Mental Health Trust		Director of Resources - AWP Director - PJH Management Consulting Ltd Director - Raregift Ltd (T/A Alison	Yes	15/4/2016

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
				Miles Couture) Chair - Pound Arts Centre Trust, Corsham Director - Pound Café Corsham (Community Interest Company)		
Clive	Hamilton	Governor - Public, North Somerset	n/a	None	n/a	7/4/2016
Jeanette	Jones	Governor - Partnership, Joint Union Committee	n/a	Greater Bristol Branch Member for the South West Board of the Royal College of Nursing	n/a	5/4/2016
Florene	Jordan	Governor - Staff, Nursing and Midwifery	n/a	None	n/a	7/4/2016
Julia	Lee	Governor – Appointed, Youth Council	n/a	None	n/a	30/10/2015
Philip	Mackie	Governor - Patients, Carers (patients under 16 years)	n/a	None	n/a	*21/04/2015*
Angelo	Micciche	Governor - Patients, Local		Current employee – manager at North Bristol Trust	Yes	15/4/2016
Sue	Milestone	Governor - Patients, Carers (patients 16 years and over)		Labour & Co-operative Party Councillor at Bristol City Council - St George West Ward.	No	19/4/2016
Bill	Payne	Governor - Appointed, Bristol City Council		Bristol City Council – Labour Councillor for Frome Vale - Chair of the Bristol Group of the Haemophilia Society - Governor at the Bristol Hospital Education Service.	Expenses No No	15/4/2016
Tim	Peters	Governor - Appointed, University of Bristol	2011-ongoing	Employee of the University of Bristol	Yes	5/4/2016

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
Jim	Petter	Governor - Appointed, SW Ambulance Service NHS FT		- Employed by South Western Ambulance Service NHSFT. -Trustee of the College of Paramedics (unpaid) -Trustee of the patient safety charity AvMA: Action for Victims of Medical Accidents (unpaid).	Yes No No No	15/4/2016
Isla	Phillips	Governor – Appointed, Youth Council	n/a	none	n/a	30/10/2015
Ray	Phipps	Governor – Patients, Local	n/a	- Daughter is employed by pharmaceutical company Astra Zeneca as quality control manager at bulk manufacturing plant. - Niece works as Research Associate in Clinical Trials Management in CTEU with University of Bristol School of Clinical Sciences.	No	6/4/2016
Tony	Rance	Governor - Public, Rest of England and Wales		- The Toastmaster Partnership – Managing Partner - Tony Rance Toastmaster – Sole Trader - Rance Regalia - Proprietor	Yes Yes Yes	5/4/2016
Brenda	Rowe	Governor - Public, Bristol	n/a	None	n/a	15/4/2016
Mo	Schiller	Governor - Public, Bristol	n/a	None	n/a	5/4/2016
Sue	Silvey	Governor - Public, Bristol	Linkage: 2013 - ongoing RSVP West: 2012 -ongoing	- Linkage - Charity preventing social isolation in older people. Director. - RSVP West - Volunteer recruitment charity for over 50s. Bristol Surgery	No No	5/4/2016

First Name	Surname	Trust Position	Date interest started/ ended	Interest role	Remunerated?	Date of declaration
				Schemes Organiser		
Anne	Skinner	Governor - Patients, Local	n/a	None	n/a	15/4/2016
John	Steeds	Governor - Patients, Local	n/a	None	n/a	5/4/2016
Karen	Stevens	Governor - Staff, Non-clinical Healthcare Professional	n/a	None	n/a	15/4/2016
Tony	Tanner	Governor - Public, South Gloucestershire	n/a	None	n/a	*25/03/2015*
Sylvia	Townsend	Governor – Public, Bristol	n/a	Trustee of St. Peter's Non Ecclesiastical Charities.	n/a	18/4/2016
Ben	Trumper	Governor - Staff, Nursing and Midwifery	n/a	None	n/a	18/04/2016
Lorna	Watson	Governor - Patients, Carers (patients under 16 years)	n/a	None	n/a	17/4/2016
Pam	Yabsley	Governor - Patients, Local	n/a	None	n/a	17/4/2016

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 14 – Governors' Log of Communications
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 added or modified since the previous Council of Governors meeting.
The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governor Log – Items since the previous meeting.

ID	Governor Name		
148	Ed Brooks	***Theme:*** Maternity Services	***Source:*** Governor Direct

Query **16/03/2016**

Following a recent Chair, Chief Executive and Governor 'Walk Around' visit to St. Michael's, please can more detail be provided with regards to the reported proposed trial of husbands and partners staying overnight with new mothers. How long would a trial run for, how would the trial be managed, who would be included from the staff side and how would it be assessed?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 22/03/2016

Response **23/03/2016**

The maternity team in response to feedback from mothers and their partners that the ability to stay with partners overnight would enhance their experience of using our services are running a 6 month pilot project in ward 73 supporting partners to stay if they want to. The project is being led by the midwifery team and has been discussed at the maternity liaison Committee (Maternity Voices). Evaluation of the project will include feedback from service users, staff and a review of any risks/incidents that have occurred in this period. Staff side are not involved in the pilot. The review of the pilot and next steps will be via the Women's Executive meeting and post- natal working party.

Status: *Awaiting Governor Response*

ID	Governor Name		
147	Mo Schiller	***Theme:*** Recruitment	***Source:*** Governor Direct

Query **14/03/2016**

Can the Board give governors assurance that there is an effective and rigorous approach to the selection process for Senior Executive and NED positions including the involvement of focus groups,panel interviews and presentations if required. How satisfied is the Board that the preparation and planning for selection process activities is robust and that communication and adherence to Trust values is maintained at all times?

Division: Trust Services ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:*** 14/03/2016

Response **11/04/2016**

The criteria and process for selection of the senior executive directors of the Trust Board is overseen by the Remuneration and Nominations Committee (comprising all Non-Executive Directors). The task is to be open and transparent in line with the Trust's Recruitment Policy, including an assessment of values in line with the organisation's standards and expectations. The selection process is planned with rigour and typically includes an interview, focus groups and a presentation. Appointments are made on the basis of ability and experience and not on the basis of seniority. We would generally employ a selection company to help us plan and execute the process.

The recruitment and appointment of Non-executive Director's at the Trust is supported by the Nomination and Appointment Committee, the membership of which comprises governors, the Trust Secretary and the Trust Chairman. A thorough recruitment and selection process has been outlined and approved by the Committee, including that all applications will need to be assessed against the job description and person specification. Shortlisting will be undertaken by the Nomination and Appointments Committee, led by Chairman (and the Senior Independent Director in the recruitment of a Chair), with the Director of Workforce and Organisational Development and the Trust Secretary in attendance in an advisory role. As well as a formal interview, candidates will be required to attend a discussion group comprising of members of the wider Council of Governors, and members of the Board of Directors.

Status: *Closed*

ID	Governor Name		
146	Bob Bennett	***Theme:*** Mental Health Services	***Source:*** Governor Direct

Query **19/02/2016**

In light of the report on NHS mental health service problems, can the Trust confirm if and how many staff are trained in the treatment and handling of patients suffering from mental health disorders? Do we have psychiatric specialists available throughout the Trust? If extra funding in the provision of our mental health services is required, is funding available within the existing Trust budget?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 19/02/2016

Response **11/03/2016**

Can the Trust confirm if and how many staff are trained in the treatment and handling of patients suffering from mental health disorders? Do we have psychiatric specialists available throughout the Trust?

We have a number of staff formally trained to a high level and employed by UHB in the treatment and handling of patient with a mental health disorder. They in turn train many more. In this trust there is diverse and complex system for the assessment and management of patients suffering from mental health disorders.

The Older Adults Service within the Trust is provided by Avon and Wiltshire Partnership the staff in the team are detailed in the table below.

Clinical Staff
Consultants
Specialty Doctors
Team Manager band 7
Nurses band 6

The Older Adults service works across the campus providing mental health input into older inpatients. There is a not a specific outpatient service. They specialise in the assessment and treatment of patients with cognitive impairment, and is a needs led referral system rather than criterion led. Their working hours are 9-5 5 days a week. There is increased service provision for 16/17 for 2 sessions of consultant time and further band 6 nursing time. This is to support older adults in OPAU, and attempt to reduce the length of stay of this vulnerable. The service has a variable number of core trainees at any one time.

The Adults of Working Age (AOWA) Service

Details of staff in the adults of working age service are in the table below. These are all funded via UHBristol, with the Consultant posts being joint posts with AWP.

ID **Governor Name**

Clinical Staff
Consultants
Specialty Doctors
Team Manager band 8
Nurses band 7
Nurse band 7 (St Michaels)

This service works 07:00 until 21:00, 7 days a week. The team provide an ageless service into ED and observation ward, inpatient review in all departments, and a specialised outpatient service including Medically Unexplained Symptoms. This team also had a variable number of trainees at any one time.

Child and Adolescent Mental Health Service (CAMHS)

The CAMHS service into the Children's hospital is commissioned and provided separately. It was provided by NBT as part of their broader CAMHS remit, but from April 2016 will revert to AWP for one year until a full re-tendering process can take place. This service is provided within office hours.

Psychological services

There are a variety of psychological services available through the Trust. The psychological service can refer into psychiatry.

If extra funding in the provision of our mental health services is required, is funding available within the existing Trust budget?

If extra funding is required to support mental health services by UHBristol this would be identified and prioritised through the annual operating plan process. Liaison Psychiatry has the potential to change the culture of hospitals and the care of all patients. Any expansion must be thoughtful and mindful of the impact on the rest of the healthcare system.

Status: *Closed*

ID	Governor Name		
145	Angelo Micciche	***Theme:*** Medical Equipment	***Source:*** Governor Direct

Query **12/02/2016**

In light of a recent item in the media regarding radiation beam equipment such as CT scanners and equipment used to give radiotherapy to cancer patients, etc., does the Trust have any equipment in current use that is past its recommended "scrappage date"?

If so, how are the Trust assured that the equipment is still fit for purpose and are these items on the capital expenditure/ asset list?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 12/02/2016

Response **22/02/2016**

All assets purchased by, or gifted to, the Trust have a notional asset life assigned to them. This is the period after which time the equipment is eligible for replacement and as such the item is depreciated over this timespan which in essence means that the capital is notionally available to re-procure the item.

There is no such thing as a “scrappage” date, as equipment that remains demonstrably fit for purpose may be retained beyond this life. However, and of note, assets are only used within the Trust if they are deemed to be operating satisfactorily & compliant with all relevant regulations. Dependent on the nature of the equipment, it may be serviced and repaired by the original supplier, an external third party or the Trust’s own Medical Equipment Maintenance Organisation (MEMO) which is hosted by the Division of Diagnostics and Therapies. The Trust is required to have maintenance contracts on all equipment capable of giving exposure to radiation e.g. the CT and radiotherapy equipment mentioned and the Trust is compliant with this statutory requirement; this is a requirement of the Ionising Radiations Regulations – Regulation 32.

The Trust has a rolling replacement programme for medical equipment. Items valued in excess of 500k – which will include the equipment identified in the item i.e. CT scanners and equipment used to give radiotherapy – are planned over a five year horizon and their replacement factored into the Trust’s Medium Term Capital Plan. For medical equipment below 500k, priorities are determined on an annual basis through the Business Planning Cycle.

Status: *Closed*

ID	Governor Name		
144	Mo Schiller	***Theme:*** Hospital facilities for carers	***Source:*** Governor Direct

Query **05/02/2016**

Following my involvement with Face to Face visits in the hospital this week can the Trust outline the overnight sleeping facilities for parents/carers of adult patients (being cared for in an adult setting). For example parents of young adults with special needs who feel it is necessary to stay with the patient overnight. I observed a mattress on the floor by the patient's bedside in use, which does not seem acceptable, especially given some of the carers may also have underlying health issues and the possible implications for Health & Safety and Infection Control.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 05/02/2016

Response **22/03/2016**

Within adult services the Trust will always support patients carers who want to stay with their family member overnight. The Trust has dedicated rooms for carers who have a relative in intensive care. In other impatient areas armchairs are available for carers to use. The Trust via the carers forum is currently exploring options for purchasing arms chairs that recline to form a "bed" which would be accessible to carers if they wanted to stay overnight.

Status: *Responded*

ID	Governor Name		
143	Mo Schiller	***Theme:*** Workforce	***Source:*** Trust Board Meeting

Query **05/02/2016**

Following on from workforce reporting provided to the Trust Board, what additional resources are being utilised and what work is being undertaken regarding the continually high percentage of staff sickness, turnover rate and difficulties in recruitment in the Estates and Facilities Department. What measures can be taken to improve the staff morale to reduce the high turnover?

Division: Trust Services ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:*** 05/02/2016

Response **15/02/2016**

In order to address the turnover and recruitment difficulties, from October 2015, the Division of Facilities and Estates recruited a fixed term Recruitment and Retention Manager as a dedicated resource for the Division. Due to the stringent checks required by all staff working in clinical areas, recruitment times can vary between six weeks and six months. The post holder has reviewed the recruitment documentation and processes, enabling a more efficient recruitment timeline and is working towards a planned reduction in overall recruitment times. In addition to their Trust induction, Health Services Assistants are required to undertake clinical skills training and the Division has increased the number of places available from 9 to 18 per month thus increasing the throughput of new starters in the organisation. In January, offers were made to 60 potential new recruits and we anticipate these will reduce our vacancy rates and subsequently bank and agency usage.

The Division is also reviewing all long term sickness cases to ensure they are being managed in the most proactive, supportive and timely way. Benchmarking with other private and public sector organisations is undertaken to ensure we are adopting best practice with the aim of reducing our sickness levels.

The Division continues to implement its 2015/16 engagement plan. This includes the Facilities staff Champions project, where facilities staff from each main clinical hospital site meet with senior managers to provide feedback, raise issues and concerns. Each champion shares meeting information with their local teams to improve morale and engagement. An issues log has also been created to ensure robust resolution and response is in place. A recognition scheme is already in place recognising individual and team successes, with winners being nominated towards the Trust's annual Recognising Success event. Trade staff in Estates staff are being issued with hand held devices and we are looking to utilise the 'Happy App' on these to receive real time staff feedback. Listening events are held in both Facilities and Estates as well staff briefing for those facilities staff who work out of hours. Estates staff have been actively involved in changes to working practices and local decision-making.

Data and information from the 2015 staff survey (due to be released this month) will be used to develop staff engagement plans and retention plans. Focused work, such as increased marketing of the Trust's total reward package, comprehensive sickness management and best practices in staff engagement will be critical for both recruitment and retention across the Division.

Status: *Closed*

ID	Governor Name		
142	**Wendy Gregory**	***Theme:*** Cancer services	***Source:*** Project Focus Group

Query **22/01/2016**

Whilst it is very encouraging to see the Trust's improvement against the overall 62 day cancer standard, it is concerning to see that for the sub-specialities of Head & Neck, Lower GI and Lung Cancer the Trust is failing to achieve the local and national target. Please can assurance be provided with regards to the underlying causes and actions being undertaken to address the matter, and the expected timeframes for improvement or recovery of the position. (Reference Appendix 3, page 49 of the December 2015 Quality & performance Report)

Division: Specialised Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/01/2016

Response **26/01/2016**

It is recognised within the national standards that not every speciality will achieve the 85% standard, due to some cancers being more complex to diagnose and treat than others. Lung and head & neck cancer are two of the most complex specialities. For all three specialities mentioned, we have recently developed and are working to 'ideal timescale' pathways. We have also encouraged our referring partners to work to these, as late referrals are a key contributor to delays and breaches of the national standard.

In October, none of the lung cancer patients who waited more than 62 days did so for reasons avoidable by the Trust. Nine were referred late by other providers, one was highly complex, and one was patient choice. The national average performance in October for lung was 74%, UH Bristol performance was 68% The national performance will reflect a large number of Trusts for whom pathways are delivered in a single organisation. UH Bristol's performance for "internal" pathways i.e. those that start and finish in the Trust was 87.5%

The national average performance in October for head and neck was 70%, UH Bristol performance was 67%. Some head and neck patients were impacted by slight delays to diagnostics, which is a problem in these highly complex pathways. Even a one day delay to a single step can cause the whole pathway to exceed 62 days. This should be resolved with the ideal timescales and also demand and capacity in this speciality has been reviewed. UH Bristol's performance for "internal" pathways i.e. those that start and finish in the Trust was 70%.

Two-thirds of the colorectal cases that breached the standard in October were potentially avoidable, and these were due to a capacity shortfall in that speciality. This shortfall has arisen due to unforeseen increases in demand and difficulty in increases capacity within the same timeframe. Additional capacity was created in quarter 3 to ensure everyone was given a treatment plan but some of them were treated beyond day 62. As a result, capacity and demand modelling has been undertaken and a new consultant post approved, which will increase capacity to meet demand. The consultant will start in April 2016. The national average performance in October for colorectal was 72%, UH Bristol performance was 40% and as such this is the biggest focus of our cancer improvement work but the area with the greatest opportunity for a step change improvement on the back of the planned increase in consultant capacity.

Status: *Closed*

ID	Governor Name			
141	Chairman and NEDs Counsel	***Theme:*** Cardiac Surgery		***Source:*** Chairman's Counsel

Query **18/12/2015**

Following a point made at the Governors Counsel, it would be helpful if we could be briefed on:
1. Level of cancelled operations in cardiac surgery
2. Method for prioritising use of theatres by surgeons
3. Method of prioritising who is put on each list
4. Whether any of the above is impacted on by the private practice being carried out at the weekends.

(Query logged by Alison Ryan, Non-exectutive Director on behalf of Governors)

Division: Specialised Services ***Executive Lead:*** *Medical Director* ***Response requested:*** 18/12/2015

Response **29/01/2016**

1) The level of cancellations in cardiac surgery has been very high in recent weeks ranging between 25 and 36% over the last 4 weeks. This has led to a high level of poor patient experiences and is primarily a direct consequence of the acute pressures facing the hospital. Excel files with a detailed breakdown on a weekly basis of the cancellations and the reasons for these are kept. The files contain patient specific information and therefore inappropriate to share. The specific figures for the last few weeks have been W/c 14/12 28% cancellations, w/c 7/12 36%, w/c 30/11 25%, w/c 23/11 26% . The commonest causes for cancellation are currently
i) Shortage of theatre staff
ii) Lack of Hospital bed for admission
iii) Lack of CICU bed for admission
Although these causes will vary depending on the pressure on the service.
2) There is a matrix for scheduling as part of the SOP. This creates a balance to ensure that elective and urgent priority patients are balanced. There is always an opportunity to alter this based on clinical priority. This can never be perfect and but offers a practical way of organising the service. Given the multiprofessional environment in which we work on occasion it might be open to criticism from some.
3) The exact scheduling is a complex process based on taking into account the clinical priority of urgent patients but also ensuring that elective patients are treated within appropriate RTT timescales and also taking into account the available surgical expertise as well as issues like numbers of cancellations. This is outlined in the SOP also
4) There is currently no private practice being undertaken in cardiac surgery at the weekend. There are some waiting list initiative lists being undertaken on a Saturday when the acute pressures allow this . The idea of these is to utilise the theatre time at weekends when the level of acute pressure may be less on a Saturday. The idea is that doing these cases deals with some urgent cases and keeps us within RTT. Whether these cases impact on 1-3 is unlikely and would be hard to quantify objectively.

Status: *Closed*

ID	Governor Name

ID	Governor Name		
140	Florene Jordan	***Theme:***	***Source:*** Governor Direct

Query **22/12/2015**

In relation to the Centralisation of Specialist Paediatrics, what process was put in place to ensure adequate training of all operating theatre staff and recovery staff? What training took place prior to the transfer and during the early stages post transfer, and what measures were put in place to ensure that this training was adequate?

Division: Women's & Children's Services ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 22/12/2015

Response **15/02/2016**

Training and education was a key part of the project plan to ensure the safe transfer of services to University Hospitals Bristol NHS Foundation Trust (UHBristol) under the centralisation of specialist paediatrics project. The education and training programme for theatres started in October 2013, with North Bristol NHS Trust (NBT) providing training placements to the theatre team from UHBristol to support them to gain experience in the specialist areas of neurosurgery, scoliosis, burns and plastic surgery. Training competencies were developed for these specialities and the consultants from NBT delivered educational sessions for UHBristol theatre staff.

Further practical training commenced in January 2014, with four staff from UHBristol working in NBT theatres alongside the expert specialist teams. This was focussed primarily in the areas of neurosurgery and spinal surgery.Plastic surgery and anaesthetic training was also offered. The knowledge and skills required to support this additional work was less because UHBristol already had some skills in these specialities.

Since the CSP transfer in May 2014 training and educational opportunities have continued. Theatre staff undertaking clinical training in the department has a set of core competencies to complete relevant to each speciality area in which they will be working.

With reference to the equipment for the transferring services from NBT, there was forensic oversight of the requirements by the clinical teams from Trusts, the CSP Operational Delivery Group and the Strategic CSP Project Board to ensure the correct equipment was available at the point of transfer. Prior to the transfer, the delivery of specialist equipment to UHBristol enabled training sessions to take place, these were delivered by the specialist companies who supplied the equipment.

The programme put in place to ensure the training on equipment was adequate was based on 4 key elements: delivery of training from the respective companies who supplied specialist equipment, clinician input into training and developing the required competencies in neurosurgery supported by working with competencies developed at Birmingham Children's Hospital, Supernumerary time was dedicated for training within the speciality. A senior supernumerary theatre coordinator was available on shift Monday to Friday to discuss and resolve any issues of concern requiring escalation or to discuss training opportunities/issues that needed resolving. These 4 elements allowed staff to develop at a pace to meet their individual needs and ensured that individuals had sufficient knowledge and skills to be on-call. Scoliosis training was implemented using a similar model to neurosurgery, a big advantage was having a representative from the company

supplying the implants being used always on-site.

Status: *Responded*

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 15b: Quarterly Patient Experience and Complaints Reports

Purpose

Purpose

This quarterly agenda item covers the following reports:

- Quarter 3 Patient Experience Report
- Quarter 3 Complaints Report

Patient Experience

• UH Bristol was ranked as the top-performance trust in the 2015 National Maternity Survey
• Board headline patient experience metrics continued to be green-rated in Q3
• Poor response rates for day case Friends and Family Test; below-target response rates for FFT at BRHC; and poor FFT scores in A&Es
• Planned procurement for new patient survey system in 2016, with a renewed focus on responsive care

Complaints

• Q3 reductions in complaints for: BEH, BHI outpatients; ENT and BRI ED
• Q3 increases in complaints for: T&O, Upper GI surgery, Radiology
• Poor performance for sending complaints responses with agreed timescales
• Plans to refocus complaints training specifically on response-writing skills

Read-across

• Ward A900 had an increase in complaints and achieved poor patient experience scores in Q3

Recommendations

The Council of Governors is asked to receive these papers to **note**.

Report Sponsor or Other Author

Sponsor: Carolyn Mills, Chief Nurse

Authors: Paul Lewis, Patient Experience Lead (surveys and evaluation); and Tanya Tofts, Patien Support & Complaints Manager

Appendices

Appendix A - Quarter 3 Patient Experience Report

Appendix B - Quarter 3 Complaints Report

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 3, 2015/16

(1 October to 31 December 2015)

Author: **Paul Lewis, Patient Experience Lead (surveys and evaluation)**

1. Patient experience at UH Bristol: Quarter 3 overview

Successes	Priorities
• The Trust achieved excellent results in the Care Quality Commission's (CQC) National Maternity Survey, which asked women about their experience of hospital and community-based maternity services. UH Bristol was recognised by the CQC as the top performing trust for hospital-based services in this survey. • All of the Trust's key survey metrics remained "green" in Quarter 3 – demonstrating the provision of a high quality patient experience at UH Bristol. • Positive praise for staff remains by far the most frequent form of written feedback received from patients.	• Action by Ward A900 to address low patient experience ratings for 'kindness and understanding' and the inpatient tracker. • Action by Division of Medicine to address low patient-reported scores in that division for explaining side effects of medications that patients should look out for when they go home from hospital. • FFT priority actions for increases response rates to minimum 30% targets by the end of May 2016: day cases trust-wide, and inpatients and day cases specifically at Bristol Royal Hospital for Children. • As part of a wider Quality Strategy for the Trust, developing the Trust's new Patient Experience and Involvement Strategy, with a particular focus on "responsiveness" to patient feedback and the more effective use of technology to capture and use patient experience (strategy to be shared with SLT and Board in May).
Opportunities	**Risks & Threats**
• To improve monitoring and recording of how the Trust's Divisions are using any negative feedback from the Friends and Family Test for service improvement. This will commence in Quarter 4 2015/16 and will be coordinated by the Trust's Patient Experience and Involvement Team. • To share the positive patient feedback messages contained in this report with staff delivering care and users of our services.	• The introduction of a touchscreen survey system in the Trust's Emergency Departments has supported an increase in Friends and Family Test (FFT) response rates, but appears to have resulted in more negative scores. The ED teams continue to look for opportunities to improve care in response to feedback, whilst FFT data capture options will continue to be explored as the Trust develops and implements plans for more responsive patient feedback systems. • Although the vast majority of feedback about UH Bristol staff is positive, where a negative experience occurs, this is often related to the way a member of staff behaved. These "human factors" are usually the determinant of a positive or negative patient experience.

2. Trust-level patient experience data

The quality of patient experience at UH Bristol is monitored via the Friends and Family Test survey, which is typically completed during the patient's stay / visit to the Trust, and via a programme of postal surveys carried out independently of the Trust by an external contractor[1]. Key metrics from these surveys are reported to the Trust Board each month (see Charts 1 to 6 - over)[2]. The scores have been consistently rated "green" in the periods shown[3], indicating that a high standard of patient experience is being maintained. The scores would turn "amber" or "red" if they fell significantly, alerting the senior management team to the deterioration.[4]

The Trust's response rate for the inpatient and day case Friends and Family Test has been below the 30% target during 2015/16 (Chart 7). This is primarily due to the day case element of the survey, which came on-stream in April 2015 and has not yet gained full "traction". The inpatient wards at the Bristol Royal Hospital for Children are also consistently below this target: again this is an area that came into the survey from April 2015 (the adult inpatient and Emergency Departments started in 2013). An action plan, approved by the Trust's Patient Experience Group, is currently in place to improve these rates. We expect the rates to increase during Quarter 4 and to be consistently meeting the 30% target by May 2016. In the medium-term the Trust is exploring the use of electronic data capture and reporting to support the Friends and Family Test in these settings.

Chart 5 (page 5) shows that the Friends and Family Test scores being achieved in 2015/16 by the Bristol Royal Infirmary and Bristol Royal Hospital for Children Emergency Departments have been relatively low compared to previous years (Chart 5)[5]. As noted in previous Quarterly Patient Experience Reports, this is likely to be due to a methodological change which involved installing touchscreen survey screens in the Emergency Departments to supplement the use of Friends and Family Test "exit cards". All of the feedback collected via these channels is shared with the Emergency Departments in order to identify opportunities for service improvement. The great majority of negative comments received via the touchscreens relate to waiting times, which is a constant focus for the Emergency Departments as they strive to meet the four-hour wait target. In order to ensure that a rounded view of patient experience is provided, the Trust's Emergency Departments are exploring alternative methods of collecting feedback alongside the touchscreens. For example, the Bristol Royal Hospital for Children have installed Friends and Family Test card dispensers in every treatment bay, and the Trust's Patient Experience & Involvement Team are exploring the potential use of proactive SMS text messaging (if this is feasible then a pilot will be carried out in Quarter 1).

[1] Patient Perspective Ltd – who have been approved by the Care Quality Commission to carry out patient surveys.
[2] Kindness and understanding is used as a key measure, because it is a fundamental component of compassionate care. The "patient experience tracker" is a broader measure of patient experience, made up of five questions from the UH Bristol 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 statistical analysis and patient focus groups conducted by the UH Bristol Patient Experience and Involvement Team. The outpatient tracker is made up of four questions relating to respect and dignity, cleanliness, communication and waiting time in clinic.
[3] Note: the Friends and Family Test and outpatient data is available around one month before the inpatient survey data.
[4] Trust Board data from the outpatient survey is provided as a "rolling three monthly score". So for example, in July the Trust Board received the combined survey score for April, May, and June; in August the Board will receive combined data for May, June and July. This is to ensure that the sample sizes are sufficiently large to generate an accurate score. This approach will be reviewed for the 2016/17 Trust Board Quality Dashboard, as there will be enough survey data at that point to test whether reliable discrete monthly data can be generated.
[5] The touchscreen feedback tends to be more negative than the previous (purely exit-card) approach, because patients are now giving their views at all stages of the journey – not just at the end.

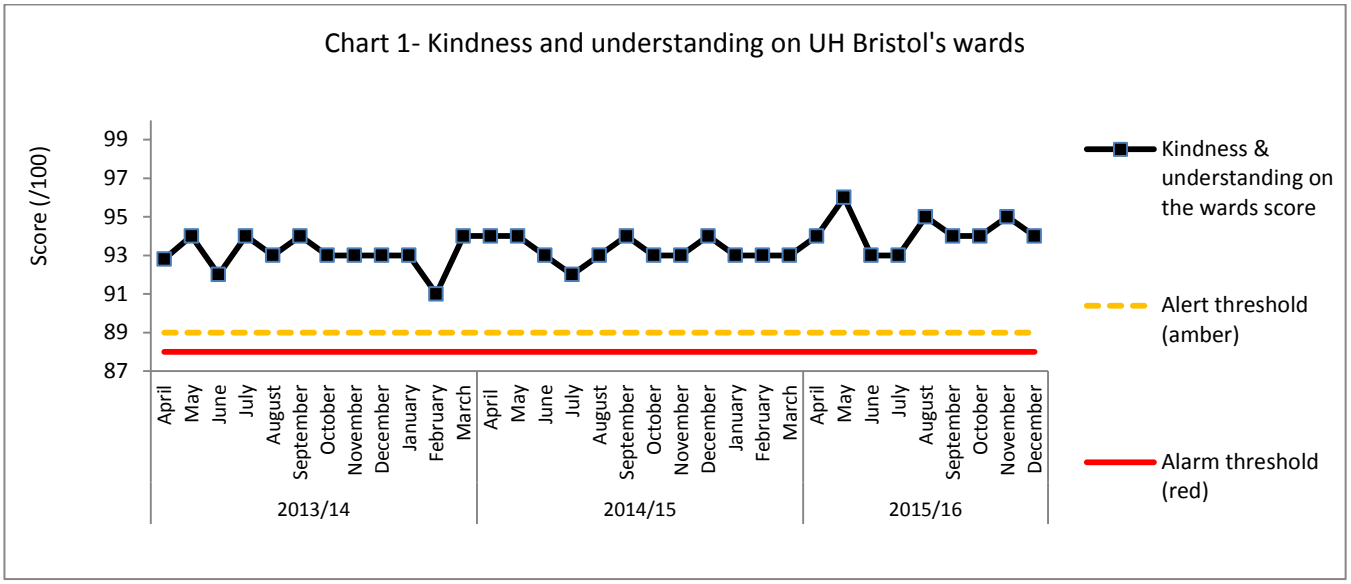


Chart 1- Kindness and understanding on UH Bristol's wards
Score (/100)
99
97
95
93
91
89
87
April May June July August September October November December January February March
2013/14
April May June July August September October November December January February March
2014/15
April May June July August September October November December
2015/16
Kindness & understanding on the wards score
Alert threshold (amber)
Alarm threshold (red)

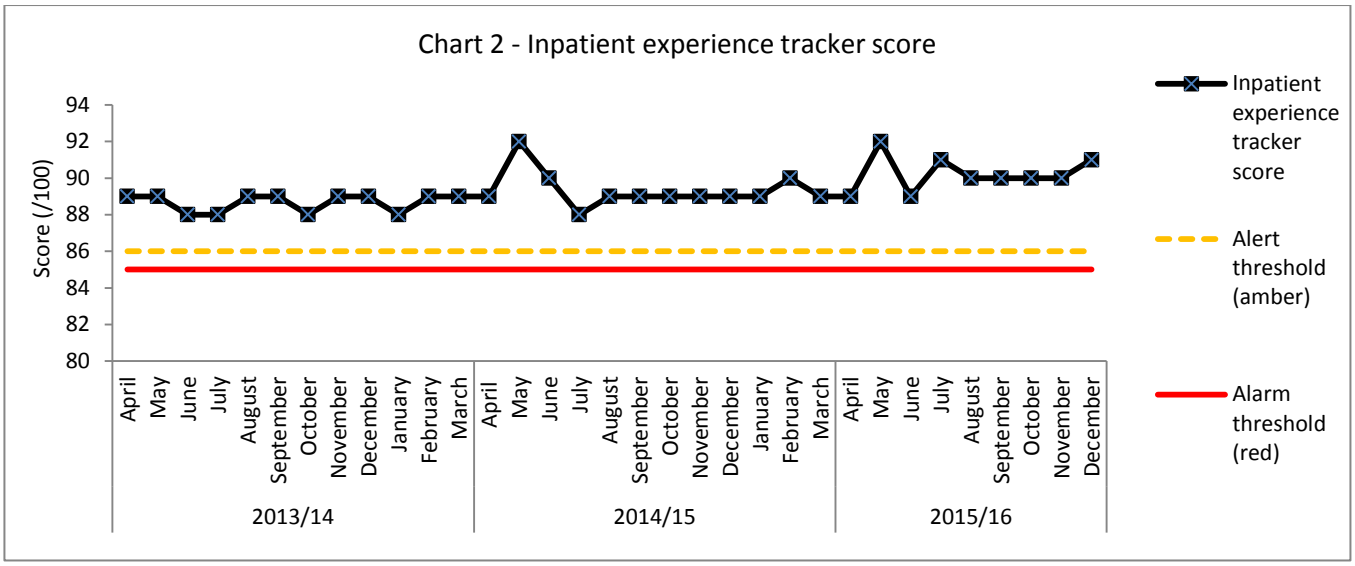


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2013/14
April May June July August September October November December January February March
2014/15
April May June July August September October November December
2015/16
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

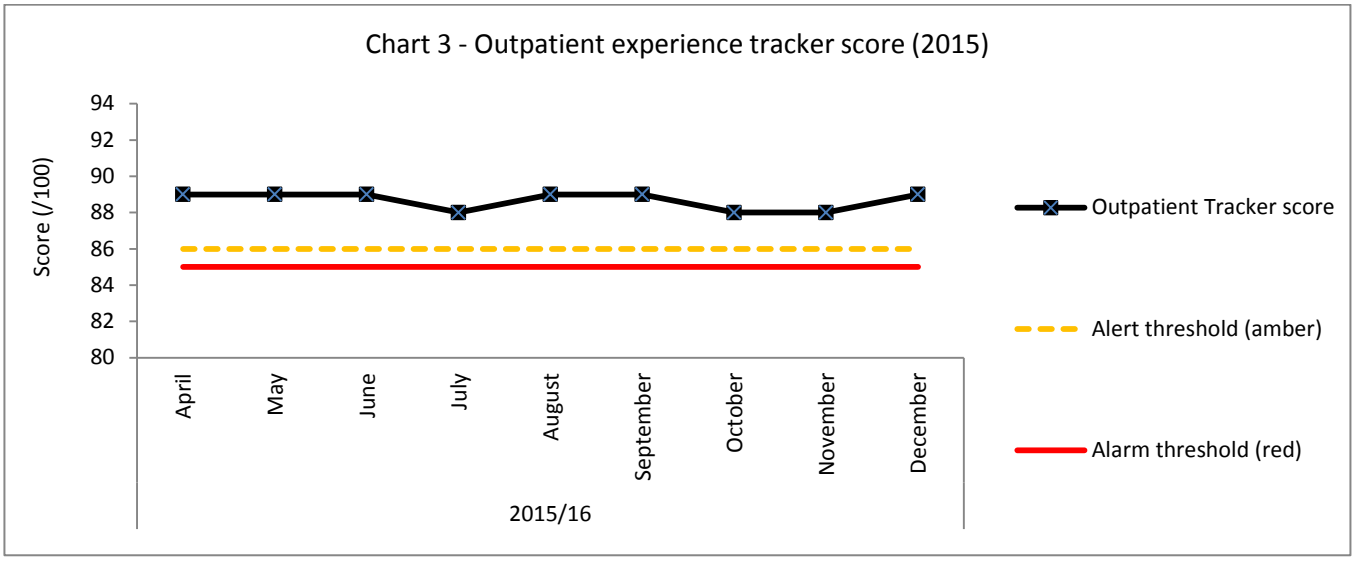


Chart 3 - Outpatient experience tracker score (2015)
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
2015/16
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

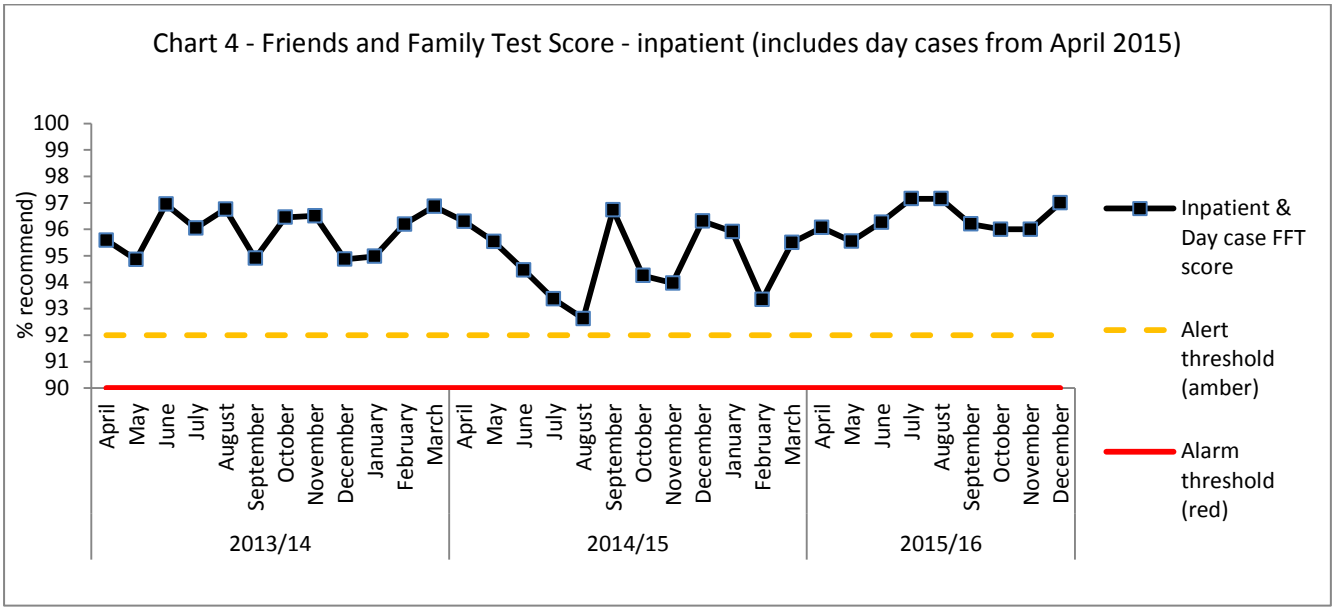


Chart 4 - Friends and Family Test Score - inpatient (includes day cases from April 2015)
% recommend)
100
99
98
97
96
95
94
93
92
91
90
April May June July August September October November December January February March
2013/14
2014/15
2015/16
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

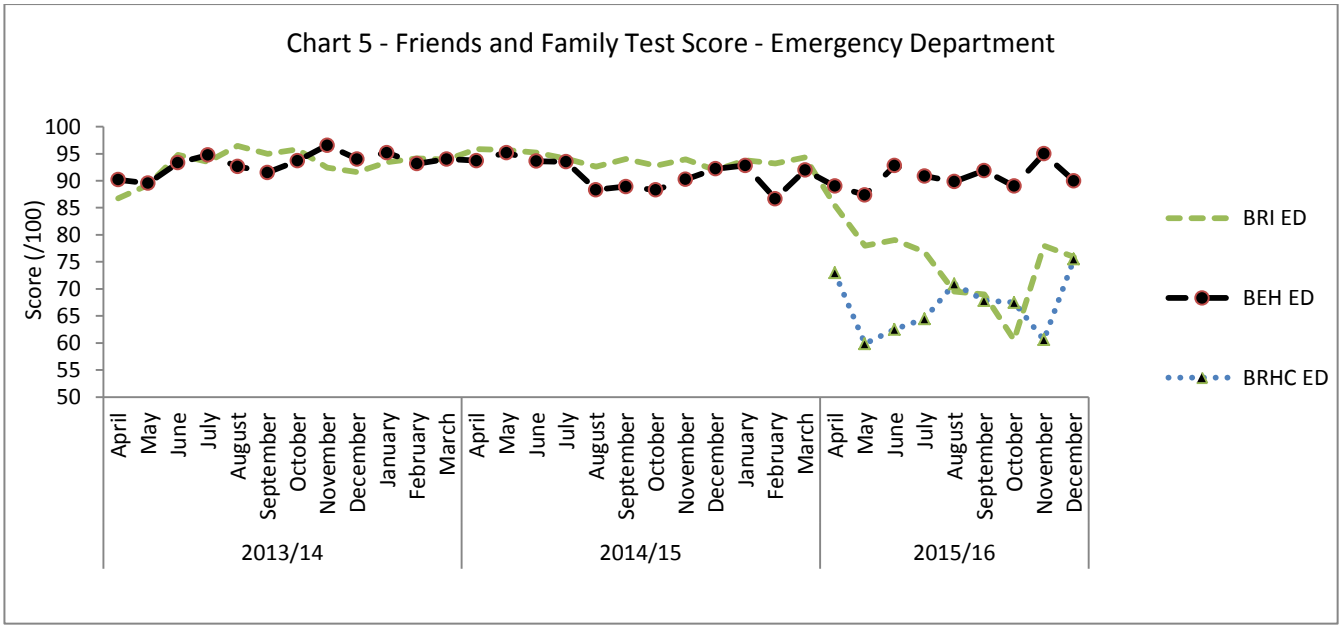


Chart 5 - Friends and Family Test Score - Emergency Department
Score (/100)
100
95
90
85
80
75
70
65
60
55
50
April May June July August September October November December January February March
2013/14
2014/15
2015/16
BRI ED
BEH ED
BRHC ED

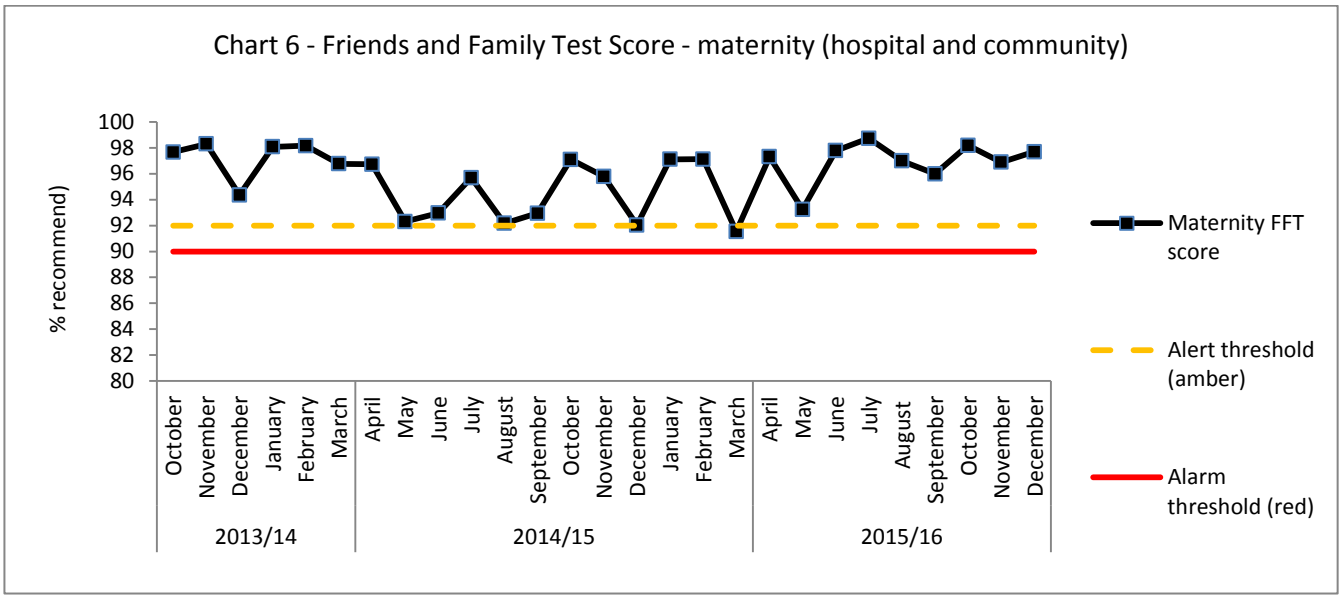
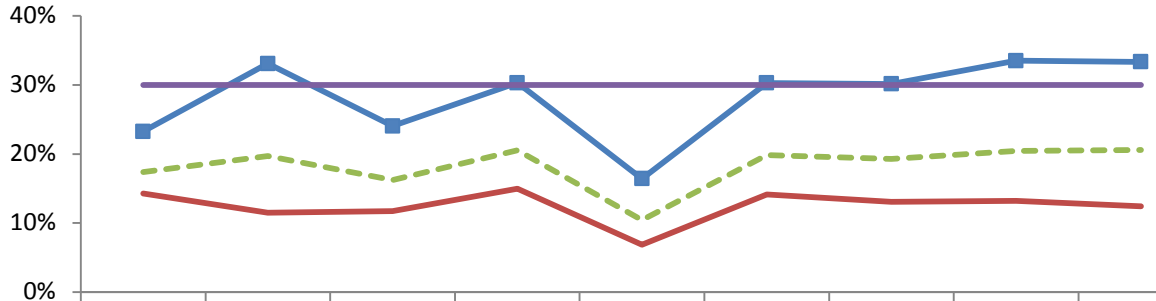


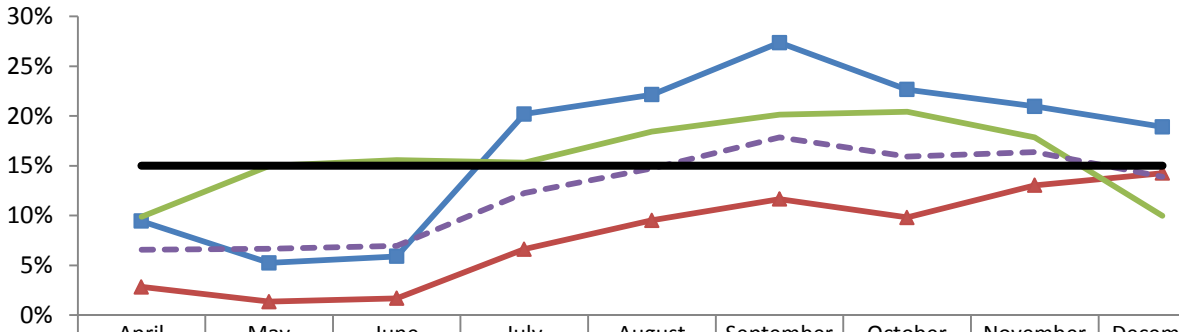
Chart 6 - Friends and Family Test Score - maternity (hospital and community)
% recommend)
100
98
96
94
92
90
88
86
84
82
80
October November December January February March April May June July August September October November December January February March April May June July August September October November December
2013/14
2014/15
2015/16
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

Chart 7: Friends and Family Test Response Rates (inpatient and day case) 2015/16



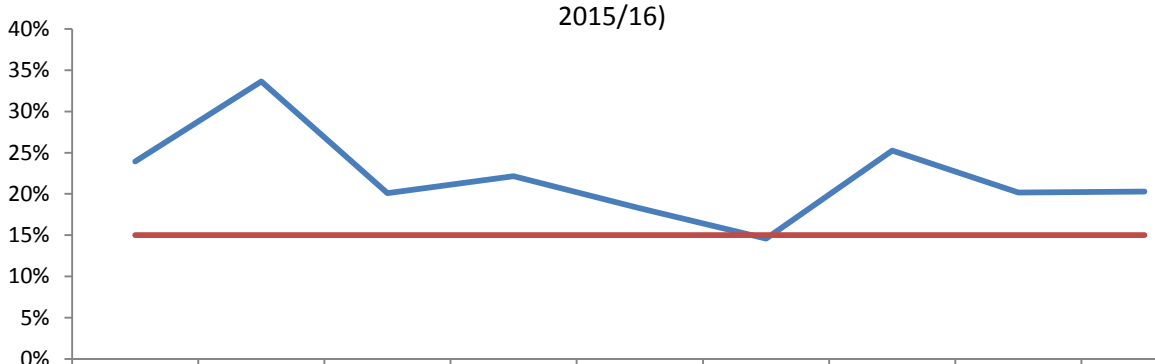
	April	May	June	July	August	September	October	November	December
Inpatient	23%	33%	24%	30%	16%	30%	30%	34%	33%
Day case	14%	11%	12%	15%	7%	14%	13%	13%	12%
All	17%	20%	16%	21%	10%	20%	19%	20%	21%
Target	30%	30%	30%	30%	30%	30%	30%	30%	30%

Chart 8: Friends and Family Test Response Rates (Emergency Departments) 2015/16



	April	May	June	July	August	September	October	November	December
BEH	9%	5%	6%	20%	22%	27%	23%	21%	19%
BRI	3%	1%	2%	7%	10%	12%	10%	13%	14%
BRHC	10%	15%	16%	15%	18%	20%	20%	18%	10%
All	7%	7%	7%	12%	15%	18%	16%	16%	14%
Target	15%	15%	15%	15%	15%	15%	15%	15%	15%

Chart 9: Friends and Family Test Response Rates (hospital and community maternity 2015/16)



	April	May	June	July	August	September	October	November	December
maternity (all)	24%	34%	20%	22%	18%	15%	25%	20%	20%
target	15%	15%	15%	15%	15%	15%	15%	15%	15%

3. Divisional, hospital and ward-level patient experience ratings

The following charts and tables provide a view of UH Bristol's performance on the key patient survey metrics, from Division down to a ward-level. Charts 10-13 show the headline survey scores by UH Bristol Division, followed by a Divisional-breakdown of the full set of survey questions (Table 1). The results by hospital site and ward are then shown in Charts 14-20. At the end of this section of the Quarterly report, a response is provided by the Divisions to key issues identified in the data.

Chart 10 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

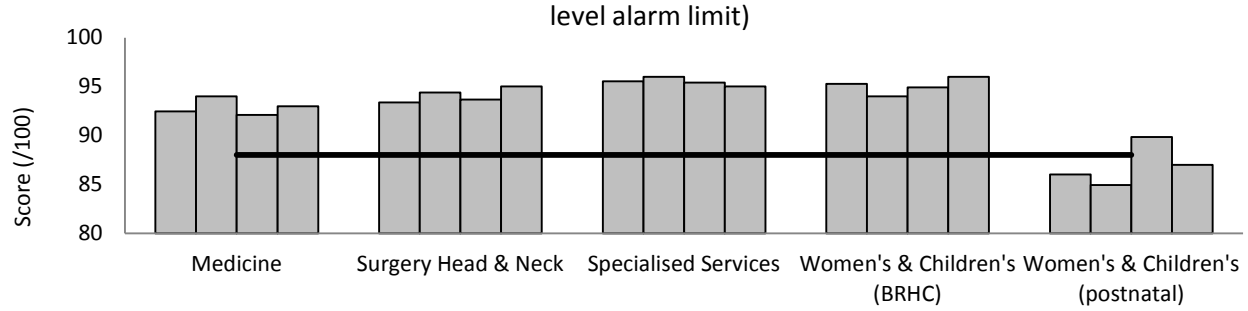


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

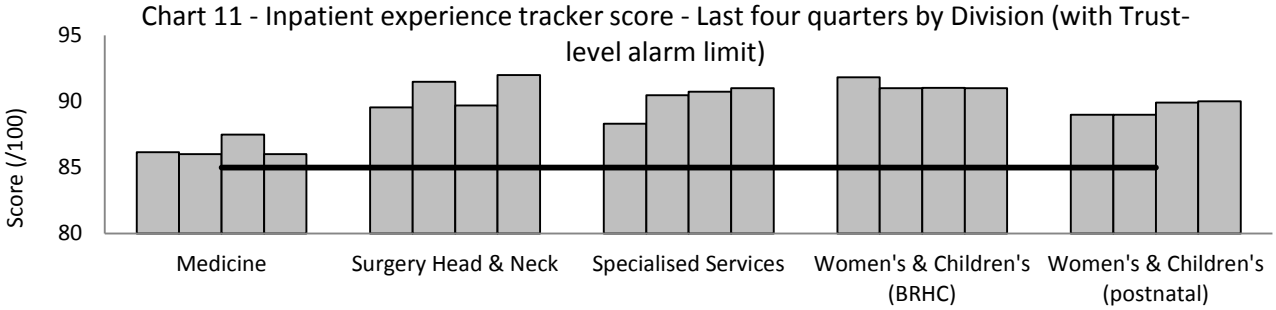


Chart 12 - Inpatient Friends and Family Test score - last four quarters by Division (with Trust-level alarm limit)

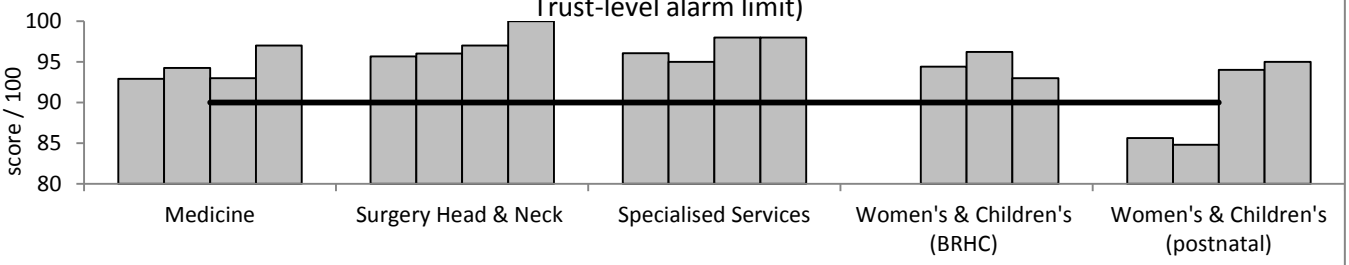


Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit

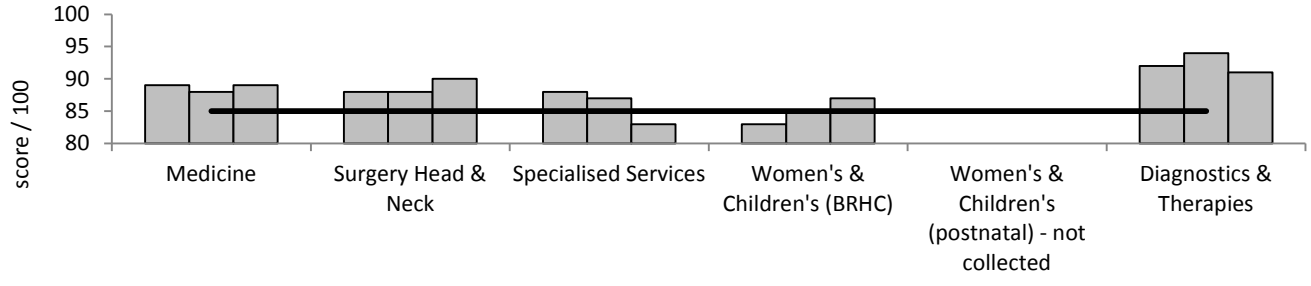


Table 1: full-set of Quarter 3 Divisional scores from UH Bristol's monthly postal survey (cells are highlighted if they are 10 points or more below the Trust score)

	Division					
	Medicine	Surgery, Head and Neck	Specialised Services	Women's & Children's	Maternity	Trust
Were you / your child given enough privacy when discussing your condition or treatment?	91	94	94	94	n/a	93
How would you rate the hospital food you / your child received?	63	61	62	69	59	63
Did you / your child get enough help from staff to eat meals?	78	88	78	81	n/a	82
In your opinion, how clean was the hospital room or ward you (or your child) were in?	93	95	96	95	92	95
How clean were the toilets and bathrooms that you / your child used on the ward?	91	92	93	92	86	92
Were you / your child ever bothered by noise at night from hospital staff?	79	83	80	82	n/a	81
Do you feel you / your child was treated with respect and dignity on the ward?	95	97	96	97	92	96
Were you/your child treated with kindness and understanding on the ward?	93	95	95	96	87	95
How would you rate the care you / your child received on the ward?	86	90	90	91	84	89
When you had important questions to ask a doctor, did you get answers you could understand?	83	90	90	89	89	88
When you had important questions to ask a nurse, did you get answers you could understand?	82	91	88	90	94	87
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	71	75	73	77	79	74
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	80	86	86	90	90	85
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	79	86	84	87	86	84
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	86	90	88	87	n/a	88
Did you / your child find someone to talk to about your worries and fears?	66	79	74	82	81	74

	Division					
	Medicine	Surgery, Head and Neck	Specialised Services	Women's & Children's	Maternity	Trust
Did a member of staff explain why you needed these test(s) in a way you could understand?	81	87	85	92	n/a	86
Did a member of staff tell you when you would find out the results of your test(s)?	68	71	68	80	n/a	71
Did a member of staff explain the results of the test(s) in a way you could understand?	75	82	74	82	n/a	78
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	79	93	89	95	n/a	90
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	64	79	75	85	n/a	77
Staff were respectful any decisions you made about your / your child's care and treatment	89	94	92	92	n/a	92
During your hospital stay, were you asked to give your views on the quality of your care?	22	29	28	26	38	26
Do you feel you were kept well informed about your / your child's expected date of discharge?	83	92	87	90	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason? (% answering "no")	66	61	50	67	73	61
% of patients delayed for more than four hours at discharge	19	18	18	23	25	19
Did a member of staff tell you what medication side effects to watch for when you went home?	48	67	56	68	n/a	59
Total responses	*472*	*514*	*422*	*301*	*232*	*1941*

Key: BRHC (Bristol Royal Hospital for Children); BEH (Bristol Eye Hospital); BHOC (Bristol Haematology and Oncology Centre); BRI (Bristol Royal Infirmary); BHI (Bristol Heart Institute); SBCH (South Bristol Community Hospital); STMH (St Michael's Hospital); BDH (Bristol Dental Hospital)

Chart 14: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

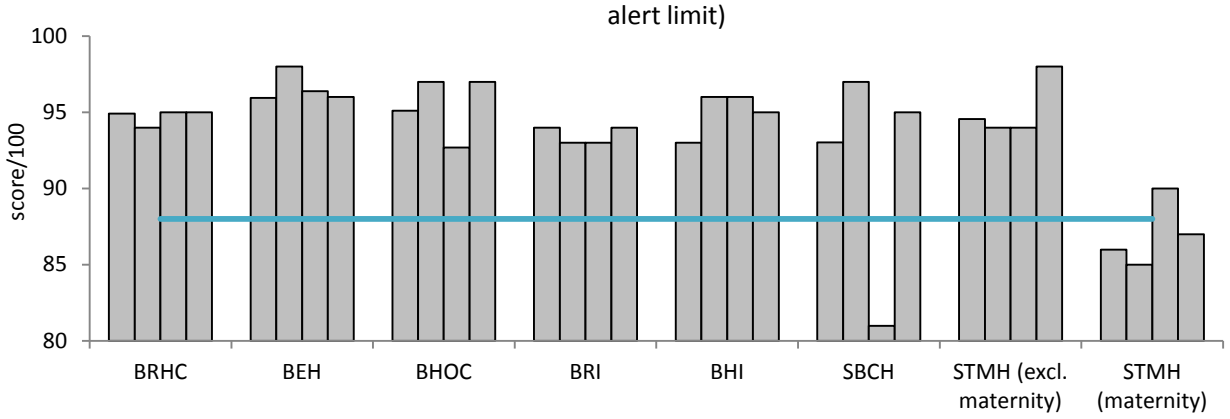


Chart 15: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

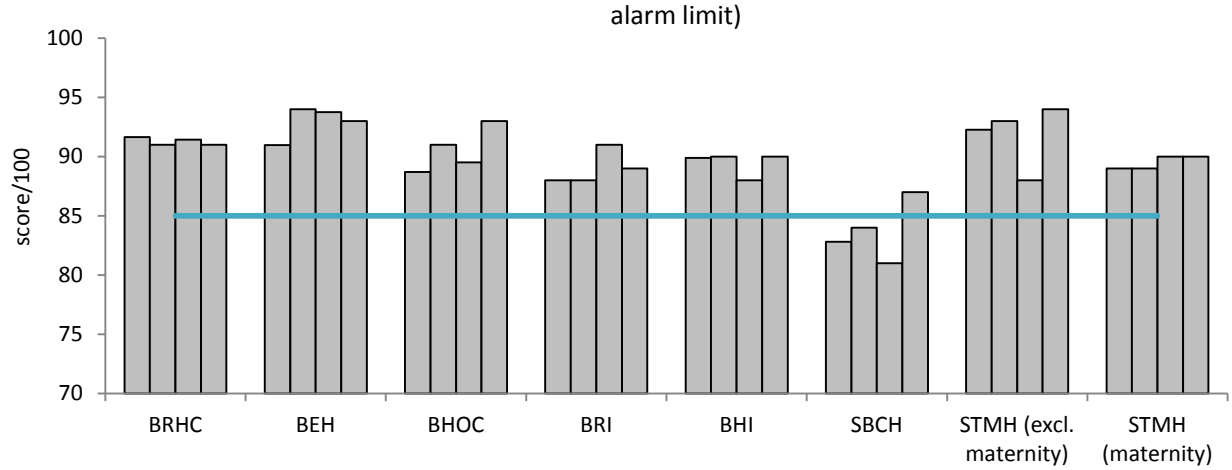
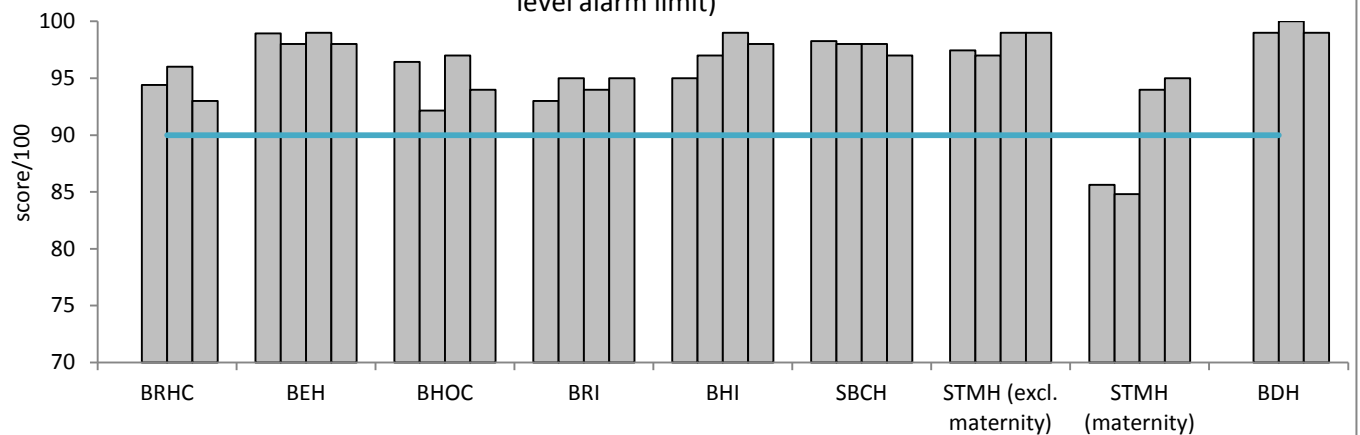


Chart 16: Inpatient and day case Friends and Family Test (last four quarters; with Trust-level alarm limit)



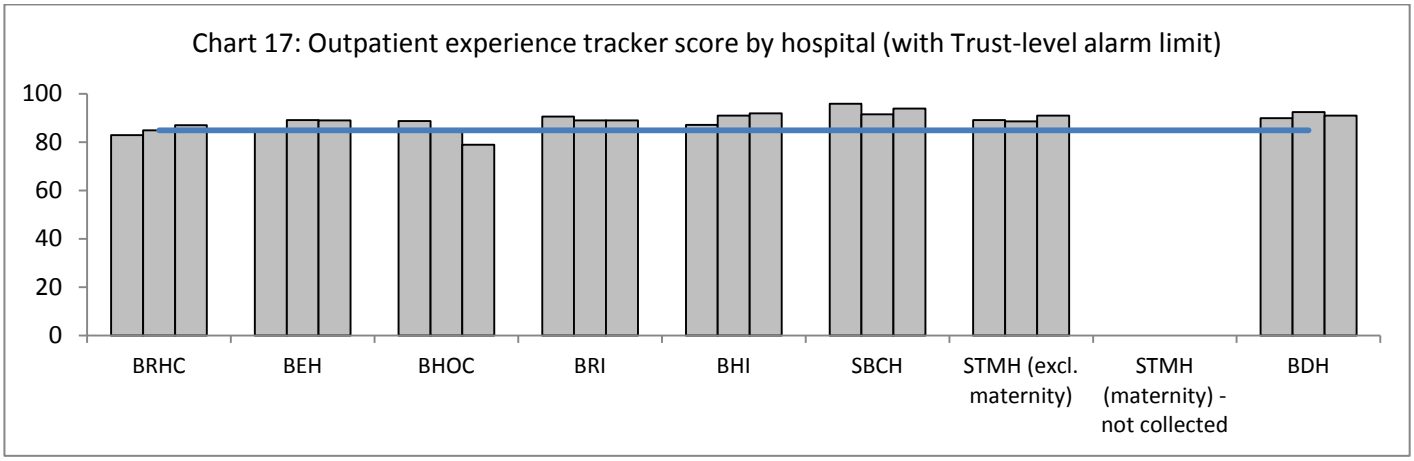


Chart 17: Outpatient experience tracker score by hospital (with Trust-level alarm limit)
100
80
60
40
20
0
BRHC
BEH
BHOC
BRI
BHI
SBCH
STMH (excl. maternity)
STMH (maternity) - not collected
BDH

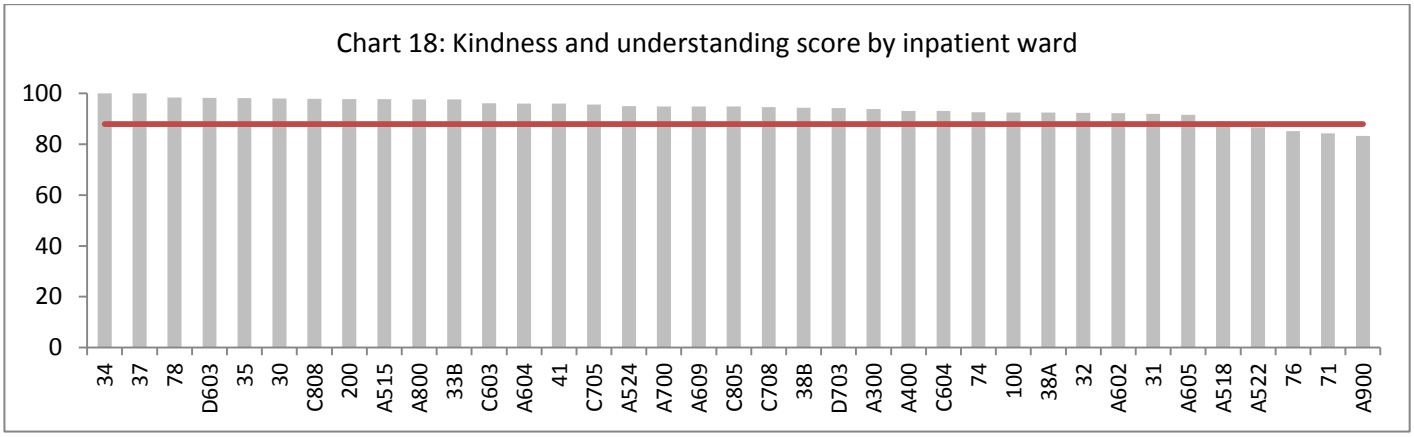


Chart 18: Kindness and understanding score by inpatient ward
100
80
60
40
20
0
34 37 78 D603 35 30 C808 200 A515 A800 33B C603 A604 41 C705 A524 A700 A609 C805 C708 38B D703 A300 A400 C604 74 100 38A 32 A602 31 A605 A518 A522 76 71 A900

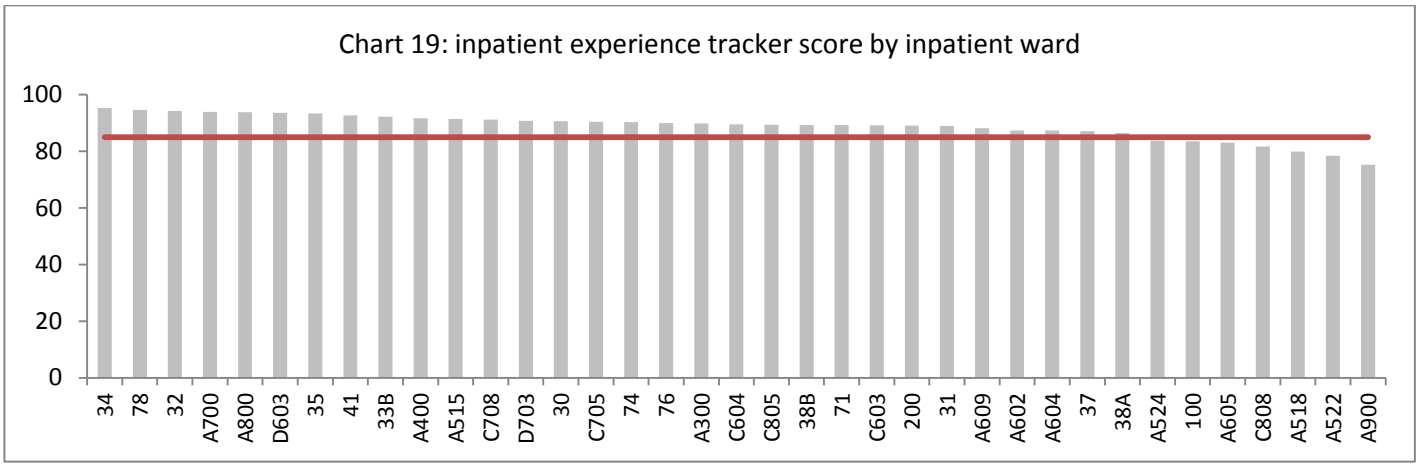


Chart 19: inpatient experience tracker score by inpatient ward
100
80
60
40
20
0
34 78 32 A700 A800 D603 35 41 33B A400 A515 C708 D703 30 C705 74 76 A300 C604 C805 38B 71 C603 200 31 A609 A602 A604 37 38A A524 100 A605 C808 A518 A522 A900

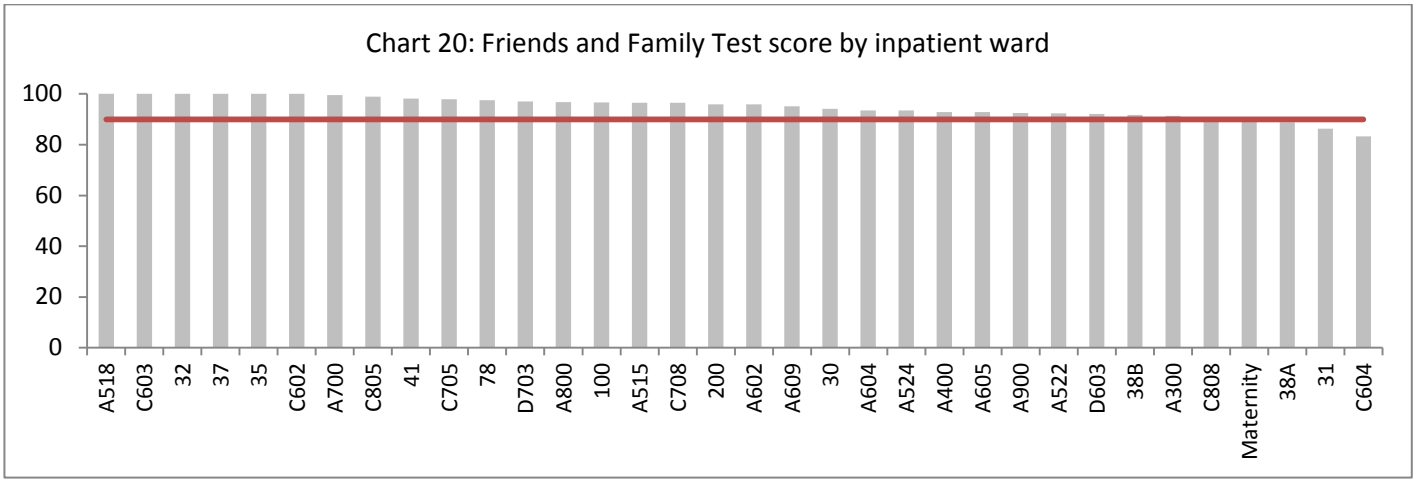


Chart 20: Friends and Family Test score by inpatient ward
100
80
60
40
20
0
A518 C603 32 37 35 C602 A700 C805 41 C705 78 D703 A800 100 A515 C708 200 A602 A609 30 A604 A524 A400 A605 A900 A522 D603 38B A300 C808 Maternity 38A 31 C604

Table 2: Divisional response to issues identified in the survey data

Division	Concern	Explanation from Division	Action
Division of Medicine	Ward A900 received the lowest scores on the "kindness and understanding" and "inpatient tracker" survey measures in Quarter 3 (see Charts 18 and 19)	Patients with Cystic Fibrosis in particular have expressed concerns about the quality of care on this ward. This followed a move in care from a long-established Cystic Fibrosis ward / team to the new ward A900	A series of actions has been carried out by the Division of Medicine to address patient concerns, in particular around staffing expertise / levels, and to establish patients' trust in the new ward teams. Feedback from patients in the Face2Face survey (February 2016) is positive and we expect this to feed through in to the survey results in Quarter 4
	Ward A522 - received relatively low scores on both the "kindness and understanding" and "inpatient tracker" measures (see Charts 18 and 19)	This ward location changed specialties three times during Quarter 3, as part of the reconfiguration / upgrade of the Bristol Royal Infirmary. Although we tried to keep disruption to patients to a minimum, this seems to have negatively affected the survey scores	The moves involving this ward were completed in Quarter 3, and this should be reflected in positive survey scores for Quarter 4 onwards
	Explaining medication side effects at discharge (see Table 1)	This a challenge for all trusts (as evidenced by the national surveys), but particularly for areas of care where patients often have a large number of medications along with complex / multi-agency discharge packages - as is the case with the Division of Medicine	In the short-term, the Pharmacy Department has been contacted to establish whether the prototype on-line tool developed for side-effects information can be rolled-out to the Division of Medicine. If this is available and is suitable for use on Division of Medicine wards, then implementation will form part of the actions within the 2016/17 Divisional Objectives around this issue (see below). This issue will also be highlighted to ward Sisters at their next Divisional meeting, so that ward staff are reminded of the importance of good communication around medication side effects. In recognition that this is a difficult but important issue to solve, it has been incorporated into the wider 2016/17 Divisional Quality Objectives around communication at discharge. Further / specific actions will be developed as part of this objective.

Division	Concern	Explanation from Division	Action
Division of Medicine (continued)	Explaining the risks and benefits of operations and procedures to patients, and how they can expect to feel afterwards (see Table 1)	Communication about operations and procedures was a negative outlier for the Division in Quarter 3. However, the Division does not perform operations and so this must have been related to "procedures" - many of which are minor and do not require a thorough explanation of risks and benefits or after-effects to the patient.	This issue will be discussed at the next Divisional Sisters meeting. It will also be explored further in the next *Face2Face* patient interview survey (May 2016), in order to gauge whether patients are satisfied with this aspect of their care and / or whether further specific actions are required by the Division
Maternity services (Women's and Children's Division)	Kindness and understanding on postnatal wards (Chart 14)	Although this score is better than the national average, and has been on an upward trajectory since 2010, it is still often below other adult inpatient areas at UH Bristol	Continued use of the Patient Experience at Heart staff workshops, to explore and promote the delivery of a positive experience for all service users (the next workshops are planned for April 2016). Continued use of values-based recruitment for maternity posts. Implementation of the Trust's action plan in response to the national maternity survey (during the 2016 calendar year).
Specialised Services	Ward C604 (Cardiac Intensive Care Unit) had the lowest Friends and Family Test score in Quarter 3 (Chart 20)	This ward has relatively few eligible patients for the Friends and Family Test (most patients are transferred to a ward rather than "home"), and so a small number of negative responses can affect the overall score. Nevertheless, two patients said they wouldn't recommend the care on this ward in Quarter 3 (both from October 2015)	The patients who stated that they would not recommend the care did not leave comments about the reasons for their answer, and so we cannot determine the underlying cause for this score. The results were however shared with the ward and will continue to be monitored going forward (note: in Quarter 4 to date, a score of 95% is being achieved)
	Patients waiting in clinic more than 15 minutes after their outpatient appointment time (Chart 17)	The "outpatient tracker" score was below the target threshold for the Division of Specialised Services in Quarter 3. This was due to a relatively high proportion (63%) of patients waiting more than 15 minutes in the Bristol Haematology and the Oncology Centre (BHOC)	The BHOC appointments booking process is being reviewed, with the aim of developing a more flexible service that allows for urgent appointments to be accommodated without affecting those with established appointments. The aim is to complete this work during Quarter 1 2016/17.
	Delays at discharge (Table 1)	A relatively high proportion of inpatients (50%) stated that their discharge was delayed (these delays occurred across both the Bristol Heart Institute and the Bristol Haematology and Oncology Centre)	Many patients across the Division require discharge-dependant tests and their results on the day of discharge. Whilst patients are aware that they are likely to be going home, they must wait for their tests and the results. Ward staff will be reminded that it is important to communicate this to patients, in order to set realistic expectations around discharge times

4. Themes arising from inpatient free-text comments in the monthly postal surveys

At the end of our postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. All comments are categorised, reviewed by the relevant Heads of Nursing, and shared with ward staff for wider learning. The over-arching themes from these comments are provided below. Please note that "**valence**" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed).

All inpatient /parent comments (excluding maternity)			
Theme	**Valence**	**% of comments**[6]	
Staff	Positive	69%	*69% of the comments received contained praise for UH Bristol staff. Improvement themes centre on communication and staff behaviour and communication*
Staff	Negative	14%	
Communication	Negative	13%	
Division of Medicine			
Theme	**Valence**	**% of comments**	*Negative comments about "staff" are often linked to other thematic categories (e.g. poor communication from a member of staff). This demonstrates that our staff are often the key determinant of a good or poor patient experience.*
Staff	Positive	68%	
Communication	Negative	14%	
Staff	Negative	12%	
Division of Specialised Services			
Theme	**Valence**	**% of comments**	*Negative comments about staff also often relate to a one-off negative experience with a single member of staff, showing how important each individual can be in shaping a patient's experience of care.*
Staff	Positive	66%	
Staff	Negative	17%	
Communication	Negative	17%	
Division of Surgery, Head and Neck			
Theme	**Valence**	**% of comments**	*Communication is a key issue, but it is a very broad theme which includes ease of contacting the trust, patient information, clinic letters, and face-to-face discussions with individual staff.*
Staff	Positive	69%	
Communication	Negative	14%	
Staff	Negative	13%	
Women's & Children's Division (excl. maternity)			
Theme	**Valence**	**% of comments**	*This data includes feedback from parents of 0-11 year olds who stayed in the Bristol Royal Hospital for Children. Comments about "facilities" often refers to availability of food / drink and accommodation available to parents (this is a key work-stream in the Division's response to the national maternity survey (see Section 5 / Appendix A).*
Staff	Positive	71%	
Staff	Negative	13%	
Facilities	Negative	9%	
Maternity comments			
Theme	**Valence**	**% of comments**	*For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth. The negative result for food has been shared with the catering team.*
Staff	Positive	59%	
Staff	Negative	10%	
Food / catering	Negative	9%	

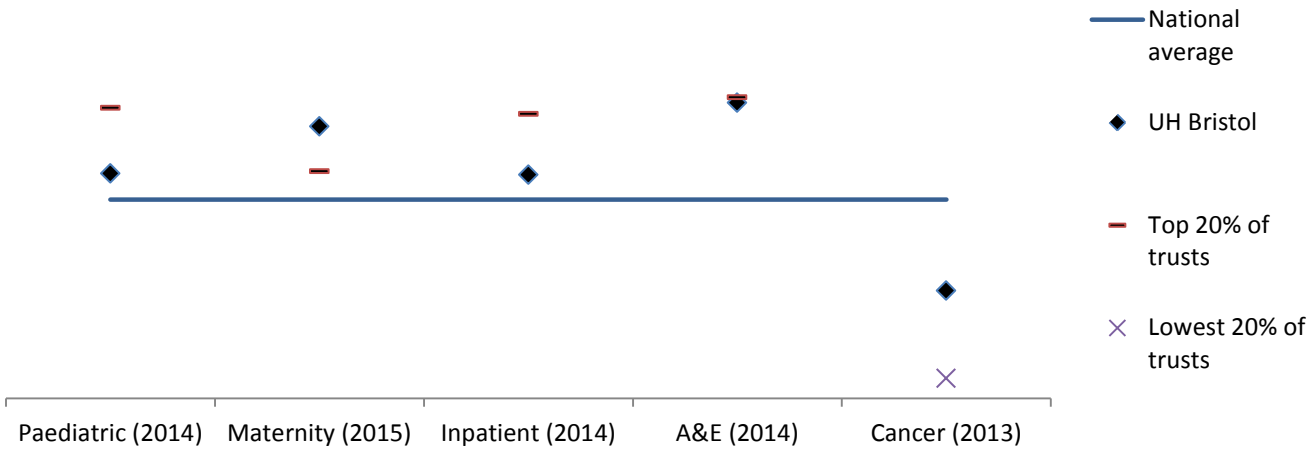
[6] Each of the patient comments received may contain several themes within it. Each of these themes is given a code (e.g. "staff: positive"). This table shows the most frequently applied codes, as a percentage of the total comments received (e.g. 61% of the comments received contained the "staff positive" thematic code).

5. National Patient Surveys

The Care Quality Commission's (CQC's) National Patient Survey programme is a mandatory survey programme for acute English trusts. It provides a robust national benchmark against which the patient experience at UH Bristol can be compared to other organisations. Chart 21 provides an overview of UH Bristol's performance in these surveys. Although this is a relatively simplistic analysis, and is not an official CQC classification, it is a means of conveying a snapshot of UH Bristol's relative position across all of the national surveys. It can be seen that the Trust had strong performances in the most recent national maternity and Accident and Emergency surveys, and that inpatient care (both children and adult) tends to be slightly above the national average (although this is not to a statistically significant degree). UH Bristol's performance in the National Cancer Survey is therefore a negative outlier in this respect. In order to understand these national cancer survey results, a detailed analysis was carried out by UH Bristol's Patient Experience and Involvement Team in conjunction with the Patient's Association. This work suggested that methodological issues with the survey unduly skew the results for UH Bristol, and that there are many examples of excellent cancer care being provided at the Trust, but over and above these factors there are also many genuine opportunities for service improvement. An action plan is in place to improve the scores on this survey.

The Trust Board receives a full report containing the results of each national survey and UH Bristol's action plan in response to these results. Further information is provided in Appendix A of the Quarterly Patient Experience report.

Chart 21: Comparison of UH Bristol's national patient experience survey results against the national average (year in brackets / nearest quintile threshold shown)



Appendix A: summary of national patient survey results and key actions arising for UH Bristol (note: progress against action plans is monitored by the Patient Experience Group)

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2014 National Inpatient Survey	57/60 scores were in line with the national average. One score was below (availability of hand gels) and two were above (explaining risks and benefits and discharge planning)	July 2015	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Explaining potential medication side effects to patients at discharge	May 2016
2015 National Maternity Survey	9 scores were in line with the national average; 10 were better than the national average	March 2016	Six-monthly	• Continuity of antenatal care • Partners staying on the ward • Care on postnatal wards	January 2018
2013 National Cancer Survey	30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average	November 2014	Six-monthly	• Providing patient-centred care • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	September 2015
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	Not known
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	Not known

Appendix B – UH Bristol corporate patient experience programme

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	Before leaving hospital, all adult inpatients, day case, 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. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	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: survey scoring methodologies

Postal surveys

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 survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

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

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*100 = 81
Yes, probably	0.5	18%	18*50= 9
No	0	1%	1*0 = 0
Score			*90*

Friends and Family Test Score

The inpatient and day case Friends and Family Test (FFT) is a card given to patients at the point of discharge from hospital. It contains one main question, with space to write in comments: How likely are you to recommend our ward to Friends and Family if they needed similar care or treatment? The score is calculated as the percentage of patients who tick “extremely likely” or “likely”.

The Emergency Department (A&E) FFT is similar in terms of the recommend question and scoring mechanism, but at present UH Bristol operates a mixed card and touchscreen approach to data collection.

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 3, 2015/2016

(1 October to 31 December 2015)

Author: **Tanya Tofts, Patient Support and Complaints Manager**

1. Quarter 3 overview

Successes	Priorities
• Complaints received by the Bristol Eye Hospital decreased for the second consecutive quarter, from 71 in Q1, to 56 in Q2 and 49 in Q3; • Complaints received by the Bristol Heart Institute Outpatients Department reduced from 26 in Q2 to 16 in Q3; • There was a significant decrease in the number of complaints received by the Ear Nose and Throat service, from 36 in Q2 to 13 in Q3; • The Emergency Department at Bristol Royal Infirmary received half the number of complaints in Q3 that it received in Q2 (14 compared to 27).	• Re-focus existing complaints training specifically on writing effective responses to formal complaints – new training materials have been prepared in readiness. • Re-focus on achieving targets for responding to complaints within agreed deadlines (which is directly related to the quality of draft response letters); • Reduce the number of cases where the deadline agreed with the complainant is extended; • Divisions to focus on specific actions to reduce numbers of complaints, in particular those received by: Trauma and Orthopaedics; Upper GI; Cardiology GUCH services; and Radiology
Opportunities	**Risks & Threats**
• Roll out new training package which is focused specifically on how to write a good response letter *(timescales to be included in final edit for QOC)*; • Share any lessons learned from complaints upheld or partially upheld by the PHSO via bimonthly Patient Experience Group meetings.	• Managers responsible for investigating complaints and drafting response letters have not all received appropriate and up to date training; • Risk of breaches to complaints response timescales in light of winter pressures/black escalation; • Ongoing sickness absence in the Patient Support and Complaints Team; • Risk of new Datix complaints database slowing down processing of complaints whilst corporate and divisional staff develop familiarity with new system.

2. Complaints performance – Trust overview

The Board monitors three indicators of how well the Trust is doing in respect of complaints performance:

a. Total complaints received, as a proportion of activity
b. Proportion of complaints responded to within timescale
c. Numbers of complainants who are dissatisfied with our response

The table on page 5 of this report provides a comprehensive 13 month overview of complaints performance including all three key indicators.

2.1 Total complaints received

The Trust received 446 complaints in Quarter 3 (Q3), which equates to 0.23% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[2]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q3 represents a decrease of approximately 20% compared to Q2 (560) and a 6% increase on the corresponding period a year ago.

2.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with, or arrange a meeting to discuss, our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

The Trust's target is to respond to at least 95% of complainants within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q3, only 56.5% of responses were posted within the agreed timescale, compared to 83.9% in Q2 and 84.9% in Q1. This represents 70 breaches out of 161 formal complaints which were due to receive a response during Q3[3]. Figure 1 shows the Trust's performance in responding to complaints since September 2014.

[2] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.
[3] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

Figure 1: Percentage of complaints responded to within agreed timescale

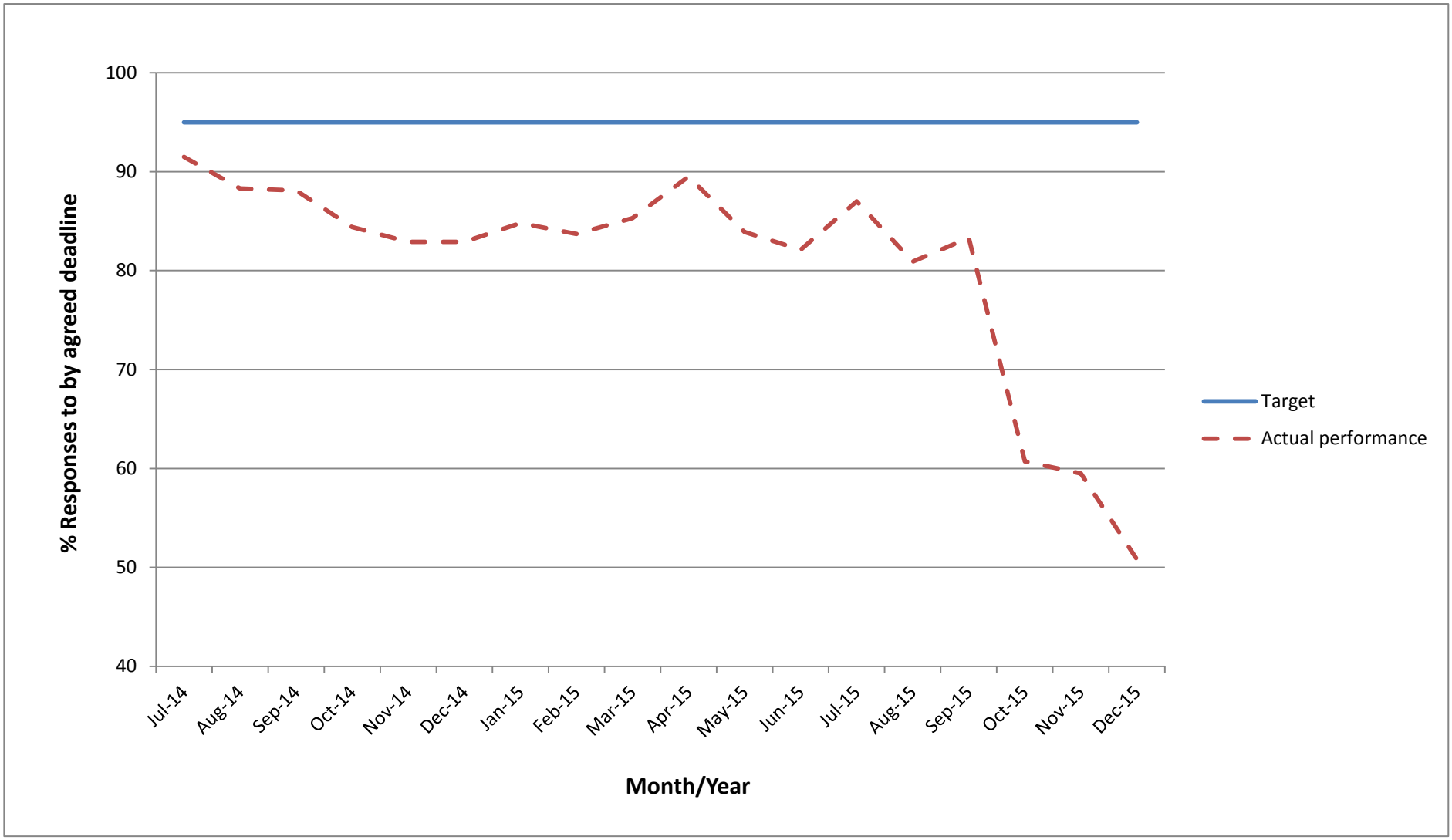


Table 1 – Complaints performance
Items in italics are reportable to the Trust Board.
Other data items are for internal monitoring / reporting to Patient Experience Group where appropriate.

	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Total complaints received (inc. TS and F&E from April 2013)	133	165	171	181	158	147	154	207	168	185	182	148	116
Formal/Informal split	52/81	70/95	79/92	88/93	72/86	46/101	57/97	61/146	51/117	54/131	75/107	66/82	44/72
Number & % of complaints per patient attendance in the month	0.22% (133 of 59,487)	0.27% (165 of 61,683)	0.29% (171 of 58,687)	0.27% (181 of 66,317)	0.27% (158 of 59,419)	0.25% (147 of 58,716)	*0.23% (154 of 66,548)*	*0.31% (207 of 65,810)*	*0.30% (168 of 55,657)*	0.28% (185 of 66,285)	0.27% (182 of 68,131)	0.22% (148 of 67,434)	0.19% (116 of 61,126)
% responded to within the agreed timescale (i.e. response posted to complainant)	82.9% (58 of 70)	84.8% (56 of 66)	83.7% (36 of 43)	85.3% (58 of 68)	89.5% (51 of 57)	83.9% (52 of 62)	*82.1% (55 of 67)*	*87.0% (47 of 54)*	*80.9% (38 of 47)*	83.3% (40 of 48)	60.7% (34 of 56)	59.5% (25 of 42)	50.8% (32 of 63)
% responded to by Division within required timescale for executive review	87.1% (61 of 70)	87.9% (58 of 66)	81.4% (35 of 43)	92.6% (63 of 68)	87.7% (50 of 57)	91.9% (57 of 62)	94.0% (63 of 67)	98.1% (53 of 54)	93.6% (44 of 47)	95.8% (46 of 48)	80.4% (45 of 56)	81.0% (34 of 42)	90.5% (57 of 63)
Number of breached cases where the breached deadline is attributable to the Division	1 of 12	7 of 10	2 of 7	8 of 10	3 of 6	9 of 10	12 of 12	6 of 7	3 of 9	2 of 8	7 of 22	7 of 17	20 of 31
Number of extensions to originally agreed timescale (formal investigation process only)	11	16	4	7	7	21	16	11	14	10	23	13	26
Percentage of Complainants Dissatisfied with Response					1.8% (1 case)	1.6% (1 case)	1.5% (1 case)	1.9% (1 case)	2.1% (1 case)	4.2% (2 cases)	8.9% (5 cases)	4.8% (2 cases)	

Figures 2 and 3 below show a decrease in the volume of complaints received in Q3 (2015/16) compared to Q2 (2015/16) and the increase when compared to the corresponding period last year. Figure 3 shows the numbers of complaints dealt with via the formal investigation process, against those dealt with via the informal; complaints investigation process.

Figure 2: Number of complaints received

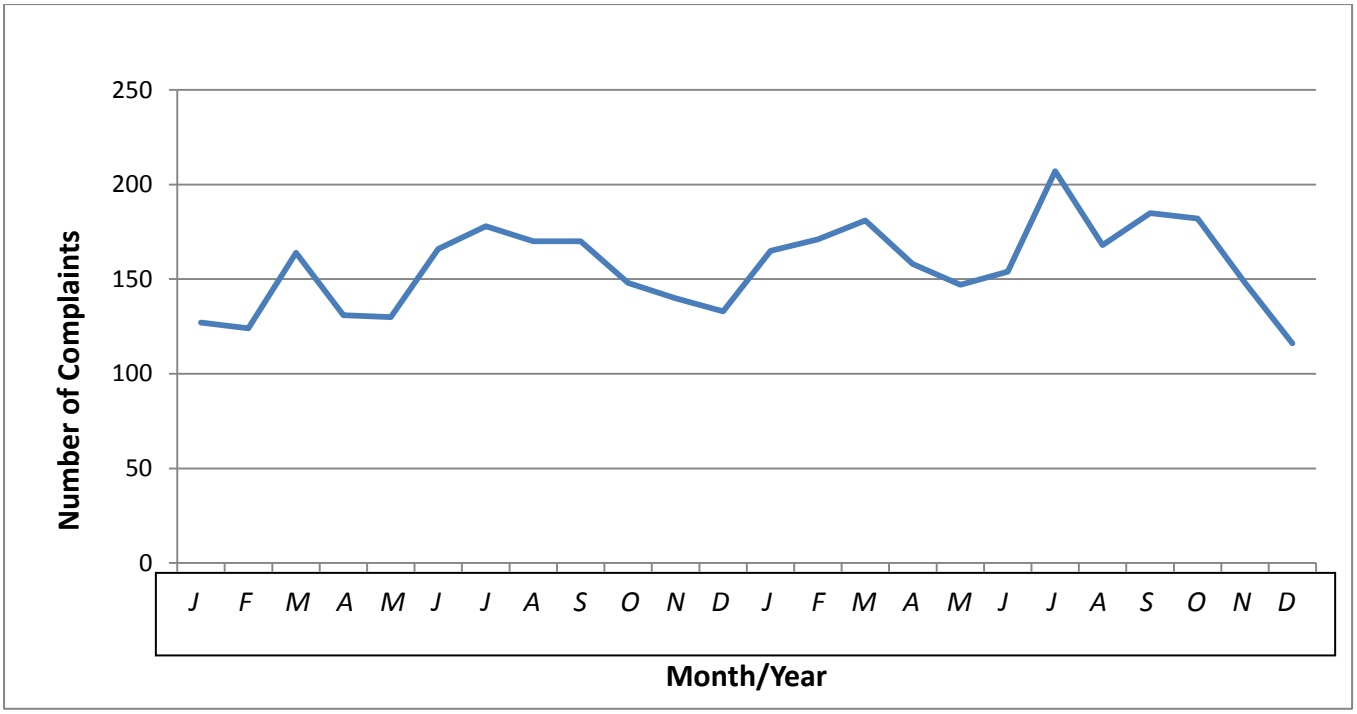


Figure 3: Complaints received, as a percentage of patient activity

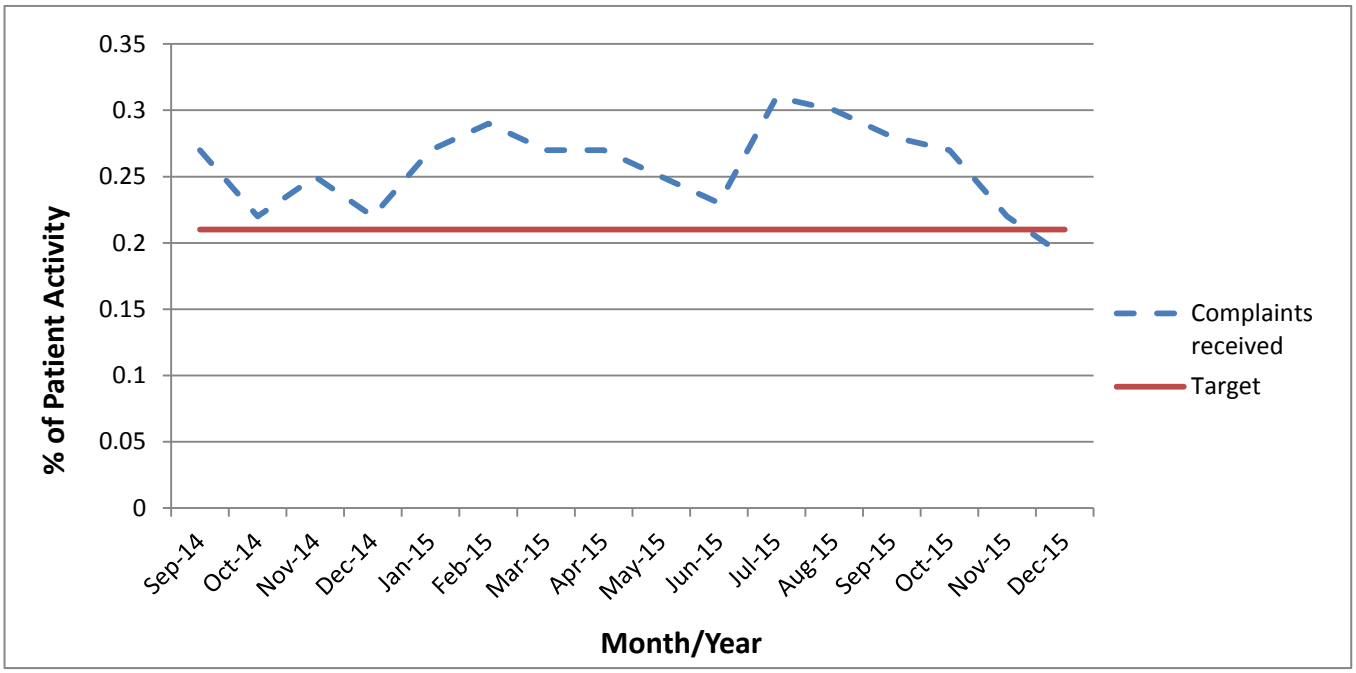
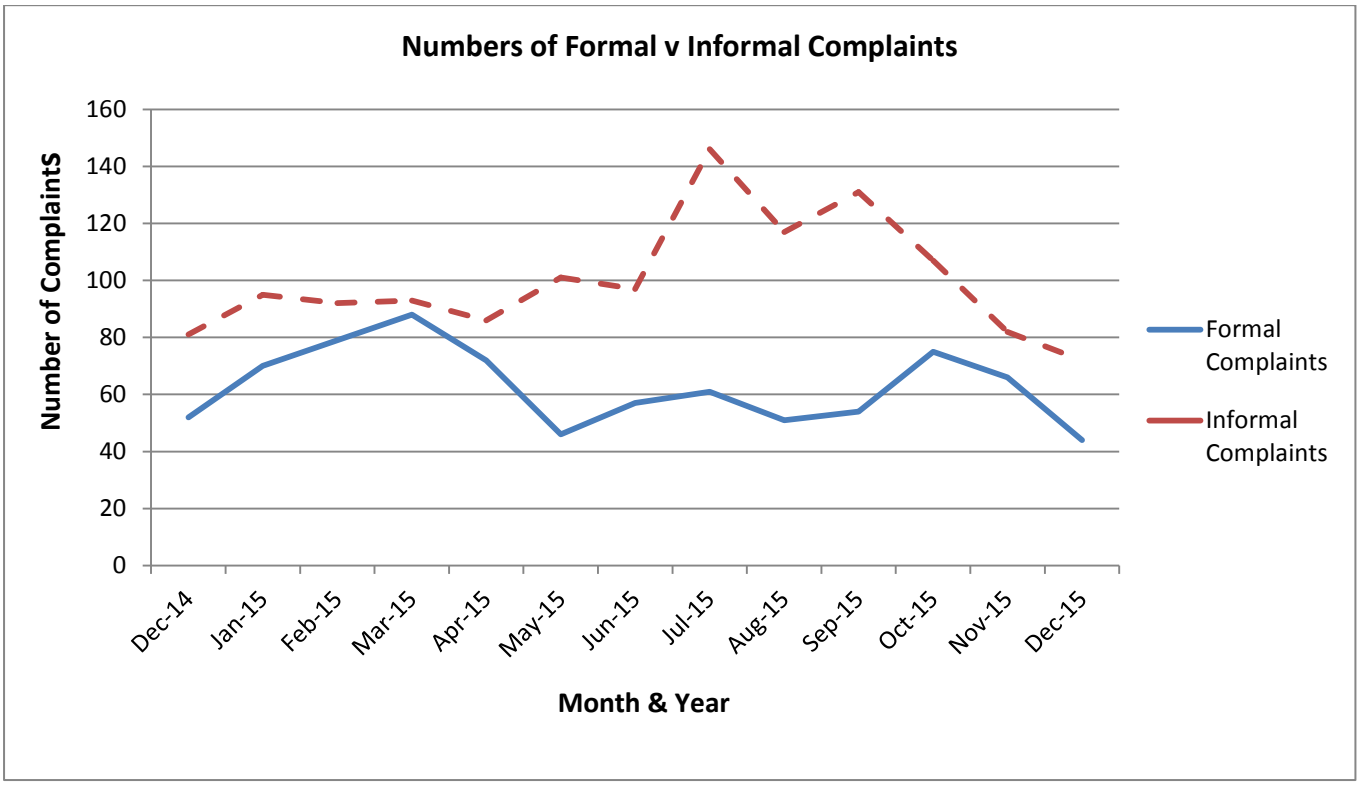


Figure 4: Numbers of Formal v Informal Complaints



2.3 Dissatisfied complainants

Reducing numbers of dissatisfied complainants is one of the Trust's corporate quality objectives for 2015/16. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are dissatisfied with the quality of our investigation of their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation so that we do not make the same mistake again. Our aim is that nobody should be dissatisfied with the quality of our response to their complaint. Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response. Since April 2016, the Trust has dissatisfied cases as a percentage of the responses the Trust has sent out in any given month. In Q1 and Q2 of 2015/16, our target was for less than 10% of complainants to be dissatisfied, reducing to less than 5% from Q3 onwards.

In Q3, a total of 161 responses were sent out. By the cut-off point of 15th January 2016 (the date on which the complaints data for December was finalised), 10 people had contacted us to say they were dissatisfied with our response. This represents 6.2% of the responses sent out. This compares to 10 cases out of 149 responses (6.7%) in Q2 of 2015/16.

Whenever a complainant comes back to us to advise they are dissatisfied with our response, the case is reviewed by the Patient Support and Complaints Manager. This review leads to one of the following courses of action:

a) The lead Division for the complaint is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues.

b) The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues.

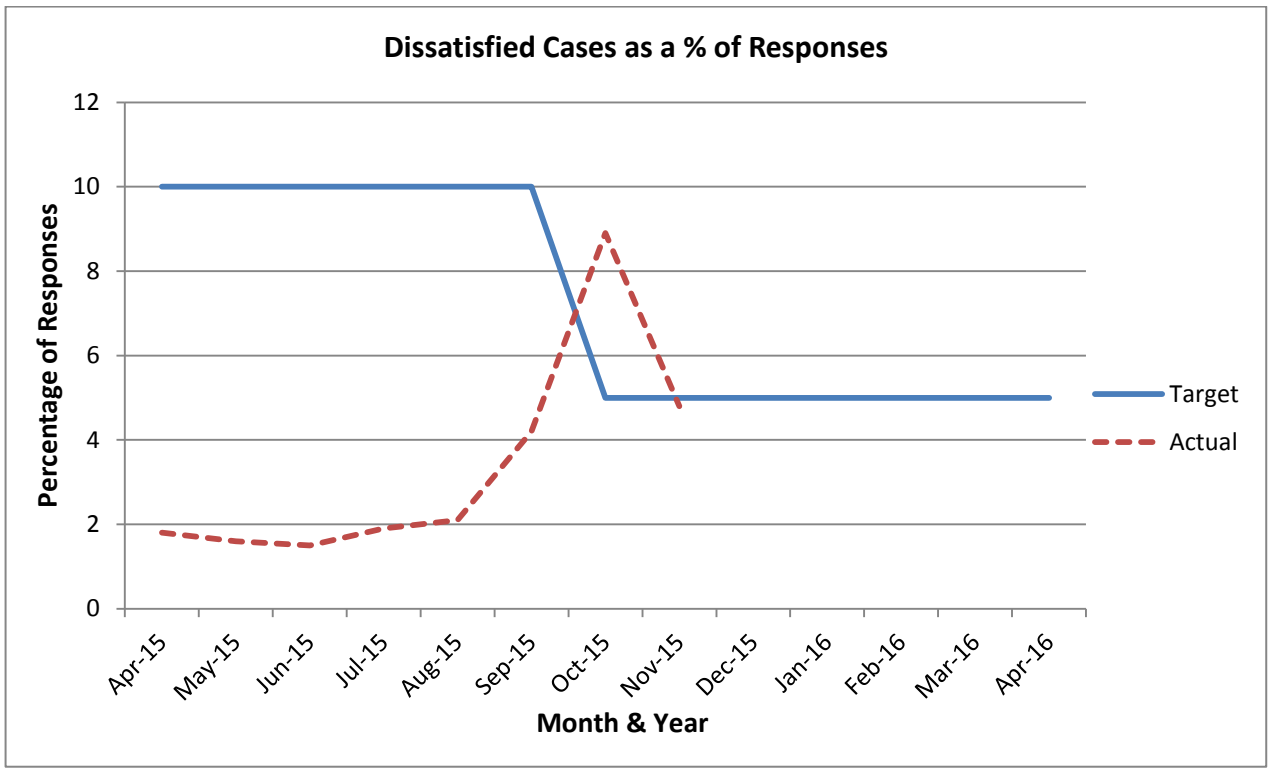
c) A letter is sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of

asking the PHSO to independently review their complaint.

If necessary, a caseworker from the Patient Support and Complaints Team will contact the complainant in order to clarify the details of any unresolved concerns.

In all cases where a further written response is produced, this response is reviewed by the Patient Support & Complaints Manager and by the Head of Quality (Patient Experience and Clinical Effectiveness) before sending it to the Executive Directors for signing.

Figure 5: Percentage of complainants who were dissatisfied with aspects of our complaints response



2.4 Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major **themes**. The table below lists these themes and provides a breakdown of complaints received in Q3 compared to Q2. Viewed at this level, **the most notable change in Q3 was a reduction in complaints about appointments and admissions** (also see Figure 6). Complaints about clinical care increased slightly in Q3 compared to Q2, however a longer term view of the data for this theme (see Figure 7) reveals a fluctuating picture of medical/surgical complaints and a downwards (improving) trend for nursing/midwifery complaints.

Table 3

Theme	**Number of complaints received – Q3 2015/16**	**Number of complaints received – Q2 2015/16**
Appointments & Admissions	139 (31% of total complaints) ↓	202 (36% of total complaints) ↑
Attitude & Communication	125 (28%) ↓	146 (26%) ↑
Clinical Care	127 (29%) ↑	112 (20%) ↓
Facilities & Environment	23 (5%) ↓	39 (7%) ↑
Access	9 (2%) ↓	16 (3%) ↑
Information & Support	23 (5%) ↓	45 (8%) ↑
Total	**446**	**560**

Each complaint is then assigned to a more specific sub-category (of which there are 121 in total). The table below lists the seven most consistently reported complaint sub-categories. In total, these seven sub-categories accounted for 59% of the complaints received in Q3 (262/446).

Table 4

Sub-category	**Number of complaints received – Q3 2015/16**	**Q2 2015/16**	**Q1 2015/16**	**Q4 2014/15**
Cancelled or delayed appointments and operations	103 ↓	151	124	140
Clinical Care (Medical/Surgical)	54 ↑	48	49	78
Communication with patient/relative	41 ↑	31	33	26
Clinical Care (Nursing/Midwifery)	18 ↓	20	24	26
Failure to answer telephones	17 ↓	22	34	26
Attitude of Medical Staff	16 ↓	24	11	21
Attitude of Nursing/Midwifery	13 ↓	14	10	10

Viewed at the level of sub-categories, the dominant trust-wide complaint issue is cancelled or delayed appointments and operations, however – in common with the wider 'Appointments & Admissions' theme described above, performance improved notably in Q3 compared to the three preceding quarters. Complaints about communication with patients/relatives were higher than in the three previous quarters although the increase was small in absolute terms.

Figures 6, 7, 8 and 9 show the most commonly recorded complaint categories, as per section 2.3 above.

Figure 6: Cancelled or delayed appointments and operations

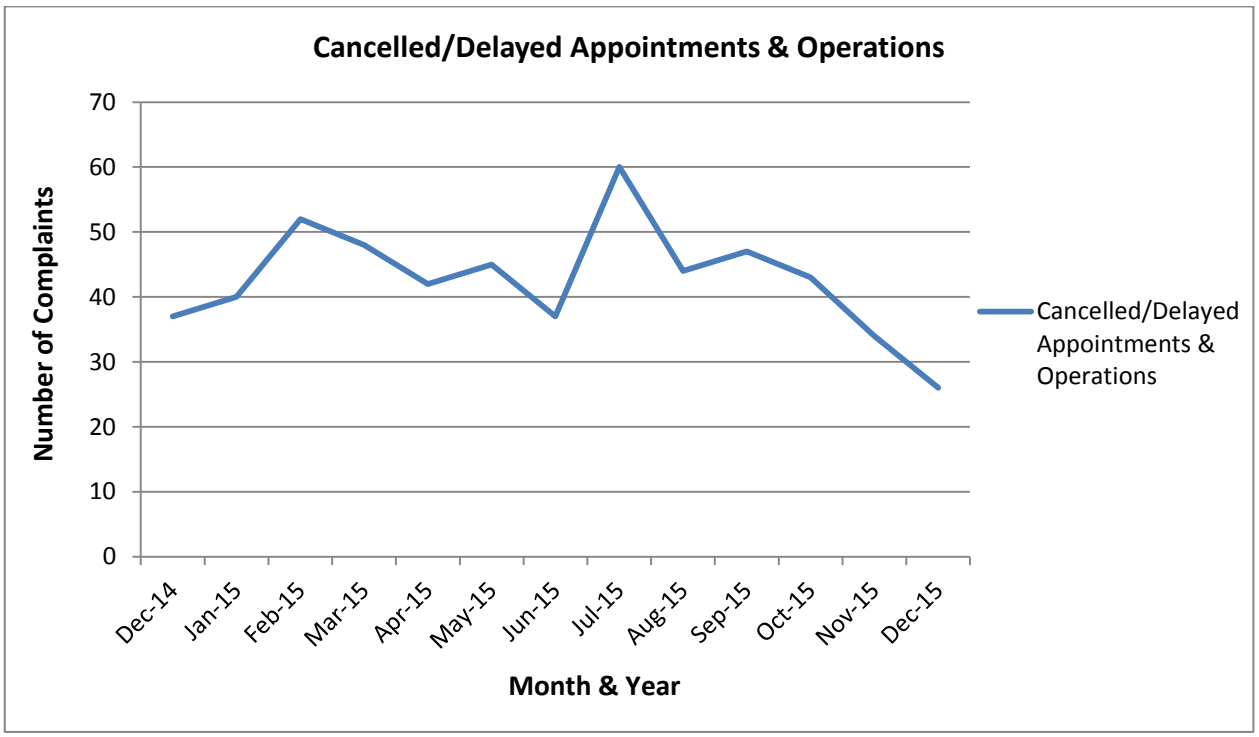


Figure 7: Clinical Care – Medical/Surgical and Nursing/Midwifery

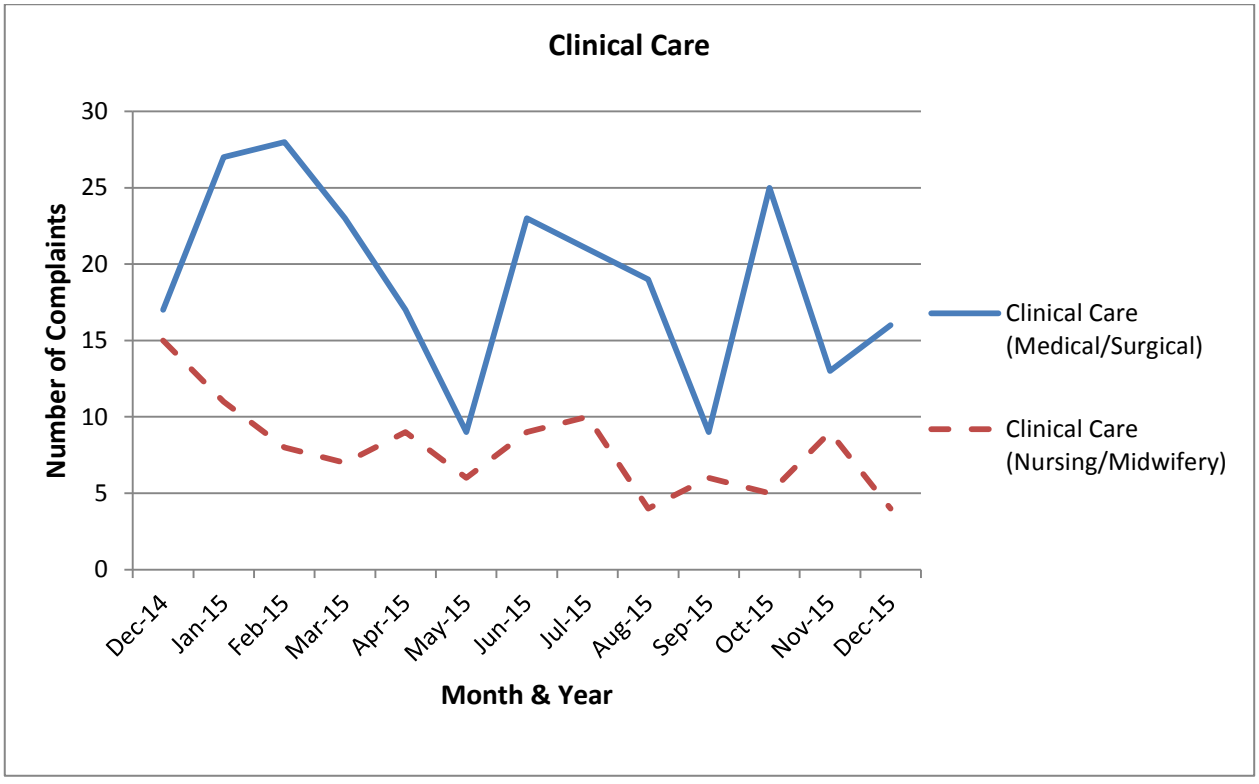


Figure 8: Communication with patients/relatives and failure to answer telephones

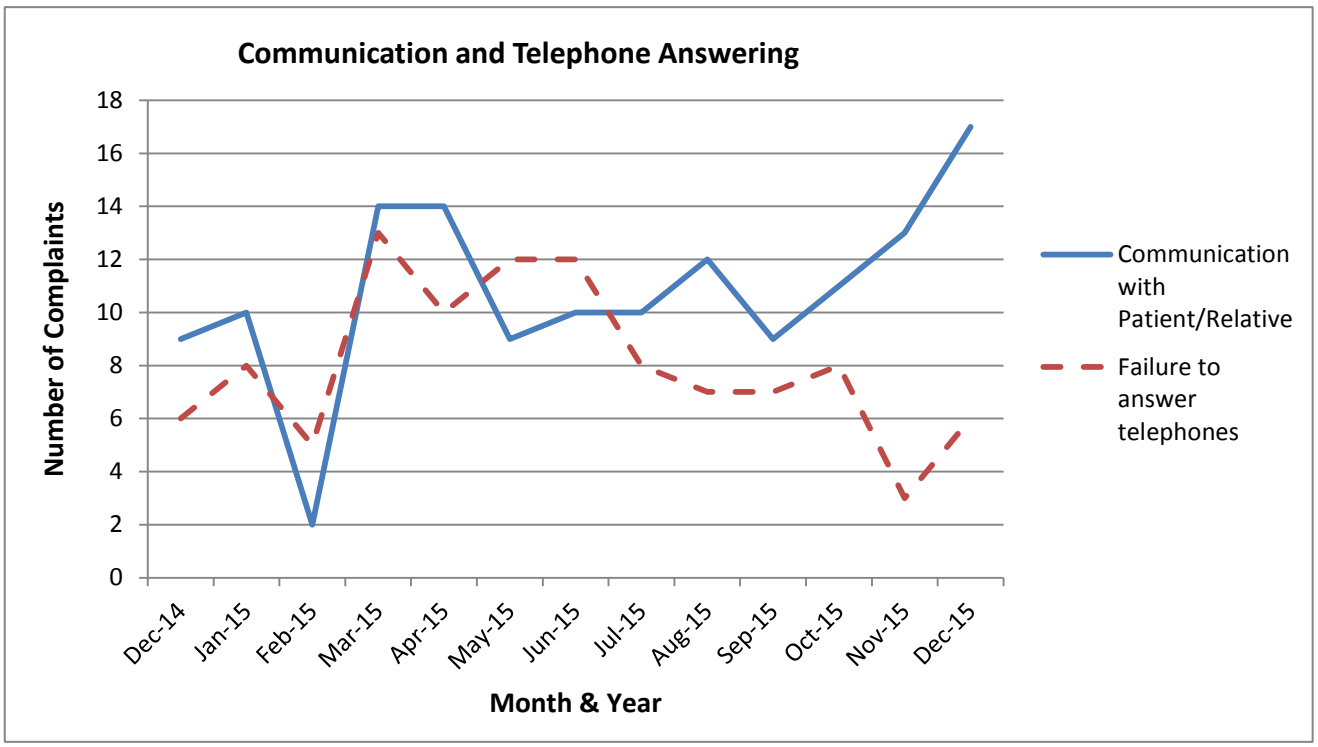
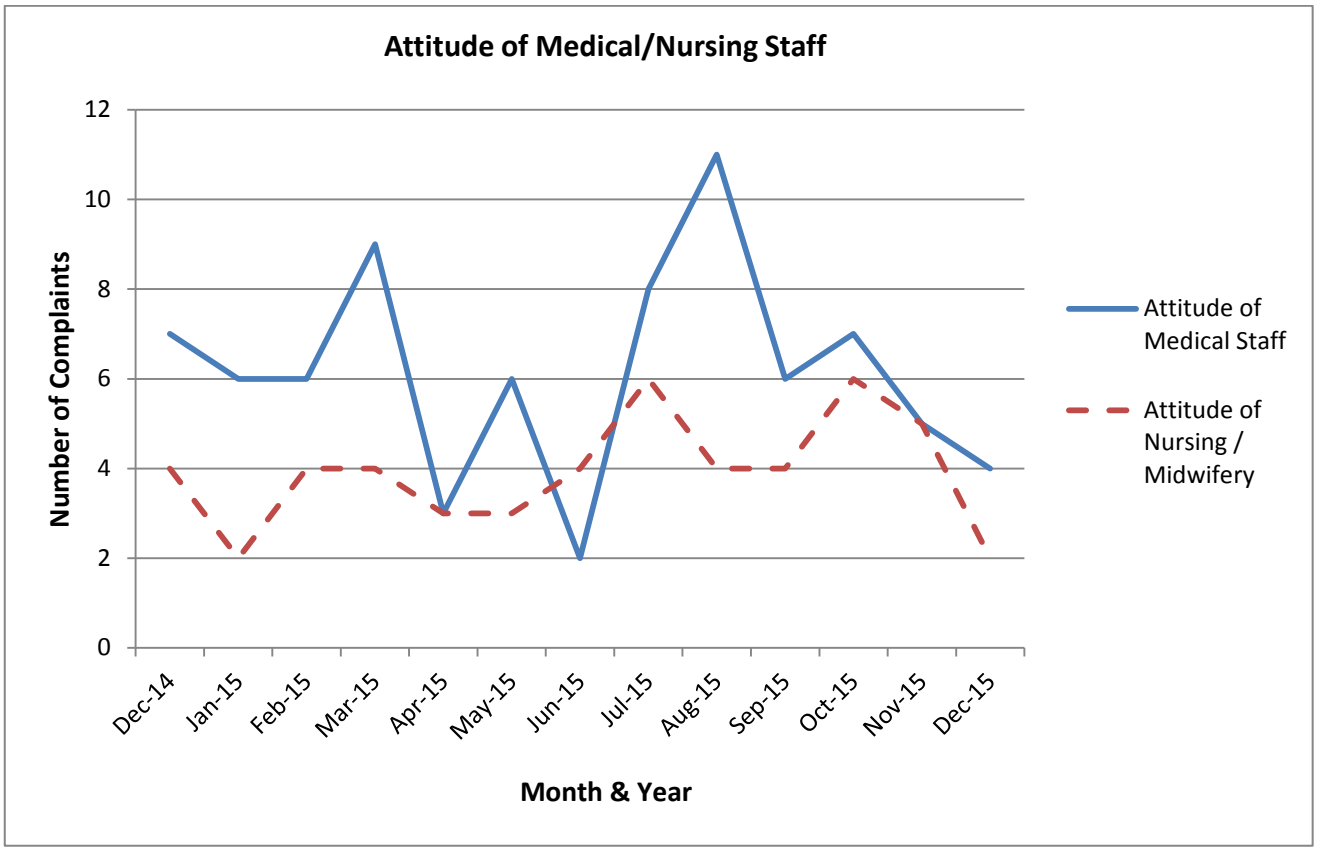


Figure 9: Attitude of medical and nursing/midwifery staff

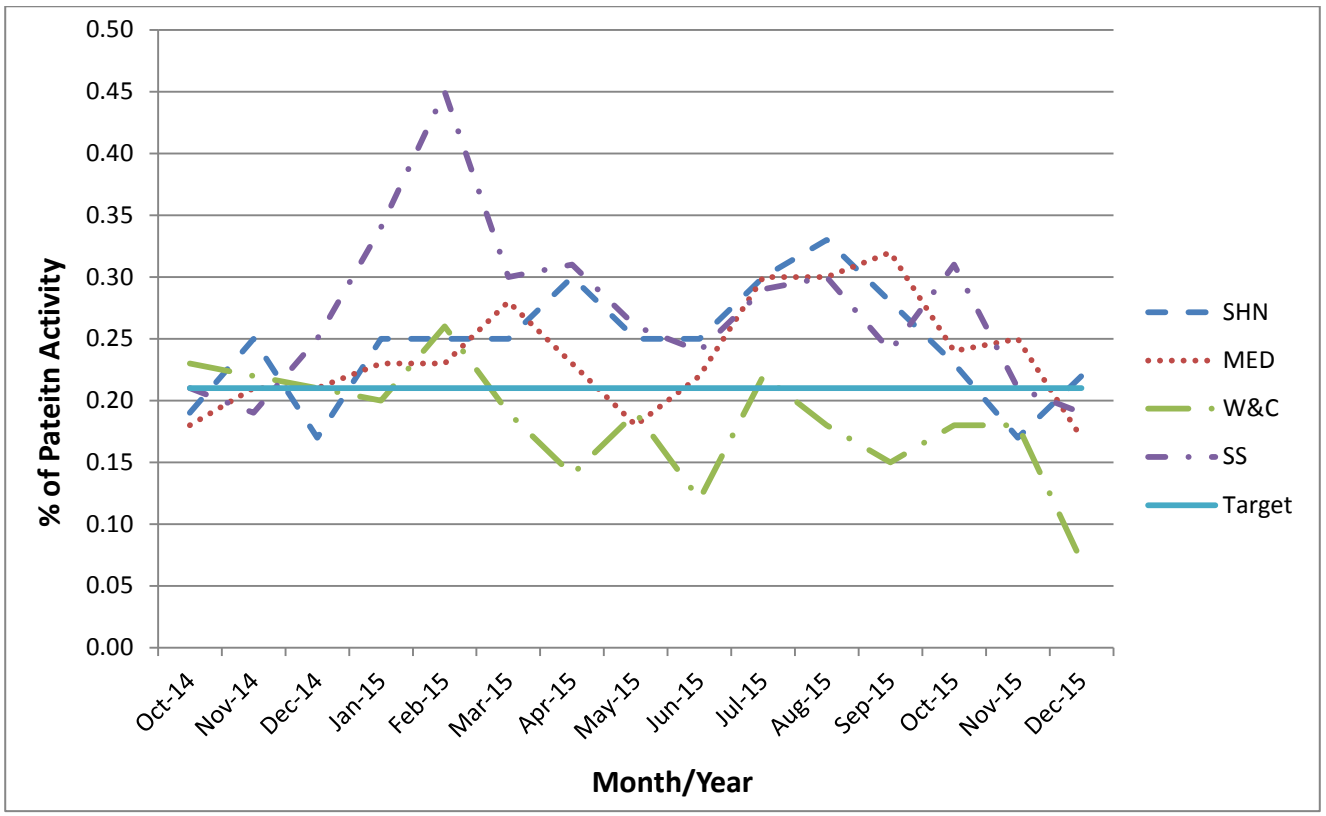


3. Divisional performance

3.1 Total complaints received

A divisional breakdown of percentage of complaints per patient attendance is provided in Figure 10. This shows an overall downturn in the volume of complaints received in the bed-holding Divisions during Q3.

Figure 10: Complaints by Division as a percentage of patient attendance



When analysed as a proportion of patient activity, complaints received by Women's & Children's Division show signs of a downward (i.e. improving) trend in the period of time since October 2014.

Data for the Division of Diagnostics and Therapies is not reported in Figure 10 because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Complaints relating to services in Diagnostics and Therapies are more likely to occur as elements of complaints within bed-holding Divisions. Overall reported Trust-level data includes Diagnostic and Therapy complaints, however it is not appropriate to make direct comparisons with other Divisions. For reference, numbers of reported complaints for the Division of Diagnostics and Therapies since January 2015 have been as follows:

Table 5. Complaints received by Diagnostics and Therapies Division since January 2015

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of complaints received	7	5	11	2	5	7	10	4	5	12	5	7

3.2 Divisional analysis of complaints received

Table 6 provides an analysis of Q3 complaints performance by Division. The table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 6.

	Surgery Head and Neck	**Medicine**	**Specialised Services**	**Women and Children**	**Diagnostics and Therapies**
Total number of complaints received	169 (236) ↓	94 (125) ↓	59 (69) ↓	67 (80) ↓	24 (18) ↑
Total complaints received as a proportion of patient activity	0.20% (0.30%) ↓	0.22% (0.31%) ↓	0.24% (0.27%) ↓	0.14% (0.18%) ↓	N/A
Number of complaints about appointments and admissions	70 (103) ↓	17 (37) ↓	21 (26)↓	25 (30) ↓	6 (6) =
Number of complaints about staff attitude and communication	48 (64) ↓	38 (33) ↑	15 (22)↓	10 (22) ↓	7 (5) ↑
Number of complaints about clinical care	38 (45) ↓	35 (27) ↑	19 (11) ↑	27 (22) ↑	8 (7) ↑
Areas where the most complaints have been received in Q3	Bristol Eye Hospital – 49 (57) ↓ Bristol Dental Hospital – 31 (41) ↓ Trauma & Orthopaedics – 31 (24) ↑ Ear Nose and Throat – 13 (36) ↓ Upper GI – 14 (8) ↑	A&E – 14 (27) ↓ Ward A300 (MAU) – 9 (6) ↑ Dermatology – 8 (9) ↓ Gastroenterology & Hepatology 7 (12) ↓ Respiratory – 5 (3) ↑ Ward A605 – 5 (1) ↑ Ward C808 – 5 (1) ↑ Ward A900 – 5 (1) ↑	BHI Outpatients – 16 (26) ↓ GUCH Services – 10 (5) ↑ Chemo Day Unit / Outpatients – 9 (15) ↓ Ward C708 – 6 (4) ↑	Children's ED & Ward 39 – 9 (10) ↓ Paediatric Neurosurgical – 9 (5) ↑ Paediatric Orthopaedics – 4 (5) ↓	Radiology – 10 (6) ↑ Adult Therapy – 3 (3) = Pharmacy – 5 (2) ↑
Notable deteriorations compared to Q2	Trauma & Orthopaedics – 31 (24) Upper GI – 14 (8)	Ward A605 – 5 (1) Ward C808 – 5 (1) Ward A900 – 5 (1)	GUCH Services – 10 (5)	Paediatric Neurosurgical – 9 (5)	Radiology – 10 (6) Pharmacy – 5 (2)
Notable improvements compared to Q2	Bristol Eye Hospital – 49 (57) Bristol Dental Hospital – 31 (41) Ear Nose and Throat – 13 (36)	A&E – 14 (27)	BHI Outpatients – 16 (26) Chemo Day Unit / Outpatients – 9 (15)	None	None

3.3 Areas where the most complaints were received in Q3 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Table 7 - Complaints by category type[4]

Category Type	Number and % of complaints received – Q3 2015/16	Number and % of complaints received – Q2 2015/16
Access	2 (1.2% of total complaints) ↓	6 (2.5% of total complaints) ↑
Appointments & Admissions	71 (42%) ↓	103 (43.6%) ↑
Attitude & Communication	48 (28.4%) ↓	64 (27.1%) ↑
Clinical Care	38 (22.5%) ↓	45 (19.1%) =
Facilities & Environment	3 (1.8%) ↓	6 (2.5%) ↑
Information & Support	7 (4.1%) ↓	12 (5.1%) ↑
Total	169	**236**

Table 8 - Top sub-categories

Sub-category	Number of complaints received – Q3 2015/16	Number of complaints received – Q2 2015/16
Cancelled or delayed appointments and operations	59 ↓	88 ↑
Communication with patient/relative	15 ↑	12 ↑
Clinical Care (Medical/Surgical)	14 =	14 ↓
Attitude of Medical Staff	8	6 ↑
Failure to answer telephones	6 ↓	15 ↓
Attitude of Nursing/Midwifery	2 ↓	8 ↑
Clinical Care (Nursing/Midwifery)	2 ↓	9 ↑

Table 9 - Divisional response to concerns highlighted by Q3 data

Concern	Explanation from Division	Action
Consecutive quarterly increases in complaints about Trauma & Orthopaedics. This service has had a consistently high number of complaints: 18 in Q1, 24 in Q2 and 31 in Q3. In Q3, 12 of these complaints were about appointments and admissions (including cancelled or delays appointments and operations); 10 were about attitude and communication (including attitude of medical staff, communication with patient/ relative, etc); and nine were about clinical care.	The department is currently short of three whole time equivalent administration staff. The department is not currently using a telephone answering system. The rationale is that the line is so busy that an answering service would create a constant cycle of retrieving messages rather than being able to answer live calls.	One position has been recruited to and interviews were held week commencing 15/02/2016 for a second post. The department is currently investigating with IM&T whether it is possible to have a telephone queuing system that will provide patients with information regarding their position in the queue and offering alternative options regarding best times to call, etc. The Deputy Performance and Operations Manager has put in place a system to ensure that telephones are not left unanswered and, once fully recruited, the team plan to have a dedicated member of staff assigned to answer patient calls without the added distracted of

		manning a reception desk at the same time.
	Concerns have been identified about the approach of a member of the clinical team who appears to be receiving more complaints than other colleagues.	The divisional management team will review concerns and address with the individual concerned as appropriate.
In Q3, there was a 75% increase in complaints about the Upper GI service compared to Q2. Complaints about this service have remained above average with 10 complaints in Q1, eight in Q2 and 14 in Q3. The majority of the complaints in Q3 (nine) were in respect of appointments and admissions, with three being about attitude and communication and two relating to clinical care.	These complaints relate to significant shortages in the Upper GI consultant group and in the Clinical Nurse Specialist (CNS) group.	Recruitment to an additional consultant post has been successful and it is hoped that a reduction in complaints will be seen by Q1 of 2016/17 at the latest, when the new consultant commences in post. Recruitment to the CNS posts is currently under review.
	The communication issues relate to the way that patients are informed about cancellations and delays.	This issue will be dealt with via the Administrative Standards Group to ensure that staff have appropriate standards of responses when delivering difficult news to patients regarding their appointments. The administrative standards group will have achieved this with the waiting list coordinators by the end of April (division-wide training). Two new members of staff have been employed by the Division to manage these difficult conversations with patients.
	Two patients complained about their clinical care. These were both very complex patients for whom the journey had not been as predicted – one related to a deceased patient whose family felt that staff had not dealt with them as sensitively as they would have expected.	Sister shares all patient complaints with her team and also the responses to these complaints, in order that they can consider the impact of their actions and how they can improve a patient's/family's experience going forward.

[4] Arrows in Q3 column denote increase or decrease compared to Q2. Arrows in Q2 column denote increase or decrease compared to Q1. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

Figure 11: Surgery, Head & Neck – Formal and informal complaints received by Division

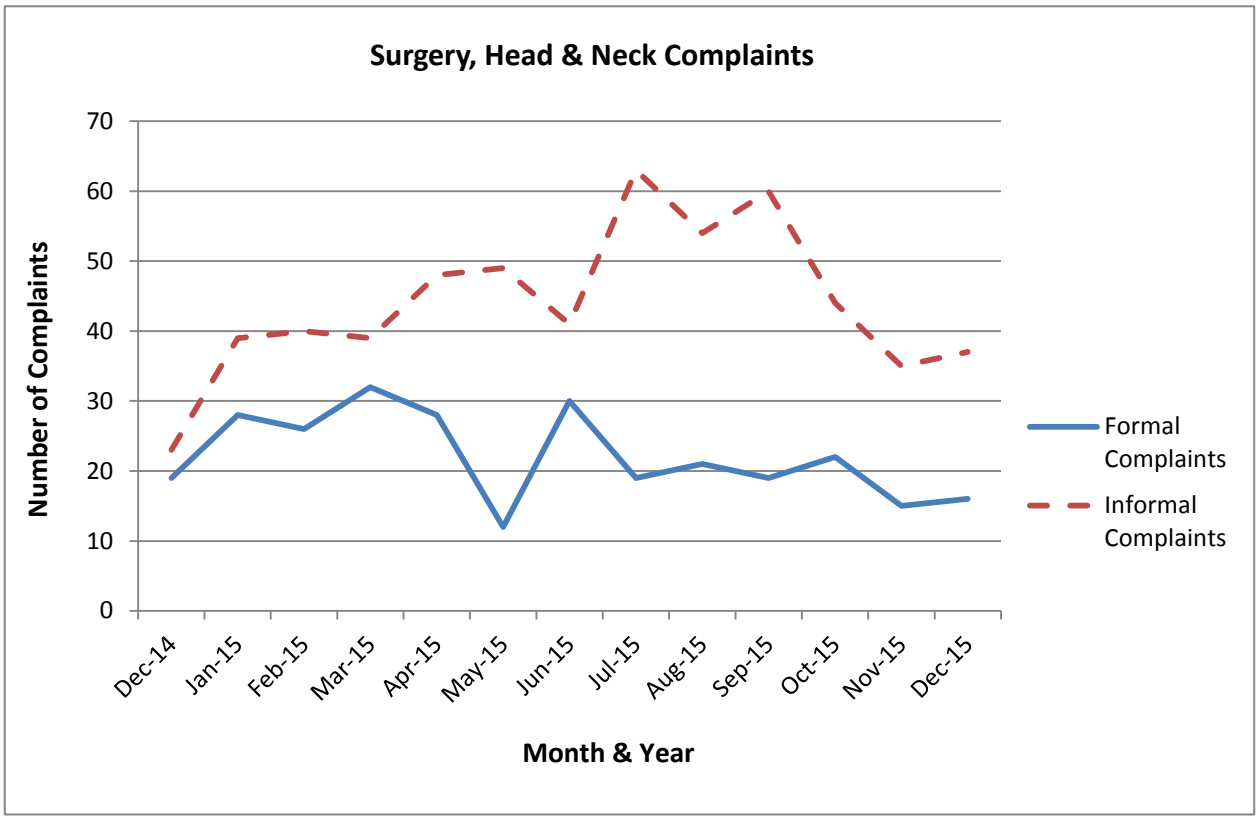
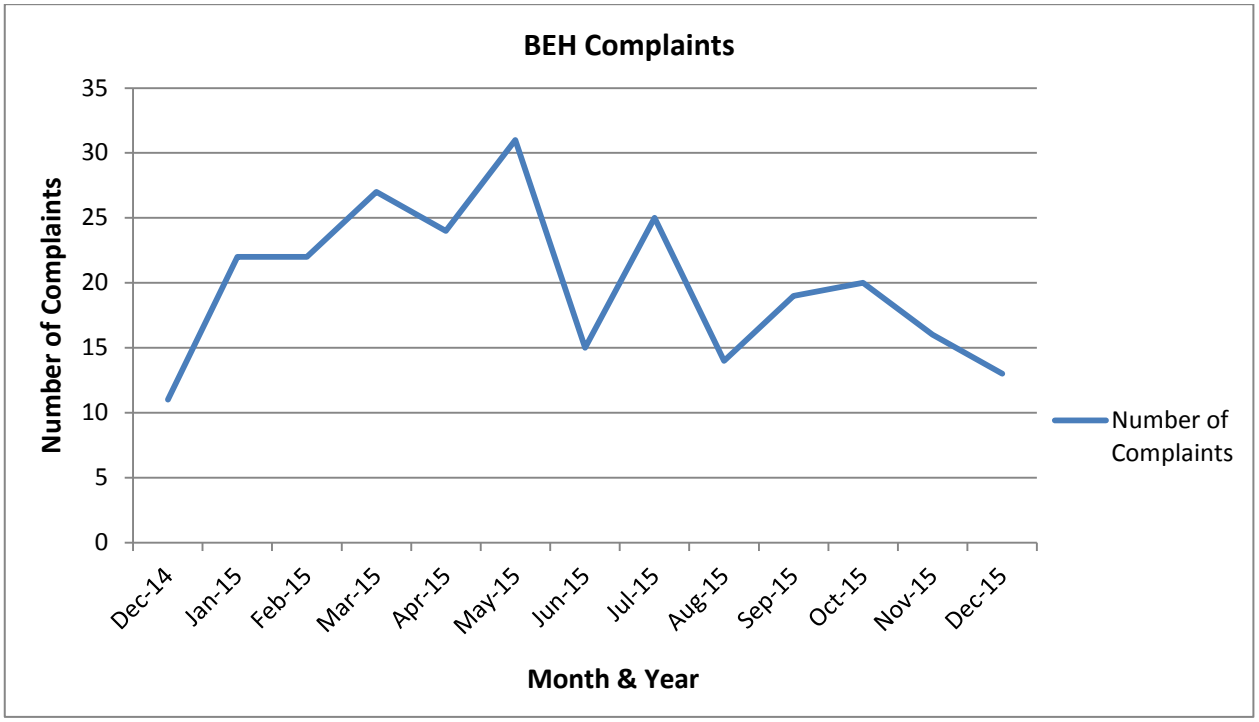


Figure 12 shows an encouraging reduction in complaints received about Bristol Eye Hospital since a peak in May 2015.

Figure 12: Complaints received by Bristol Eye Hospital



3.3.2 Division of Medicine

Table 10 - category type

Category Type	Number and % of complaints received – Q3 2015/16	Number and % of complaints received – Q2 2015/16
Access	0 (0% of total complaints) ↓	2 (1.6% of total complaints) ↑
Appointments & Admissions	16 (17%) ↓	37 (29.6%) ↑
Attitude & Communication	36 (38.3%) ↑	33 (26.4%) ↑
Clinical Care	33 (35.1%) ↑	27 (21.6%) ↓
Facilities & Environment	4 (4.3%) ↓	15 (12%) ↑
Information & Support	5 (5.3%) ↓	11 (8.8%) ↑
Total	**94**	**125**

Table 11 - Top sub-categories

Category	Number of complaints received – Q3 2015/16	Number of complaints received – Q2 2015/16
Clinical Care (Medical/Surgical)	18 ↑	7 ↓
Communication with patient/relative	14 ↑	9 ↑
Attitude of Nursing/Midwifery	8 ↑	4 ↓
Cancelled or delayed appointments and operations	7 ↓	22 ↑
Clinical Care (Nursing/Midwifery)	7 ↑	6 ↓
Failure to answer telephones	6 ↑	2 ↓
Attitude of Medical Staff	3 □	5 □

Table 12 - Divisional response to concerns highlighted by Q3 data

Concern	Explanation from Division	Action
In Q3 there was an increase in the number of complaints received by Wards A605, A900 and C808 (five complaints for each ward compared to one each in Q2).	A605 received two complaints about communication with patients/ relatives and one each about discharge arrangements, attitude of medical staff and clinical care. One of these complaints was about a patient's dignity during discharge. A900 received two complaints about clinical care (medical/surgical) and one each about attitude of nursing staff, clinical care (nursing) and failure to answer the telephone. These included a complaint about a hip fracture sustained as a result of a fall whilst in our care. C808 received one complaint each about discharge arrangements, communication	There are no common themes in these complaints but a clear message has been shared with staff on the ward about dignity on discharge. There are no common themes in these complaints. With regards to the hip fracture, an RCA investigation has been completed and a meeting is scheduled between staff and the family. There are no common themes and all complaints have been investigated and responded to with

	with patients/ relatives, clinical care (nursing), medication not received and incorrect diagnosis. Of these complaints, one related to a District Nurse not being able to contact the ward post-discharge to check a medication regime; one related to a patient's perception that they had been misdiagnosed; one related to a family's experience of care; and one was in respect of discharge planning and communication.	local actions where required.
The Gastroenterology and Hepatology service has received an average of nine complaints per quarter over the last three quarters (eight in Q1, 12 in Q2 and seven in Q3)	The majority of these complaints related to outpatient delays in new and follow-up appointments. One complaint was about the attitude of a secretary. One complaint was in respect of the timeliness of investigations.	Ongoing work with clinic coordinators to manage the patient backlog. Recruitment to a vacancy will support this. This has been addressed locally through training about application of the Trust's Values. Referral from UH Bristol to NBT for investigations and, once completed, a timely review here will be arranged. The patient has the Specialty Manager's contact details.

Figure 13: Medicine – Formal and informal complaints received by Division

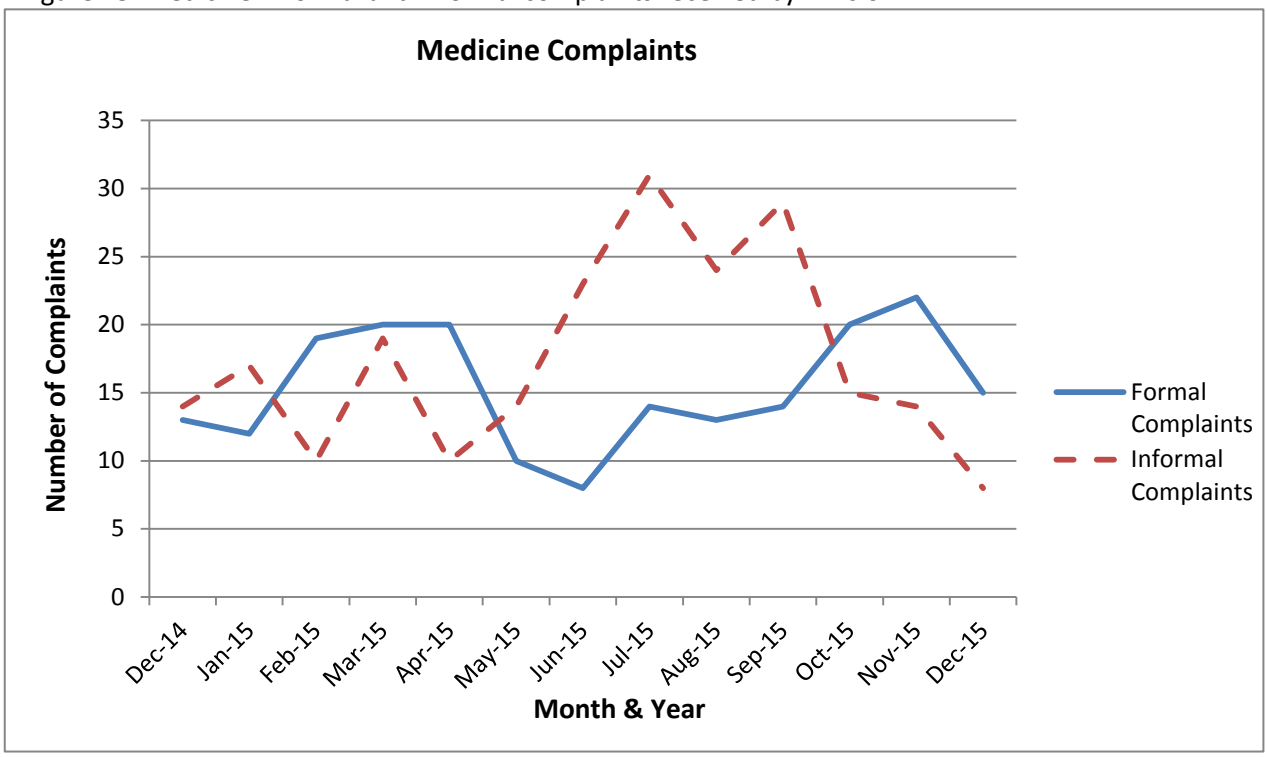
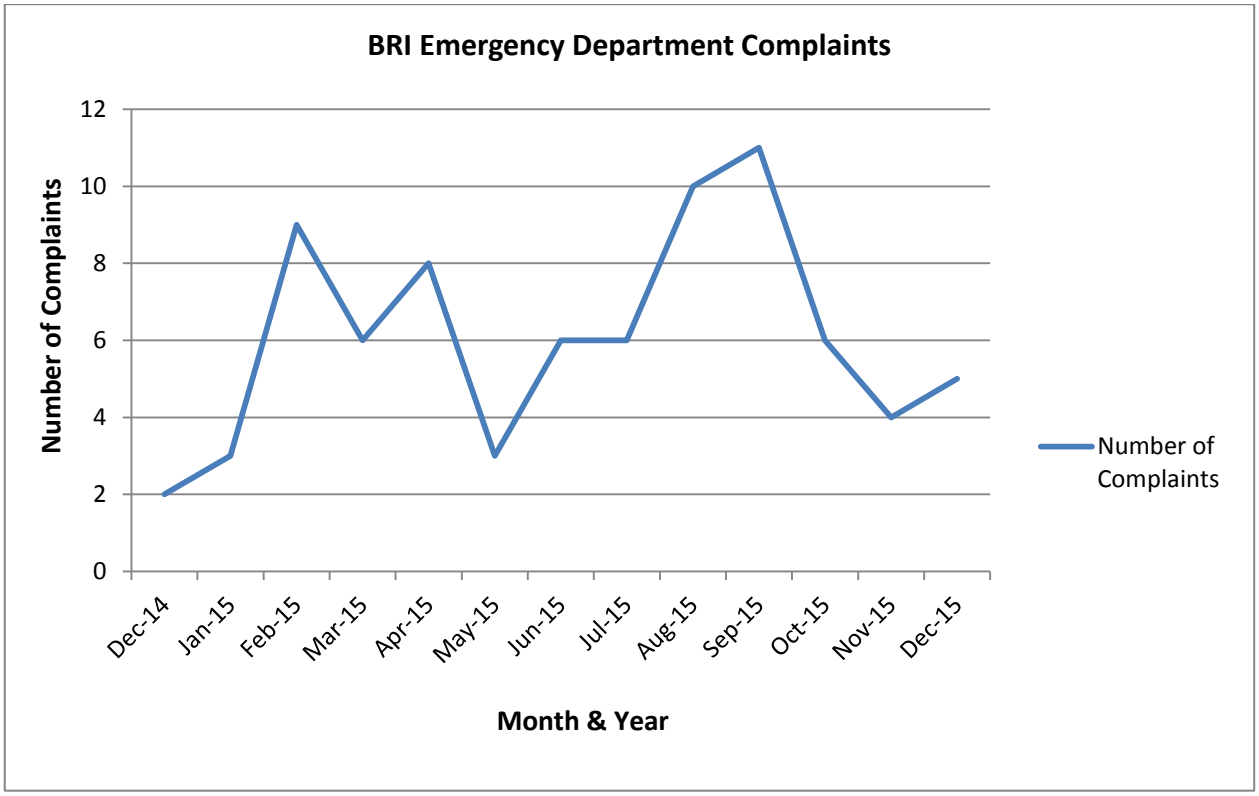


Figure 14: Complaints received by the Emergency Department at Bristol Royal Infirmary



3.3.3 Division of Specialised Services

Table 13-category type

Category Type	Number and % of complaints received – Q3 2015/16	Number and % of complaints received – Q2 2015/16
Access	0 (0% of total complaints) ↓	1 (1.4% of total complaints) ↑
Appointments & Admissions	21 (35.6%) ↓	26 (37.7%) =
Attitude & Communication	15 (25.4%) ↓	22 (31.9%) ↑
Clinical Care	18 (30.5%) ↑	11 (15.9%) ↓
Facilities & Environment	2 (3.4%) ↓	3 (4.3%) ↑
Information & Support	3 (5.1%) ↓	6 (8.7%) ↑
Total	**59**	**69**

Table 14 - Top sub-categories

Category	Number of complaints received – Q3 2015/16	Number of complaints received – Q2 2015/16
Cancelled or delayed appointments and operations	14 ↓	19 ↑
Clinical Care (Medical/Surgical)	9 ↑	7 ↑
Communication with patient/relative	6 ↑	1 ↓
Failure to answer telephones	3 ↓	7 ↓

Clinical Care (Nursing/Midwifery)	3 ↑	1 ↑
Attitude of Medical Staff	1 ↓	5 ↑
Attitude of Nursing/Midwifery	0 =	0 ↓

Table 15 - Divisional response to concerns highlighted by Q3 data

Concern	**Explanation from Division**	**Action**
In the Q2 complaints report, the Division reported that emergencies were affecting elective admissions to the GUCH service and that communication issues around the cancellation of appointments had been resolved. However, complaints about the service increased again in Q3 (to 10). Complaints were recorded variously as having been in relation to cancelled or delayed appointments or procedures; telephones not being answered; communication with patients/relatives; waiting time in clinic; clinical care (medical/surgical), and medical records not being available.	The complex nature of the patients' underlying disease and the tertiary specialist service that the BHI provides often means that demands upon the GUCH service are high. The high demand, set capacity and the requirement to communicate across organisations can often lead to extended waiting times for patients for their procedures. Complaints include concerns about the length of time waiting for a procedure known as a PFO (Patent Foramen Ovale) closure. PFO closures are currently funded by NHS England and capacity for this procedure is limited by funding.	In an attempt to meet the growing demand for this service, the Division is running additional ad hoc sessions at weekends to support a reduction in waiting times for this group of patients. The Division is working with the Trust's commissioning team to explore the potential for increasing funding and capacity to undertake PFO closure procedures.
Ward C708 has received more complaints than other wards in the Division. Complaints in Q3 were variously about communication with patients/relatives; admissions arrangements; a delayed operation; clinical care (nursing); and personal property.	The increase in complaints is consistent with the challenges which the Division is currently experiencing in undertaking cardiac surgery and corresponds with an increase in the length of time that patients are waiting for their operation.	The Division continues to experience elevated numbers of cancellations and delays to cardiac surgery. The Division is working hard to resolve this and has employed a clinical operational lead to support the patient flow agenda. These challenges will continue with winter pressures in early 2016. The Division also acknowledges the increased numbers of both formal and informal complaints specifically related to discharge and is implementing a project to address this across 2016/17. This will be monitored through the Division's operating plan.

Figure 15 shows that the total number of complaints received by the Division of Specialised Services has been decreasing over the past year. This improvement corresponds with a reduction in complaints about outpatient services at the Bristol Heart Institute.

Figure 15: Specialised Services – Formal and informal complaints received by Division

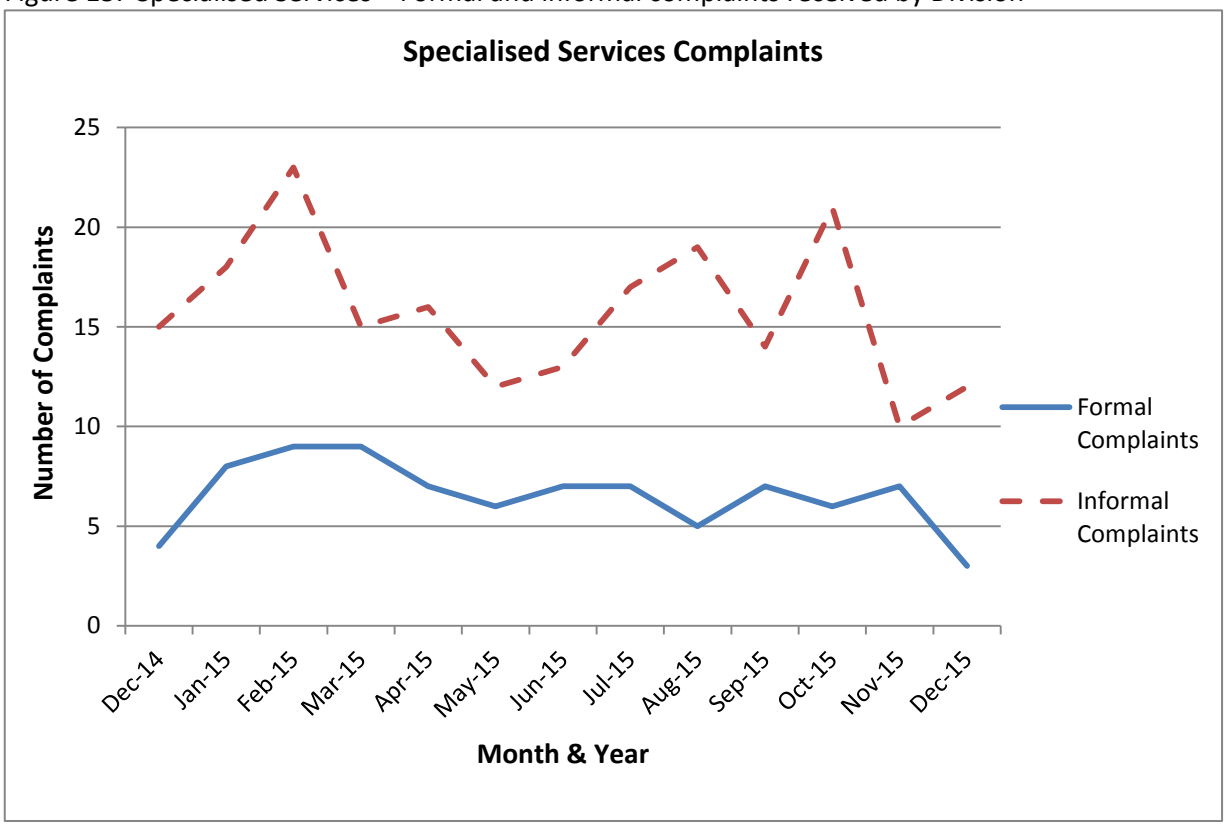
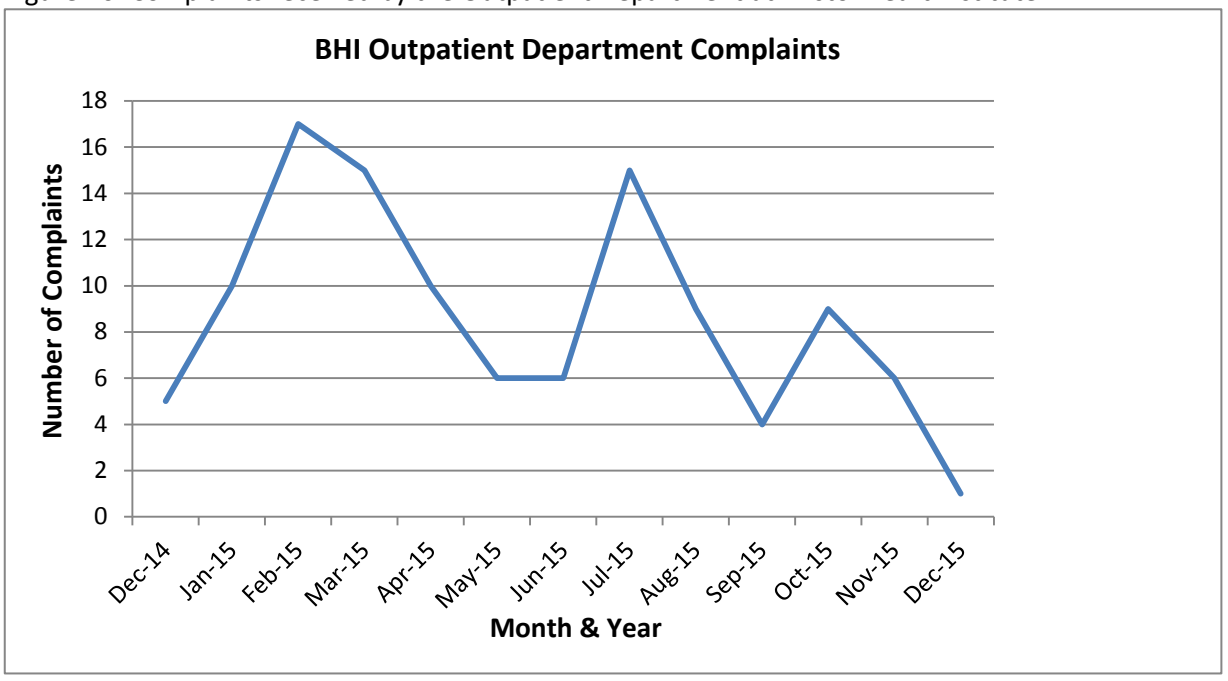


Figure 16: Complaints received by the Outpatient Department at Bristol Heart Institute



3.3.4 Division of Women & Children

Table 16 - category type

Category Type	Number and % of complaints received – Q3 2015/16	Number and % of complaints received – Q2 2015/16
Access	0 (0% of total complaints) ↓	1 (1.25% of total complaints) =
Appointments & Admissions	26 (38.8%) ↓	30 (37.5%) ↑
Attitude & Communication	11 (16.4%) ↓	21 (26.3%) ↑
Clinical Care	27 (40.3%) ↑	21 (26.3%) ↓
Facilities & Environment	2 (3%) =	2 (2.5%) ↑
Information & Support	1 (1.5%) ↓	5 (6.3%) ↑
Total	**67**	**80**

Table 17 - Top sub-categories

Category	Number of complaints received – Q3 2015/16	Number of complaints received – Q2 2015/16
Cancelled or delayed appointments and operations	19 ↓	25 ↑
Clinical Care (Medical/Surgical)	12 ↑	11 ↓
Clinical Care (Nursing/Midwifery)	6 ↑	5 ↑
Communication with patient/relative	5 ↓	7 ↑
Attitude of Medical Staff	3 ↓	6 ↑
Attitude of Nursing/Midwifery	2 ↓	3 =
Failure to answer telephones	1 ↑	0 =

Table 18 - Divisional response to concerns highlighted by Q3 data

Concern	Explanation from Division	Action
Paediatric Neurology Services received nine complaints in Q3, compared to five in Q2 and three in Q1. Two of the Q3 complaints were in respect of clinical care (medical/surgical); another two were about cancelled operations. Of the remaining five complaints, one was about a delayed procedure, one about a referral error, one about the attitude of medical staff, one about delayed treatment and one about lost/delayed test results.	Cancelled operations: • one complaint was due to the withdrawal of funding for Selective Dorsal Rhizotomy (SDR); • two complaints were due to a blood cross-matching failure/ communication between teams. Staff attitude/communication with family. Clinical care – one complaint was compounded by communication issues between hospital teams and then each team communicating decisions to the family. The second complaint about clinical care was a complex complaint involving various points along the care pathway, including the ward	Communication going out to all families re SDR from the Deputy Divisional Director. An apology has been given and all teams have been reminded of the importance of timely communication with families and between hospital teams.

	stay, discharge summaries and the LIAISE team. Delayed treatment – long wait to be seen in the ENT Department. Delayed results – again due to communication with the family about these results.	The consultant has apologised and acknowledged his responsibility for following up the results of investigations and communicating these appropriately with the family.
The number of complaints received by Children's ED & Ward 39 in Q3 was similar to Q2. Of the nine complaints received in Q3, two were about the A&E wait and two were about clinical care (medical/surgical). The remaining seven complaints were about attitude of nursing staff, communication (administrative), communication with patients/relatives, clinical care (nursing) and a missed diagnosis respectively.	Children's ED saw 36,000 patients in 2014/15, so it is a high volume/turnover clinical area. In 2015/16 YTD, attendances are up by around 10% and admissions are higher, all of which has put additional pressure on the department. There are also gaps in the nursing and medical establishments, meaning that there is a reliance on agency/locums and a high number of newly qualified nurses, reducing the overall skill mix.	The Divisional Management team is working on an operating plan for 2016/17 that reflects the increase in activity and anticipates further growth next year. This will enable us to further invest in the service and enable the team to cope with the rising demand in a more timely way.

Figure 17: Women & Children – Formal and informal complaints received by Division

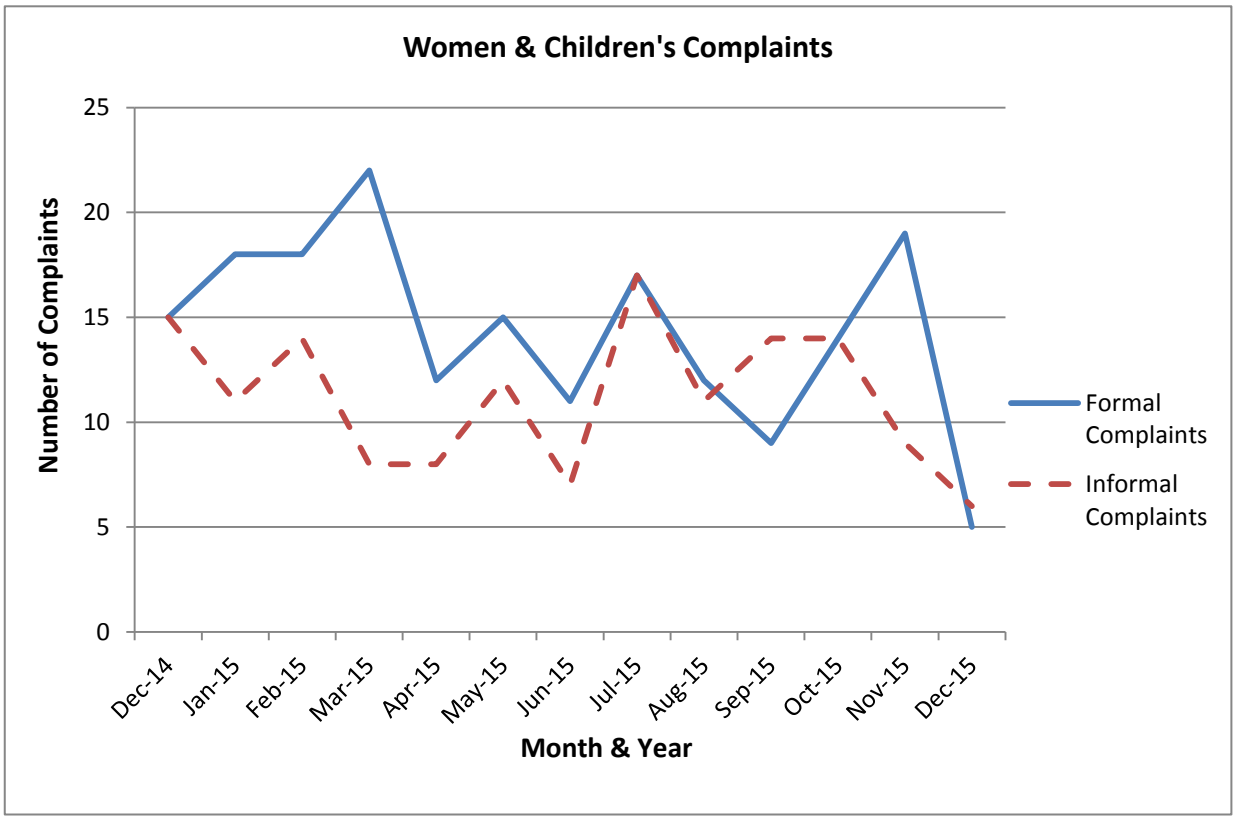
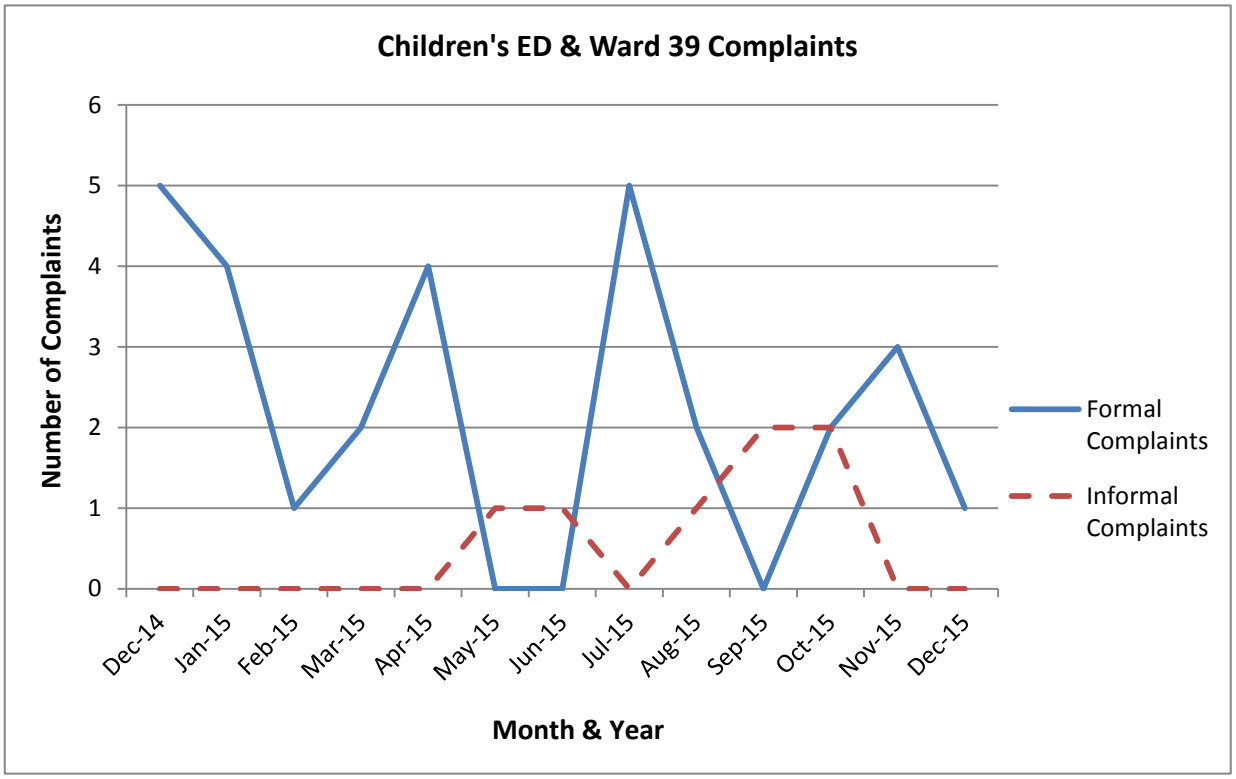


Figure 18: Complaints received by the Children's ED & Ward 39 at Bristol Children's Hospital



3.3.5 Division of Diagnostics & Therapies

Table 19 - category type

Category Type	Number and % of complaints received – Q3 2015/16	Number and % of complaints received – Q2 2015/16
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	6 (25%) =	6 (33.3%) ↑
Attitude & Communication	7 (29.2%) ↑	5 (27.8%) =
Clinical Care	8 (33.3%) ↑	7 (38.9%) ↑
Facilities & Environment	2 (8.3%) ↑	0 =
Information & Support	1 (4.2%) ↑	0 ↓
Total	**24**	**18**

Table 20 - Top sub-categories

Category	Number of complaints received – Q3 2015/16	Number of complaints received – Q2 2015/16
Cancelled or delayed appointments and operations	4 ↓	6 ↑
Clinical Care (Medical/Surgical)	1 ↓	4 ↑
Communication with patient/relative	1 ↓	2 ↓
Attitude of Medical Staff	1 ↓	2 ↑
Attitude of Nursing/Midwifery	1 ↑	0 =
Failure to answer telephones	1 ↑	0 =
Clinical Care (Nursing/Midwifery)	0 =	0 =

Table 21 - Divisional response to concerns highlighted by Q3 data

Concern	Explanation from Division	Action
Radiology Services overall, including x-ray and MRI, received 10 complaints, compared with six in Q2 and three in Q1.		
Two of the complaints related to attitude and communication.	The first formal complaint regarding attitude and communication was in respect of a patient's appointment for a DEXA scan being discussed with his estranged wife, and the appointment letter being sent in error to the estranged wife's address, causing a breach of confidentiality.	An apology was issued to the complainant and the matter was discussed with the radiology booking clerk involved, who has subsequently been retrained on information governance. The investigation found that the patient's details had not been updated on the system as the referring GP had not provided this updated information as is usually the case. This information has now been updated on the Trust's systems.
	The second formal complaint regarding attitude and communication related to a partially sighted patient who was sent an appointment letter in the wrong size font, despite having previously raised this issue with two other departments within the Trust.	The Radiology Department had an alert on their information system that this patient required information in a large font size. The letter was in a large font size but the accompanying leaflet was not. Unfortunately, the patient did not receive this and when a second letter and leaflet were sent out, they were both in a standard font size. An apology was issued to the patient and booking clerks in the department have been reminded to always meet patient requirements in line with system alerts. The patient subsequently received a copy of the letter and the leaflet in the larger font size.
Five complaints related to clinical care	The formal complaint regarding clinical care was in respect of a patient who experienced an adverse reaction to the oral preparation they were required to take for a bowel MRI scan.	An apology was given to the patient together with an explanation that an adverse reaction is very rare but that in light of the complaint, the department has updated its patient information leaflet advising patients to inform the department if they have previously had any adverse reactions to laxatives. An alert has also been placed on the patient's record.

	An informal complaint was received about a CT scan report being delayed.	The department was experiencing high volumes of requests at the time and as soon as the report was verified, the results were emailed to the GP.
	A second informal complaint was received in respect of a delayed response from a clinician to queries from an internal referrer who required further information about their patient's scan.	The query had been sent to the clinician by email and had not been picked up. The clinician apologised and has made arrangements to ensure that his secretary can now view his emails.
	An informal complaint was received from a referrer regarding mislaid MRI scan results.	The MRI scan was carried out and reported on the same day that it was requested and the complainant was advised that the results were available on ICE.
	A further informal complaint was received in respect of delayed x-ray results.	The x-ray was carried out on 22/10/2015 and the patient enquired about the results seven days later. They were advised that the target date for results was 10 working days. The x-ray was reported on day 11, one day beyond the target date.
Three complaints related to appointments and admissions.	The first informal complaint about appointments and admissions related to an MRI appointment letter that had not arrived with the patient, the subsequent DNA (Did Not Attend) letter they received and the delay in the booking clerk returning the patient's call when they contacted the department.	The address on the letter was correct but the letter did not arrive. Apologies were given to the patient for the non-delivery of the letter and the subsequent DNA letter they received. The booking clerk was reminded of the need to return all calls in a timely manner.
	The second informal complaint related to a cancelled appointment. When they attended clinic, they were informed that the consultant was sick and they would not be seen for two hours after their appointment time.	Due to staff sickness, the patient's appointment had to be moved at short notice and the covering clinician was late arriving at clinic. An apology and explanation was given to the patient.
	An informal complaint was received regarding a patient's appointment letter being sent to the wrong address and the patient was subsequently put at the bottom of the waiting list.	The patient received an apology for the incorrect information on the hospital system, which was subsequently updated. An earlier appointment was offered and accepted by the patient.

There were five complaints received in respect of Pharmacy services, compared with two in Q2 and three in Q1.		
One complaint related to clinical care.	The formal complaint related to a delay in the patient receiving their medication and the attitude of a member of staff from the service that delivers medication to patients' homes.	The department apologised to the patient for the failure by their contracted provider to deliver their medication within the timescales requested by the clinician. The provider's account manager was asked to investigate and feedback at the next monitoring meeting.
Two complaints were in respect of facilities and environment.	One formal complaint and one informal complaint were received regarding the closure of the BEH pharmacy and a lack of clarity regarding the prescription options available to patients.	Apologies and explanations were provided to the patients involved. It was explained that the trust had outsourced outpatient prescriptions to Boots so that the BEH pharmacy could concentrate on inpatient and discharge prescriptions. The options available were explained to the patients and the department will be refreshing the information available in the outpatient areas so that these options are clear to all patients.
One complaint was received regarding information and support.	This complaint related to the complainant thinking that they could bring their own prescriptions into the Boots pharmacy.	The Director of Pharmacy telephoned the complainant to discuss their concerns and explained how the arrangement with the Boots pharmacy is set up and managed.

Figure 19: Diagnostics & Therapies – Formal and informal complaints received by Division

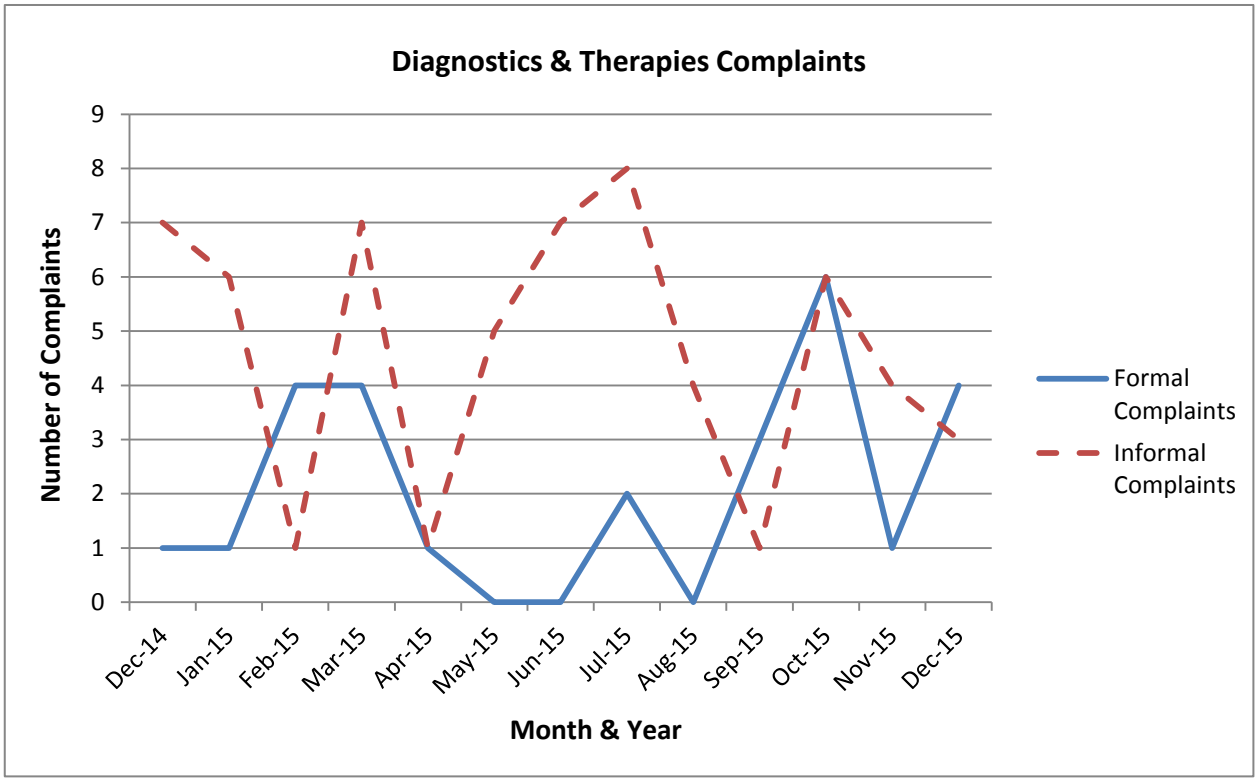
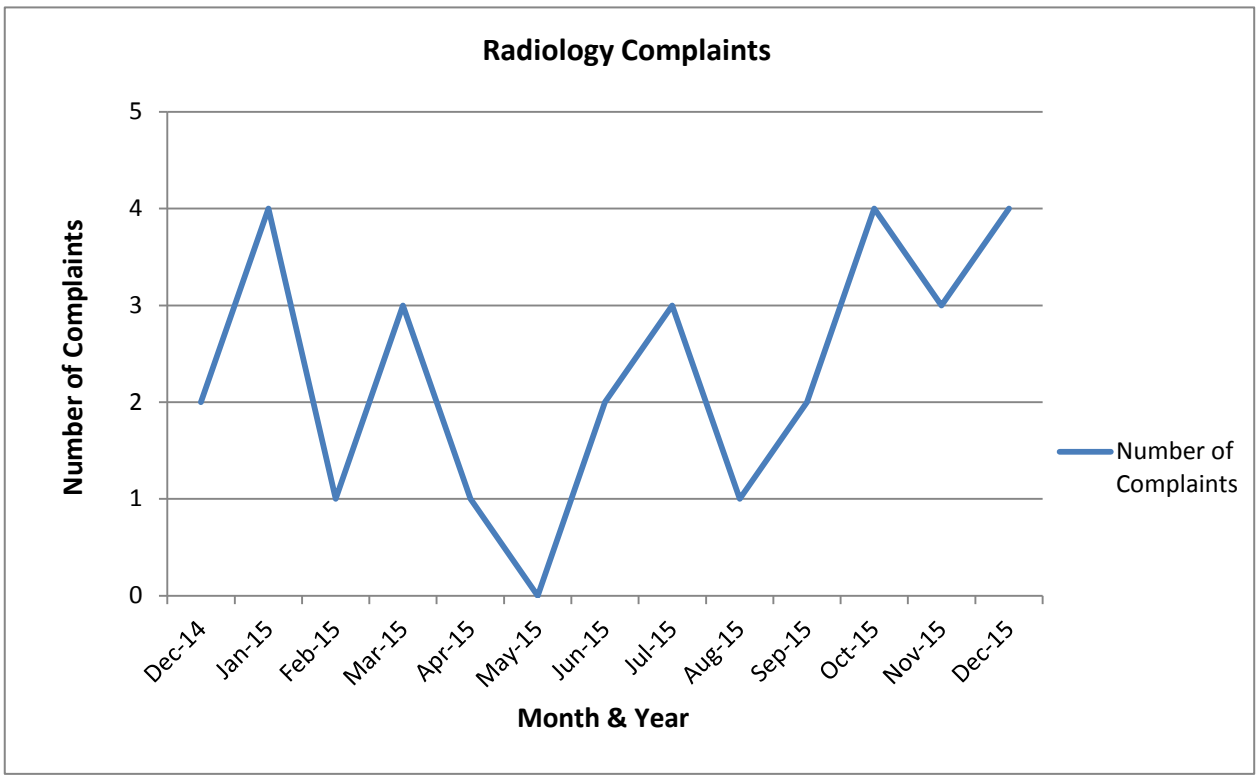


Figure 20: Complaints received by the Radiology (Trust-wide)



3.4 Complaints by hospital site

Of those complaints with an identifiable site, the breakdown by hospital is as follows:

Table 22

Hospital/Site	Number and % of complaints received – Q3 2015/16	Number and % of complaints received – Q2 2015/16
Bristol Royal Infirmary (BRI)	196 (43.8% of total complaints) ↓	225 (40.2% of total complaints) ↑
Bristol Royal Hospital for Children (BRHC)	55 (12.3%) ↓	64 (11.4%) ↑
Bristol Heart Institute (BHI)	52 (11.7%) =	52 (9.3%) ↑
Bristol Eye Hospital (BEH)	49 (11%) ↓	57 (10.2%) ↓
Bristol Dental Hospital BDH)	31 (7%) ↓	41 (7.3%) ↑
St Michael's Hospital (STMH)	31 (7%) ↓	66 (11.8%) ↑
Bristol Haematology & Oncology Centre (BHOC)	17 (3.8%) ↓	29 (5.2%) ↑
South Bristol Community Hospital (SBCH)	15 (3.4%) ↓	26 (4.6%) ↑
Total	**446**	**560**

The table below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints each hospital site receives is broadly in line with its proportion of attendances. For example, in Q3, St Michael's Hospital accounted for 10.22% of the total attendances and received 7% of all complaints.

Table 23

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	196	59,641	**0.33%**	30.4%	**43.9%**
BEH	49	31,301	0.16%	15.94%	11.0%
BDH	31	21,872	0.14%	11.14%	7.0%
STMH	31	20,069	0.15%	10.22%	7.0%
BHI	52	4,849	**1.07%**	2.47%	**11.7%**
BHOC	17	18,346	0.09%	9.34%	3.8%
BRHC	55	32,830	0.17%	16.72%	12.3%
SBCH	15	7,491	0.20%	3.81%	3.4%
TOTAL	**446**	196,399	**0.23%**		

The analysis in the two tables above shows that around 40% of all complaints come from patients at the Bristol Royal Infirmary, but also that this is proportionately greater than the BRI's share of patient activity. Similarly, the Bristol Heart Institute receives around 10% of all complaints, but accounts for less than 3% of patient activity.

In Q3, there was a notable reduction in complaints received about St Michael's Hospital.

3.5 Complaints responded to within agreed timescale

All of the clinical Divisions reported breaches in Quarter 3, totaling 65 breaches, which represents a significant increase on the 23 breaches reported in Q2. There were also four breaches by the Division of Facilities & Estates and one breach by the Division of Trust Services, which are not included in the table below, making a total of 70 breaches for Q3.

Table 24

	Q3 2015/16	Q2 2015/16	Q1 2015/16	Q4 2014/15
Surgery Head and Neck	16 (31.4%)	12 (22.6%)	9 (12.9%)	8 (11.6%)
Medicine	18 (48.6%)	3 (8.8%)	9 (20%)	5 (14.7%)
Specialised Services	8 (36.4%)	6 (30%)	2 (11.1%)	1 (5.6%)
Women and Children	21 (65.6%)	2 (5.1%)	7 (17.1%)	11 (23.9%)
Diagnostics & Therapies	2 (22.2%)	0 (0%)	1 (10%)	0 (0%)
All	**65 breaches**	**23 breaches**	**28 breaches**	**25 breaches**

(So, as an example, there were 18 breaches of timescale in the Division of Medicine in Q3, which constituted 48.6% *of the complaints responses that had been due in that Division in Q3*.)

Breaches of timescale were caused either by late receipt of final draft responses from Divisions which did not allow adequate time for Executive review and sign-off, delays in processing by the Patient Support and Complaints team, or by delays during the sign-off process itself. Sources of delay are shown in the table below.

Table 25

	Source of delays (Q3, 2015/2016)			Totals
	Division	**Patient Support and Complaints Team**	**Executive sign-off**	
Women and Children	19	1	1	**21**
Medicine	13	5	0	**18**
Surgery Head and Neck	13	2	1	**16**
Specialised Services	8	0	0	**8**
Diagnostics & Therapies	2	0	0	**2**
All	55 breaches	8 breaches	2 breaches	**65**

The majority of divisional delays have resulted from increased corporate scrutiny of draft responses. The majority of responses were prepared by Divisions within the agreed timescale (136 out of 161 responses, or 84.5%), however the need for significant changes/improvements following executive review led to 65 cases breaching the deadline by which they had been due to be sent to the complainant.

The table below contains information about the length of time by which each of the 65 breached case exceeded its due date and whether any of those cases had been extended but still breached the deadline. The number of days is shown as total days, rather than working days, as this is the delay that the complainant will have experienced.

Table 26

Date originally agreed with complainant	Date deadline extended to	Date response posted to complainant	Number of days deadline breached by
14/08/2015	25/09/2015 & 23/10/2015	28/10/2015	5 days
28/08/2015	18/09/2015, 28/09/2015, 05/10/2015 & 09/10/2015	26/10/2015	17 days
10/09/2015	08/10/2015	21/10/2015	13 days
15/09/2015	20/10/2015	21/10/2015	1 day
30/09/2015	12/10/2015 & 23/010/2015	27/10/2015	4 days
02/10/2015	08/10/2015	12/10/2015	4 days
02/10/2015	10/10/2015	15/10/2015	3 days
05/10/2015	N/A	21/10/2015	16 days
05/10/2015	N/A	30/10/2015	25 days
06/10/2015	20/10/2015	30/10/2015	10 days

08/10/2015	N/A	28/10/2015	20 days
08/10/2015	N/A	15/10/2015	7 days
09/10/2015	N/A	12/10/2015	3 days
12/10/2015	N/A	14/10/2015	2 days
13/10/2015	26/10/2015	27/10/2015	1 day
13/10/2015	N/A	15/10/2015	2 days
16/10/2015	N/A	21/10/2015	5 days
20/10/2015	N/A	26/10/2015	6 days
20/10/2015	N/A	21/10/2015	1 day
20/10/2015	26/10/2015 & 17/11/2015	25/11/2015	8 days
23/10/2015	N/A	26/10/2015	3 days
28/10/2015	N/A	30/10/2015	2 days
28/10/2015	30/10/2015 & 23/11/2015	27/11/2015	4 days
30/10/2015	05/11/2015 & 06/11/2015	10/11/2015	4 days
03/11/2015	N/A	09/11/2015	6 days
04/11/2015	N/A	09/11/2015	5 days
06/11/2015	N/A	09/11/2015	3 days
06/11/2015	16/11/2015, 27/11/205, 21/12/2015, 08/01/2016 & 18/01/2016	Still outstanding	
06/11/2015	N/A	09/11/2015	3 days
09/11/2015	N/A	27/11/2015	18 days
26/11/2015	N/A	02/12/2015	6 days
12/11/2015	N/A	16/11/2015	4 days
12/11/2015	16/11/205, 04/12/2015 & 10/12/2015	15/12/2015	5 days
13/11/2015	N/A	16/11/2015	3 days
16/11/2015	N/A	18/11/2015	2 days
18/11/2015	14/12/2015 & 21/12/2015	22/12/2015	1 day
18/11/2015	14/12/2015	30/12/2015	16 days
23/11/2015	08/12/2015	15/12/2015	7 days
25/11/2015	N/A	02/12/2015	7 days
03/12/2015	N/A – awaiting consent	08/01/2016	36 days
03/12/2015	11/12/2015	31/12/2015	20 days
08/12/2015	15/12/2015 & 18/12/2015	23/12/2015	5 days
08/12/2015	N/A	23/12/2015	15 days
09/12/2015	N/A	30/12/2015	21 days
09/12/2015	N/A	10/12/2015	1 day
09/12/2015	N/A	14/12/2015	5 days
10/12/2015	N/A	23/12/2015	13 days
10/12/2015	N/A	15/12/2015	5 days
11/12/2015	18/12/2015	04/01/2016	17 days
11/12/2015	N/A	23/12/2015	12 days
14/12/2015	N/A	17/12/2015	3 days
14/12/2015	N/A	30/12/2015	16 days
14/12/2015	23/12/2015	24/12/2015	1 day
15/12/2015	N/A	06/01/2016	22 days
15/12/2015	31/12/2015	04/01/2016	4 days
16/12/2015	N/A	07/01/2016	22 days
17/12/2015	N/A	31/12/2015	14 days
21/12/2015	N/A	23/12/2015	2 days

22/12/2015	N/A	24/12/2015	2 days
22/12/2015	N/A	23/12/2015	1 day
23/12/2015	N/A	07/01/2016	15 days
24/12/2015	N/A	30/12/2015	6 days
24/12/2015	N/A	30/12/2015	6 days
30/12/2015	N/A	31/12/2015	1 day
30/12/2015	N/A	31/12/2015	1 day

The average (mean) delay was 8 days, the median was 5 days and the range was 1- 36 days.

Actions taken to improve the quality of written complaints responses and reduce breaches have been described in previous quarterly reports. In addition, with effect from 18th January 2016, the number of days set aside for corporate review and sign-off of complaints has been increased from four days to seven, within an unchanged total response timescale of 30 working days.

3.6 Number of dissatisfied complainants

In Q3, 161 responses were sent out. By the cut-off point of 15th January 2016 (the date on which the complaints data for December was finalised) 10 people had contacted us to say that they were dissatisfied with our response. This represents 6.2% of the responses issued during that period, compared to 6.7% in Q2.

Training on investigating complaints and writing response letters has now been delivered to at least one group of senior staff/management from all Divisions. Dates have been confirmed for further sessions for other staff requesting the training in each Division. The training delivered so far has been well received, with positive feedback from attendees.

4. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with the help and support including:

a. Non-clinical information and advice;
b. A contact point for patients who wish to feedback a compliment or general information about the Trust's services;
c. Support for patients with additional support needs and their families/carers; and
d. Signposting to other services and organisations.

In Q3, the team dealt with 153 such enquiries, compared to 138 in Q2. These enquiries can be categorised as:

e. 104 requests for advice and information (74 in Q2)
f. 41 compliments (57 in Q2)
g. 8 requests for support (7 in Q2)

The table below shows a breakdown of the 112 requests for advice, information and support dealt with by the team in Q3.

Table 27

Category	**Number of Enquiries**
Hospital Information Request	20
Information about Patient	15
Clinical Care	12
Attitude and Communication Staff	8
Complaints Handling	7

Emotional Support	7
Clinical Information Request	7
Medical Records Enquiries	6
Signposting	6
Accommodation Enquiry	5
Benefits and Social Care	4
Wayfinding	3
Bereavement Support	2
Appointment Enquiries	2
Freedom of Information Request	2
Premises/Environment	2
Organ Retention	1
Personal Property	1
Car Parking	1
Mortuary Arrangements	1
Total	**112**

5. Acknowledgement of complaints by the Patient Support & Complaints Team

The Complaints and Concerns Policy states that when the Patient Support & Complaints Team reviews a complaint following receipt: a risk assessment will be carried out; agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so; the appropriate paperwork will be produced and sent to the Divisional Complaints Coordinator for investigation; an acknowledgment letter confirming how the complaint will be managed will be sent to the complainant. In line with the NHS Complaints Procedure (2009), the Trust's policy states that this review will take place within three working days of receipt of written complaints (including emails), or within two working days of receipt of verbal complaints (including PSCT voicemail).

In Q3, 194 complaints were received verbally and 252 were received in writing. Of the 194 verbal complaints, 171 (88.1%) were acknowledged within two working days. Of the remaining 23 cases, 22 were all acknowledged within five days. The remaining case was missed due to human error: the case was not correctly logged by the Patient Support and Complaints Team. The patient accepted the team's sincere apologies when he was contacted and his concerns were fully addressed.

Of the 252 written complaints, 225 (89.3%) were acknowledged within three working days. All of the remaining 27 cases were acknowledged within four working days.

Delays in acknowledging both verbal and written complaints were due to a backlog in the Patient Support and Complaints Team due to staff sickness.

6. PHSO cases

During Q3, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in five new complaints (compared to three in Q2 and three in Q1) as follows:

Table 28

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
15464	JR	LM-J	10/04/2014	BHI	Ward C708	Specialised Services

Contacted by PHSO in October 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. In January 2016, the PHSO provided the Trust with their draft report advising that they do not intend to uphold the complaint and asking for our comments. These comments have been sent to the PHSO and we are currently awaiting their final report.						
18420	MK		31/03/2015	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Contacted by PHSO in October 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.						
16474		CM	05/08/2014	BRI	Ward A604	Surgery, Head & Neck
Contacted by PHSO in October 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.						
17400	NM	KT	26/11/2014	BHOC	Ward D603	Specialised Services
Contacted by PHSO in October 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.						
16977	LG	KG	30/09/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Contacted by PHSO in October 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.						

Six cases are currently the subject of ongoing investigations by the PHSO:

Table 29

17584	LT	CT	19/12/2014	BRI	Trauma & Orthopaedics	Surgery, Head & Neck
Draft report received from PHSO in January 2016, advising that they have decided to partially uphold the complaint and giving the Trust the opportunity make any further comments. We did not wish to make any further comments and we are awaiting the PHSO's final report following any comments from the complainant.						
17173	DF	DJ	29/10/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Contacted by PHSO in September 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from PHSO regarding their investigation.						
12124 & 11500		SM	21/11/2012 & 13/08/2012	BRI & BHI	Urology & Cardiology (GUCH)	Surgery, Head & Neck & Specialised Services
Received PHSO's draft report advising that their provisional decision is to partially uphold the complaint, subject to any further comments from the Trust and from the complainant. We have confirmed that we have no further comments to make and we are awaiting the PHSO's final report.						
15952	KH	JH	09/06/2014	BRI	Ward 11	Medicine
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Advised PHSO that some issues complainant raised with them had not previously been raised with the Trust. PHSO advised Trust in July 2015 that the case is currently waiting to be allocated to an investigator. Advised by PHSO on 11/01/2016 that they will be sending us a further request for information.						

15213	WE	VE	10/03/2014	BHOC	Chemotherapy Outpatients	Specialised Services
Copy of complaint file, correspondence and medical records sent to PHSO. Received further request from PHSO for patient's oncology records, which were sent to them in August 2015. Trust's comments on PHSO's draft report sent 19/11/2015. Currently awaiting PHSO's final report and outcome.						

6.1 Learning from upheld PHSO Complaints

Two cases were closed by the PHSO during Q3, neither of which was upheld by the PHSO.

Table 30

Case Number	**Complainant (patient unless stated)**	**On behalf of (patient)**	**Date original complaint received**	**Site**	**Department**	**Division**
16120	CL	LW	30/06/2014	BHI	Coronary Care Unit (CCU)	Specialised Services
PHSO's final report received 23/12/2015 – they have decided not to uphold the complaint. Division advised accordingly.						
17608	JR	AH	19/12/2014	BRI	Ward A604	Surgery, Head & Neck
PHSO's final report received 26/11/2015 – they have decided not to uphold the complaint. Division advised accordingly.						

Appendix - Protected Characteristics

The tables below reflect the protected characteristics of **patients** who have made a complaint, or on behalf of whom a complaint has been made.

Age

Age Group	**Number of Complaints Received – Q3 2015/16**
0-15	77
16-24	30
25-29	16
30-34	22
35-39	19
40-44	18
45-49	29
50-54	22
55-59	33
60-64	27
65+	153
Total Complaints	**446**

Ethnic Group

Ethnic Group	**Number of Complaints Received – Q3 2015/16**
White - British	303
White - Any Other White Background	9
Mixed - White And Black Caribbean	7
Black Or Black British - Caribbean	6
Black Or Black British - African	2
Mixed - Any Other Mixed Background	2
Mixed – White and Asian	2
African or British African	1
Asian or Asian British - Bangladeshi	1
Asian or Asian British – Pakistani	1
Mixed - White And Black African	1
White – Irish	1
Any Other Ethnic Group	19
Not Collected At This Time	44
Not Stated/Given	47
Total Complaints	**446**

Religion

Religion	**(Christian denomination)**	**Number of Complaints Received – Q3 2015/16**
Christian	Anglican	2
	Baptist	3
	'Christian'	21
	Church of England	158
	Methodist	9
	Protestant	3
	Roman Catholic	21
	United Reform	2
	(Total Christian)	*(219)*
No Religious Affiliation		101
Muslim		7
Atheist		5
Buddhist		3
Sikh		2
Unknown		109
Total Complaints		**446**

Civil Status

Civil Status	**Number of Complaints Received – Q3 2015/16**
Married/Civil Partnership	174
Single	123
Widowed/Surviving Civil Partner	25
Divorced/Dissolved Civil Partnership	21
Co-habiting	17
Separated	3
Unknown	83
Total Complaints	**446**

Gender

Of the 446 complaints received in Q3 2015/16, 249 (56%) of the patients involved were female and 197 (44%) were male.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting, to be held on 28 April 2016 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 15c: NHS Improvement 2016/17 Operational Plan submission
Purpose
Purpose The plan is reported for information to the Council following review and approval at the Governors Strategy Group meeting held on 15th March and at the Governors Development Seminar on 8th April. Governors were made aware at these sessions of the outstanding issues in relation to the financial position the Trust faced, and were briefed by the Director of Finance & Information, Associate Director of Finance and Head of Business Planning & Strategy.
Recommendations
The Council of Governors is asked to receive the report for information.
Report Sponsor or Other Author
Sponsor: Paul Mapson, Director of Finance & Information
Appendices
Appendix A - NHS Improvement 2016/17 Operational Plan submission

Final 2016/17 Operational Plan submission – supporting narrative

1. Context for the Operational Plan

This plan is submitted to NHS Improvement on the 18th April 2016 as the final version, following the draft plan which was submitted on the 8th February 2016. The draft plan has been further developed with the plans for activity, capacity, workforce and quality now achieving a robust level which gives confidence in its delivery. The financial plan, however, is not in its final form due to delays in Service Level Agreement (SLAs) negotiations requiring estimates to be used based on the best information available.

The plan submission is a by-product of the Trust's Divisional Operating Plan process which requires:

- Final cut Operating Plans for each Division by 1st April 2016;
- Review by Governors during March and April;
- Approval by the Trust Board at an extra-ordinary meeting on the 5th April 2016;
- Agreement of SLAs with Commissioners during April;
- Submission to NHS Improvement on 18th April 2016; and
- Final submission ratified by Trust Board on 28th April 2016.

The financial plan has been further developed from the draft plan and presents a planned income and expenditure surplus of £14.2m (before donations and impairments). This compares with the draft plan surplus of £15.9m. This change is explained fully later in the document (section 4.7).

The financial plan is predicated on two key assumptions:

- Receipt of 80%-85% CQUIN income from Commissioners; and
- Receipt of Sustainability funding of £13.0m.

Both assumptions carry significant risk as they have not yet been formally agreed with NHS England and NHS Improvement respectively. Should these assumptions subsequently be proved incorrect a revised plan may need to be submitted.

Whilst the Trust reserves the right to revise its financial plan in the light of Commissioner SLAs that will be agreed in the post submission period, it remains confident in the delivery of an Operational Plan in 2016/17 that will:

- Deliver the agreed performance trajectories for Referral To Treatment (RTT), Cancer and the Accident and Emergency (A&E) four hour waiting standard;
- Continue with the necessary upgrading of the Estate along with medical equipment replacement;
- Continue to implement our Clinical Systems Implementation Programme (CSIP) along with system wide initiatives such as Connecting Care. This will include the necessary capital investment;
- Deliver a sustained improvement in quality from the programme described in this document (section 4.1); and
- Maintain sound financial control working to a surplus plan for the 14th year running, albeit caveated with significant remaining risks – both from Commissioner SLAs and internal pressures.

We will continue to develop the plan to both enhance the robustness of its delivery and to improve the financial plan through local and national negotiations with Commissioners, Health Education England and NHS Improvement.

2. Strategic Backdrop

2.1 Introduction

Our 2016/17 Operational Plan has been written in the context of the longer term direction set out in our existing five year strategic plan (2014-2019).

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

2.2 Our Strategy

As an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite resources available. We are also clear that we operate as part of a wider health and care community and our strategic intent sets out our position with regard to the key choices that we and others face.

Our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services.

We are committed to addressing the aspects of care that matter most to our patients and the sustainability of our key clinical service areas is crucial to delivering our strategic intent. **Our strategy outlines nine key clinical service areas:**

- Children's services;
- Accident and Emergency (and urgent care);
- Older people's care;
- Cancer services;
- Cardiac services;
- Maternity services;
- Planned care and long term conditions;
- Diagnostics and therapies; and
- Critical Care.

Our **Mission** is *to improve the health of the people we serve by delivering exceptional care, teaching and research, every day* and we are committed to the delivery of this tripartite focus. The clinical services strategy outlined above is also underpinned by our Teaching and Learning and Research and Innovation Strategies.

2.3 Strategic Priorities

Our 2014-19 five year Strategic Plan outlines seven strategic priorities, structured according to the characteristic of our Trust Vision outlined above. Our strategic priorities are:

- We will consistently deliver high quality individual care, delivered with compassion;
- We will ensure a safe, friendly and modern environment for our patients and our staff;
- We will strive to employ the best staff and help all our staff fulfil their individual potential;
- We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation;
- We will provide leadership to the networks we are part of, for the benefit of the region and people we serve;
- 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; and
- We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.

Throughout 2015/16 we have reviewed our five year strategy, taking account of the changing context in which we operate. We are confident that our five year strategy is still relevant and sound in the evolving local and national environment and we will continue to refresh our delivery objectives to ensure our priorities remain correct. A full refresh of our strategy will be completed in Autumn 2016 to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) currently in development and also that our approach to our key strategic choices positions us to be effective in progressing this agenda over the next five year period.

We have a clear governance route through which we measure progress against the delivery of our strategic priorities. Annual objectives are described and monitored through the Board Assurance Framework, and any emerging risks to delivery are subject to quarterly Board scrutiny. For 2016/17 we will also ensure that our in year objectives outline how we will deliver the priorities agreed as part of the system STP.

2.4 Progress with our Strategic Plan

In 2015/16 we have continued to make progress towards developing our specialist portfolio in the nine key clinical service areas outlined above. Our focus has been on driving the benefits to our patients from the major service transfers in previous years, including Head and Neck services, Cleft, and the centralisation of specialist paediatrics from North Bristol NHS Trust. It is our ambition to further evaluate opportunities to continue to develop this portfolio throughout 2016/17.

A key focus of our strategy is also to deliver excellence in care for our local patients, as well as regional and tertiary services and we consider the delivery of operational and financial sustainability key to this. Progress has been made throughout 2015/16 in the ongoing achievement of reductions in the total number of patients waiting over 18 weeks RTT. Although challenging, we have also delivered our improvement trajectory for 62 day GP RTT cancer standard for each month of quarter three, which is a notable improvement from performance at the start of the year.

Although we have made significant progress in 2015/16 towards the recovery of performance against national access standards, there continue to be specific risks relating to high levels of referrals for outpatient appointments and diagnostic tests and high levels of emergency admissions into the Trust in 2015/16 relative to the same period last year.

The level of delayed discharges also remained above plan and despite ongoing difficulties maintaining effective flow, and performance against the 4 hour Emergency Department (ED) standard, the focus remains on delivering high quality care in the right setting, with the number of days patients spent outlying for their specialty ward remaining within target levels.

Further progress needs to be made, but results like this give us confidence that we are moving in the right direction in operational terms. There will be significant challenges, but we are well placed to meet them in light of our track record of sound financial management and recent improvements in performance.

2.5 Progress with our Strategic Priorities

Significant progress has been made in 2015/16 against our strategic priorities to ensure a safe, friendly and modern environment for our patients and our staff. The new Bristol Royal Infirmary (BRI) ward block is now fully open, with new state of the art surgical, medical and paediatric wards, a new twenty bedded adult Critical Care Unit (CCU) and fully refurbished ED and Medical Assessment Units transforming the environment for our staff and patients.

Aligned to this new and modern estate, progress has been made towards our strategic priority to deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation. The new CCU contains a new state of the art Clinical Information System and we have also started the implementation of an Electronic Document Management (EDM) system, meaning that a number of our core clinical services now operate paperless documentation systems. Further priority will be placed in 2016/17 on the development of our technology and innovation functions to place the Trust at the forefront of these developments.

Although notable progress has been made in 2015/16, effective cross sector and patient flow remains a challenge due to external system wide factors. We are clear that fundamental improvements are required in this area for the year ahead, to be successful in delivering our strategic, quality, operational and financial objectives and expect these improvements to inform the system STP as a key priority to address.

2.6 Link to the emerging Sustainability and Transformation Plan (STP)

We are a clear that system leadership, partnership working and system sustainability is key to driving progress for the year ahead. Our 2016/17 Operational Plan is being developed in the context of delivering the Five Year Forward View. Critically, it will align with the system wide planning and is being developed in the context of the emerging priorities linked to the development of the system wide STP.

Agreement on the strategic planning footprint has been reached for Bristol, North Somerset and South Gloucestershire (BNSSG) and one of our key aims for 2016/17 will be to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability and transformation.

As a system we believe that a BNSSG STP will enable the development and implementation of another phase of a major transformation programme for the local health system, which has already delivered large change since 2004. For example, including a range of system and service-based initiatives which including the reorganisation of Breast, Head and Neck, Pathology, Urology and Vascular, Stroke and Children's services.

Notable progress has been made in the development of the BNSSG STP. The BNSSG System Leadership Group (SLG) is in place, bringing together chief officers from NHS organisations across BNSSG. There is also senior representation from each of the BNSSG Councils and Public Health. The South Western Ambulance Services NHS Foundation Trust will also be invited and a request for specialised commissioning involvement has been received. A sub-group of the SLG has been established, chaired by Robert Woolley, who is the BNSSG STP Senior Responsible Officer (SRO). This group is overseeing the development of the STP on behalf of SLG and is supported by a working group of strategic planning leads nominated by each organisation on the SLG. External support has been commissioned (in place from 4th April), with a remit to assist with the coordination of the STP

development phase and in particular supporting the decision-making process, challenging and testing developing plans and facilitating the difficult choices among the system leaders about the major changes needed to ensure a clinically and financially sustainable health and care economy for the long term. As a Trust we are taking an active role in the development of the STP and are clear that the objectives within our one year Operational Plan support progress towards individual organisational and system priorities.

The vision and priorities for the local health and care system's STP, as outlined by the SLG is as follows:

- Sustainable and efficient acute configuration, including the future of Weston Hospital;
- The transformation of community and primary care services, shifting care out of acute hospital settings;
- A step-change in the coordination of health and social care, supported by the roll out of the Connecting Care (interoperable patient records) programme;
- A shift in working practices and organisational culture to make prevention and self-care a priority in service delivery;
- Transformation in identified key disease areas to deliver value and improved outcomes. While not yet formally agreed, these are likely to include long term conditions, cancer, frailty, musculoskeletal (MSK) services and mental health pathways; and
- Workforce and Informatics to support required transformational change.

The scoping exercises undertaken to date have identified the high level proposed themes and workstreams for the emerging STP as follows:

- Out of hospital health and social care provision and pathways including urgent care flow, demand management systems, integrated model of community care across organisations, discharge models, sustainability of primary care and general practice;
- Self-care at scale and prevention;
- Developing overarching clinical models of care/clinical pathways engaging and involving clinicians across BNSSG to understand and deliver with ambition against the challenge of; efficiency; improved outcomes/value and safety/quality (including BNSSG Right Care opportunities) for example:
    - Acute service configuration, including Weston and specialised pathways, supporting diagnostics etc. including reviews of key pathways such as stroke;
    - Mental health including urgent mental health;
    - Dementia;
    - Long term conditions, multi morbidity and frailty models;
    - Cancer; and
    - Maternity services.
- Enabling workstreams for workforce planning, Information Technology, Estates;
- System financial model development and system capacity and demand model development;
- Continued public health modelling of the health and wellbeing gap and priority action areas; and
- Communications and engagement including Public and Patient Involvement (PPI).

2.7 Organisational Strategy – 2016/17 Focus

Clear alignment can be drawn between the annual 2016/17 organisational objectives outlined in this plan and the emerging priorities within the developing STP. We are committed to continuing to lead and support the process of developing and implementing the plan to address the identified system gaps in Care and Quality, Health and Wellbeing and Finance and efficiency. Our Operational Plan forms year one of the five year plan and in this context, our 2016/17 organisational strategy and operational plans will continue to focus us on:

- **Operational and financial sustainability**, with a specific focus on aligning our workforce and clinical strategies towards reducing agency costs, maintaining service stability to continue to deliver excellent, patient centred high quality care, as well as continuing to improve performance against our core access standards. In addition to this our workforce strategy will look to innovate, with partners to developed new roles to meet the challenges for cross sector and pathway transformation. Through this focus, we will deliver four of the 2016/17 'must dos' outlined in the 2016/17 planning guidance which describes the requirement to achieve the core access standards and restore financial sustainability;
- **Our estates and capital strategy** for 2016/17 will closely align the modernisation and development of our estate to our evolving clinical services strategy, ensuring that opportunities are taken to transform our environment and innovate in the technological solutions we look to in improving the quality and timeliness of our services for patients;
- Development and delivery of a successful **system STP,** with an on-going focus on patient flow, evaluation of specific clinical services, with a focus on the **ongoing development of our specialist services portfolio** underpinned by effective **partnership working;**
- Development of our **innovation and technology strategy**; and

- Delivery of our annual quality objectives, including progress towards delivery of the four key **seven day services** standards by 2020.

In summary, in the specific context of a developing system wide strategic approach, our 2016/17 plan will remain focussed on our mission to *improve the health of the people we serve by delivering exceptional care, teaching and research every day.*

3. 2015/16 Performance

3.1 Non Financial

In the 2015/16 Operational Plan the Trust declared risks to five of the standards against Monitor's Risk Assessment Framework. The five standards (with the service performance score shown in brackets) not forecast to be achieved in one or more quarters were as follows:

- A&E 4-hour waiting standard (1.0);
- 62-day GP and 62-day Screening cancer standard (combined score of 1.0);
- RTT non-admitted pathways standard (1.0);
- RTT admitted pathways standard (1.0); and
- RTT incomplete/Ongoing pathways standard (no score - RTT standards failure capped at 2.0).

Table 1 below shows the planned performance against those standards not expected to be achieved in 2015/16, as declared in the 2015/16 Annual Plan, along with the actual reported performance for the quarter. Please note that the RTT admitted and RTT non-admitted pathway standards were removed from Monitor's Risk Assessment Framework during quarter one in 2015/16 and for this reason are not shown in the in reported position for any quarters.

Table 1 : Performance against access standards in 2015/16

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Standards not forecast to be met	RTT Non-admitted RTT Admitted RTT Incomplete 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted RTT Incomplete 62-day GP cancer 62-day Screening cancer	RTT Non-admitted RTT Admitted 62-day GP cancer 62-day Screening cancer	RTT Admitted A&E 4-hours 62-day GP cancer 62-day Screening cancer
Forecast score	**3.0**	**3.0**	**3.0**	**3.0**
Standards not met in the quarter	RTT Incomplete A&E 4-hours 62-day GP cancer 62-day Screening cancer	RTT Incomplete A&E 4-hours 62-day GP cancer 62-day Screening cancer	RTT Incomplete A&E 4-hours 62-day GP cancer 62-day Screening cancer	A&E 4-hours 62-day GP cancer 62-day Screening cancer
Actual score	**3.0**	**3.0**	**3.0**	**2.0**
Governance Risk Rating	**GREEN**	**GREEN**	**GREEN**	**GREEN** **To be confirmed**

3.1.1 RTT Performance

As planned, the Trust made significant progress during 2015/16 in reducing the number of patients waiting over 18 weeks from RTT. In line with the agreed recovery trajectory, performance was restored to above the 92% national standard at the end of January 2016. At the start of the year 3,339 patients were waiting over 18 weeks for treatment. By the end of February 2016 the backlog of long waiters had dropped by 38% to 2,083. More than half of this reduction related to patients waiting for an elective procedure, with the number of patients waiting over 18 weeks on an admitted pathway reducing from 1,513 at the end of March 2015 to 861 at the end of February 2016. Demand for outpatient appointments was above plan in 2015/16 for several of the high volume RTT specialties, resulting in slower progress being made during the first half of the year in reducing the number of patients waiting over 18 weeks on non-admitted pathways.

3.1.2 Cancer Performance

The Trust continued to perform well against the majority of the national cancer waiting times standards, achieving the 2-week wait for GP referral for patients with a suspected cancer, the 31 day wait for first definitive treatment,

and the three 31-day standards for subsequent treatment (i.e. surgery, drug therapy and radiotherapy) in each quarter in 2015/16. The Trust failed to achieve the 62-day referral to treatment standard for patients referred by their GP with a suspected cancer. However, performance against the standard improved over the year, with the 85% standard being met in December 2015 for the first time since June 2014. At the time of writing, the Trust has achieved its monthly improvement trajectory, which was agreed as part of a national submission of 62-day GP cancer improvement plans in August 2015. The Trust failed to achieve the 62-day referral to treatment standard for patients referred by the national screening programmes in 2015/16.

In each quarter of 2015/16 the majority of the breaches of this standard were outside of the Trust's control, including patient choice, medical deferral and breaches at other providers following timely referral. Following the transfer-out of the Avon Breast Screening service, the majority of treatments the Trust reports under this standard are for bowel screening pathways, which nationally performs significantly below the 90% standard. This is largely due to high levels of patient choice to defer diagnostic tests, which continues to be the main cause of breaches of this standard for the Trust.

3.1.3 A&E Performance

System pressures continued to be evident in 2015/16 with levels of emergency demand at the Bristol Children's Hospital being significantly above plan for the majority of the year. During the first six months of 2015/16, levels of emergency admissions via the Bristol Children's Hospital Emergency Department were 15.2% above the same period in the previous year, reaching typical winter levels in some months. This increase in demand was a significant driver of the Trust's underperformance against the 4-hour standard during the year. Work with the Commissioners to understand the reason for the higher than expected levels of paediatric emergency demand continues.

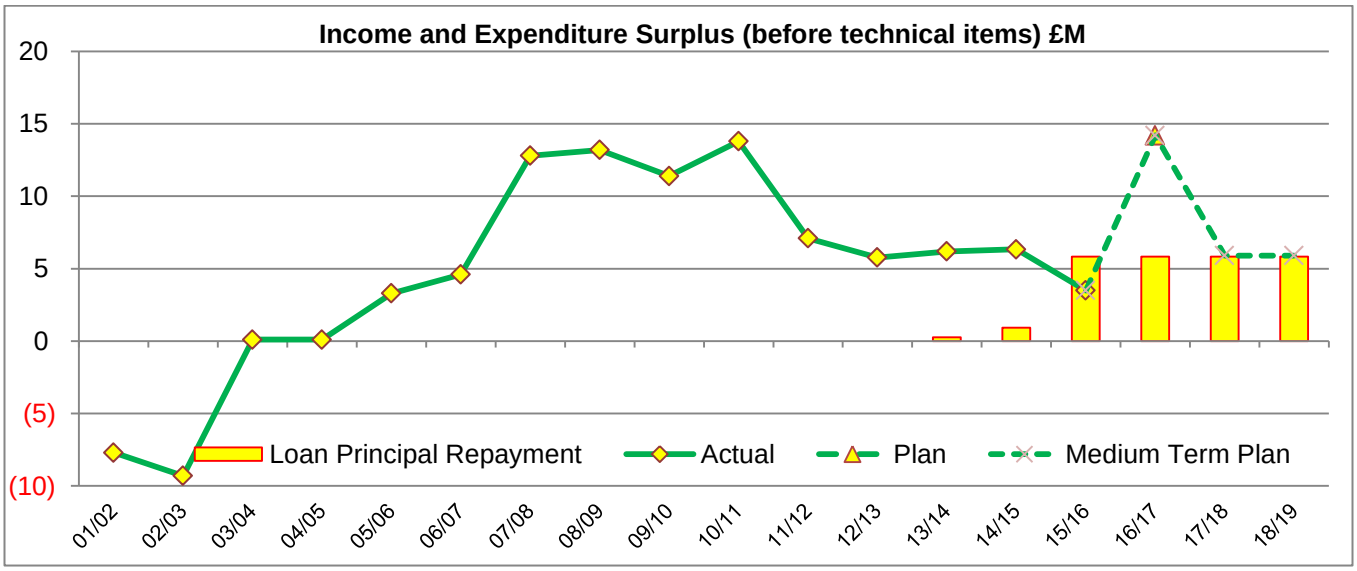
Following improvements early in 2015/16 the Trust experienced a significant increase during much of the year in the number of medically fit patients whose discharge from the BRI was delayed, with levels at their peak reaching more than double those seen at the start of the year. This was primarily due to a lack of sufficient domiciliary care packages as a result of providers taking time to reach their planned operating capacity, following the recommissioning of these services by Bristol City Council during quarter 2. An acute shortage of social workers also contributed to the increase in delayed discharges. Consistent with other parts of the country, the last quarter of the year has seen exceptional pressures on both the adult and paediatric Emergency Departments, with significant increases in emergency department attendances, emergency admissions and patient acuity leading to a significant deterioration in 4-hour performance. The combination of these system pressures on both the adult and paediatric emergency services led to the failure to achieve the 95% A&E 4-hour standard in each quarter of 2015/16.

3.2 Financial

3.2.1 Net surplus

The Trust is forecasting a 2015/16 net income & expenditure surplus of £3.5m before technical items against a revised plan of break-even. This translates to a surplus of £5.1m including donations but excluding impairments against a plan of £3.1m. This will be the Trust's thirteenth year of break-even or better. A summary of the Trust's financial position, including the historical performance, is provided below in figure 1.

Figure 1: Income and Expenditure Surplus



The Trust is one of only six Acute Trusts who are reporting both a year to date surplus at the end of February and a forecast outturn surplus. To achieve this, however, non-recurrent savings of £12.7m are being used to deliver this position. This makes the 2016/17 position more difficult to deliver as much of the non-recurrent savings cannot be repeated.

3.2.2 Savings

The Trust's 2015/16 savings requirement is £19.9m, net of £4.5m funded non-recurrently to support clinical services. Savings of £16.4m are forecast to be delivered by the year end. The forecast shortfall of £3.5m is due to unidentified schemes. The forecast shortfall of recurrent savings delivery in 2015/16 of £4.0m and the support provided in 2015/16 of £4.5m will be carried into 2016/17 as a requirement.

3.2.3 Capital expenditure

The Trust is forecasting capital expenditure of £24.9m for 2015/16 against a plan of £34.5m due to scheme slippage. It should also be noted that the generation of a capital receipt from the sale of the BRI Old Building at £13.0m has been brought forward into 2015/16. The Trust's carry forward commitments into 2016/17 are £20.0m.

3.2.4 Financial Sustainability Risk Rating

The Trust is forecasting a Financial Sustainability Risk Rating (FSRR) of 4. The Trust has strong liquidity with forecast net current assets of £30.2m and achieves 12.3 liquidity days and a liquidity metric of 4. The Trust's forecast EBITDA performance of £35.0m delivers capital service cover of 2.1 times and a metric of 3. The Trust's forecast net income and expenditure margin is 0.8% and achieves a metric of 3. The I&E margin variance is 0.3% and achieves a metric of 4. The position is summarised below.

Table 2 : FSRR Performance

	Metric	Rating
Liquidity	12.3	4
Capital servicing cover	2.1 times	3
Net I&E margin	0.8%	3
I&E margin variance	0.3%	4
Overall FSRR		**4**

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

4. The year ahead

4.1 Quality

4.1.1 Approach to quality planning

The Trust is committed to and expects to provide excellent health services that meet the needs of our patients and their families and provides the highest quality standards. The Board and Senior Leadership Team of UH Bristol have a critical role in leading a culture which promotes the delivery of high quality services. This requires both vision and action to ensure all efforts are focussed on creating an environment for change and continuous improvement. The Trust's annual quality delivery plans set out the actions we will take to ensure that this is achieved.

We have much to be proud of. The Trust's quality improvement programme has shown us what is possible when we have a relentless focus on quality improvement. Healthcare does not stand still. We need to continuously find new and better ways of enhancing value, whilst enabling a better patient experience and improved outcomes. Never has there been a greater need to ensure we get the best value from all that we do.

The focus of our strategy will continue to be on improving patient safety, patient experience and the effectiveness of care. It will be underpinned by our commitment to address the aspects of care that matter most to our patients in collaboration with our strategic partners. They also take into account national quality and commissioning priorities, our quality performance during 2015/16 and feedback from our public and staff consultations. Subject to final agreement and sign off, our objectives for 2016/17 are outlined below. Our priorities for 2016/17 can be themed into five key areas, which are:

- Objectives carried forward from 2015/16;
- Improving different aspects of communication;
- Improving responsiveness to patients' needs;
- Maintaining a strong focus on the fundamental need for patient safety; and
- Improving staff experience.

Our specific twelve quality objectives for 2016/17 are as follows:

- Reducing cancelled operations;
- Ensuring patients are treated in the right ward for their clinical condition;
- Improving management of sepsis;
- Improving timeliness of patient discharge;
- Reducing patient-reported in-clinic delays for outpatient appointments, and keeping patients informed about how long they can expect to wait;
- Reducing the number of complaints received where poor communication is identified as a root cause;
- Ensuring public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible;
- Ensuring inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen;
- Fully implementing the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted;
- Increasing the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving;
- Reducing avoidable harm to patients; and
- Improving staff-reported ratings for engagement and satisfaction.

Our 'Sign Up To Safety' priorities for 2016/17 and the following year are:

- Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury;
- Medicines safety at the point of transfer of care with cross system working with healthcare partners;
- Developing our safety culture to help us work towards, for example, zero tolerance of falls; and
- Reducing never events for invasive procedures.

We view quality, safety and efficiency as mutually beneficial. We will continue to use the following four questions to examine our approach to quality:

- Do we understand quality well enough in the Trust?
- How do we know that the services we provide are safe, effective, caring, responsive and well-led?
- What will it take to make all our services as good as they can be?
- How well do we understand the views of our staff and patients in relation to this agenda?

In the development of the priorities for 2016/17, we have also taken into consideration of national and local commissioning priorities and relevant national guidance. One of these key areas is delivering the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients"*

The two priority objectives outlined in the guidance are:

"*A patient's entire stay in hospital should be coordinated and caring, effective and efficient with an individual named clinician – the Responsible Consultant/Clinician – taking overall responsibility for their care whilst retaining the principles of multidisciplinary team working"; and*

"*Ensuring that every patient knows who the Responsible Consultant/Clinician, with this overall responsibility for their care is and also who is directly available to provide information about their care – the Named Nurse".*

The Trust is focussing on progress towards the delivery of these two objectives with actions located in the Ward Processes work stream as part of the Trust's Transforming Care programme. These actions focus on the delivery of standardised ward processes to update Medway, the Trust's Electronic Patient Record (EPR) system within 15 minutes of admission to the, along with the roll out of electronic whiteboards to all wards, which will contain information relating to each patient, including the identified lead consultant.

Another National priority which forms an area of focus for 2016/17 is the participation in the annual publication of avoidable deaths. Through 2015/16 we have implemented an internal standardised process, whereby all deaths are flagged through Medway to the lead consultant for each patient, prompting a standard notes review. Patient deaths are also identified and escalated through the standard Trust incident reporting process if appropriate. These initiatives mean that the Trust is well placed to both participate in any required national reporting, but also to ensure that learning is taken into the clinical services wherever possible.

The Trust did not receive a Care Quality Commission (CQC) comprehensive inspection during 2015/16; our last major inspection was in September 2014. Key challenges around patient flow remain, and vital work continues with our partners in health and social care to make improvements in the areas identified as not meeting the required standards and will inform the development of the STP in addressing the system challenge in the area.

4.1.2 Approach to quality improvement

The Trust's objectives, values, quality and efficiency strategies provide a clear message to all staff that high quality services and excellent patient experience are the first priority for the Trust.

These priorities are reinforced through our five clinical Divisions having specific, measurable quality goals as part of the process of producing their annual Operating Plans. Progress against these plans is monitored by Divisional Boards and by the Executive Team through monthly Divisional Performance Review. The Trust's Clinical Quality Group monitors our compliance with CQC Fundamental Standards on an ongoing basis; our Board Quality and Outcomes Committee monitors performance against a range of performance standards.

Our governors engage with the quality agenda via their Strategy Focus Group and Quality Focus Group. Each quarter, the Board and its sub-committees receive the Board Assurance Framework and the Trust's risk register which report high level progress against each of the Trust's corporate objectives (including quality objectives) and any associated risks to their achievement. Additionally, the Board's Audit Committee works with the Trust's Clinical Audit and Effectiveness team to consider evidence that the Trust's comprehensive programme of clinical audit effectively supports improving clinical quality in alignment with the Trust's quality objectives.

Despite our quality strategy and work to improve our patient flow, we have identified ongoing risks in relation to access and patient flow. The top three risks to quality within the 2016/17 plan are within this theme of access and patient flow. Firstly, we have declared that we may not achieve the threshold of at least 95% of patients spending less than four hours in our A&E department during 2016/17, in the context of the rising paediatric and adult emergency admissions and increasing patient acuity which was particularly evident in quarter 4 of 2015/16. Our aim in 2016/17 is to try to mitigate these system pressures by reducing hospital emergency admissions and potentially reducing the lengths of stays in hospital for appropriate groups of patients that can be cared for in their own home. Secondly, associated with the risk described with managing urgent care flow and demand within the Trust, is the risk of the last minute cancellation of planned operations and the clear impact this has on the quality of care we provide to patients. This remains one of our core quality objectives for 2016/17 and plans to address this are associated with the improvement to urgent care flow within the Trust and across the system. We will also however, be focussing in 2016/17 on our planned care pathways to ensure the last minute cancellation of patients is avoided where possible. Thirdly, the treatment of patients diagnosed with cancer within 62 days of referral by their GP remains a challenge. Whilst improvements in the Trust's performance were seen during 2015/16, late referral by other providers remains a leading cause of breaches of the 62-day GP cancer standard. Further network-wide pathway improvement is planned, building on the work already undertaken during the latter half of 2015/16. This should complement the work on Ideal Timescale Pathways already undertaken within the Trust, and lead to further improvements in the timely treatment of cancer patients in 2016/17.

We continue to be an active member of the Strategic Resilience Group, one of the key aims of which is to provide a local whole system approach to addressing local emergency care and patient flow pressures. The challenges of improving patient flow across the health system in Bristol do pose risks to the quality of care that we can provide to our patients specifically in the areas of mental health and the frail elderly. The Trust is fully aware of these risks and has detailed plans in place to mitigate any impact on patients. It will also ensure that this gap in care and quality informs the emerging priorities in the STP.

In 2015/16, the Trust commissioned an independent review against Monitor's 'Well-led framework for governance.' This provided the Trust Board with assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of care quality, operations and finances. The Board recognises the importance of good governance in delivery of the Trust's objective to provide safe, sustainable high quality care for patients and is undertaking a number of actions to further improve the governance systems in the Trust as a result of the review.

4.1.3 Quality impact assessment process

The Trust has a robust approach to the assessment of the potential impact of cost reduction programmes on the quality of services. This includes a formal Quality Impact Assessment (QIA) for all Cost Improvement Plans (CIP) with a financial impact of greater than £50k and any scheme that eliminates a post involved in front line service delivery.

These QIAs are required to be reviewed through Divisional quality governance mechanisms to ensure robust clinical oversight of plans, from those service areas affected. In addition to this internal assurance of the impact of CIPs on quality, local commissioners also review plans, on a sample basis, to assure both the quality of approach and the impact of the most significant schemes (in financial terms). Finally, the Medical Director and Chief Nurse are responsible for assuring themselves and the Board that CIPs will not have an adverse impact on quality. Any QIA that has a risk to quality score over a set threshold, which the Trust wants to proceed with, is presented to the Quality and Outcomes Committee, our Non-Executive quality committee.

4.2 Seven Day Services

In 2013 NHS England's Seven Day Services Forum, established and led by Professor Sir Bruce Keogh, identified ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive seven days a week. Analysis commissioned by NHS England, in consultation with the Academy of Medical Royal Colleges, led them to advise that there are four standards that are most likely to help reduce weekend mortality: consultants being present to assess and regularly review patients and access to diagnostic tests and consultant-led interventions. University Hospitals Bristol has identified actions that could be taken to progress the seven day service model during 2016/17 in line with expectations for the four standards referred to below. These proposals have been outlined, with the associated resource implications to commissioners as part of the 2016/17 contracting round. The resources required to progress with these plans have not however, been supported through the 2016/17 contract and as the implementation of these schemes is dependent on funding, they will unfortunately not be progressing in 2016/17.

The sections below however, outline the current UH Bristol baseline against these standards and the schemes that have been scoped that would be considered possible to implement in year, should funding be available.

4.2.1 Time to Consultant review

Baseline data analysis shows that the most pressing need to develop Consultant review within 14 hours is within general surgery, trauma & orthopaedics and gynaecology services. The Trust proposed plans to commissioners that would provide 8.75 direct clinical care programmed activities within Consultant job plans for this purpose. Implementation of these schemes would deliver incremental progress towards the delivery of this standard.

4.2.2 Access to diagnostics

Analysis shows that all diagnostic modalities are seven day available apart from Interventional Radiology (IR). University Hospitals Bristol does not have a vascular service and consequently has an interventional radiology capability limited to normal hours and an informal arrangement with North Bristol NHS Trust for emergency provision. Plans proposed for 2016/17 included the formalisation of IR arrangements with North Bristol NHS Trust and development of an in-house non-vascular IR service. These plans have been fully costed and were proposed to Commissioners as part of the 2016/17 contracting round. As implementation in 2016/17 is dependent on the agreement of funding there are no plans to progress with this development in 2016/17.

4.2.3 Access to Consultant delivered interventions

Analysis shows that the Trust has a seven day capability for this standard with the exception being for lower gastrointestinal endoscopy. Plans proposed to Commissioners for 2016/17 included the investment of two direct clinical care programmed activities to allow for the delivery of two additional weekend endoscopy lists, this would provide progress towards the full delivery of this standard, but will not be mobilised in 2016/17.

4.2.4 On-going review

Baseline analysis shows that all acute areas, with the exception of the Surgical Admissions Unit, currently meet this standard. This would be addressed however, by the plans to increase job planned programmed activities in surgery, as described under the Time to Consultant Review standard above. Most non-acute medical and surgical services also meet this standard, with the exception of colorectal surgery and cardiology. Colorectal weekend ward rounds currently take place on a fortnightly basis and could be increased to weekly with the investment of a single programmed activity. This is not in the Trusts 2016/17 plan but could be part of the 2017/18 plans. Meeting this standard within cardiology would require the investment of four programmed activities, which may be considered in the 2017/18 planning round. Plans to make progress towards the achievement of this standard, with associated resource implications in 2016/17 were outlined to Commissioners through the 2016/17 contract discussions, but as with the above standards will not be progressed in 2016/17 due to the funding position.

4.3 Capacity and performance

4.3.1 Approach to capacity planning

During quarter 3 of 2015/16, the Trust again undertook a detailed capacity and demand planning exercise, using the capacity planning tools provided in the previous year by the Interim Management and Support Team (IMAS). Each specialty used the IMAS capacity and demand models to estimate the level of capacity required to reduce waiting times for first outpatient appointment, diagnostic tests and elective admissions. The Trust modelled the capacity required to further reduce these treatment waits, where these were not already forecast to be met by the end of March 2016, in order to achieve 18-week compliant RTT pathways in 2016/17. This exercise has informed the amount of recurrent activity that the Trust needs to provide, subject to Commissioner agreement, to maintain 18-week waits once any residual backlogs have been addressed. The level of non-recurrent work needed to reduce backlogs of long waiting patients forecast to remain beyond March 2016, has also been assessed.

From these inputs the Trust has built-up a Service Level Agreement (SLA) proposal which adjusts the 2015/16 Forecast Outturn to meet recurrent demand, using the IMAS modelling, and has built-in the level of non-recurrent activity which is deliverable in 2016/17 to maintain Trust-level achievement of the 92% incomplete pathways standard and also achieve the required standard at a specialty level. The level of planned activity for 2016/17 also takes account of the impact of any planned service transfers, service developments, recurrent (demographic) growth and other known planned changes to activity levels. Whilst the SLA has not yet been finalised, Commissioners have confirmed their commitment to commission sufficient activity, both recurrent and non-recurrent to meet RTT. This requires significantly less non-recurrent activity than in 2015/16 and as such, the vast majority of activity will be delivered "in-house" with a small amount of outsourcing to maintain flexibility where activity is more volatile including ophthalmology, endoscopy and interventional cardiology. Additional in house capacity required to deliver activity increases is fully understood and plans are in place to mobilise this capacity. Any workforce and financial implications are built into this plan.

The Trust has planned for a level of demographic growth but should activity significantly exceed this, RTT delivery will be at risk. However, the Trust has proactive systems for identifying rising demand and in such scenarios additional waiting list initiative will be mobilised, as has been the case previously. Of note, discussions continue with Taunton and Somerset NHS Foundation Trust, with respect to the possible transfer of clinical genetic services to UH Bristol though this plan does not take account of that, pending further on-going discussions also involving Royal Devon & Exeter NHS Foundation Trust.

The schedule of planned day-case and inpatient activity for 2016/17 has been used to assess the number of beds required in the Trust in the coming year. The baseline bed requirements have been estimated from the forecast specialty and work-type level spell volumes and current length of stay. In doing so the increased demand for beds seen in 2015/16, through increases in paediatric emergency admissions and delayed discharges, has been factored-in. The bed requirements have then been apportioned across quarters according to historic seasonal variation. Planned bed-days savings from improvements in the delivery of planned and unplanned care have then been applied and the resulting modelled bed requirements have then been uplifted to an operational bed occupancy of 92.5%.

Of note, the Trust has just signed Heads of Terms with an independent provider *Orla Healthcare* to deliver a community based "virtual ward". This innovative model of care has been piloted for the last 18 months in Harlow, Essex and is targeted at those patients for whom a 'Decision To Admit' has been reached and who can be discharged back home and cared for by the Orla team. This is the not the traditional step up / step down care model. *Orla* can manage stable, acutely ill patients who would otherwise be admitted to the Trust's Acute Medical Unit (AMU). The service is expected to commence in July 2016 and be fully operational from January 2017 with capacity for 35 patients. This service will not only enable improvements in occupancy as it ramps up but will also provide Winter flex capacity in quarter 4 when it is typically most needed.

Children's services will continue to plan for an expanded bed base in quarter 3 and quarter 4 to respond to seasonal respiratory peaks and subject to commissioner non-recurrent funding will also open an additional Paediatric Intensive Care bed over the Winter months.

The table overleaf summarises key activity changes over 2015/16 plan and outturn. The Trust has plans to deliver this activity with limited risks compared to 2015/16.

Table 3: Activity Volumes and Contract Value

	2015/16 Plan	2015/16 Outturn	Growth over 2015/16 Plan	2016/17 Plan	Growth over 2015/16 Outturn	Growth over 2015/16 Plan
Accident & Emergency	120,799	123,654	2.4%	125,693	1.6%	4.1%
Bone Marrow Transplants	183	195	6.6%	198	1.5%	8.2%
Critical Care Beddays	50,805	51,977	2.3%	52,341	0.7%	3.0%
Day Cases	56,724	54,415	(4.1%)	57,003	4.8%	0.5%
Elective Inpatients	15,339	14,227	(7.2%)	14,237	0.1%	(7.2%)
Emergency Inpatients	39,185	40,283	2.8%	40,513	0.6%	3.4%
Excess Beddays	27,551	26,616	(3.4%)	26,357	(1.0%)	(4.3%)
Non-Elective Inpatients	14,214	13,823	(2.8%)	13,888	0.5%	(2.3%)
Outpatients	652,173	636,539	(2.4%)	674,168	5.9%	3.4%
Total	**976,973**	**961,729**	(1.6%)	**1,004,397**	4.4%	2.8%

4.3.2 Improvement trajectories for Non Financial Performance in 2016/17

The improvements in performance realised in 2015/16 will be built-upon in the coming year. The Trust achieved the RTT Incomplete pathways standard at the end of January 2016, with the standard forecast to continue to be achieved throughout 2016/17. The Trust also recovered performance against the 99% 6-week diagnostic waiting times standard during 2015/16, and expects to remain compliant in 2016/17.

The Trust is expecting to continue to make improvements against the 62-day GP cancer waiting times standard in 2016/17 through the ideal timescale pathways which were implemented in the latter half of 2015/16. The improvement trajectories set have been calculated from the expected reduction in pathway waiting times delivered through a combination of these ideal timescale pathways and planned increases in capacity in particular tumour sites. However, the established seasonal patterns of patient choice, which result in unavoidable pathway delays and breaches of the standard, have also been taken account of within the trajectory. Late referrals from other providers remains the leading cause of breaches of the 62-day standard, but for which improvements have needed to be assumed in the trajectory for quarters 3 and 4 on the basis of the work being undertaken network-wide to agree timescales for referral, and through agreement of a local Commissioning for Quality and Innovation (CQUIN) to encourage earlier referral amongst BNSSG Trusts. The trajectory delivers the 85% national standard in aggregate in quarter 3 and quarter 4. The regional ambition is to achieve the 85% national standard in September 2016, which the Trust cannot at this stage commit to without further assurances that a reduction in late referrals from other providers will be realised earlier than quarter 3. Due to the small number of treatments the Trust undertakes, and the high proportion of breaches of the standard that are outside of the control of the Trust, the Trust is not expecting to report compliance with the 62-day screening standard in 2016/17.

Quarter 4 of 2015/16 has proved to be a challenging period for emergency access, with levels of demand and patient acuity exceeding planning assumptions. This has re-set expectations for quarter 1 of 2016/17, which has traditionally been seen as one of the higher performing quarters in the year. An improvement trajectory has been developed using the established statistical relationship between bed occupancy and 4-hour performance, and the expected impact of the planned actions on bed occupancy during each month of 2016/17. This trajectory shows an improvement in 4-hour performance over quarter 1, relative to quarter 4 2015/16, with each subsequent quarter representing an improvement on the same period in the previous year. Whilst the regional ambition is to restore performance to 95% by March 2017, the Trust does not at present have sufficient confidence in the system-wide delivery plan to commit to achievement of the 95% standard at the end of 2016/17.

Unusually, the Trust is now also expecting to report a failure of the 31-day first definitive and 31-day subsequent surgery cancer waiting times standards in 2016/17. This is due to exceptional levels of demand on the adult Intensive Therapy Unit / High Dependency UnitT, in terms of both numbers and increasing patient acuity. Plans are being progressed to treat these patients as quickly as possible, with the expectation that the impact on performance will be limited to quarter 1 2016/17. Table 4 below reflects the predicted performance for 2016/17.

Table 4: Performance against access standards in 2016/17

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Standards not forecast to be met	A&E 4-hours 62-day GP cancer 62-day Screening cancer 31-day first definitive cancer 31-day subsequent surgery	A&E 4-hours 62-day GP cancer 62-day Screening cancer	A&E 4-hours 62-day Screening cancer	A&E 4-hours 62-day Screening cancer

4.4 Information Technology

UH Bristol has a mature, effective Informatics Service that has established a good track record of delivering transformative technology. Clinical Informatics at UH Bristol is driven through the Clinical System Implementation Plan (CSIP), now in its fifth year and well-positioned to take advantage of the emerging alignment of DoH, NHSE and HSCIC that will help make the digital future a reality for our health and care system.

UH Bristol is an active member of the national CIO Network and HSCIC's Digital Leaders Forum, helping us to drive digital best practice and innovation within the Trust whilst lobbying and contributing to the 'digital agenda' at a National level.

Recognizing the challenges set in FYFV whilst focusing on the specific requirements of the National Information Board in *Personalized Health & Care 2020* and subsequent guidance, CSIP is delivering a comprehensive range of digital capabilities and systems to fulfil local digital strategy and meet the national objectives set for 2018 and 2020.

"Our vision ... is one in which 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...".

Our strategy is Board-led, clearly defined, fully funded and aligned to clinical and corporate objectives. Over the past few years we have delivered the foundations of our strategy and built upon this to provide a Trust-wide Electronic Patient Record (EPR) that supports our core patient activity recording and provides a range of clinically-relevant functions that are in routine use across the Trust. Operating within a secure, resilient technical infrastructure, these functions include:

- Fully integrated EPR modules covering inpatients, outpatients, ED, maternity and theatres, with clinical noting and ad hoc data collection suites;
- Digitized case notes in use across the first of our hospital sites;
- Order communications and results reporting for pathology, radiology and a wide range of other services;
- A range of services to deliver and share diagnostic images across the region;
- A sophisticated Intensive Care System in use across all four intensive care units;
- Widespread intra-operability between our core EPR and the wealth of specialist departmental systems to ensure authentication;
- A document sharing portal providing digital delivery of discharge summaries and other documents to GPs;
- Digital dictation and speech recognition; and
- Increasing use of 'right here, right now' real-time dashboards and reports.

Looking outside the Trust, UH Bristol is a founding member of Connecting Care, a digital shared care record service that boasts participation of all health and social care organisations across BNSSG and rich content. Connecting Care is not only a leading example of shared care technology, but also the focal point of effective cross-organisational collaboration under the guidance of BNSSG's System Leadership Group. The influence of Connecting Care on our digital roadmap cannot be overstated. The range of shared information and functions delivered by Connecting Care is extending all the time, with new content and collaboration tools as diverse as safeguarding, care-planning, document sharing and genomics featuring on our development roadmap.

During the coming year we will continue to deploy new digital capability throughout the Trust, further embedding and extending existing functions with particular emphasis on:

- Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation;
- Commencing delivery of a new nursing e-observations and replacement e-rostering systems;
- Going live across the Trust with electronic prescribing and medicines administration;
- Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and
- Delivering the objectives of the Clinical Utilisation Review (CUR) by using existing systems rather than purchasing duplicate systems which are not supported by Clinicians or the IT function.

As a part of this practical delivery of technology, we will work with our partners to:

- Make our digital systems work harder and more reliably, interoperating more intelligently to promote better information sharing inside and outside the Trust;
- Help our clinicians and staff become better equipped, more 'expert' users who understand the value of good information and are able to use it meaningfully; and
- Allow our patients and service users to benefit from cohesive cross-organizational pathways and smoother, more convenient encounters with our services.

4.5 Commissioning Position

4.5.1 Review of the Local and national commissioning landscape

The local commissioning landscape largely reflects the national landscape. The Trust's services are commissioned in the majority by the three local Clinical Commissioning Groups (CCG) Bristol, North Somerset and South Gloucestershire (BNSSG) and NHS England. The Trust has issued seven detailed contract proposals (activity and value) to Commissioners, and contract discussions are ongoing. CCG Commissioners' counter offers are currently under review and negotiation. However, NHS England are yet to make a comprehensive counter offer which can form the basis of detailed negotiation.

The Trust's contract proposals reflect the key sustainability and transformational priorities for both the Trust and the local health system with particular focus on:

- Ensuring sufficient capacity to meet local demand for emergency and planned care and manage RTT waiting times in line with agreed capacity;
- Service development proposals which ensure we maintain the Trust's ability to adhere to national specialised service specifications, as well as local developments to address key local priorities;
- Addressing the Trust's strategic intent to provide the right level of specialist and acute care to the local and regional population; and
- A neutral impact of coding and counting proposals.

4.5.2 NHS England South West – Specialised Services (contract value £224.5m)

The key aspects subject to negotiations are:

- Specialised Services now make up around 43% of our proposed contract income;
- The Trust will seek investment to embed hosted Operational Delivery Networks (ODNs), such as Paediatric Neurosciences and (subject to final designation) Congenital Heart Disease;
- UH Bristol continues to perform well against key requirements of national services specifications, but investment is being negotiated with NHS England to ensure continued compliance in a number of key areas. Service development proposals have been reduced to the absolute minimum value;
- NHS England's approach of linking CQUINs to Quality Innovation Productivity and Prevention (QIPP) in 2016/17 has been rejected in principle and presents a real challenge to the Trust, particularly where delivery is dependent on other providers and carries significant delivery costs;
- Very late in the contract negotiation process, NHS England has introduced a mandatory CQUIN for Hepatitis C ODN lead providers. This accounts for over 57% of the total value of the Specialised CQUIN scheme, and requires the ODN to manage resources within an indicative financial budget forecast, prioritising patients with highest clinical need despite National Institute for Health and Care Excellence (NICE) Technology Appraisal guidance having been published. The indicative financial budget is substantially understated and out of line with the rest of the country, hence a revised budget is required in order to be acceptable to UH Bristol. Non-delivery of the CQUIN would result in a loss of £2.7m CQUIN income;
- NHS England continues to seek the mandatory implementation of Clinical Utilisation Review (CUR) from a recognised CUR provider through a QIPP-related CQUIN. The potential effect of this initiative would have significant impact on the current delivery of key IM&T projects, and is not supported by the CIO or clinicians. It also requires the CQUIN income to be spent which is not affordable. The Trust has proposed that the aims of the CQUIN could be achieved through the use of its existing integrated systems;
- We are seeking to ensure CQUINs are earnable, as per national guidance, at circa 80-85% net earnable income. This currently remains a point of significant misalignment in relation to the national Hepatitis C ODN and CUR CQUINs and other QIPP-related CQUIN proposals, where in most cases NHS England is enabling a maximum 10% net earnability;
- NHS England's proposal includes circa £9m of Specialised QIPP, which the Trust believes is a balancing figure and too high to be deliverable. Significant QIPP is assigned to Payment by Results (PbR) excluded drugs (through compliance with NICE and commissioning policies). Further QIPP is expected to be released through the extension of Blueteq prior approval to a range of specialised procedures and devices (principally cardiac), coupled with the centralisation of device procurement. The extension of Blueteq for this purpose is being challenged. Very brief details of schemes have now been received and are being reviewed. The Trust will engage in those schemes which are considered realistic and clinically supported, but expects the inclusion of QIPP in contracts to be at Commissioner risk; and
- The issues relating to CQUINs and QIPP have been escalated to the National level where resolution must be achieved in order for a contract to be agreed. The negotiations are extremely challenging.

4.5.3 Local Commissioning (contract value £259.5m)

A key consideration this year continues to be the effect of programmes designed to divert services away from acute settings. CCGs aim to achieve this through levers such as the Better Care Bristol (an extension of the Better Care Fund (BCF)) and other QIPP proposals which have largely rolled over from 2015/16, moving urgent care into the community, reviewing pathways and integration. The Trust continues to be actively engaged in discussions around these initiatives in order to manage the demand being calculated through IMAS and other capacity modelling. However, pressure on acute services has not reduced and has, in fact, significantly increased in year bringing into question the impact of the programmes in 2015/16. The Trust will expect that QIPP included in the contract is at Commissioner risk.

Negotiations on CCG CQUIN proposals are progressing, and a CQUIN scheme has been agreed in draft, which addresses mutually agreed priorities and principles such as organisational responsibility and deliverability/ appropriate net earnability. The 2016/17 national CQUINs will be extremely challenging, in particular new CQUINs relating to Staff wellbeing (including unachievable flu vaccination targets and healthy food requirements which cannot be imposed on existing contracts with suppliers) and Antimicrobial resistance (where the Trust has improved markedly in recent years and further reductions in antibiotic prescribing will be difficult). These issues are also being escalated Nationally.

There is broad alignment with CCGs on activity in the contract. Negotiations on service development proposals are continuing, with CCGs unable to invest in 7-day services and therefore an expectation of derogation in this respect. CCGs are reconsidering their ability to fund Patient Transport Services and a small number of other proposals.

Re-procurement of sexual health services will commence in April 2016. The Trust has committed to maintaining its contract with the local authority for the duration of the procurement. The key challenge in 2016/17 is the Public Health funding allocations and the need for Councils to continue to seek service efficiencies, in the order of up to 10% across the board for public health services together with additional services required in the tender specification.

Following the procurement of an interim solution, CCGs have consulted on the re-procurement of the Children's community health contract. Procurement is ongoing. UH Bristol will be fully engaged as a key partner in both the interim and substantive community children's health services.

Commissioners and the Trust will seek to be aligned on activity and finance within the contract in order to move to contract signature by the end of April, subject to the satisfactory resolution at a National level of the CQUIN and QIPP issues noted above.

4.5.4 Education Commissioning

Health Education England (HEE) commissions education and training from the Trust including Undergraduate Medical (SIFT) and Dental (DSIFT) teaching, post-graduate Medical and Dental (MADEL) teaching and non-medical education and training (NMET). The baseline contract is £35.9m, but a loss of £2.5m is expected due to a 5% efficiency requirement and changes in student numbers plus transitional SIFT tariff being reduced. Formal communication has now been received confirming the Trust's assumption. The main outstanding item is the funding for the Junior Doctors proposed pay award.

4.6 Workforce

4.6.1 Background

Our Workforce and Organisational Development Strategy recognises that achieving financial and operational sustainability depends on robust workforce planning, including effective recruitment and retention plans to meet service needs within an agreed financial envelope. In addition, there is increasing recognition of the need for transformational change to release productivity savings, engaging staff in the process, as described in the Carter (February 2016) report.

One of the Five Year Forward View "must dos" is the completion of a system wide STP, and the associated workforce approach includes explicit consideration of cross sector, pathway development and how we need to change our staffing models and develop our staff to deliver new pathways. The work is also considering how to attract and retain key staff groups in the context of changes to the supply of traditional labour sources. Cross sector work is already underway using Health Education England South West funding to introduce 'Well-Being Partner Apprentices'. These new roles are supported by training programmes that will prepare staff to work across different care settings to meet patient need; whilst the new career pathway should help reduce turnover among nursing assistants across all organisations, public and private, in the local health economy.

The Five Year Forward View also highlights the importance of delivering seven day working, although the challenge is to do this in an affordable way. We have completed an audit led by our Medical Director to identify gaps in our delivery against the four key standards. Plans have been developed to address these gaps and demonstrate incremental progress towards the 2020 requirements. We are keen to build on the early successes with our therapy services: in 2014 we introduced 6-day working across all in-patient teams. We achieved this through the redistribution of resources; all staff continue to work only standard contractual hours over the 6-days, and no staff work more than 5 days consecutively.

4.6.2 Workforce Planning Approach – Operating Plans

The annual workforce planning process at UH Bristol forms an integral part of the annual Operational Plan cycle. Each Division is required to provide a detailed workforce plan aligned to finance, activity and quality plans.

An assessment of the 'demand' for workforce is linked to commissioning plans reflecting service changes, developments, CQUINS, service transfers and cost improvement plans. The IMAS capacity planning tool is used to identify workforce requirements associated with capacity changes. We have agreed nurse to patient ratios which are reflected in the plans.

The planning process also considers workforce 'supply'; including an assessment of the age profile of our existing workforce, turnover, sickness absence and the impact these will have on vacancy levels and the need for temporary staff. Divisional plans are developed by appropriate service leads and clinicians, directed by the Clinical Chair and Divisional Director, and are subject to Executive Director Panel review prior to submission to Trust Board.

Throughout the course of the year, actual performance against the Operating Plan, including workforce numbers, costs and detailed workforce KPIs are reviewed through Quarterly Divisional Performance reviews held with the Executive team, chaired by the Chief Executive.

4.6.3 Workforce Planning Approach - Strategic Workforce Plans

We also undertake strategic workforce planning, taking a five year view of changing workforce needs. Strategic workforce planning workshops with Divisional teams, including clinicians, will take place in each Division between February and May 2016. This work is used to refresh our Organisational Development Strategy and supporting programmes of work and informs the Health Education England submission on which future education commissioning is based. Some of the emerging themes from the workshops include the following:

- **Apprenticeships**: the need to develop apprenticeships in a range of areas including radiography and other scientific and technical roles to address workforce shortfalls and attract new recruits into the workforce;
- **Development of new skills:** the complexity and acuity of our patients in the future, combined with increased technological interventions, will mean new skills are required. For example, more cardiological interventions and less cardio-thoracic surgery will change consultant specialty mix and require different types of technical staff, including more of the Band 4 technical roles we have developed to work flexibly across physiology and other technical areas;
- **Partnership working with academic providers**: removal of bursaries and changes in education commissioning will make educational partnerships even more important to ensure there are sufficient numbers of the right staff with the right skills in the future. We will need to build on work already underway with the Universities of Bristol and the West of England such as joint appointments to Clinical Academic posts, consideration of new roles and developing our existing workforce;
- **Pathway redesign and transformation:** linking with the Five Year Forward View, the need for pathway redesign and transformation across a range of services with roles which support a more integrated approach across the health and social care system;
- **Potential reductions in Junior doctors**: the need to develop clinical fellow and specialty doctor posts, with more roles which combine education, research and service elements to make them more attractive to potential recruits, combined with further exploration of physicians associates and increasing the range and number of our advanced nurse practitioner roles;
- **Specialist Nurses:** training and development of the specialist nursing workforce, including advanced nurse practitioners, and improving retention of nursing by increasing their skills and developing their roles in specialist areas to backfill junior doctors; and
- **Succession Planning:** we have a number of potential consultant and senior nurse retirements in hard to recruit areas, and succession planning at a Divisional and specialty level for these areas will be vital.

4.6.4 Achieving NHS Improvement's Locum and Agency expenditure ceiling

The following principles have been agreed by the Senior Leadership Team in relation to the implementation of the agency and locum ceiling:

- Maintaining patient safety is paramount;
- To adhere to the new rules and to only use agencies on approved frameworks whilst maintaining patient safety; and
- There is a clear clinical and business exception approval process for all staff groups which will be followed.

There are clear escalation arrangements for all staff groups, which have been tightened and standardised, especially in respect of the approval of agency staff costing more than the capped agency rates.

Improved rostering and job planning will ensure that there a fewer gaps, reducing the need for temporary staffing. Robust process and outcome KPIs are in place to evidence effective rostering, as outlined in the Carter report and re-procurement of an e-rostering system for nursing staff, to include acuity and dependency scoring, is underway. This will enable real time monitoring and reporting. However, recognising there is a place for a contingent workforce to provide flexibility to cover unavoidable absence and peaks in demand, we have been strengthening our Temporary Staffing Bureau (bank staff) through a range of initiatives and incentives.

Recruitment, retention and sickness absence management are also fundamental to the management of agency usage, which are described below. The scale of the challenge to achieve the agency and locum ceiling from a 2015/16 forecast outturn of £19.7m to £12.8m is well recognised, and is reflected in the scope and range of programmes which feed into the reduction plan.

The achievement of the ceiling is underpinned by the implementation and acceptance of the NHS Improvement capped rates by Approved Frameworks and associated agencies. Agencies that refuse to implement the 1st April 2016 rates will put the Trust at risk of not achieving the planned expenditure levels.

4.6.5 Workforce Numbers

The anticipated workforce plan, expressed in whole-time equivalents (wte) for 2016/17 and how this compares to the previous year is set out in the tables below.

Table 5 : Workforce Demand

	Funded Establishment 2015/16 Actual wte	Service Developments wte	Service Transfers wte	Savings Programme wte	Funded Establishment Mar-17 wte	Change wte
Medical and Dental	1,204	57	(3)	0	1,258	55
AHP/Clinical scientists	1,333	37	(17)	(3)	1,350	17
Nursing and midwifery	3,126	108	0	(4)	3,230	104
Ancillary	858	4	0	(7)	855	(3)
Admin and Clerical	1,680	36	(10)	(4)	1,702	22
Total	**8,200**	**242**	**(30)**	**(17)**	**8,395**	195

Table 6 : Workforce Supply

	2015/16 Actual Employed wte	2015/16 Actual Bank wte	2015/16 Actual Agency wte	2015/16 Total Staffing wte	Change in Planned Employed (Starters) wte	Change in Planned Employed (Leavers) wte	Change In Bank wte	Change in Agency wte	Total Changes wte	2016/17 Planned Employed wte	2016/17 Planned Bank wte	2016/17 Planned Agency wte	2016/17 Planned Total Staffing wte
Medical and Dental	1,153	0	52	1,205	390	(330)	0	(8)	53	1,214	0	44	1,258
AHP/Clinical scientists	1,296	7	3	1,306	267	(228)	5	0	44	1,335	12.1	3	1,350
Nursing and midwifery	2,933	207	76	3,216	577	(453)	(55)	(56)	14	3,058	152.3	20	3,230
Ancillary	787	44	14	845	145	(96)	(29)	(9)	10	835	14.7	5	855
Admin and Clerical	1,544	79	23	1,646	307	(246)	(6)	1	56	1,605	73.1	24	1,702
Total	**7,713.0**	**337**	**168**	**8,218**	**1,687**	**(1,353)**	**(85)**	**(72)**	**177**	**8,047**	**252**	**96**	**8,395**

The tables above includes planned cost savings, and transfers; for example, Histopathology to North Bristol NHS Trust, and aligns with the financial assumptions.

4.6.6 Safe Staffing Levels

The NHS national staffing return compares expected and actual staffing levels on the ward for each day and night. This information is triangulated with the Trust quality performance dashboard to assess whether the overall standard of patient care was of good quality (safety/clinically effective/patient experience). This forms part of the monthly report to a Trust Board Sub Group, the Quality and Outcomes Committee. Each ward receives its own RAG rated quality performance dashboard including workforce KPIs on a monthly basis. This enables the triangulation of workforce and quality data at a ward, divisional and trust wide level.

As actioned in the quality section of this plan a Quality Impact Assessment is completed for all cost improvement schemes which involve the removal of a patient facing post to identify and assess the quality and operational risk. These are reviewed monthly at the Savings Board and work stream accountability meetings which include both the Medical Director and Chief Nurse.

4.6.7 Transformation and productivity programmes

Our overarching Trust wide programme of work to deliver quality and efficiency improvements - Transforming Care – is overseen by the Trust Board and consists of six pillars. Within the "Deliver Best Value" pillar we have focussed savings work-streams which are delivering productivity initiatives focussed on each staff group. The key actions in respect of each are described below.

- **Nursing and Midwifery**
  - Improving efficiency through E-Rostering – our E-rostering system will be re-tendered in 2016/17.
  - Reducing turnover and sickness absence, especially for registered nurses in specialist areas (theatres, critical care) and for nursing assistants.
  - Exploring more cost effective ways of providing safe care to patients with mental health needs.

- **Medical Staff**
  - Review of consultant on-call payments.
  - Productivity based job plans.
  - Harmonisation of premium payments paid to substantive and locum medical staff.
  - Absence/leave management to ensure effective rota cover for medical staff.

- **Allied Health Professionals (AHP)**
  - Establishing integrated pathway teams across adult therapy services (physiotherapy, occupational therapy, speech and language and dietetics).
  - Development of shared support worker roles.
  - Improving efficiencies by Benchmarking workforce levels with other Trusts.
  - Expanding the newly developed role of independent pharmacist prescriber into other outpatient areas including urology (oncology) and myeloma clinics, and breast and lymphoma pre-assessment clinics.

- **Administrative and Clerical**
  - Focus on speed of recruitment, clear competency standards underpinned by training for all roles.
  - New standard operating plans to improve theatre booking procedures.
  - Implementation of a digital dictation and speech recognition system.
  - Mobile phone technology to enable clinicians to send dictation to secretaries in real-time and client side dictation during ward rounds.
  - Homeworking is being successfully piloted which will enable improve flexible working options.

4.6.8 Workforce Risks

Workforce risks are recorded at departmental, divisional and corporate level on Datix, our Risk Management System, and are managed and reviewed at an appropriate level, in line with Trust Policy. Our workforce risks are considered by the Workforce and Organisation Group and by the Trust's Risk Management Group on a quarterly basis. Our main workforce risks, identified in our 2015-2020 Workforce and Organisational Development Strategy, include the impact of higher than planned turnover, vacancies, and sickness absence on our ability to sustain safe services without recourse to agency usage. We also recognise the link between good staff engagement and motivation and high vacancies, turnover and sickness absence and have more work to do in this respect. Detailed plans are in place to mitigate these risks and the headlines are described below.

4.6.9 Workforce KPIs

Our workforce KPIs are set at a divisional and staff group level, taking account of historic performance and comparable benchmarks.

4.6.10 Workforce KPIs - Turnover

During 2016/17 turnover levels at UH Bristol have reduced against the background of other Teaching Trusts experiencing higher rates. Although this is encouraging, we started at a higher baseline than many and this is remains a key area of focus. We have set a target for 2016/17 reducing it from 13.6% to 12.1%, approximately 95 fewer leavers.

Our key areas of work in our retention and engagement plan include the following:

- **Visible leadership and improving two-way communication**: A number of staff experience and engagement workshops across different UH Bristol sites have taken place to agree how we improve communications between managers and teams;
- **Appraisal improvement project:** The embedding of role competency and career frameworks into a new appraisal process which will be fully implemented from September 2016;
- **Investment in staff development and team building:** This includes the provision of critical care modules and a theatre transformation programme including role development for band 6s. We also have also piloted the Aston team coaching model, with 20 coaches trained to work across the Trust;
- **Local Engagement Plans:** There are a range of activities tailored to the service and staff group context within divisions, including staff suggestion schemes, engagement events, ward away days, staff champions, newsletters, and the development of a "happy app" for staff to give feedback**;**
- **Health and Well-being programme:** The second year of the programme includes free on site health checks over the next 2 years with a target of reaching 2000 staff and the launch of "Step into Health" 12 week physical activity/lifestyle programme; and
- **Best Care Weeks:** designated weeks to strengthen team working and help all our staff focus on improving the quality of care, mobilising staff and leaders to help identify barriers to delivery of high quality care and escalating issues which local teams need help to resolve.

4.6.11 Workforce KPIs - Vacancies

Recruiting to vacancies is an important element in our agency reduction plan, together with reducing turnover given the link with increased vacancies on staff motivation and work pressure. The UH Bristol vacancy rate (5.2% in February 2016 for all staff) continues to compare favourably with other Teaching Trusts. With a thriving local economy with a high employment rate, our highest vacancy rates are for administrative and clerical staff at 8.1% in February 2016. Vacancy rates are below 5% for nursing and midwifery, and 1.2% for medical staff. However, there are hotspots amongst these two groups, which have been the focus of specific campaigns, including overseas recruitment for hard to fill consultant posts such as radiology and targeted theatre nurse campaigns. We have implemented an assessment centre approach for nursing assistant recruitment and vacancies have reduced to 1.3% compared with 10.4% a year ago. Ancillary vacancies have also reduced by 28% in the last six months, due to the appointment of a Recruitment Lead to focus on this staff group. We have implemented a new recruitment IT system, TRAC, to improve workflow management, and intelligence of pipeline recruitment. There continues to be an ongoing plan of work in place to sustain our progress in reducing vacancies.

4.6.12 Workforce KPIs - Sickness Absence

Our 2015/16 sickness absence rate at 4.2% is similar to the average performance for other Teaching Trusts. We are aiming to significantly reduce absence in the longer term, with a target of 3.9% during 2016/17. Benchmarking has identified that our unregistered nursing and administrative and clerical sickness absence levels are above average and ancillary sickness absence rates are also a cause for concern, and targeted interventions are being actively pursued. We already have a robust sickness absence management framework and we continue to test how this might be improved.

We have put in place a comprehensive Health and Well-being Programme. Our main programmes of work target our top three reasons for absence which are as follows:

- **Stress related absence:** Although the staff survey indicates there has been a reduction in work related stress, suggesting that staff perceive a reduction in stress levels, this has not yet been shown in the sickness absence data. Support for staff includes an in house staff counselling service for all staff, a Resilience Building Programme providing self-help tools and techniques to prevent absence for psychological reasons and an Employee Assistance Programme for Women`s and Children`s Division.
- **Colds and flu:** Flu vaccine is offered to all staff throughout the annual flu campaign.
- **Musculo-skeletal/back problems:** Physio Direct continues to offer telephone advice and clinics by self or manager referral providing about 1,200 such interventions in the last year. In addition, there are around 1,400 site visits per year by the Manual Handling team including staff work place risk assessment for assessing musculo-skeletal health.

4.6.13 Staff Engagement

Our second all-staff annual survey was carried out in 2015. Our overall staff engagement score has improved from 3.69 in 2014 to 3.78 in 2015 compared with a National average score of 3.79. Our scores show a particular improvement in the following areas:

- Reporting good communication between senior management and staff;
- Staff satisfaction with level of responsibility and involvement;
- Support from immediate managers;
- Increase in staff motivation at work;
- Less staff suffering from work related stress in the last 12 months; and
- Less staff witnessing potentially harmful errors, near misses or incidents in the last month.

However, we retain a key focus on this agenda particularly as we aim to be in the top 20 teaching hospitals. Our work programme is multifaceted and the priority is to equip our leaders and managers at all levels to improve the following areas in the coming year:

- Effective Team working;
- Staff motivation at work;
- Percentage of staff satisfied with the opportunities for flexible working patterns;
- Staff satisfaction with the quality of work and patient care they are able to deliver; and
- Staff confidence around speaking up if they have concerns.

4.7 Financial Plan

4.7.1 Introduction

The financial plan narrative describes the Trust's current assessment and presents the 2016/17 position in outline. It should be noted that the current assessment of 2016/17 is based on SLA proposals to Commissioners and Health Education England which have not yet been concluded and hence carry potential upside benefits but more likely further downside risks. The plan is based on the following key drivers:

- The Trust's CIP target is set at 2.2% of recurring budgets plus the assessed underlying deficit carried forward from 2015/16 generating a target of £21.9m or 4.6% for 2016/17. However, the Trust's Board view is that 4.6% is too high and not deliverable therefore we have agreed not to plan on this basis (corporate support of 1% or £4.5m is provided) leaving a net CIP requirement of £17.4m (3.6%);

- The net favourable impact of 2016/17 national tariff guidance, specifically the removal of the specialised services marginal tariff at £2.4m offset by the adverse impacts of the Stereotactic Radiosurgery Service (SRS) tender at £0.6m plus the reversal of previous Monitor guidance on MDT services which reduces income by £0.8m;

- The loss of Health Education England (HEE) Service Increment for Teaching (SIFT) funding of £1.1m in addition to a 5% CIP requirement likely to be advised by HEE – so in total a £2.1m loss of funding on top of the £0.3m SIFT transition loss already planned for;

- Sustainability funding (general element) of £13.0m is assumed to be received. This has not yet been confirmed by NHS Improvement. It is anticipated that discussions about the build-up of the Control Total for UH Bristol will inform this. In particular the impact of Health Education England changes (£2.0m) and the baseline for the calculation (i.e. using the 2015/16 balanced plan rather than the Q2 £1.6m surplus) are issues which the Trust believes require consideration for adjustments to the Control Total on which the receipt of Sustainability funding is predicated;

- Service Level Agreement (SLA) proposals are at an advanced stage from the Trust with Version 7 of our offers having been sent to Commissioners. Whereas good progress has been made with local CCG contracts (the only significant issue is the National CQUINs being largely undeliverable), the NHS England (specialist and non-specialist) contracts are at an early stage with only one partial offer being received. The likely residual issues that could impact on the Trust's financial plan are largely for national resolution (CQUINS, QIPP and Pharmacy gain-share); and

- There is an expectation, however, that Heads of Terms could be signed by the end of April subject to the issue of CQUINs being resolved nationally. The Trust will consider using the dispute resolution process including Arbitration if the SLA issues cannot be resolved in April.

4.7.2 Financial Summary

The 2016/17 financial plan of a £14.2m surplus has changed from the draft plan submitted on the 8th February 2016 (a £15.9m surplus) in the following respects:

- The new guidance on MDT charging has reduced income by £0.8m;
- A residual level of non-core fines of £0.7m is included – originally the assumption was for no fines to be levied;
- Non-recurring measures are needed to be used to support the Divisional Operating Plans (mainly unadjusted CIP) instead of supporting the overall Trust position – this amounts to £2.2m;
- Other offsetting savings leave the net change at a £1.7m deterioration; and
- It should be noted that the donated income and depreciation is now excluded from the headline surplus quoted. Hence the £16.6m surplus at the draft plan stage becomes the £15.9m surplus referred to (i.e. net donations amounts to £0.7m).

4.7.3 Financial Plan

The Trust's 2016/17 financial plan is constructed as follows:

Table 7: Financial position

Surplus / (Deficit)	**Draft Plan 8th February**	**Final Plan 18th April**	
	£m	**£m**	
Underlying position brought forward	3.3	3.3	
Cost Pressures			
Capital Charges	(1.6)	(1.0)	Strategic schemes completion
BRI Old Building	0.9	0.9	Vacation in September 2016
Dental SIFT	(0.3)	(0.5)	Reduction in student numbers
Medical SIFT	(0.6)	(0.6)	Change in ratio WTE / weeks by HEE
Risk provision for cost pressures	(0.5)	(0.5)	Unavoidable recurrent costs only
Reduction in contingency	0.3	0.3	
Tariff – Capital Charges	1.0	1.0	Tariff inflator funds capital growth
Other	-	0.6	Various cost reductions
Sustainability Fund	13.0	13.0	Based on a revised control total of £14.2m.
SLA Contracting Issues			
Specialised Marginal Tariff	2.5	2.4	Per NHS Improvement guidance
Impact of Tariff			
SRS tender	(0.9)	(0.6)	Tender reduces the SLA price
MDT	-	(0.8)	Per Monitor Prices team correction
Other	-	0.6	Other tariff impacts
Non Recurrent			
Change costs / spend to save	(1.0)	(1.0)	To fund schemes that generate recurring savings
Risk provision for cost pressure	(0.5)	(0.5)	Unavoidable non-recurrent costs only
Transition costs for strategic schemes	(0.9)	(0.7)	
Clinical IT programme	(1.0)	(1.0)	Funds the IT Programme support costs
SLA fines charge	-	(0.7)	Residual fines
Other non-recurring measures	2.2	-	Now required to support Divisional plans
Net I&E Surplus / (Deficit) excluding technical items	**15.9**	**14.2**	
Donations	2.2	2.7	
Donated asset depreciation	(1.5)	(1.5)	
Net I&E Surplus / (Deficit) excluding impairments, including donations	**16.6**	**15.4**	
Net Impairments	(6.6)	(7.1)	
Net I&E Surplus / (Deficit)	**10.0**	**8.3**	

The final plan above requires c. £7m of non-recurring savings for delivery of Divisional Operating Plans in addition to the above Trust level changes, due to a combination of unidentified CIP (£5.0m) and nursing spend risks (£2.0m).

4.7.4 Income

The 2016/17 income plan is subject to further negotiation of SLAs with Commissioners and the resolution of the following key issues:

- Agreement of activity plans to deliver trajectories towards constitutional targets, allow for specialty specific growth, necessary service developments and NICE guidance;
- Agreement of CQUINs that can be earned to the baseline requirement of 80-85%;
- The non-payment of core fines as defined by the National Standard Contract plus non-reimbursement to Commissioners of re-admission penalties. The residual requirement for fines is £0.7m;
- Agreement of counting and coding changes; and
- Discussion of QIPP proposals from Commissioners including challenges raised.

Heads of Terms and SLAs are expected to be signed at the end of April 2016. The current 2016/17 income plan is £631.1m and includes the following key changes:

Table 8 : 2016/17 Income build up

		£m	£m
Rollover Income	Recurrent income from 2015/16		**592.1**
Tariff	Gross inflation including CNST	15.3	
	Efficiency	(10.1)	
			5.2
Impact on Guidance	Specialised Marginal Tariff Adjustment	2.5	
	Stereotactic Radiosurgery & Stereotactic Radiotherapy	(0.5)	
	MDTs	(0.8)	
	Other	0.5	
			1.7
Activity Changes	2015/16 forecast	(1.2)	
	Forecast outturn adjustment	4.8	
	RTT Recurrent	1.3	
	RTT Non-recurrent	4.5	
	Activity Growth	3.4	
			12.8
Other	Sustainability and Transformation funding	13.0	
	NICE Changes	4.1	
	Service Transfers	(0.9)	
	Service Developments	2.1	
	CQUINs	1.3	
	QIPP Savings	(0.5)	
	Fines	(0.7)	
	Dental SIFT	(0.5)	
	Medical SIFT	(0.9)	
	Other	(0.4)	
			16.6
	Total 2016/17 Income excluding donations		**628.4**
	Donations		2.7
	Total 2016/17 Income		**631.1**

4.7.5 Costs

The 2016/17 cost outlook for the Trust is challenging and should be considered in the context of operational pressures on spending, the full delivery of savings plans and transformation initiatives. Firm control will continue to be required to avoid the Trust's medium term plans being undermined beyond 2016/17. The main assumptions included in the Trust's cost projections are:

- Pay award at 1.0%, incremental drift at 0.5%, employer NI contributions at 1.6%;
- Controlling locum and agency costs to a maximum of £12.8m for the year;
- Drugs at 5.0%, clinical supplies 2.0%, CNST at 17.0%, and capital charges at 5.6%;
- Savings requirement of £17.4m;
- Payment of loan interest at £2.9m; and
- Depreciation of £21.6m.

The 2016/17 position includes non-recurring costs of £3.2m as follows:

- £1.0m Change / invest to save costs;
- £0.7m Transitional costs relating the disposal of the BRI Old Building;
- £1.0m Clinical Systems Implementation Programme (CSIP); and
- £0.5m Risk reserve.

4.7.6 Cost Improvement Plans

The delivery of CIP is an essential element in the Trust delivering its 2016/17 financial plan, including the conversion of non-recurring schemes to recurring schemes. The Trust sets CIP targets for 2016/17 in the light of:

- National tariff efficiency requirements for Commissioners at 2.0% for 2016/17;
- The impact of HEE requirements at 5.0% (0.2% on Trust total); and
- Underlying deficits in divisions carried forward from the previous year (2.4%).

The Trust's CIP target is set at 2.2% of recurring budgets plus the assessed underlying deficit carried forward from 2015/16 generating a target of £21.9m for 2016/17. However, 1.0% or £4.5m will be dealt with recurrently corporately leaving a net recurring requirement of £17.4m. Currently, risk assessed plans exist for £12.4m. A reduction in nursing expenditure of £4.0m is required for the overall plan to be delivered.

The Trust has an established process for generating CIPs. It operates an established programme of transformation, called Transforming Care. The key transformational work streams which support CIP are as follows:

- Theatre Productivity transformation programme to focus on improving theatre efficiency;
- The Model of Care Programme which is our patient flow programme and focuses on reductions in length of stay along with improved productivity and reductions in cancellations;
- The Diagnostic Testing project addresses the processes for delivering efficient diagnostic testing across the Trust for Pathology and Radiology services; and
- Outpatient productivity which focusing on the efficient utilisation of outpatient capacity.

The challenge is to identify quantifiable savings from these transformation work streams.

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

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

The Trust's risk assessed CIP plan is summarised below. The total of unidentified savings is currently £5.0m.

Workstreams	**£m**
Allied Healthcare Professionals Productivity	0.5
Medical Staff Efficiencies Productivity	0.6
Nursing & Midwifery Productivity	0.3
Diagnostic testing	0.2
Technology / Admin & Senior Managers Productivity	0.2
Reducing and Controlling Non Pay	3.8
Medicines savings (Drugs)	1.4
Theatre productivity	0.3
Outpatients Productivity	0.1
Facilities & Estates	0.7
Trust Services	0.4
Corporate and other savings	3.9
To be identified	5.0
	17.4

4.7.7 Carter review

The final Carter Report has been published and the Trust is now actively developing an action plan to address the key issues within the report. The Trust has already been actively engaged with regards to Medicines / Pharmacy efficiencies and Estates and Facilities. The report also highlights the current local collaborative medicines procurement process as an example of good practice. Each of the trusts savings work streams will be tasked with establishing a clear action plan to take forward the recommendations in the Carter report particularly those concerned with developing efficiencies in relation to the use of staffing resources.

The Carter report introduces a number of new measures of efficiency relating to staffing which the Trust is keen to develop over the coming months as delivering savings from pay is recognised as one of the trusts biggest challenges in 2016/17 and beyond.

The Trust is keen to become involved with the 'Model Hospital' aspects of the Carter approach as the Trust recognises the considerable benefits this might bring in future. As yet this is relatively underdeveloped, however as this improves the Trust will actively use this as a further means of identifying opportunities for efficiency savings.

With regard to benchmarking the Trusts performance against peer Trusts which is a key element of the Carter approach, the Trust has in the past actively used Reference Costs to identify areas of potential efficiency improvement. Using the benchmarking portal released by the Carter team, the Trust will increase the benchmarking it carries out with a view to identifying examples of best practice in other Trusts. It should be noted however that it has been the experience of the Trust that identifying areas of inefficiency is relatively easy, transferring this knowledge into practical implementable cost reduction takes time and therefore improvements from this source will only become available later in 2016/17 at the earliest.

4.7.8 Capital expenditure

The Trust has a significant capital expenditure programme investing £452m from April 2008 until March 2021 in the development of its estate. In 2016/17, the Trust's planned gross capital expenditure totals £41.1m and incorporates slippage of £20.0m from 2015/16.

With the remaining uncertainty regarding SLA agreement, the capital programme has been retained at £41.1m but assumes up to £12.0m slippage into 2017/18. This will be reviewed mid-year when the position is firmed up. The net 2016/17 capital expenditure plan is therefore £29.1m and is summarised below:

Table 9 : Source and applications of capital

Source of funds	2016/17 Plan £m	Application of funds	2016/17 Plan £m
Cash	16.5	Carry forward schemes	20.0
Depreciation	21.6	Estates replacement	2.5
Disposals	0.0	IM&T	2.6
Donations	2.7	Medical equipment	6.5
Public Dividend Capital	0.3	Operational capital	4.6
		Strategic schemes	4.9
Subtotal	**41.1**	**Total**	**41.1**
Net cash retention	(12.0)	Net slippage	(12.0)
Total	**29.1**	**Total**	**29.1**

The allocation of the £12.0m reduction is yet to be agreed but is likely to be:

- Reduction in strategic schemes to that already committed by £3.6m; and
- Estimated slippage – this creates a first call on 2017/18 resources of £8.4m.

Once the position regarding Sustainability funding and Commissioners SLAs has been confirmed, along with the arrangements for the other conditions required, the position will be re-assessed with additional schemes being agreed if possible.

4.7.9 Financial Sustainability Risk Rating (FSRR)

The planned net surplus of £14.2m is the driver behind the Trust's overall FSRR of 4. The components of the FSRR are summarised below:

Table 10 : FSRR Performance

	Metric	**Score**
Liquidity	14.3 days	4
Capital service cover	2.7 times	4
Net I&E margin	2.4%	4
Margin variance	0.3%	4
Overall FSRR		**4**

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

4.7.10 Summary Statement of Comprehensive Income

The 2016/17 Statement of Comprehensive Income (SoCI) is summarised below.

Table 11: SoCI and closing cash balance

	2016/17 Plan £m
Income	628.4
Operating expenditure	(581.0)
EBITDA (excluding donation income)	47.4
Non-operating expenditure	(33.2)
Net surplus / (deficit) excluding technical items	**14.2**
Add net donations	1.2
Net surplus / (deficit) excluding net impairments, including net donations	**15.4**
Net impairments	(7.1)
Net surplus / (deficit) including technical items	**8.3**
Year-end cash	**70.8**

4.7.11 Financial Risks

The main risks to the delivery of the plan include:

- Sustainability funding is not yet confirmed;
- Commissioner SLAs are not yet agreed – it is likely that significant risks remain of insufficient funding being made available for activity, necessary developments and existing agreements that underpin the Trust's financial position. The level of risk is not quantifiable at this stage as Commissioner proposals have not yet been made in sufficient detail;
- The need to further develop the Trust's savings programme is high risk. The Trust will review its approach to the delivery of CIP to mitigate this risk; and
- The impact of emergency pressures not being sufficiently mitigated by system measures is significant and could result in the need for additional unfunded capacity (at premium agency cost) and/or the constraint of elective activity together with an associated increase in fines by Commissioners.

5. Membership and elections

5.1 Governor elections in the previous years and plans for the coming 12 months

The last governor elections held at the Trust were in 2014. This year we will hold elections in May 2016, which will include 15 governor seats, including Public, Patient and Staff governor roles. We are currently in the process of promoting the opportunity to stand for a governor role via our membership and wider network of contacts in health and social care. Once the election process is complete, newly elected (or re-elected) governors will start their term of office on 1st June 2016, and will be supported by a thorough induction process. There will be further elections in May 2017.

5.2 Governor recruitment, training and development

We promote the opportunity to become a governor when undertaking any wider membership promotion. We have increased the focus since October 2015, to support the governor elections being held this year.

We provide governors with a comprehensive programme of training and development that begins upon appointment with an induction. In additional to regular updates on Trust Strategy, Quality & Performance and Membership/ Constitution, we run four Governor Development Seminars each year, which for example have included training from NHS Providers/ Govern well and updates and training from leads within the organisation on topics such as Staff Health and Well Being. We use the governor development sessions and governor focus groups to ensure that the Council of Governors are sighted on the same issues as the Board. We are in the process of setting personal objectives with each governor, and from this will support them with an additional tailored personal development programme.

Engagement between governors and members is proactively encouraged, and governors support the facilitation of five member events held each year, Trust Patient and Public Involvement work and events organised by partners such as the University of Bristol.

5.3 Membership strategy

The Trust has a Membership Engagement and Governor Development Strategy that was refreshed in 2015 and approved by the Council of Governors. The strategy outlines the intended approach to membership is to grow member numbers and improve the frequency and quality of opportunities for engagement with members.

In addition to regular membership stands across the hospital sites and in the local community, the Trust holds five main member events a year, each with a focus on a particular health topic and with time for Q&A and feedback. In 2015 over 250 members from a broad demographic attended these events.

The Trust membership is under-represented in certain areas, such as 22-39 years age group, males and in some ethnic groups. Plans are in development for a 2016 summer membership recruitment and engagement drive that will incorporate additional focus in these areas. The 2016 member events are being developed to allow for increased learning from members' experience and feedback and we are working with colleagues from across the organisation on this agenda, for example leads from Palliative Care services.

6. Conclusion

This Operational Plan is the product of much hard work and has been built up from detailed Divisional Plans which makes it robust and hence has an excellent chance of being delivered.

The financial plan is still under review due to late engagement by Commissioners – especially NHS England – and a change in approach in the guidance re CQUINs. The issues outstanding are still under discussion at national level – the outcome will have a material impact on the final financial plan. We still, intend to deliver a surplus plan for the 14th year in row but significant changes need to be agreed nationally to make this a reality.

Paul Mapson
Director of Finance

Robert Woolley
Chief Executive

18th April 2016