University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for the Meeting of the Trust Board of Directors held in Public
To be held on Thursday 28 July 2016 at 11.00am – 1.00pm
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page No*
1. Chairman's Introduction and Apologies To note apologies for absence received	Chairman	
2. Patient Story and Chaplaincy Annual Report 2015/16 To receive the Chaplaincy Annual Report 2015/16 and the Patient Story for review	Chief Nurse	3
3. Declarations of Interest To declare any conflicts of interest arising from items on the agenda	Chairman	
4. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 30 June 2016	Chairman	14
5. Matters Arising (Action log) To review the status of actions agreed	Chairman	24
6. Chief Executive's Report To receive the report to note	Chief Executive	25
Delivering Best Care and Improving Patient Flow		
7. Independent Review of Children's Cardiac Services in Bristol To receive the report for assurance	Chief Executive	29
8. Congenital Heart Disease commissioning standards To receive the report for assurance	Chief Executive	95
9. Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital. To receive the report for assurance	Chief Executive	117
10. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer/Deputy CEO	124
11. Quality and Outcomes Committee Chair's report To receive the report for assurance	Quality & Outcomes Committee Chair	To be tabled
12. Quarterly report on achievement of Quality Objectives To receive the report for assurance	Chief Nurse	184

Item	*Sponsor*	*Page No*
13. Quarterly report on Research and Innovation To receive the report for assurance	Medical Director	197
14. Annual Education, Learning & Development Report To receive the report for assurance	Acting Director of Workforce & OD	203
15. Equality and Diversity Annual Report 2015/16 To receive the report for assurance	Acting Director of Workforce & OD	241
16. Complaints Annual Report 2015/16 To receive the report for assurance	Chief Nurse	284
17. National In-Patient Survey Results 2015 To receive the report for assurance	Chief Nurse	296
18. Transforming Care Report To receive the report for assurance	Chief Executive	323
Leading in Partnership		
19. Clinical Research Network Annual Report 2015/16 and Annual Plan 2016/17 To receive the Annual Report and approve the Annual Plan for 2015/16	Medical Director	To follow
Delivering Best Value		
20. Finance Report To receive the report for assurance	Director of Finance & Information	330
21. Finance Committee Chair's Report To receive the report for assurance	Finance Committee Chair	To be tabled
22. Quarterly Capital Projects Status Report To receive the report for assurance	Interim Chief Operating Officer	367
Compliance, Regulation and Governance		
23. Annual Review of Risk Management Strategy To review the Risk Management Strategy for approval	Chief Executive	372
24. Board Assurance Framework Report: Quarter 1 Update To receive the Board Assurance Framework for approval	Chief Executive	425
25. Q1 Risk Assessment Framework Declaration Report To approve the report prior to NHS Improvement submission	Chief Executive	448
Information		
26. Governors' Log of Communications To receive the Governors' log to note	Chairman	463
27. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: Thursday 29 September 2016, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

Cover report to the Board of Directors meeting held in public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
02. Patient Story									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author:** Brenda Dowie, Chaplaincy Team Leader									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality.

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

- To set a patient-focussed context for the meeting.
- For Board members to understand the impact of the lived experience for this patient and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

Patient Story Summary

This story charts the experience of a child who was air lifted to the Paediatric Intensive Care Unit following an accident on a family outing in Tiverton and the subsequent chaplaincy input on their arrival into our care.

In summary, one Sunday morning last September, a chaplain was paged to come to the Paediatric Intensive Care Unit regarding a 13 year old boy (one of a twin) who had been admitted on the Saturday afternoon having been air lifted from near Exeter to A&E.

The boy had been at a local football match, watching one of his older brothers playing. His brother was tackling another young lad near the goal mouth. During the tackle, one of the metal hooks that keep the netting in place became loose, flew in the air and landed in the back of the 13 year old's head.

The boy had an emergency operation on the Saturday night; however the trauma was so great that the doctors were not able to save his life. Graham was asked to visit and support his parents, two elder brothers and their girlfriends, plus his twin brother. His brother, who had been playing in the football match, was full of guilt. Graham offered prayers and a blessing and pastoral support. The family were all in a great deal of shock and grief. During the remainder of that day, members of the wider family visited the Children's Hospital to say their goodbyes.

The life support machines keeping the boy alive were finally switched off on the Tuesday. The parents requested that his organs to be donated to help give life to other people.

Some of the considerations around this case are

- The impact on families, staff and the supporting chaplain in complex situation which have a traumatic outcome

- The relationship between spiritual, religious and existential care.
- The enabling and processing of guilt especially in accidental circumstances
- The ability and skills needed to form a relationship quickly with families at their most vulnerable.
- The process of going on supporting staff
- The debrief and process required for the chaplains to process their own feelings reflections and theological/philosophical understanding

Recommendations
To receive the patient story, and note the context from which it was generated.
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
None
Implications (Regulatory/Legal)
Learning from feedback supports compliance with CQC's fundamental standards, in particular: regulation 9, person centred care; regulation 10, dignity and respect; regulation 17, good governance.
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
02b. Chaplaincy Annual Report 2015/16									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author**: Rev Brenda Dowie, Chaplaincy Team Leader									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose This report summarises the activities and contribution of the Chaplaincy during 2015/16. Key issues to note As described in the report.									
Recommendations									
The Board is recommended to note the report.									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		
Date the paper was presented to previous Committees									

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

University Hospitals Bristol NHS
NHS Foundation Trust

Annual report for the Department of Spiritual and Pastoral Care (Chaplaincy) and Patient Affairs (Bereavement Services) 2015/16

Reverend Brenda Dowie, Chaplaincy Team Leader

1. Introduction

The Department of Spiritual and Pastoral Care (Chaplaincy) at University Hospitals Bristol NHS Foundation Trust (UH Bristol) provides Spiritual, Religious and Pastoral Care to patients, staff, relatives and carers.

With colleagues from North Bristol NHS Trust (NBT) and the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), UH Bristol's chaplains are part of a city-wide chaplaincy service providing continuity of care across the city's hospitals twenty-four hours a day, three hundred and sixty-five days a year.

The Patient Affairs Team (Bereavement Services) provides UH Bristol with the expertise to manage the legal and practical requirements following a death in hospital. The team works closely with doctors, the wards and the mortuary; they manage the release of the deceased from the hospital to the appropriate care in the community.

This report summarises the activities and contribution of the Chaplaincy during 2015/16.

2. The work of the Chaplaincy – two stories

In order to highlight a little of the work of the Chaplaincy, two different life-changing events supported by our team are presented below. Although these stories are sadly far from unique, they throw light on some of the sensitive work we all do as Chaplains, on a regular basis.

A call out to a 13 year old boy

Last September, Graham was paged to come to the Paediatric Intensive Care Unit regarding a 13 year old boy (one of a twin) who had been admitted on the Saturday afternoon having been air ambulanced from near Exeter to A&E. This was now Sunday morning.

The boy had been at a local football match, watching one of his older brothers playing. His brother was tackling another young lad near the goal mouth. During the tackle, one of the metal hooks that keep the netting in place became loose, flew in the air and landed in the back of the 13 year old's head.

The boy had an emergency operation on the Saturday night; however the trauma was so great that the doctors were not able to save his life. Graham was asked to visit and support his parents, two elder brothers and their girlfriends, plus his twin brother. His brother, who had been playing in the football match, was full of guilt. Graham offered prayers and a blessing and pastoral support. The family were all in a great deal of shock and grief. During the remainder of that day, members of the wider family visited the Children's Hospital to say their goodbyes.

The life support machines keeping the boy alive were finally switched off on the Tuesday. The parents requested that his organs to be donated to help give life to other people.

Baby care after death brought this response by e-mail from the parents

"Good Morning,

I hope you are well.

I was just writing to say thank you for how lovely you done with the service of our daughter [redacted] at South Bristol Crematorium.

Even during my stay at St Michael's Hospital you put me at ease by answering our questions and ensuring our daughter had the send-off she

deserved. The service itself was fantastic even with family and friends commenting on how lovely it was so thank you for that. It was far better than I was ever expecting it to be.

I loved the fact I was able to carry her in and out to her plot and me and [redacted] were able to lower her in. It will be something we will never forget so I appreciate you in letting us have those final moments with our princess.

I don't think people like you sometimes are told how much of an amazing job you do but I wanted to let you know how much I appreciate all you have done for us from the moment we met you. I will be eternally grateful for my daughter having the best service she could have had in her final moments and a beautiful resting place.

I know the job you do must be so depressing and hard at times but you should be so proud that you've made my experience 'the best it could have been given the circumstances'.

Thank you so much once again."

3. Changes to the Department of Spiritual and Pastoral Care in 2015/16

The Department of Spiritual and Pastoral Care has again experienced a significant number of changes in the year 2015/16. In July 2015, Rev Steve Oram stood down as team leader (a post hosted by NBT, shared and funded equally between the two trusts) and transferred to UH Bristol to become team chaplain with particular responsibilities for Women's and Children's services. On 1st March 2016, Rev Brenda Dowie took up the post of team leader.

At the end of 2015/16, chaplaincy team staffing was therefore as follows:

- Rev Brenda Dowie Spiritual and Pastoral Care Team Leader (0.5 WTE)
- Rev Stephen Oram, Team Chaplain with particular responsibility for Children's and Women's Services (1.0 WTE)
- Rev Graham Reaper-Brown, Team Chaplain with particular responsibility for Oncology and Palliative Care (1.0 WTE)
- Fr Cavan McElligott, Team Chaplain with particular responsibility for the Roman Catholic community in the Trust's hospitals (0.5 WTE)
- Rev Jillianne Norman, Team Chaplain with particular responsibility for second stage care and care of the older person (0.5 WTE)
- Imam Rafiqul Alam (0.1 WTE) is employed with particular responsibility for Muslim patients (funding is provided by Above and Beyond for this post).
- Supplementary team chaplain bank hours (0.2 WTE)

This team provides cover across all of UH Bristol's services, including South Bristol Community Hospital.

We also enjoy the services of three Honorary Chaplains, who provide occasional additional chaplaincy support via the Temporary Staffing Bureau ('Bank'), to cover periods of sickness or general short staffing.

The Patient Affairs team has also experienced some changes of staff during 2015/16. At the end of March 2016, the team comprised:

- Robert "Bob" Baker – Team Leader (0.8 WTE)
- Kath Billsberry (0.6 WTE)
- Amanda Lynn (0.6 WTE)
- Diane Kennington and Sue Champion provide Bank support

4. Chaplaincy activity

Chaplains record the visits they make on Medway. This information sits within the patient profile and is accessible to any member of staff who uses the system. The information recorded provides a factual record of when the visit took place and any religious rites performed.

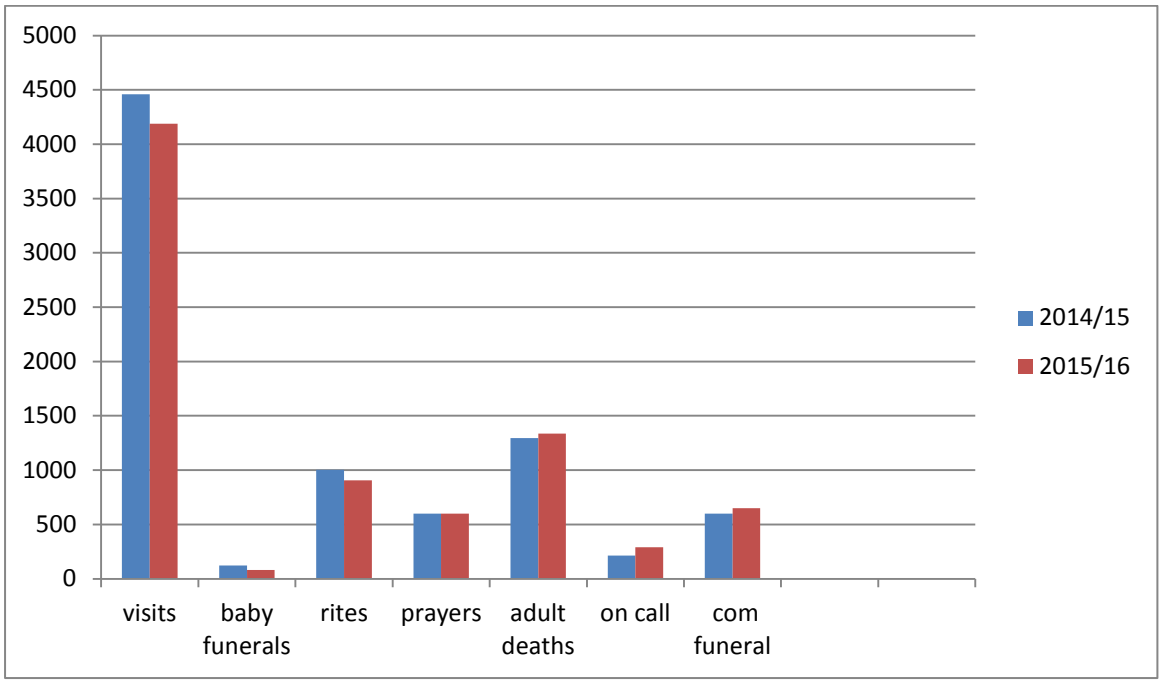
4.1 Chaplaincy visits

During 2015/16, the chaplaincy team recorded 4,188 'significant visits' with patients across UH Bristol. A 'significant visit' is one where either the conversation itself was a long one and/or the conversation itself was a particularly important one for the patient (the decision to record or not is made by the chaplain or volunteer on a case by case basis). It is noteworthy that many of the visits carried out were to patients for whom the Medway system does not record a religious affiliation.

A proportion of the work carried out by chaplains involves visits to patients in palliative care situations. This includes not only patients in the Bristol Haematology and Oncology Centre, but also those in the four Continuing Health Care funded beds at South Bristol Community Hospital as well as elsewhere around the Trust. Records on the Medway system show 195 recorded visits with this group of patients during 2015/16.

Although chaplains currently have no means of recording the encounters they have with staff, chaplains spend a significant proportion of their time supporting staff through private traumas and difficulties which arise as a result of the difficult jobs they do.

Figure 1 – A comparison of significant activity over the last two years



4.2 Rites performed

During 'significant visits', there were 906 occasions in 2015/16 when patients requested a variety of Christian religious rites which the chaplains carried out with them. So only a small proportion of significant visits resulted in a religious rite being performed; this shows that chaplains are not just visiting people who want religious rites, but are mostly visiting those who simply want trained pastoral support during a time of crisis. It is also interesting to note that many of those receiving religious rites had no known faith affiliation recorded in Medway.

4.3 Baptisms and Blessings

During the year, there have been 13 baptisms across the Trust. There were also 38 blessings of babies, undertaken at the request of their parents.

4.4 Baby Funerals

Chaplains undertake funerals for the majority of the stillbirths and non-viable foetuses born in St Michael's Hospital, as well as babies who die on the Neonatal Intensive Care Unit (NICU) without ever having gone home. In the past year, 82 funerals were undertaken. Funerals are tailored to the needs of the parents, whether they are of a particular faith or none. Most of these services were attended by parents, and many by members of the wider family.

In addition, chaplains undertake the disposal of the products of conception, of which there were 650 in the period 2015/16. These are cremated communally. Parents are told when these services take place, but do not attend.

4.5 On-call

In the period 2015/16, the chaplains were called to emergencies on 289 occasions.

4.6 The wider contribution of Chaplains

Trust committees and working groups

- **Equality and Diversity** – The Chaplaincy Team Leader is a member of the Equality and Diversity Group, bringing a religious, spiritual and cultural perspective.
- **End of Life –** The Chaplaincy Team Leader is a member of the End of Life Steering Group, which meets every two months, offering to the group insights from the pastoral support that chaplains offering End of Life care provide to patients and seeking to bring a spiritual and religious perspective to discussions.
- **Patient Experience Group –** The Chaplaincy Team Leader is a member of this group, for which an annual report is prepared.
- **Voluntary Services Steering Group**

Multi-Disciplinary Team Meetings

Chaplains routinely attend a number of multidisciplinary team meetings. Their presence at the meetings allows them to be aware of any ongoing medical or social issues which are affecting the care of patients they are visiting. It may also inform the way in which they approach visiting and can give chaplains a forum which enables them to feed back to the multidisciplinary team any insights which they have gained from their visits. These include:

- **Oncology and Palliative Care** – Rev Graham Reaper-Brown attends the weekly MDT meeting.
- **PICU -** Rev Steve Oram attends as trust chaplain with special responsibility to the children's hospital.
- **Bereavement Forum for St. Michael's Hospital** – Rev Steve Oram attends
- **Integrated Care Round** – Steve Oram attends Tuesday morning meetings in the Neonatal Intensive Care Unit (NICU) at St Michael's Hospital.

Nurse Assistant Training

We contribute to the monthly teaching sessions as part of Essential Care training, introducing the department to Nurse Assistants in training. The session is designed to help staff think about how they can help provide spiritual and pastoral care for their patients.

4.7 Chaplaincy Volunteers

At the end of 2015/16, UH Bristol had a total of 35 registered chaplaincy volunteers working with the department in a variety of capacities.

4.8 City-wide Christmas Carol Service

For a number of years, the department has organised a city-wide Carol Service for UH Bristol and NBT staff.

4.9 Courses attended by Chaplains in 2015/16

Chaplains undertake regular personal development activities. For some of the team, this also contributes to maintaining their professional registration with the UK Board of Healthcare Chaplaincy.

4.10 Students

When requested we will provide placements for chaplaincy students. In particular, the chaplaincy provides week-long placements for students who are in the final year of training at Trinity College, Bristol.

5. Patient Affairs (Bereavement Services)

In 2015/16, Patient Affairs dealt with 1,335 adult deaths. In the same period, 600 products of conception were cremated through collectives at South Bristol Crematorium. Parents are notified of the dates of the cremation, but do not attend the service which precedes it.

82 funerals were organised and taken by the chaplains for Stillbirths, Non-Viable Foetuses and babies dying on the Neonatal Intensive Care Unit (NICU).

6. Redevelopment

It is intended that the current chaplaincy offices and sanctuary in the Bristol Royal Infirmary will be relocated to the King Edward Building towards the end of 2016. The conversion of the building is now well underway and it is planned that we will move in late September. This work will also provide new accommodation for Patient Affairs and the Mortuary. A representative from the chaplaincy team, Jillianne Norman, has provided significant support for this project.

7. 2016/17 Plans

A detailed annual work plan for pastoral and spiritual care is in the process of being drawn up for approval by the Patient Experience Group in August (the first time that a formal work plan for the service will have been put in place). The plan includes:

- Work on the application and implementation of new Department of Health guidelines regarding Medical Examiners
- Development of a Strategy for Pastoral Care
- Support, training and development opportunities to enable the integration of recent new recruits to the chaplaincy team
- Work on new ways to use the new sanctuary and what might be offered to both staff and patients
- Developing a new training course for chaplaincy volunteers

Minutes of the Meeting of the Trust Board of Directors held in Public on Tuesday 28 June 2016 at 15:00, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Board members present:
John Savage, Chairman
Emma Woollett, Non-Executive Director / Vice-Chair
Robert Woolley, Chief Executive
Carolyn Mills, Chief Nurse
Paula Clarke, Director of Strategy and Transformation
Paul Mapson, Director of Finance and Information
Sean O'Kelly, Medical Director
Owen Ainsley, Interim Chief Operating Officer
Alison Ryan, Non-Executive Director
Jill Youds, Non-Executive Director
John Moore, Non-Executive Director
Julian Dennis, Non-Executive Director
Lisa Gardner, Non-Executive Director

In attendance:
Alex Nestor, Deputy Director of Workforce and Organisational Development (attending in place of Sue Donaldson)
Pam Wenger, Trust Secretary
Sarah Murch, Membership & Governance Administrator (minutes)
Clive Hamilton, Public Governor
Mo Schiller, Public Governor
Sue Silvey, Public Governor
Carole Dacombe, Public Governor
Tom Frewin, Public Governor
Hussein Amiri, Public Governor
Angelo Micciche, Patient Governor
Kathy Baxter, Patient Governor
Garry Williams, Patient/Carer Governor
Florene Jordan, Staff Governor
Jeanette Jones, Appointed Governor / Joint Union Council
Fiona Reid, Head of Communications
Alison Grooms, Deputy Chief Operating Officer
Philip Kiely, Divisional Director
Louise Couzens, Care Quality Commission Inspector
Nikki Evans, Care Quality Commission inspector
Wendy Bateman, Member of the Public (items 1-2 only)
Tony Watkin, Patient Experience Lead (Engagement and Involvement) (items 1-2 only)
Caroline Beale, Patient Safety Programme Manager (items 1-2 only)
Alistair Haigh, Acting Divisional Director (items 1-2 only)

42/06/16 Chairman's Introduction and Apologies (Item 1)
John Savage, Chairman, welcomed everyone to the meeting. Apologies for absence were received from Guy Orpen, Non-Executive Director, David Armstrong, Non-executive Director, and Sue Donaldson, Director of Workforce and Organisational Development. John extended a particular welcome to Nikki Evans and Louise Couzens, Care Quality Commission inspectors, and also to those newly-elected governors who had taken up

office on 1 June and were attending their first Board meeting. He also welcomed Wendy Bateman, who was in attendance to share her patient story under item 2.

43/06/16 Patient Story (Item 2)
The purpose of this item was to set a patient-focussed context for the meeting, and to enable Board members to understand the impact of patient experience. Carolyn Mills, Chief Nurse introduced this month's patient story from Wendy Bateman.

Wendy told the Board the story of her mother, who had attended the Bristol Heart Institute in December 2015 for a routine heart valve operation. The operation appeared to have been successful; however, Wendy had felt that once on ward C708 her mother had not received the clinical care that she needed. In particular she was concerned that nursing staff had not seemed to notice that her mother was not drinking a lot and that something was wrong. Wendy had raised her concerns with nursing staff at the time, but they had not been acted upon, which she was concerned was due to a lack of availability of doctors on a bank holiday. On the following day, her mother had been rushed back to the Cardiac Intensive Care Unit with dehydration and kidney failure, which had then necessitated a four-month stay in hospital.

Alistair Haigh, Acting Divisional Director, informed the Board of the actions taken by the Division following the issues raised by Wendy. Wendy had helped Alistair to formulate an action plan around ward-based care and escalation to medical staff. As a result a plan had now been implemented to monitor patients who were one step down from critical care. Additional training was also being implemented on Early Warning Scores, and staffing arrangements had been reviewed to ensure that there was a resident registrar on site 24 hours per day.

John Savage expressed his sincere regret to Wendy for her mother's experience. Robert Woolley added his gratitude to Wendy for taking the time to work with the Trust to make improvements to the service for others.

There followed a discussion about the issues raised by Wendy's experience. Alison Ryan, Non-executive Director, commented that Wendy's experience had illustrated the need to reinforce the ability of professional staff to recognise the invaluable insight of the carer into the deterioration of their person that they care for.

Lisa Gardner, Non-executive Director sought assurance that improved measures to monitor fluid intake would be implemented throughout the hospitals. Carolyn Mills explained that the measures described were designed to ensure a higher level of monitoring in areas for higher-dependency patients.

John Moore and Emma Woollett, Non-executive Directors, enquired whether there was a need for training and empowerment of nursing staff to give them the confidence to take action if they could see a problem and a doctor was not available. Carolyn Mills responded that escalation procedures would be considered as part of the actions arising from this event. She also agreed to provide data on the Trust's response to elevated Early Warning Scores, which included appropriate escalation, to the next Quality and Outcomes Committee meeting. It was:

MEMBERS RESOLVED TO:
- **Agree** that the Chief Nurse will provide data on Early Warning Scores to the July Quality and Outcomes Committee meeting.

44/06/16 Declarations of Interest (Item 3)
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. There were no new declarations made.

45/06/16 Minutes from previous meeting (Item 4)
The Board considered the minutes of the meeting held in public on 26 May 2016. Subject to the correction of a minor typographical error on page 16, it was:

MEMBERS RESOLVED TO:
- **Approve** the minutes of the meeting held on 25 May 2016 as a true and accurate record of proceedings

46/06/16 Matters Arising (Item 5)
Outstanding and completed actions were noted by the Board.

47/06/16 Chief Executive's Report (Item 6)
The Board received a report summarising the key business issues considered by the Senior Leadership Team in June 2016.

Robert Woolley, Chief Executive, highlighted several further matters. Firstly, the topping-out ceremony for the new façade of the Bristol Royal Infirmary had been held last week. He welcomed the significant improvement to the streetscape and the professional exterior that the façade presented.

Robert Woolley advised the Board that the conclusion of the Independent Review into Children's Congenital Heart Services in Bristol conducted by Eleanor Grey QC was expected on 30 June. There would be much media interest in the review findings and he assured the Board that significant preparation had been undertaken to ensure that all internal and external stakeholders had been fully briefed. The Trust did not yet know the content of the report but had committed to being fully open and transparent, creating a dedicated space on the Trust website where the report and responses would be published, and taking care to ensure that referring hospitals, clinicians and families in the Trust's care were assured about the service that the Trust was currently running. He committed to acknowledge mistakes that had been made in the past, including occasions when care had fallen below acceptable standards in the case of some children, and he would apologise to the families where this had happened. However, there was a duty to reassure families in the Trust's care and the wider population that there was significant external assurance in relation to both the Trust's surgical results and also the quality of the experience of the majority of families. This was evidenced by regular surveys, the Care Quality Commission expert case note review report (which had looked at a sample of the most complex cases in this service and had found no significant concerns and some examples of good practice), and the Care Quality Commission inspection report from 2014 (which had rated the services for children and young people at this Trust as good across the board and outstanding for their effectiveness). He undertook to keep staff and governors updated.

There were no comments or questions from the floor. John Savage voiced his support for Robert Woolley and gave his assurance on behalf of the Board that the Trust had done everything it could to support the Review. The support of the Board for the staff of Bristol

Royal Hospital for Children was noted who continued to provide the best care they could for children on a daily basis.

MEMBERS RESOLVED TO:
- **Note** the report from the Chief Executive.

48/06/16 Quality and Performance Report (Item 7)
Owen Ainsley, Interim Chief Operating Officer, presented this report, the purpose of which was to review the Trust's performance on Quality, Workforce and Access standards.

He summarised the report and it was noted that the initial signs of recovery against a range of access standards seen in April continued into May, following the easing of emergency pressures, though overall demand was still 3% higher than the same period last year. The month had seen slightly lower bed occupancy and the number of cancelled operations was showing an improved situation as well.

The number of patients waiting over 18 weeks from Referral to Treatment (RTT) had decreased slightly, with the 92% national standard and stretch target of 92.6% being achieved at month-end. However, in same period there was a rise in the outpatient waiting list partly due to an external growth in demand, which posed a risk to continued achievement of the Referral to Treatment targets in the next quarter.

There had been improvement in the Trust's 6-week diagnostic performance, and Owen Ainsley drew particular attention to sleep studies, where there had been an increase in demand, and endoscopy, where he highlighted a risk due to around 260 cases lost as an effect of the junior doctors' industrial action coupled with delays in planned recruitment.

In relation to cancer performance, the 62 day target continued not to be met, but remained above trajectory. Late referrals from other Trusts had been an issue in relation to this metric and also delays resulting from the centralisation of histopathology services at North Bristol Trust (NBT) in May which will impact on future performance. Owen gave his assurance that UH Bristol was working with NBT on a recovery plan in this regard.

He highlighted the strong performance on a range of Quality indicators, including the timeliness of reporting and investigation of Serious Incidents, achievement of the Green threshold for the National Early Warning Scores (NEWS) acted upon for deteriorating patients, along with sustained good performance for a number of other indicators of good patient safety, including non-purposeful omitted doses of listed critical medication, Safety Thermometer measures of Harm Free Care, and the rate of inpatient falls and pressure ulcers per 1,000 bed-days.

Sean O'Kelly, Medical Director, drew the Board's attention to better-than-average mortality figures, but highlighted that the Trust's performance in treating patients with fractured neck of femur was still not satisfactory. He was awaiting a report from the British Orthopaedic Association on this issue and he assured the Board that the Division was already starting to formulate an action plan to address the issues.

In relation to the workforce metrics, the Board noted that recruitment and retention remained key issues. While some metrics had improved, such as sickness absence, agency use remained high due to additional demand. Alex Nestor, Deputy Director of Workforce and Organisational Development, brought the Board's attention to the risk

around essential training in the areas of fire safety and information governance which were below expectations. Work was ongoing with divisions to agree the trajectories in July.

Emma Woollett enquired about the progress of recruitment compared with the trajectory, particularly in challenging areas such as Heygroves Theatres. It was noted that the gap was narrowing but that there were still issues to overcome in this regard.

MEMBERS RESOLVED TO:
- **Note** the Quality and Performance Report for assurance

49/06/16 Quality and Outcomes Committee Chair's Report (Item 8)
Alison Ryan gave a verbal report on the business of the Quality and Outcomes Committee (QOC) meeting held on 28 June 2016.

Members noted that the Committee had received a presentation on Paediatric Bereavement Support and had gained a good understanding of the value and need for this service. They were confident that the service was able to identify parents who needed extra support and give them the help they required. Committee members had found it particularly encouraging that bereavement support was not just the job of this team, but that they also supported other members of staff in their communication with families, in particular in identifying a key point of contact for each family.

It was noted that the Quality and Outcomes Committee had considered the Quality and Performance Report at some length, in particular Fractured Neck of Femur targets, the number of patients waiting over 18 weeks for referral-to-treatment, and cancer waits (including the planned improvements and their impact on lung cancer). They welcomed the significant improvement in Early Warning Scores acted upon which had increased from 87% in April to 100% in May. They would be monitoring the issues around the transfer of cellular pathology to North Bristol Trust to ensure that the problems were transitional rather than long-term.

The committee had looked into the use of non-registered nurses and had cautioned that this should happen only where it was safe to do so and that Trust should ensure that staff could still request registered nurses where needed. They had received an annual report on infection control, and noted that rates of immunisation of staff would need to improve as there would shortly be a Commission for Quality and Innovation (CQUIN) payment relating to this measure. They had also considered the Complaints and Patient Experience Reports, particularly response times to complaints and the quality of complaints responses. They were pleased to note that complaints in relation to Ward A900 (cystic fibrosis patients) seemed to be reducing.

At their next meeting, the Quality and Outcomes Committee would receive a report on the governance and assurance measurements for the virtual ward scheme provided by Orla Healthcare.

MEMBERS RESOLVED TO:
- **Note** that the report from the Quality and Outcomes Committee Chair's Report for assurance.

50/06/16 Terms of Reference for Quality and Outcomes Committee (Item 9)
The purpose of this report was to approve the Terms of Reference for the Quality and Outcomes Committee following their annual review by the Committee.

Significant amendments to the Terms of Reference had been made in 2015. This year, there was only minor change: updating the reference from Monitor to NHS Improvement in section 2.1.1. Subject to this amendment and the correction of an additional typographical error noticed by Julian Dennis.

MEMBERS RESOLVED TO:
- **Approved** the Terms of Reference for the Quality and Outcomes Committee.

51/06/16 Strategic Planning and Implementation Framework (Item 10)
Paula Clarke, Director of Strategy, introduced this item, the purpose of which was to provide an update to the Trust Board and assurance on the development and delivery of a revised approach to the planning, development and implementation of strategy within the Trust.

Paula Clarke summarised the revised approach as covering the following areas of focus:
1. The Trust's strategic governance structure;
2. A stocktake of the content, alignment and consistency of existing and future Trust Strategies;
3. The Strategic Implementation Framework, including;
    a. Prioritisation of Clinical Strategy
    b. A standardised framework and tools for development and route map for implementation
    c. Renewing our Hospitals – a revised strategic capital prioritisation process
4. A full refresh of the Trust Strategy – with consideration of the context of the developing local Sustainability and Transformation Plan.

Paula Clarke drew the Board's attention to the outline timelines and cautioned that the timelines for the next decisions on strategic capital may be subject to change due to internal and external factors. It was:

MEMBERS RESOLVED TO:
- **Note** the Strategic Planning and Implementation Framework.

52/06/16 Complaints and Patient Experience Quarterly Reports (Item 11)
Carolyn Mills, Chief Nurse, introduced this report, the purpose of which was to provide the board with a summary of patient-reported feedback and complaints received during Quarter 4 of 2015/16.

Complaints: The Trust had received 476 complaints in Quarter 4, representing an increase of approximately 7% compared to Q3 and an 8% decrease on the corresponding period one year previously. There was a continued focus on complaints responded to within timescale and concentrated work ongoing on the quality of complaints responses.
Members noted that training had now been rolled out by the Patient Support & Complaints Team on how to write a good response letter, including a checklist when writing complaints responses to make sure that people deal adequately with all the issues raised.

Patient Experience: All of the Trust's key survey metrics remained "green" in Quarter 4 – indicating a high quality patient experience. Survey scores showed improvement for ward A900, following service improvements in response to dissatisfaction amongst patients with Cystic Fibrosis. There was however action needed by Ward 38B (paediatric neurology) to address low patient experience ratings for 'kindness and understanding'.

Carolyn Mills added that the Q4 report had for the first time included divisional responses to negative comments made by patients via the Friends and Family Test (FFT).

Jill Youds referred to the categorisation of complaints by sub-category and asked whether there was a general issue underpinning the 51% increase in Q4 in complaints in which communication with a patient/relative was a key factor, or whether it was specific to place. Carolyn Mills responded that there had been no Trust-wide themes arising from this metric and that there were a variety of issues underpinning it.

John Moore made reference to complaints about patient letters containing inaccurate contact details for Trust staff, and asked who was responsible for checking the accuracy of departmental data in patient letters. Alison Grooms explained that previously, Trust staff did not have much control over the ability to edit letters; however, measures had been put in place last year which should change this. Alison Ryan added that it might be useful for one of the governor focus groups to receive an update on this work.

Clive Hamilton, Public Governor, referred to the risk highlighted in the report that complaints investigations and responses may not be given appropriate priority due to other conflicting pressures, and he enquired as to the guidance received by staff as to the prioritisation of complaints. Carolyn Mills explained that this was a risk that the Board needed to be aware of, but she voiced confidence that the work of responding to complaints was being dealt with appropriately.

Garry Williams, Patient/Carer Governor, expressed his appreciation of the Patient Support and Complaints Team, which he had found to be very supportive and responsive when he had recently had cause to use it. He enquired about the report's findings of complaints relating to failures to answer the telephone, of which he had personal experience. Carolyn Mills responded that there was a workstream ongoing on this issue as it was the theme of one of this year's quality objectives. There was due to be a pilot project in Bristol Dental Hospital, which would be monitored and potentially rolled out across the Trust.

MEMBERS RESOLVED TO:

- **Note** the quarterly Patient Experience and Complaints Reports; and
- **Agree** that an update on the Patient Letters workstream be provided to a governor meeting.

53/06/16 Finance Report (Item 12)

Paul Mapson, Director of Finance, provided an update to the Board on the Trust's financial position at month two. Paul Mapson highlighted a number of uncertainties in relation to targets, funding, and rules if targets were not achieved.

The summary income and expenditure statement showed a surplus of £1.861m (before technical items) for the first two months of the year. The 2016/17 financial plan, which

included receipt of £13.0m sustainability funding, was to deliver a surplus of £14.2m before technical items. At month two the Trust was £0.550m adverse to plan, largely due to nursing pay both in terms of agency and demand.

The delivery of activity had been encouraging, particularly elective activity, and for first time ever, the Trust was overspending on capital expenditure, which was a positive sign as it meant that it was delivering the capital schemes that it had agreed to fund.

He highlighted uncertainties nationally which could affect the Trust, in relation to the funding of acute trusts, and also due to the UK vote to leave the European Union in the recent referendum.

MEMBERS RESOLVED TO:
- **Note** the Finance Report.

54/06/16 Finance Committee Chair's Report (Item 13)
Lisa Gardner, Chair of the Finance Committee, reported the business discussed at the meeting of the Finance Committee on 27 June 2016.

Members noted that the Finance Committee had received a presentation from the Division of Surgery Head and Neck on new ways of working and action plans. The Committee had discussed key risks including the agency cap, contract growth, recruitment challenges, the savings programme, and junior doctors' expenditure. Controls on nursing and how these were being implemented were discussed, as were recruitment issues in endoscopy and their effect on performance. The committee had been advised of current pressures facing Trauma and Orthopaedics which were structural in nature and were affecting the entire region. At next month's Committee meeting there would be a presentation from the Women's and Children's Division.

Julian Dennis referred to the agency cap and asked whether the Trust could influence the behaviour of the agencies in any way. Paul Mapson responded that there was little that the Trust could do in this regard.

MEMBERS RESOLVED TO:
- **Receive** the Finance Committee Chair's report for assurance

55/06/16 Monitor Q4 Risk Assessment Framework Feedback (Item 14)
Robert Woolley introduced this report, the purpose of which was to inform the Trust Board of Monitor's analysis of the Trust's Quarter 4 submission. He welcomed the news that Monitor (now NHS Improvement) had given the Trust a Continuity of Services Risk Rating of 4 and a Governance Risk Rating of Green.

He added that contrary to the written report, Monitor was not 'returning' the Trust to a governance rating of Green, as the Trust had in fact been rated Green all year due to its robust recovery plans.

MEMBERS RESOLVED TO:
- **Note** the Monitor Q4 Risk Assessment Framework Feedback; and
- **Note** the correction to the report in relation to the green rating for the entire year.

56/06/16 Corporate Governance Self-Certification (Item 15)
Robert Woolley introduced the report which provided the necessary assurance for the Board to enable approval of the proposed Corporate Governance Statement for submission to NHS Improvement on 30 June 2016. He explained that the requirements changed slightly each year and asked the Board to agree that the assurances described in the paper were sufficient to certify each statement. The Board approved the statements with no amendments.

MEMBERS RESOLVED TO:
- **Approve** the Corporate Governance Statement for submission to NHS Improvement on 30 June 2016.

57/06/16 Register of Seals (Item 16)
Members received the report and noted on the application of the seal in the last quarter in accordance with the Standing Orders.

MEMBERS RESOLVED TO:
- **Note** the report and the register of seals for the last quarter.

58/06/16 West of England Academic Health Science Network Board Report June 2016 (Item 17)
Robert Woolley introduced this report updating the Boards of the member organisations of the West of England Academic Health Science Network of the decisions, discussion and activities of the Network Board. Emma Woollett welcomed the report's findings that UH Bristol's participation was leading to clear benefits. Robert Woolley cautioned that the funding envelope for WEAHSN was at risk, but that it was likely to remain in place for at least the next four years.

MEMBERS RESOLVED TO:
- **Note** the report from the West of England Academic Health Science Network.

59/06/16 Audit Committee Chair's Report (Item 18)
John Moore introduced the report of the business discussed at the meeting of the Audit Committee on 24 May 2016 (of which a verbal report had already been given to May Board meeting) and 7 June 2016.

Members noted that one of the issues considered by the Audit Committee was the ongoing progress in the Estates and Facilities Department in relation to controls and habits around their procurement system. The Committee had received assurance that new controls were being embedded and that this would be subject to a follow up audit later in the year.

Members noted that counter fraud training had been brought in line with national recommendations. The totals for the quarter for Losses and Compensations were significantly higher than typically reported but reflected the approach taken towards the year-end, with a number of aged debts that had been deemed to be unrecoverable.

Internal audit reports had been discussed in the areas of the management of resuscitation equipment, infection control, management of waiting list initiatives and e-rostering. The Risk Management Group had been challenged to consider if any areas that were not currently monitored should be monitored.

An update from the Clinical Audit team had revealed that almost all Priority 1 Audits had been completed. In addition the committee had reviewed the policy on the Register of Interests, Gifts and Hospitality and also the Register itself.

Jill Youds raised an issue in relation to Cyber Security and there was a discussion in relation to the current controls in place. Paul Mapson confirmed that scrutiny largely took place at the point when bogus suppliers tried to invoice the Trust. In response to a further question from Jill Youds about handling protocols, Paul Mapson assured the Board that controls were as good as they could be.

MEMBERS RESOLVED TO:
- **Note** the Audit Committee Chair's report for assurance.

60/06/16 Governors' Log of Communications (Item 19)
The report provided the Trust Board with an update on governors' questions and responses from Executive Directors. John Savage added he was aware that two additional questions would be added to the Governors' Log in relation to volunteers' uniforms and the remaining work outstanding to improve the pavement outside the Bristol Royal Infirmary.

MEMBERS RESOLVED TO:
- **Note** the Governors Log of Communications.

61/06/16 Any Other Business (Item 20)

a) Jeanette Jones, Royal College of Nursing lead, invited the Board to afternoon tea at the Bristol Heart Institute, at 2-4pm on 16 August to celebrate the 100th birthday of the Royal College of Nursing.
b) Garry Williams, Patient Carer governor asked that access to the drop-off facilities outside the Bristol Royal Infirmary be kept under observation once the work on the façade was complete.
c) Angelo Micciche, Patient Governor, reported that while in hospital last Friday, he had noticed that news of the exit of the UK from the European Union had deeply worried some members of staff and he asked whether any reassurance from the Board had been provided to staff on this matter. Robert Woolley responded that he had written a statement in this week's staff e-bulletin Newsbeat to reassure staff that nothing would change for at least two years, that NHS had always needed to supplement staff from overseas, and to emphasise that at UH Bristol staff from the EU were greatly valued.

Meeting close and Data and Time of Next Meeting
There being no other business, the Chair declared the meeting closed at 12.30pm. The next meeting of the Trust Board of Directors will take place on Thursday 28 July 2016 at 11:00-13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

Trust Board of Directors meeting held in Public 28 June 2016
Action tracker

Outstanding actions following meeting held 28 June 2016					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**181/02/16**	The Board to receive an update on the major strategic schemes for consideration and prioritisation.	Director of Strategy & Transformation	Autumn 2016	Update provided at the Board in June 2016. Further update to be provided following the completion of the process.
Completed actions following meeting held 28 June 2016					
2	**43/06/16**	Agree that the Chief Nurse will provide data on Early Warning Scores to the July Quality and Outcomes Committee meeting.	Chief Nurse	July 2016	**Completed.** Added to the agenda plan for QoC July 2016.
3	**31/05/16**	The Board to receive, as part of the Quality and Performance Report, comparative performance figures for the access and quality standards.	Medical Director	July 2016	**Completed.** To be included within the next exception report for review by the Quality and Outcomes Committee

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 July 2016 at 11.00 am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
06. Chief Executive's Report									
Sponsor and Author(s)									
Sponsor & Author: Robert Woolley, Chief Executive									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.

Key issues to note
The Board will receive a verbal report of matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in July 2016.

Recommendations

The Trust Board is recommended to note the key issues addressed by the Senior Leadership Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.

Impact Upon Board Assurance Framework

The Senior Leadership Team is the executive management group responsible for delivery of the Board's strategic objectives and approves reports of progress against the Board Assurance Framework on a regular basis.

Impact Upon Corporate Risk

The Senior Leadership Team oversees the Corporate Risk Register and approves changes to the Register prior to submission to the Trust Board.

Implications (Regulatory/Legal)

There are no regulatory or legal implications which are not described in other formal reports to the Board.

Equality & Patient Impact

There are no equality or patient impacts which are not addressed in other formal reports to the Board.

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JULY 2016

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in July 2016.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **noted** the impact and risks around the revised payments for additional hours worked by consultant staff in a number of specialties that had been implemented and **agreed** the need to urgently explore further options to avoid breaching Referral to Treatment performance trajectories.

The group **supported** the recommendation to declare the standards failed in quarter 1 to be the Accident and Emergency 4-hour standard, the 31-day first definitive, the 31-day subsequent surgery, the 62-day GP and 62-day Screening cancer standards. It was also **supported** to recommend the ongoing risks to achievement of the 62-day screening and 62-day GP cancer standards and the Accident and Emergency 4-hour standard be flagged as part of the narrative that accompanied the declaration.

The group **received** an update on the current financial position for 2016/2017.

3. STRATEGY AND BUSINESS PLANNING

The group **noted** an update the Operating Plan 2016/2017.

The group **agreed** further discussion was required on the proposed scoring matrix and prioritisation process for the allocation of strategic capital.

The group **agreed** further standardised sessional payments for additional work by junior doctors and dentists in the Trust.

The group **noted** an update on the National Staff Health and Wellbeing CQUIN, including an influenza vaccine update) and **supported** the action plan and communications for the flu campaign in 2016/2017.

The group **noted** an update on the new apprenticeship framework being implemented in 2017 and **supported** the establishment of a steering group to take this forward.

4. RISK, FINANCE AND GOVERNANCE

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

The group received and **noted** the Quarter 1 2016/2017 Themed Serious Incident Report, prior to submission to the Quality and Outcomes Committee.

The group received and **noted** the Quarter 1 2016/2017 update on Corporate Quality Objectives.

The group **received** the headline results and local analysis report in relation to the 2015 National Inpatient Survey for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **received** the Board Assurance Framework 2016/2017 Quarter 1 update prior to onward submission to the Trust Board.

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

The group **received** the revised Risk Management Strategy and Risk Management Policy prior to onward submission to the Trust Board.

The group **approved** the Education Annual Report, Equality and Diversity Annual Report and Complaints Annual Report 2015/2016 for onward submission to the Trust Board.

The group **approved** the terms of reference for the Senior Leadership Team as part of their annual review.

Reports from subsidiary management groups were **noted,** including updates on the current position following the transfer of Cellular Pathology to North Bristol Trust and on the Transforming Care Programme.

The group **received** two low impact Internal Audit Report in relation to Serious Incident Management and Pharmacy Controlled Drugs.

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

The group **noted** concerns regarding the project to implement a replacement Pathology system (LIMS).

5. RECOMMENDATIONS

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

Paul Mapson
Acting Chief Executive
July 2016

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
07. Independent Review of Children's Cardiac Services in Bristol									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author:** Robert Woolley, Chief Executive									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

The purpose of this paper is to report to the Board the outcome of the Independent Review of Children's Cardiac Services in Bristol and the Trust's response to the reports published on 30 June.

The main conclusions of the Independent Review and the related Care Quality Commission expert case review are given in the paper. The Trust fully accepts the findings of both these reports and welcomes their publication as a way to learn from mistakes.

As the reports acknowledge, we have already acted to improve the care and support children and their families receive and there are areas where the investigation teams saw examples of good practice. However, we know there are improvements still to be made and we will act with determination and pace to deliver on the recommendations within these reports. In formulating our plans, we aim to make a partnership with parents the fundamental building block of our approach.

A schedule of all the recommendations is provided, along with proposed organisational and individual ownership. A governance structure for oversight of the work programme is also proposed.

The Chief Nurse will be the Board sponsor of the work programme. A dedicated project manager has been appointed, hosted in the Division, to co-ordinate and support action planning, delivery, and progress reporting..

Recommendations

The Board is recommended to:

- Reiterate to the affected families how sorry we are for the things we got wrong – for when our care fell below acceptable standards, for not supporting some families as well as we could have and for not always learning adequately from our mistakes, adding to their distress at an already very upsetting time for them.
- Re-affirm its full acceptance of the recommendations of these reports.
- Acknowledge publicly the role which parents have played in bringing about significant changes in practice and in improving the provision of care in the paediatric cardiac service (Independent Review recommendation 31) and support this as an ongoing approach.
- Approve the allocation of responsibilities shown in Annex 5 for addressing the reports' recommendations.
- Approve the proposed governance structure set out in section 7 of this paper.
- Require monthly progress reports until further notice, starting with the next Trust Board meeting in September 2016.

Impact Upon Board Assurance Framework
This report is relevant to strategic priority 1 (we will consistently deliver high quality individual care, delivered with compassion) and the related risk of failure to act on feedback from patients, staff and our public.
Impact Upon Corporate Risk
Reputational risk applies.
Implications (Regulatory/Legal)
It is expected that the Trust's progress with delivery of the report recommendations will be monitored by regulators and commissioners.
Equality & Patient Impact
These reports have significant implications for the Trust's approach to partnership with families in the care of their child and wide-ranging recommendations for further improvement.

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources	✓	Buildings	

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

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

**INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES IN BRISTOL
JUNE 2016**

1. INTRODUCTION

This paper sets out the context for the Independent Review of Children's Cardiac Services in Bristol and the Trust's response to the reports published on 30 June.

The Board is asked to consider and agree the proposed allocation of responsibilities for delivery of the Review recommendations and the governance structure for oversight of the related work programme.

2. BACKGROUND

Concerns were raised by two families about the deaths of their children in March and April 2012, following cardiac surgery at the Bristol Royal Hospital for Children. Although the trust had received and responded to formal complaints from these families and sought to address their concerns to the best of its ability, they were not satisfied with our responses and contacted the Care Quality Commission (CQC). This prompted the CQC to inspect the children's cardiac ward and paediatric intensive care unit at the hospital in September 2012. This inspection found insufficient numbers of experienced staff to provide high dependency care on ward 32. The CQC served us a warning notice requiring improvement.

An unannounced follow-up inspection by the CQC in November 2012 reported improvements in nurse staffing, with adequate levels of suitably trained staff on ward 32 and high dependency provision in place on the paediatric intensive care unit.

A subsequent inspection in April 2013 found that the trust had taken action to ensure that children on ward 32 experienced care and treatment that met their needs. The trust opened a dedicated high dependency unit on ward 32 on a staged basis between April and September 2013, which remains part of our provision for sick children.

However, some of the families whom we had provided care for continued to voice their concerns. In February 2014, the Medical Director of NHS England commissioned an independent review of the children's cardiac service at the Bristol Royal Hospital for Children, in response to the continuing concerns by families. NHS England worked with the families to develop and publish terms of reference for the review and asked Eleanor Grey QC to lead it, with Sir Ian Kennedy acting as an advisor.

At the same time, in consultation with NHS England, the Chief Inspector of Hospitals for the CQC agreed separately to review the clinical outcomes of the service with support from the National Institute for Cardiovascular Outcomes Research and to conduct a clinical case note review, on a random sample of notes, to assess the care provided by the service. The purpose of the review was to provide an assessment of

current practice at the hospital. The review focused on surgical interventions undertaken in the three-year period between January 2012 and December 2014.

The Independent Review panel led by Eleanor Grey QC was able to study the findings of the CQC's work, prior to finalising its own report.

In September 2014 the CQC carried out a comprehensive inspection of University Hospitals Bristol NHS Foundation Trust, which included the services provided by the Bristol Royal Hospital for Children. Services for children and young people were rated as good overall and, specifically, good for safety, outstanding for effectiveness, good for caring, good for responsiveness and good for the 'well-led' domain.

In April 2016, the National Institute for Cardiovascular Outcomes Research reported that the 30-day survival for all heart surgery procedures at Bristol was comparable with all 14 children's specialist cardiac centres during the three-year period 2012 to 2015.

The reports of the Independent Review and the CQC expert review were published on 30 June 2016.

In 2015, NHS England published new commissioning standards for specialist congenital heart disease services, following extensive consultation with patients and their families, clinicians and other experts. Since then, hospital trusts providing these services have been asked to assess themselves against the standards, which came into effect from April 2016, and to report back on their plans to meet them within the set time-frames.

As a result of these assessments, and following further verification with providers, on 8 July 2016, NHS England announced how it intends – subject to necessary engagement and service change process in relation to this assessment – to take action to ensure all providers comply with the set standards. This included NHS England's announcement of its intention to support and monitor progress at University Hospitals Bristol (and a number of other recognised specialist surgical centres at major teaching Trusts) to assist us in our plans to fully meet the new commissioning standards which, as stated above, came in to effect in April of this year.

The Board will receive a separate report on the Congenital Heart Disease review.

3. FINDINGS

The executive summary of the Report of the Independent Review is attached at **Annex 1** and the CQC's report at **Annex 2**. We have published the full reports of both the Independent Review and the CQC on the Trust website.

Detailed conclusions and related recommendations are set out in each chapter of the Independent Review Report and it executive summary, and in the body of the CQC Clinical Case Note Review Report. The extracts below are drawn respectively from the Independent Review Report (the Executive Summary and Chapter 17, 'Concluding Remarks and Recommendations') and the 'Conclusions' section of the

CQC Report. They are reproduced faithfully here in their entirety and represent the published conclusions of each review.

Independent Review conclusions:

The Review reached the firm conclusion that there was no evidence to suggest that there were failures in care and treatment of the nature that were identified in the Bristol Public Inquiry of 1998-2001. The outcomes of care at the Children's Hospital were broadly comparable with those of other centres caring for children with congenital heart disease. There was evidence that children and families were well-looked after and were satisfied with the care their children received. There was, however, also evidence that, on a number of occasions, the care was less good and that parents were let down. The principal focus of the Review was on Ward 32 where children were cared for. It was clear that, particularly prior to the CQC's inspection in 2012, the nursing staff were regularly under pressure, both in terms of the numbers available and the range of skills needed. This led on occasions to less than good care for children and poor communication with parents and families.

The Review also reached the conclusion that, on occasions, the senior managers of the Hospital failed adequately to understand and respond effectively to the concerns of parents and adopted an unnecessarily defensive position in the face of the CQC's observations. This led to a deeply regrettable breakdown in communication which culminated in the commissioning of this Review.

…

We have noted what we consider to have been weaknesses in the response to evidence of risks on Ward 32, prior to the CQC inspection of September 2012, as well as strains on the capacity of outpatient clinics and the PICU.

Detailed review of individual families' concerns suggested that there were some flaws in the management of investigations, such as RCAs [root cause analyses] and CDRs [child death reviews], but viewed overall, we accept that these processes were reasonably thorough, and candid. We did not see evidence of attempts to mislead or to avoid confronting areas of weakness. The investigations formed the basis of much of the work set out in the action plan which followed the CQC inspection. In the Review's judgment, there had been substantial learning, within cardiac services, from the criticisms which had been voiced and the findings of the Trust's own reviews and investigations.

The process of investigating a number of complex complaints or concerns did not succeed in maintaining, or rebuilding, trust between a number of families and the UHB and its staff…

CQC expert case review conclusions:

Overall the expert panel found the standard of care provided, as evidenced by the cases reviewed, to be within the expected level of quality and comparable with other centres in the UK.

The clinical panel noted that the findings changed during the period under review with more extensive documentation towards the later part of this period and particularly after the opening of a dedicated high dependency unit towards the end of 2012.

There was evidence of good practice, especially in relation to documentation with some excellent examples in the high dependency unit and paediatric intensive care unit and in relation to child death reviews.

There was evidence of thorough investigation of incidents, with documented explanations and apologies to families, including appropriate reference to duty of candour. Action plans agreed as a result of incidents were seen to be monitored and actions completed.

The expert panel noted that the methodology of this review meant that the majority of cases reviewed were complex conditions. There were no concerns about the management of any individual case reviewed. Individual outcomes for the patients reviewed were within the expert panel's expectations.

4. TRUST RESPONSE

We fully accept the findings of both these reports and welcome their publication as a way to learn from mistakes.

We are deeply sorry for the things we got wrong - for when our care fell below acceptable standards, for not supporting some families as well as we could have and for not always learning adequately from our mistakes. This undoubtedly added to the distress of these families at an already very upsetting time for them. We did not get it right for them, and we have apologised to the families unreservedly, on behalf of everyone at the Trust.

We are pleased the review found our outcomes were comparable with other hospitals caring for children with heart conditions, and that there was evidence that children and families were well-looked after and satisfied with their care, but we want to get our care right for everyone, every time, especially so when it involves children.

As the reports acknowledge, we have already acted to improve the care and support children and their families receive and there are areas where the investigation teams saw examples of good practice. However, we know there are improvements still to be made and will act with determination and pace to deliver on the recommendations within the reports.

Parents have already played an important role in bringing about significant changes and in improving the care we provide. This includes the way we communicate with families.

In formulating our plans to deliver the recommendations of these reports, we aim to make a partnership with parents the fundamental building block of our approach.

5. COMMUNICATION WITH THE FAMILIES

We do not know the identity of all the families who contributed to the Independent Review. We have therefore posted an open letter on our website **(Annex 3)**, repeating our apology for the things we got wrong, acknowledging the role played by parents in bringing about significant improvements to care and inviting contact from any of these families who wish to discuss their own child's care or wish to register an interest in working more closely with us in future.

The letter also notes that a number of families gave the Independent Review panel permission to share with us the reports of their individual expert case-note reviews. The Division of Women's and Children's Services has been reviewing these reports to inform a personal response to each family concerned, which is being drafted and sent to each family as soon as possible.

A further open letter from the Clinical Chair of the Division to families currently under the care of the service invites any parents who have questions or concerns about their child's care in the light of the Independent Review to contact us. It also signposts a number of other sources of support and information such as support groups and websites.

6. ACTION PLANNING

As indicated above, we took immediate action following the CQC inspection in 2012 to make a range of improvements, including but not limited to the creation of a dedicated paediatric cardiac high dependency unit.

Chapter 14 of the Independent Review report recognises that "significant changes were made in the delivery of care on Ward 32 and in cardiac services more generally, in the wake of the CQC's inspection of September 2012" and that there has been "substantial learning, within cardiac services, from the criticisms which had been voiced and the findings of the Trust's own reviews and investigations".
The Review specifically highlights a number of important improvements it had noted:

- the process of obtaining consent
- arrangements to support the Joint Cardiac Conference
- measures to improve team-building and develop leadership
- introduction of a new Paediatric Early Warning Score system and new Paediatric 'Core Care Plans'
- family involvement in the development of a new protocol empowering parents to 'escalate' concerns about their child's clinical condition or care
- improvements in multi-disciplinary team communication and participation in ward rounds
- creation of the new high dependency unit and associated cover arrangements
- an investment of £1.6 million to increase the number of children's nurses to levels which support one nurse to three patients receiving care on the ward during the day and one to four at night, with one nurse to two patients in the Cardiac High Dependency Unit
- investment in a dedicated cardiac educator for PICU and Ward 32 to support staff in the development of clinical skills.

Notwithstanding the substantial progress already made, the Trust fully accepts that more needs to be done to meet the comprehensive and far-reaching recommendations of both the Independent Review and the CQC's expert case-note review.

Executive Directors have met with senior Divisional leaders to agree the approach to delivery of those recommendations that fall to the Trust, and to make sure we embrace and act upon any further learning from these reports and reviews.

The schedule at **Annex 4** sets out our current analysis of the organisation responsible for delivery of each recommendation and, where that organisation is the Trust, the designated corporate or divisional owner, as well as our initial assessment of the expected time to complete key first steps in each case.

The Chief Nurse will be the Board sponsor of the work programme. The role of the Chief Nurse as Board representative of Children's Services was strengthened in consultation with the Division in April 2015, but will be reviewed again in the light of Recommendation 22 from the Independent Review.

A dedicated project manager has been appointed, hosted in the Division, to co-ordinate and support action planning, delivery, and progress reporting to the Trust Board, the Senior Leadership Team, and other agencies as required.

7. PROGRAMME MANAGEMENT

A model of governance for the work programme to make decisions, deliver and report on all the recommendations relevant to the Trust is proposed as follows:

- A **steering group**, chaired by the Chief Nurse, and via her linked to the Executive Team and the Trust Board, will be responsible for oversight and co-ordination of the work programme and will include - at a minimum – the divisional Clinical Chair and relevant Clinical Director, and representatives of the children's cardiac service, the South West and South Wales Congenital Heart Network and parent support groups.
- In keeping with the Trust's commitment to strengthen its partnership with families, a **parent reference group** will be established to support the work of and advise the Steering Group. We will ask the parent reference group to provide assurance that plans to meet the recommendations take proper account of the needs and perspectives of families.
- **Working groups**, reporting to the steering group, will be established as needed to take discrete areas of the work programme forward, including but not limited to a review of the consent policy and process (Independent Review recommendations 13, 14, 16 and 17 and CQC recommendation 1) and subsequent actions, and a review of incident and complaints investigation processes and subsequent actions (Independent Review recommendations 26 to 30). The working groups will include appropriate front-line staff within the children's cardiac service and the wider Children's Hospital.

Figure 1 shows the proposed governance structure. External reporting arrangements will be agreed in due course with regulators, commissioners and local overview and scrutiny committees.

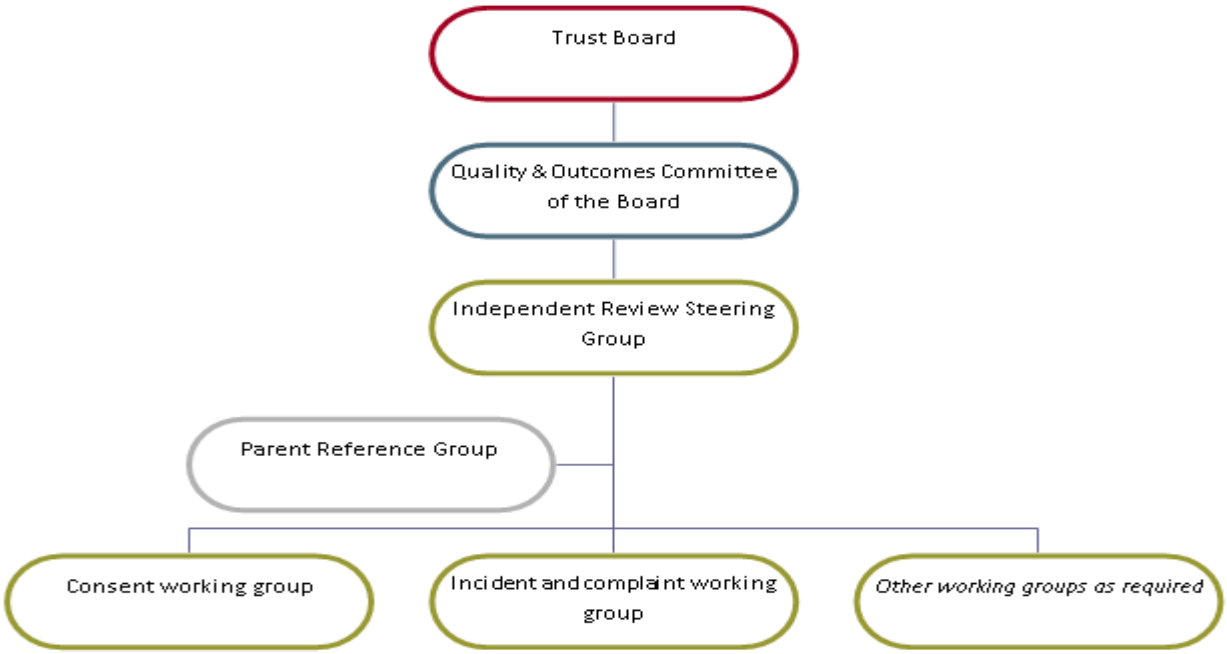


Figure 1. Proposed governance model.

8. RECOMMENDATIONS

The Trust Board is recommended to:

- Reiterate to the affected families how sorry we are for the things we got wrong – for when our care fell below acceptable standards, for not supporting some families as well as we could have and for not always learning adequately from our mistakes, adding to their distress at an already very upsetting time for them.
- Re-affirm its full acceptance of the recommendations of these reports.
- Acknowledge publicly the role which parents have played in bringing about significant changes in practice and in improving the provision of care in the paediatric cardiac service (Independent Review recommendation 31) and support this as an ongoing approach.
- Approve the allocation of responsibilities shown in Annex 5 for addressing the reports' recommendations.
- Approve the proposed governance structure set out in section 7 of this paper.
- Require monthly progress reports until further notice, starting with the next Trust Board meeting in September 2016.

Robert Woolley
Chief Executive
21 July 2016

EXECUTIVE SUMMARY

Introduction

1.1 This Review is concerned with the care of children born with congenital heart disease. It was commissioned in June 2014 by NHS England's Medical Director after hearing the concerns expressed by a number of families regarding the care and treatment of their children while patients in Bristol Royal Children's Hospital. The Review concentrates on these concerns. It investigated a wide range of specific issues brought to it by parents and families. The Review's Terms of Reference also required it to carry out a wider examination of the paediatric cardiac service at the University Hospitals Bristol NHS Foundation Trust. This report presents an overview of the service from 2010 – 2014, informed by the results of the investigation it carried out. It follows the pathway of care, from initial diagnosis onwards. It examines the evidence of parents and members of staff.

1.2 The Review records its thanks to all those who took part. It pays particular tribute to parents whose persistence led to the involvement of the Care Quality Commission (CQC) in 2012.

1.3 The Review was advised by a Panel of Experts. At the request of the Review, the Experts also carried out a more detailed examination in response to specific concerns and questions raised by a number of individual families. The results of these Case Reviews have been reported back to these families. They are not published in this Report, given the need to respect patients' confidences.

1.4 Alongside of our work but in a separate and independent process, the CQC carried out a review of selected clinical case notes. We have been able to study its findings, prior to finalising this report.

1.5 After weighing all that it saw and heard, the Review sets out its conclusions and a number of recommendations.

1.6 The Review reached the firm conclusion that there was no evidence to suggest that there were failures in care and treatment of the nature that were identified in the Bristol Public Inquiry of 1998-2001. The outcomes of care at the Children's Hospital were broadly comparable with those of other centres caring for children with congenital heart disease. There was evidence that children and families were well-looked after and were satisfied with the care their children received. There was, however, also evidence that, on a number of occasions, the care was less good and that parents were let down. The principal focus of the Review was on Ward 32 where children were cared for. It was clear that, particularly prior to the CQC's inspection in 2012, the nursing staff were regularly under pressure, both in terms of the numbers available and the range of skills needed. This led on occasions to less than good care for children and poor communication with parents and families.

1.7 The Review also reached the conclusion that, on occasions, the senior managers of the Hospital, failed adequately to understand and respond effectively to the concerns of parents and adopted an unnecessarily defensive position in the face of the CQC's observations. This led to a deeply regrettable breakdown in communication which culminated in the commissioning of this Review.

The National Picture

1.8 The national picture regarding Congenital Heart Disease (CHD) is one in which more children have been receiving treatments which are increasingly successful and where more are reaching adulthood.

1.9 This improvement in results has been achieved despite the absence, at least until April 2016, of a mandatory set of standards on quality relating to CHD services in England and Wales. The period of time examined by the Review is one in which surgical units were aware that a future process of commissioning would prescribe such standards and were seeking to enable CHD services to meet them at some uncertain point in the future.

1.10 This uncertainty has been reduced by the adoption of the New Congenital Heart Disease Review's (NCHDR) standards, from April 2016. There remain a significant number of standards which must be met within the next few years rather than immediately. The point has not yet been reached where standards could be said to be met in a uniform fashion by all hospitals offering treatment for congenital heart disease.

1.11 At present, work on a 'quality dashboard' continues, seeking to ensure that an extended range of key information on quality and performance is made available to commissioners on a monthly basis. The measures are still under development. The commitment given by the NCHDR that the quality dashboard will become publicly available in due course was welcomed by this Review, as potentially such information could significantly add to understanding and accountability to the public.

The University Hospitals Bristol NHS Foundation Trust

1.12 Much has changed since the Public Inquiry into paediatric cardiac surgery at the Bristol Royal Infirmary, not least as regards the dedicated paediatric environment in which children with congenital heart defects are cared for. The CHD service at Bristol has developed from one in which two surgeons were employed and the number of open-heart congenital paediatric procedures was in the region of 130 – 140 procedures per annum, to a situation in which three surgeons were employed and, in 2014, the Children's Cardiac Service undertook 326 paediatric surgical operations.

1.13 The ability of commissioners and regulators to monitor the performance of hospital services, including cardiac services, has developed significantly.

Data on Mortality and Morbidity

1.14 There is a fundamental difference between the circumstances revealed by the Bristol Public Inquiry (where systemic weaknesses in the management of AVSD and switch operations by the two surgeons then employed at the Hospital were revealed by the Inquiry), and the situation now. The National Congenital Heart Disease Audit (NCHDA), which is managed by the National Institute for Cardiovascular Outcomes Research (NICOR), publishes information on activity and outcomes across surgical centres, and raises 'alerts' about potential outliers. This should ensure that such a situation would now not go undetected.

1.15 The value of the NCHDA, as a single trusted source of information upon activity and outcomes, is considerable. Those who manage it are aware that improvements are needed to the accessibility and ease of understanding of the information on NCHDA's website, to assist patients and families.

1.16 The data available from the NCHDA shows that the outcomes of surgery and other interventional procedures at BRHC were comparable with those in other centres within the UK, from April 2010 – March 2015.

1.17 The Children's Cardiac Centre did trigger 'alert' notifications from NICOR regarding the arterial shunt procedure, on the basis of data relating to 2009 – 2012 and 2010 – 2013. The BRHC paediatric cardiac services responded appropriately to these warnings, setting out its explanation for the outcomes and the actions taken. The results for the period 2012 – 2015 showed that Bristol was no longer triggering the alert.

1.18 Because information upon the responses made to these alerts was not easy to locate, we **recommend:**

(1) That any review of the Department of Health's Outlier policy (the policy followed by the NCHDA when its audits trigger alerts or alarms) should give specific attention to the need for publication of the responses to outlier alerts, and of any actions taken as a result.

1.19 Concerns were raised by parents that the data submitted by Bristol to the audit was inaccurate or incomplete were understandable, and they have led directly to changes and improvements in the national audit. But we have set out why, ultimately, those concerns about poor submission of data were not justified.

1.20 Any gaps in the data were not the result of incomplete or inaccurate information returns from Bristol, but were caused either by how the NCHDA checked those returns using information from the Office of National Statistics; or from the scope of the audit which did not, until recently, include the results of diagnostic catheterisation.

1.21 There are concerns that the Trust staff involved in this data collection remain over-stretched, and, given the importance of the integrity of the data returned, this requires attention.

1.22 In the light of the above, we **recommend:**

(2) That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.

1.23 It is not possible at present to make robust comparisons of rates of morbidity between centres. A major research project on this topic is in hand which, together with data collected by the NCHDA, should secure improvements in the information available over the next few years.

1.24 It is important not to view statistical information in isolation and all sources of information should be examined when looking a unit's performance. The statistical information summarised above is not a reason to dismiss the concerns of those parents whose unhappiness triggered the work of the Review.

1.25 In particular, the fact that statistics on mortality may not suggest cause for concern does not mean that there could not have been failings, or the need for improved practice, in individual cases or areas of practice. Such information cannot be seen in isolation. Furthermore, the death or suffering of any child is a tragedy, and any failings, if they occurred, would be profoundly distressing regardless of whether any failings were 'one-offs' or repeated. We set out to explore the concerns about the cases drawn to our attention with these perspectives in mind.

Networks, Diagnosis and Outpatient Care

1.26 In December 2010, the Safe and Sustainable Review's Independent Expert Panel had concluded that arrangements across the network were based on strong individual relationships rather than documented protocols. The Review noted limited change to that position in the course of the Review, the development of a protocol between clinicians in Bristol and Wales on the management of patent ductus arteriosus being an exception to this picture. But it felt such limited development was not surprising, given how the Safe and Sustainable process came to a halt. The Review noted the recent appointment of a Network Manager by the UHB, and the plans for future development as a result.

1.27 There were challenges in ensuring consistent information was given to families, particularly when care was shared or passed between referring clinicians outside of the Bristol service, and those based at the UHB. The difficulties in managing communication and expectations in the treatment of patent ductus arteriosus, between Wales and Bristol, was one example of those challenges.

1.28 The matters most frequently raised by families concerned recurring problems with the robustness of systems for booking outpatient appointments, for re-scheduling missed or cancelled appointments and for following up those who did not attend. There were also concerns about the capacity of the service, given the demand for outpatient clinics, and the need to systematise the procedures in the outpatient clinic, such as observations of patients, review of observations by medical staff, and procedures for taking more urgent action in the face of abnormal observations.

1.29 The causes of these difficulties appear to have been many and varied.

1.30 Appointments systems are frequently the source of patient frustration and complaint. It is difficult to eliminate occasional error or instances of poor communication. There is evidence that, as might be expected, problems in the management of outpatient appointments were not limited to the paediatric cardiac department, but were a Trust-wide issue. Without suggesting that the situation described was an acceptable one, the Review's Expert Panel felt that the challenges in the management of paediatric cardiac outpatient appointments were likely to be similar to those faced not only more generally in the UHB, but in many hospitals across the country. Moreover, the Review considered that there had been a 'step change' in the response to these issues from early 2013 onwards, when it appeared that more vigorous action had been initiated. That said, some clinicians still expressed concern that the outpatient service was still under pressure, the cardiologists were stretched and further support was required. There was also a need to review the facilities and resources for outpatients.

1.31 Cardiac children are a vulnerable group. Their condition can change and deteriorate quickly, with potentially life-threatening consequences. This highlighted both the general need for stringent adherence to the times planned for appointments and the importance of dealing properly with question of those children 'lost to follow-up'. It felt that this was an issue of real importance throughout the course of a child's life, and not only at the stage of transition to adult services.

1.32 The standards developed by the NCHD Review should enable the development of an effective network, with consistent standards to be met by all centres within the network, including in the planned deployment of professional expertise (e.g., the appointment of 'paediatricians with an interest') at local hospitals. Without underestimating the challenges that will be faced in meeting those standards, their development nevertheless represents an important step towards achieving equitable access to services.

1.33 The process of commissioning in Wales was outside the NCHD Review. This Review felt that there was an urgent need for the effective implementation of standards designed to ensure consistency of services for patients/families across the network, including in fetal medicine, maternity and neonatal services both within Wales and between Wales and Bristol.

1.34 The Review noted the commitment given by the Welsh Health Specialised Services Committee (WHSSC) to working with the NHS England Congenital Heart Disease Review Team, the new Congenital Heart Network and providers to ensure the coordination of plans to improve services. It endorsed the importance of ensuring the consistent provision of services, to a uniform standard, across both England and Wales.

1.35 In the light of the above, we make the following **recommendations**, addressed respectively to those named:

(3) That the Trust should review the information given to families at the point of diagnosis of CHD (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.

(4) That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth.

(5) The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.

(6) There should be explicit recognition at a national level that children are 'lost to follow up' at points in time other than transition and transfer to other centres, which are the points explicitly reflected in the NCHD's current standard. The standard should be broadened by NHS England, to recognise the matters of safeguarding which can arise for vulnerable children.

(7) The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments.

(8) The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective.

(9) In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.

(10) NHS England should gather and/or publish, to the extent possible, the data necessary to assess the implementation of the NCHD standard, that tertiary centres should employ one consultant cardiologist per half million people served, working flexibly across the Network.

Admissions to Hospital

1.36 During the period of the Review, the ability of clinicians at Bristol and Cardiff to co-operative effectively in planning operations and interventions at the Children's Hospital was constrained by the difficulties in securing the consistent involvement of Cardiff clinicians in Bristol Joint Cardiac Conference (JCCs), in person or remotely. The difficulties were a product both of the limits upon the ability of Cardiff clinicians to attend meetings in Bristol, and of the limited technology available to them to share images and other clinical resources.

1.37 We recommended in the previous Chapter that achieving better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol should be recognised as a priority in the development of the Bristol network.

1.38 In the light of the above, we further **recommend:**

(11) That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC.

1.39 We heard a range of concerns expressed by some families regarding the process of obtaining consent to their child's treatment. These included concerns about the completeness of information provided and the manner in which it was conveyed and the support provided to parents during the process. We also heard of concerns about knowledge of the identity of the clinician who performed the procedure. There was, at times, a lack of transparency about who would be performing an operation. We noted that guidance on information to families about the identity of clinicians involved in procedures or treatment lacks clarity and consistency.

1.40 We note that improvements have been made to the arrangements for obtaining consent for surgical procedures from 2015 onwards, to provide additional support and information to families.

1.41 We **endorse**, the recommendation from the CQC's clinical case note review of the need to review the 'Recording [of] the percentage risk of mortality or other major complications discussed with parents or carers on consent forms.'

1.42 The Review considered that most if not all families would now readily be able to record discussions with clinicians by using their mobile phones. In the light of this we **recommend**:

(12) That clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed.

1.43 We also make the following further **recommendations**:

(13) That the Trust reviews its Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought.

(14) That the Trust reviews its Consent Policy to take account of recent developments in the law in this area, emphasising the rights of patients to be treated as partners by clinicians, and to be properly informed about material risks.

(15) That a national protocol be agreed explaining the role of individuals and teams in paediatric cardiac surgery and cardiac catheterisations. Such a protocol should be shared at an early stage of the pathway of care, to ensure that all families are clear about how teams work and the involvement, under supervision of junior members of staff.

(16) As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members.

(17) That the Trust carry out a review or audit of (i) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent.

Surgery and Theatres

1.44 A number of parents were concerned that their children had not received proper care; at times this included concerns or questions about the management of operations or procedures in the operating theatre or catheter laboratory.

1.45 Reviews of individual cases which were carried out by this Review did not point to flaws in the management of cases or failures in the technical ability of the teams involved. We have borne in mind throughout the Review the cases before us in which children, tragically, died. They include children who did not recover after surgery or other interventions, or whose operations were unsuccessful. In other parts of this report, we have set out occasions when aspects of their care either fell short or could have been improved. But we have concluded that there is no evidence to suggest that

these cases point to specific or systemic failures in the conduct of individuals carrying out procedures, whether in the operating theatre or the catheter laboratory.

1.46 The CQC's clinical case note review noted that: 'The case reviewers were not critical of the standard of surgery in any individual case.'

1.47 During the period of this Review, there were serious pressures on the capacity of the cardiac surgical service, caused both by the limited operating slots available and the finite number of beds available in PICU. As a consequence, heavy strains were placed upon parents and children by the resulting cancellations of operations. There were times of particular pressure, e.g. in late September 2013 or during the winter of 2014/15. At times surgeons considered not taking referrals but did not do so because of similar pressures in other centres.

1.48 There is very limited evidence that cancellations affected outcomes, as opposed to inflicting serious stresses on the parents and children affected. The review or 'juggling' of waiting lists that took place was aimed at ensuring that children were operated upon at an appropriate time, and clinicians were plainly keenly aware of the need to achieve this.

1.49 Steps were taken both to increase the number of operating sessions over time and to improve the management of the surgical list in 2013. The recent appointment of the cardiac pathway co-ordinator should also assist.

1.50 Cancellations cannot be avoided, despite these increases in capacity. Rates of cancellation are now monitored through the transition dashboard. Data which would allow comparison with other sites is not yet publicly available.

1.51 In the light of the above we **recommend**:

(18) That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.

The Paediatric Intensive Care Unit

1.52 Viewed overall, there was a good standard of care provided in PICU throughout the period of our Terms of Reference. This was achieved despite significant pressure on beds. High rates of occupancy, however, were a reason why planned operations could not always proceed.

1.53 The PICU has effectively managed staffing constraints. In common with many other PICUs across the country, staffing has been consistently below recommended levels.

1.54 PICU's staff were active leaders in the reporting and investigation of clinical incidents.

1.55 During the period prior to the creation of dedicated High Dependency facilities, the multi-disciplinary procedure for agreeing discharges from PICU to Ward 32, though apparently formalised, was more often ad hoc and informal. It would have benefitted from the explicit identification and documentation of the nursing needs of infants and children, when transferred to the ward.

1.56 Clinicians were frustrated at the absence of dedicated beds for cardiac patients in PICU. They felt that they would be able to provide a higher quality service, with fewer cancellations, if such beds were available, and also that PICU's staff could further specialise in the needs of children with CHD.

1.57 On the other hand, it is apparent that designating certain beds for particular categories of children could reduce the ability of a PICU to admit children who needed critical care. Changing practice against this background is a complex challenge, with changes to one part of a system (e.g. by the creation of a HDU) affecting others, both inside and outside a of hospital with a PICU serving a wide area and a broad range of patients.

1.58 We were conscious of the heavy strains created by the limitations on the capacity of the Bristol PICU, during the period of this Review, and consider that this is likely to be a national issue that requires proper attention.

1.59 In the light of the above, we **recommend:**

(19) That NHS England should commission a review of Paediatric Intensive Care Services across England. We were conscious of the heavy strains placed on families by the limitations on the capacity of the Bristol PICU, during the period of this Review, and consider that this is likely to be a national issue that requires proper attention.

End of Life Care, Bereavement and Psychological Support

1.60 There were weaknesses in the provision made by the Trust for end-of-life care and bereavement support, particularly in the early part of the period covered by this Review. More recently, services had been strengthened and there were examples of excellent practice.

1.61 The need for psychological support for patients and families is a crucial part of the service that should be provided. Although there has also been some improvement in the provision of psychological support for patients and families, it remains under-resourced and is not able to meet the needs of all those who could benefit from it.

1.62 In the light of the above, we **recommend:**

(20) That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.

(21) Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support.

Ward 32 – the Cardiac Ward

1.63 One reason why the Review was set up was the expression of concerns by a number of parents that the numbers of nurses on Ward 32, and their skills, were not adequate to provide proper nursing care to the children on the ward. Some of these parents had been instrumental in triggering an inspection of the ward by the Care Quality Commission (CQC) in September 2012. We examined information about nursing care before that date.

1.64 The number and needs of children on ward called for a high level of nursing care. There is evidence to suggest that Ward 32 was potentially the ward with the highest level of acuity (level of acuteness of a patient's condition), compared with others in the Children's Hospital. The Trust's own data collection shows that there were a significant number of children who required augmented levels of nursing care on Ward 32 during the period of the Review, and prior to changes made in the organisation of ward care following the CQC inspection in September 2012.

1.65 There was confusion surrounding the term 'high dependency' or 'high dependency care' during this period. It could be used widely, including to describe children who were not critically ill but needed considerable input from staff. At times, staff use of the term probably reflected that confusion. We accept that because of this, it is likely that, on occasion, the term was used to describe the care on Ward 32, as some parents reported to us.

1.66 The demand for nursing care on Ward 32 was further increased by the fact that a large percentage of its patients were babies or very young children with cardiac problems, who needed high levels of attention, and the fact that there were a large number of small rooms or cubicles on the ward. Nurses and medical staff also had to respond to the needs of the 'ward attenders' (children who attended the ward for a day, or less, for short reviews), and 'non-cardiac' patients whose needs were, therefore, more diverse and less familiar.

1.67 Overall, there was evidence that suggested that Ward 32 was under heavier pressure than other wards, because of the circumstances of its patients.

1.68 At the time, there was a heavy reliance on professional judgment and discretion in order to assess the numbers of nurses and level of nursing needed, on a daily basis. We do not doubt the sincerity and good faith of all those staff made those judgments. But we do consider that they needed better tools to be developed, to support them to make them.

1.69 In recent years, much work has been done on ensuring safer nursing levels. Validated tools for measuring patient's acuity have been developed, with a tool for paediatric

patients soon to be available. Trusts are now also required to put information in the public domain about staffing levels in each hospital ward.

1.70 We **endorse** the importance of this work. We emphasise the importance of the early use of, in particular, a nationally recognised paediatric staffing tool for acutely ill children. When available, this should be utilised, together with the professional judgement of senior nurses responsible for the care of the patient, to review the basis of the current nursing establishment on the cardiac ward.

Managing Levels of Staffing

1.71 The most appropriate sources of guidance or recommendations on levels of nursing staff were the 2003 RCN's guidance and the 2010 PICS' standards. As regard the nursing establishment, in the light of the numbers of patients, their ages, their need for specialist care and the increasing acuity of patients, the Review felt that the nursing numbers would have fallen below the recommended levels on a reasonably frequent basis, and that there was a clear risk of harm as a result. Further, heavy reliance on Bank and agency nurses to maintain staffing levels is not consistent with providing an appropriate quality of care.

1.72 The picture of a ward under pressure was consistent with the picture formed from the Expert Case Reviews. It was apparent that staff worked hard to ensure that the children received proper attention, so that (for example) hourly observations were generally carried out. There was concern, however, that they lacked the 'time and space' to reflect on trends in the clinical status of the children they were caring for, as illustrated by the concerns expressed, in spring 2012, about the extent of the nursing staff members' ability to identify children whose condition was deteriorating.

1.73 In both late 2010 and early 2012, there were attempts to secure funding for dedicated high dependency beds in the BRHC. It was recognised that improvements were desirable. In February 2012, there was formal recognition of the risk 'of a reduction in the quality of care for patients in children's hospital when the number of children with higher dependency needs exceeds the level planned and staffed for.' But the Review asked whether sufficient attention had been paid not only to the desirability of improvement, but to the adequacy and safety of the existing model of care before any changes to it could be introduced, prior to the CQC's inspection in September 2012.

1.74 By late 2011, there was information available in the form of a draft risk assessment for Ward 32. This, together with details of incidents relating to 'low' or unsafe staffing on the ward, the expressions of concern voiced by members of the Cardiac Clinical Governance Committee, and by a consultant paediatric cardiologist in September 2011, suggested there was a need for careful review of the existing care.

1.75 By April and May 2012, a number of incidents had prompted further consideration, both of the staff's ability to recognise children whose condition was deteriorating and

of the adequacy of levels of nursing staff. Steps to increase these levels were outlined in an email from the Matron in mid-April 2012.

1.76 These proposed changes seemed to us reasonable, particularly when linked to further improvements which followed shortly. The Review noted, however, that the intention was to audit these changes. This does not appear to have occurred. The Review considered that this should have taken place at the time, as planned. In its absence, there was a dearth of information about exactly when the changes described took effect, and their efficacy. Against that background, the CQC found that there was non-compliance with, in particular, its staffing standards, when it inspected the ward in early September 2012.

1.77 More complex was the issue of whether the proposed steps to strengthen staffing could or should have been taken more quickly. We felt that, rather than focussing on early 2012, our primary concern remained the failure to carry out a proper risk assessment in late 2011. It was at this point that an effective evaluation of the risks on Ward 32 could, and we felt should, have been carried out.

Governance and Leadership

1.78 When the CQC raised concerns about the quality of care on Ward 32 in September 2012, this came as a surprise to the senior leadership of the Trust. Overall, review of the information that was reported upwards does not suggest that reports or warnings were ignored by the Trust Executive. Rather, in our opinion, the key information that was suggestive of a need to review existing risks remained at the level of the Women's and Children's Division.

1.79 The fact that the existence of concerns about the staffing of Ward 32 were not referred to the Board until after the CQC's visit demonstrates clearly that they were not taken sufficiently seriously by the relevant managers.

1.80 These events indicated a need to review the mechanisms for risk management within the Trust. But the Review noted evidence of, first, greater focus upon the study of 'low-risk' incidents since 2012, and, in addition, reviews examining patient safety and risk management that took place within the BRHC, in 2013 and 2014. It appeared that action had been taken to review the mechanisms by which matters to do with the safety of patients were addressed throughout the BRHC hospital.

1.81 However, the review of risk management in 2014 recorded that work remained to be completed to develop staff's understanding of the nature of patient safety incidents and how such incidents should be graded.

1.82 In the light of the above, we **recommend**:

(22) That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board.

(23) That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.

The CQC's Involvement

1.83 There was effective co-ordination between commissioners, regulators and the Trust in the wake of the CQC's inspection with a view to sharing information and agreeing on the actions needed. Decisions were taken on funding for additional beds for high dependency care and there was effective monitoring of the Trust's action plan to effect widespread changes, as discussed further in the following chapter. The Risk Summit as a mechanism worked effectively to bring key individuals together.

1.84 The exception to this picture of communication and inclusion were the families who had first gone to the CQC. They were left largely outside this process and were not satisfied that proper action was being taken.

1.85 In relation to communication between families and the Trust, the Trust failed to continue attempts to involve one family in the actions recommended as a result of an RCA and to share information about continuing investigations. More generally, we perceived a sharp contrast between the early acknowledgement of either failings or areas for improvement in CDRs or RCAs shared with families, and the Trust's subsequent defence of the model of care in Ward 32 prior to September 2012, after the CQC had found that the Trust had not complied with its standards.

1.86 While there were some meetings with families held by the CQC and representatives of NHS Bristol, the SHA and the NHS's Commissioning Board and, in due course, NHS England, during the course of late 2012 and 2013 families were not only preparing for their children's inquests, but seeking support or help from a very wide range of bodies in the NHS and other organisations to answer further questions which they had. Their experience was of a lack of progress or action.

1.87 The Review concluded that organisations within the NHS, and more particularly NHS England, failed to engage consistently with families throughout 2013, and to develop and deliver a strategy for reporting on what had been done to investigate or to address concerns. This played a part in creating the situation which eventually led to the commissioning of this Review.

1.88 In the light of the above, we **recommend**:

(24) That urgent attention be given to developing more effective mechanisms for maintaining dialogue in in the future in situations such as these, at the level of both the provider and commissioning organisations.

Trust Action Following the CQC Inspection

1.89 We accept that significant changes were made in the provision of care on Ward 32 and in cardiac services more generally, in the wake of the CQC's inspection of September 2012. They went substantially beyond the establishment of dedicated cardiac high dependency beds in Ward 32. They included improvements in areas such as procedures for triggering action in response to the clinical warning scores of children, listening to parents and families, improving nursing skills, and improving team-working and communication. We have set out the main areas where there was change and development.

1.90 In the Review's judgment, there had been substantial learning, within cardiac services, from the criticisms which had been voiced and from the findings of the Trust's own reviews and investigations.

The Commissioning of High Dependency Care at Bristol Children's Hospital

1.91 The Review was not able to access the entire archive on specialised commissioning from NHS England. This has limited the Review's ability to compile a comprehensive record of the discussions and actions regarding specialised commissioning involvement. We repeat a point which we fear is made all too often: that reorganisations will lead to a significant loss of 'organisational memory' unless comprehensive steps are taken to retain and organise archives.

1.92 In the light of the above, we **recommend**:

(25) That when structural changes are made, adequate resources are devoted to organising and archiving records in a way that will enable them to be retrieved and studied at a later date.

1.93 From the perspective of commissioners (both within the PCTs and the Specialised Commissioning Group), there were widespread gaps in the provision of high dependency care in the South West region from 2010 – 2012. Steps were taken to identify those gaps, through a Review of High Dependency Care in the South West which reported in July 2011. In the case of the BRHC, the Review did not lead to seeking explicit assurances that the gaps had been identified and risks were being properly managed. We took the view that, having been notified about non-compliance with the South West's standards on HD care, commissioners should have been clear about the need for all hospital Trusts in that situation to show that they had effective plans to manage the consequent risk.

1.94 The Review did lead to a more thorough consideration of the proposal for a medical HDU which was put forward by the Trust in early 2012. Although that bid was not immediately agreed, it was not wholly dismissed and further work on the proposal continued.

1.95 The manner in which the bid was presented by the Trust was consistent with its internal assessment of the risk, which we have discussed above. Consistently with this, commissioners perceived the issue as being more about children were being cared for in the wrong place, on PICU, rather than that children were at risk. Whilst we have examined information that would have supported a different judgement, viewed overall, we accept that until autumn 2012, there was an absence of information to indicate to commissioners a pressing need to prioritise the development of HD facilities at the Bristol Children's Hospital. In particular, and in relation to paediatric cardiac services specifically, the serious incidents that were reported, NICOR's data on outcomes and the manner in which the Trust itself presented its own bids for funding, did not suggest that immediate intervention was needed.

1.96 Neither an unsatisfactory debate over who was responsible for funding HD care, nor uncertainties caused by the reorganisation of the NHS taking place at the time, were reasons why no funding was agreed before commissioners had to respond urgently to the results of the CQC's inspection of September 2012. It would also be wrong to criticise (or second-guess with the benefit of hindsight) the judgments on the priorities for funding that were made by those who assessed the bids for funding of HD care made prior to the CQC's inspection.

Investigating the Concerns of Families

1.97 We examined difficult and complex situations, perhaps unrepresentative of the general range of complaints seen by the Trust. We saw examples of good handling of complaints and at least one case where good support was offered to a family to explore their questions.

1.98 But in the difficult and complex situations which lay at the heart of the Review, investigations and handling of complaints had not succeeded in resolving concerns. At times, the approach taken had, on the contrary, deepened suspicions and rifts.

1.99. In the light of the above, we **recommend**:

(26) That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.

(27) That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue.

(28) That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or investigations which require it.

(29) That as part of the process of exploring the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.

(30) That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result of a complaint or incident involving them or their families and seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation.

(31) That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.

1.100 In our 'concluding remarks' we have made a final **recommendation**:

(32) That the Trust redesignate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care.

1.101 We express the hope any response to this Report will strengthen not only paediatric cardiac services, but the partnership between families and staff which is the basis of delivering safe and effective care of a high quality.

1.102 We repeat our thanks to all those who took part and have contributed to it.

Clinical Case Note Review:

A review of pre-operative, peri-operative and post-operative care in cardiac surgical services at Bristol Royal Hospital for Children

23 June 2016

1. Summary

The Care Quality Commission has undertaken an expert review of case notes of a group of children who underwent heart surgery at Bristol Royal Hospital for Children[1] between January 2012 and December 2014. This was in response to concerns about the service raised by families of some children treated there. The purpose of the review was to determine whether there was evidence of any systematic problems with pre-operative, operative and post-operative care in the service as currently provided.

The expert panel examined in detail every stage of the clinical pathway for each child. They found that the standard of care provided was within the expected level of quality and was comparable with other centres in the UK. They did not identify any case where the standard of care fell below the expected level. The quality of the documentation improved during the period under review, particularly after the establishment of dedicated high dependency facilities from October 2012 onwards. While no overall judgement about clinical outcomes could be made from the case note review itself, the National Institute for Cardiovascular Outcomes Research has reported that the 30 day survival for all heart surgery procedures at the hospital was within the expected range during the period reviewed.

The panel noted several examples of good practice and made recommendations for improvements that the service should consider.

2. Introduction

The Care Quality Commission (CQC) decided to undertake a review of case notes of children who have undergone surgery for congenital heart anomalies at Bristol Royal Hospital for Children after consultation with NHS England. The purpose of the review was to provide an assessment of current practice at the hospital. The review focuses on surgical interventions undertaken between January 2012 and December 2014. It was undertaken in two stages. Two nurses, with expertise in children's cardiac services, reviewed a number of records from this three year period to identify triggers which indicated that there had been unexpected clinical events during care. These cases were then reviewed by a team of clinical experts. From this list the expert panel selected a limited number of cases to be reviewed in detail. The panel individually and independently reviewed the case notes from this second group and then jointly discussed their findings to draw overall conclusions. This report presents the findings from the case note review with reference made to published guidance where this is relevant to the review methodology and findings.

[1] Bristol Royal Hospital for Children is part of University Hospital Bristol NHS Foundation Trust

3. Background

Concerns were raised by a number of families about the care of their children following cardiac surgery at the Bristol Royal Hospital for Children (BRHC) prompting the CQC to inspect the children's cardiac ward and paediatric intensive care unit at the hospital in September 2012. This inspection found insufficient numbers of experienced staff to provide high dependency care on ward 32. The CQC served a warning notice requiring improvement[2]. An unannounced follow-up inspection in November 2012 reported improvements in nurse staffing, with adequate levels of suitably trained staff on ward 32 and high dependency provision on the paediatric intensive care unit[3]. A subsequent inspection in April 2013 found that the trust had taken action to ensure that children on ward 32 experienced care and treatment that met their needs. The trust opened a dedicated high dependency unit on ward 32 on a staged basis between April and September 2013.

In September 2014 the CQC carried out a comprehensive inspection of University Hospitals Bristol NHS Foundation Trust, which included the services provided by BRHC. Services for children and young people were rated as good overall, specifically good for safety, outstanding for effectiveness, good for caring, good for responsiveness and good for well-led.

Continuing concerns by families led to the commissioning of an independent review of the service by NHS England in 2014. This review is led by Eleanor Grey QC, with advice from Sir Ian Kennedy. At the same time, in consultation with NHS England, the Chief Inspector of Hospitals for the CQC agreed separately to review the clinical outcomes of the service with support from the National Institute for Cardiovascular Outcomes Research (NICOR) and to conduct a clinical case note review to assess the care provided by the service.

NICOR undertakes an annual National Congenital Heart Disease Audit, compiling data from all 14 children's specialist cardiac centres[4]. A rolling three yearly report is published each year covering all NHS and private paediatric and congenital heart disease procedures undertaken in centres within the UK and Republic of Ireland. Analysis of findings is based on all paediatric and congenital heart surgery and interventions undertaken between April 1st and March 31st of each year. When this case note audit commenced in January 2015, NICOR had identified that BRHC was achieving outcomes worse than the warning level for 30 day survival for one procedure, arterial shunt surgery, but was within the expected range for all other

[2] CQC (October 2012) Review of Compliance: University Hospitals Bristol NHS Foundation Trust, University Hospital of Bristol Main Site
[3] CQC (December 2012) CQC Inspection Report: University Hospital of Bristol Main Site
[4] http://www.ucl.ac.uk/nicor/audits/congenital/reports

procedures[5]. In addition, the report noted that the data quality for surgical case notes was below 90% in 2012 to 2013, based on a review of 20 sets of notes.

In their response to NICOR, BRHC indicated there were 6 deaths out of 27 patients who had undergone a palliative arterial shunt procedure, representing a 30-day survival of 77.8%. From an internal audit of arterial shunt procedures, the trust identified that four of these infants fell into high risk groups, including low birth weight and complex cardiac anatomy whilst the other two died at home from blocked shunts following discharge. The team have established home monitoring for these infants, resulting in no further deaths at home in this group. In addition, the frequency that arterial shunts are performed at BRHC has fallen over the last 15 years, as children with two ventricles, such as those with Tetralogy of Fallot, undergo a primary repair rather than palliative surgery wherever possible.

In April 2016 NICOR published a further report of outcomes for congenital heart surgery covering the years 2012 to 2015[6]. It concluded that for this period survival at 30 days following paediatric heart surgery was within the expected range for all specialist children's heart units. There were no alerts for any procedure at the BRHC for this period. For children under 16 years of age BRHC undertook 835 surgical procedures, survival at 30 days was 98.3%, which was within the expected range compared to other units.

4. Terms of reference

The terms of reference were reviewed by and discussed with the expert panel before being finalised. The purpose of the case note review was to identify any systematic problems with pre-operative, operative and post-operative care. The cases were to be selected for an appropriate period to represent current rather than historical practice. The methodology would allow the expert panel to recommend particular cases for review based on clinical criteria. These would be clinical problems indicated by deviations from the planned care pathway, clinical incidents or episodes of deterioration in a child's clinical condition. Case notes were to be selected to be reviewed in detail where such problems were identified, to determine whether the care provided was appropriate based on the information available. The pathway of care to be reviewed included: pre-operative assessment and investigation, surgical intervention, post-operative care and follow up after surgery. The terms of reference of the review indicated that the scope of the case note review should be guided by the findings of the NICOR report. The report of the case note review should identify areas for improvement in care and areas of good practice. The report would cover the overall care of the patients reviewed, but would not provide findings about the care of individual patients.

[5] NICOR (2014) National Congenital Heart Disease Audit Report 2010 – 2013
[6] NICOR (2015) National Congenital Heart Disease Audit Report 2012 – 2015

The final terms of reference included criteria for case selection and an outline of the process to guide methodology (appendix 1).

5. Methodology

The case note review project was led by a Specialist Advisor from CQC and over seen by the Deputy Chief Inspector of Hospitals, both with experience in children's congenital cardiac services. A project outline was produced, consisting of a two stage process; the first part was an audit of 42 sets of case notes, undertaken by the Project Lead and a second nurse experienced in children's critical care and cardiac services. The second stage of the review involved a team of experts independently and individually undertaking a detailed review of a sub-group of the 42 cases.

The CQC has stayed in close touch with the independent Bristol Review to ensure that the two reports are complementary. The Bristol Review has reviewed cases between 2010 and 2014, where parents have raised concerns. The CQC case note review examined cases between January 2012 and December 2014, prior to and after the establishment of a designated high dependency unit. Cases for review were selected using clinical criteria rather than because a concern had been raised. No cases were reviewed by both groups.

5.1 Selection of experts

Selection of experts to be involved in the review was undertaken by the Project Lead and Deputy Chief Inspector of Hospitals. Experts were selected from children's cardiac surgical centres across England, ensuring that no unit was represented twice, to enable assessment by individuals with a variety of experience of children's congenital cardiac services. The centres where the experts were based were:

- Birmingham Children's Hospital
- Evelina London Children's Hospital
- Royal Brompton Hospital
- Southampton University Hospitals
- University Hospitals Leicester

One children's critical care nurse worked with the Project Lead to review the initial case notes. The expert advisor team, who reviewed the case notes in more detail, comprised a paediatric cardiac surgeon, a paediatric cardiologist, a paediatric intensivist and a children's critical care nurse.

5.2 Case note selection

Case notes were selected from the three year period between January 2012, prior to provision of high dependency facilities at BRHC, and December 2014, immediately prior to the review commencing. During this period there were just over 800 surgical cases of which the review team selected 42 cases (approx. 5%) for inclusion in the

initial stage of the process. The team decided to exclude any cases that had been investigated by the Coroner, as these had been reviewed in depth. Therefore, cases were selected by the CQC review team based on the following criteria:

- There were 30 deaths during this period, of which 2 were not related to surgery and 5 were investigated by the Coroner, leaving 23 deaths to be included in the review.
- 20 matched cases were identified following identification by the trust of the first three matched defects and procedures occurring after each case that had resulted in death. The review team selected the closest match for each procedure out of each set of three cases.
- There were three cases where children died with no match for either defect or procedure and three cases were similar to more than one of the matched cases.
- Two additional cases were added, as the sample group did not include any cases of transposition of the great arteries, where an arterial switch procedure had been performed. This ensured that all major lesions were included in the sample.
- A final list of 45 cases was sent to the trust to make the notes available for review by the Project Lead and a children's critical care nurse. During the process of extracting the records, a further three cases were identified as undergoing review by the Coroner and were removed from the list.

This resulted in the final list consisting of 20 children who had died with 12 months of surgery, 20 matched cases plus two cases with transposition of the great arteries.

5.3 Case note audit and final case selection

The initial stage of case note audit involved a screening process which was undertaken between 15 June and 5 August 2015, using 'The Paediatric Trigger Tool'[7]. This tool was based on evidence of the value of trigger tool methodology and was developed by the NHS Institute of Innovation and Improvement with input from clinicians from children's hospitals within England and Scotland. It provides a structure for case note audit, to detect adverse events in paediatrics in all hospital types including specialist paediatric centres.

This stage of the process involved an onsite review of the full set of case notes, including intensive care observation charts and joint cardiac meeting minutes, which were provided separately to the patient records. The auditors were experienced at reviewing case notes and reviewed the records independently. Each auditor completed a trigger tool form for each case, noting the cause for the trigger in the comments column. The final scores for each case were collated by the Project Lead

[7] http://www.institute.nhs.uk/safer_care/paediatric_safer_care/get_started.html

and discussed at an expert panel meeting to make the final selection of case notes for detailed review.

To reach the final selection, it was agreed that a quarter of the 42 cases would be reviewed in detail by the expert team. It was also agreed that those children with complex co-morbidities would not be included in the final group and one case was removed as the Project Lead was informed that this case was being reviewed by the Coroner. The final group were selected using three criteria:

- The trigger tool suggested that interventions had been required to sustain life.
- The group represented a spread of cardiac anomalies.
- In view of the NICOR analysis of outcomes, patients that had undergone palliative arterial shunt procedures were included.

The final group of 11 cases included children with hypoplastic left heart syndrome, atrioventricular septal defects including infants with trisomy 21, anomalous pulmonary venous drainage, atrial septal defect, pulmonary atresia, coarctation of the aorta, double outlet right ventricle, ventricular septal defect, pulmonary atresia/hypoplastic right heart and transposition of the great arteries. Three of these children had palliative arterial shunts operations, rather than primary repairs. Six of the children had died and five had survived.

5.4 Detailed review of the records

While stage one of the process was being completed a case note review tool was developed. This was based on a tool that had previously been used for the detailed review of paediatric case notes and the congenital heart disease pathway provided by the trust (appendix 3). The draft review tool was circulated to the team of experts for their comments and amended (appendix 2) prior to circulation for use with written guidance for completion.

Letters were sent to the families of the final group of children to inform them of the process and allow them the opportunity to ask questions or raise any concerns they had about the process. The families were given a date by which they should return comments prior to the records being circulated to the team of experts. Experts reviewed the records between December 2015 and February 2016 and returned an completed review form for each child. Information from the experts was collated for each child prior to an expert panel meeting in March 2016, when each case was discussed in detail and the findings agreed.

6. Findings

The findings below are discussed in relation to each element of the review tool to identify emerging themes arising from the case note review process. These themes are discussed in the conclusions to the report.

6.1 Admission

The admission process in the cases reviewed was judged to be satisfactory with examples of good practice noted in several cases. Four of the children under review were admitted as emergencies, two urgently and five for elective surgery. The care provided varied with the different modes of admission. The panel observed evidence of good practice for elective admissions with families provided with written information about their care and the planned procedure. Parents were copied into clinic letters to referring clinicians and general practitioners. In one case an elective procedure was cancelled after admission for operational reasons, but the child remained in hospital and surgery was undertaken during the same admission. Urgent and emergency admissions were inevitably less structured, with less evidence of written information provided. In these cases, there was evidence of discussion with families about the diagnosis and plan for management. Some infants had been diagnosed antenatally and were born in the neighbouring maternity unit. In these cases the transfer from the neonatal unit, while urgent was planned and demonstrated adherence to local guidelines for stabilisation prior to transfer. There were also examples of cases admitted from external hospitals, both as urgent and emergency admissions. Transfer procedures appeared satisfactory and there was evidence of good communication with referring centres.

6.2 Diagnosis

The observed quality of diagnosis was generally good. In nine of the eleven cases there was well documented evidence of effective multidisciplinary cardiac meetings to discuss individual cases and to plan their care. In difficult and complex cases there was evidence that appropriate advice and support was sought from other centres. There was good evidence of well documented parental counselling in cases of antenatal diagnosis, with shared care and the use of telemedicine in one case. One family was offered an interpreter to ensure understanding during these discussions but there was no evidence that this was taken up.

The panel did note examples in the case review series where in retrospect a better diagnosis of complex cases would have been valuable in planning the clinical management or predicting the risk of the planned surgical approach. However, the experts did not judge that in any of these cases the quality of diagnostic practice fell below the acceptable range. There were examples of excellent diagnostic practice in other cases.

6.3 Preparation for surgery

Preparation for surgery was satisfactory, with good evidence of discussion between professionals locally and at other centres. There was evidence that families were offered pre-operative visits to the ward and paediatric intensive care unit and that their views were taken into account in relation to surgery. There was evidence in some cases that families received information and support from the Cardiac Liaison Nurse in the pre-operative period, but this was not recorded in all cases. Few notes

contained written entries from the Cardiac Liaison Nurses of discussions and contact with parents, which the review team would recommend for effective communication across the team. The trust has subsequently explained that the Cardiac Liaison Nurses recorded their contacts and discussions with parents on a separate cardiac database rather than in the case notes.

Two particular aspects of preparation were not well documented in the records reviewed. Firstly, in the majority of cases the risk of surgery was not expressed in numerical form in the documentation of consent. This does not mean that it was not discussed, but the reviewers regard it as good practice for the surgeon to record the percentage risk of mortality or other major complication that they have discussed with the parents or carers in the record or on the signed consent form. This ensures that there is no ambiguity when a procedure is described as high risk or low risk. In two examples reviewed features of the individual child's condition meant that the surgical procedure would carry a higher risk than would normally be expected for this operation. It was unclear from the case notes whether this was discussed during the consent process.

The reviewers also commented that nursing plans for post-operative management of the child's pain were not well documented in the majority of cases. It is good practice to discuss this with the child (where appropriate) and the family pre-operatively.

In one of the cases reviewed consent for the operation was obtained not by the surgeon who undertook the operation, but by a colleague. This is not necessarily bad practice but the reason for it was not apparent from the record.

In two cases medication errors were noted, which delayed surgery by two days in one child. In both cases, the appropriate action was taken and documented in the patient records. There was evidence of an explanation and apology given by the staff concerned. Investigations were undertaken, with duty of candour recorded in one case[8]. Where additional action was required, there was evidence of action planning and monitoring with completion of actions.

6.4 Surgery

There were many examples in the cases reviewed of excellent surgical care. There were examples of highly complex procedures that were performed well with good outcomes. The case reviewers were not critical of the standard of surgery in any individual case. In one particularly complex case the operation undertaken was not what had been planned and it was not clear from the case notes the reason for this. The use of transoesophageal or epicardial echocardiography during surgery to review the cardiac function before completion of the operation is now considered good practice and it was used routinely in the cases reviewed. The reviewers commented that the recording of the findings of the investigation was often limited. In

[8] The Duty of Candour regulation took effect in November 2014.

many cases it was described as “satisfactory” with no further qualification. The reviewers would recommend that a full echocardiography report is recorded under these circumstances as this would help with post-operative management in complex cases.

6.5 Post-operative care

The arrangements for high dependency care developed during the period under review. The trust created two high dependency beds in the intensive care unit in October 2012 and opened a dedicated high dependency unit on ward 32 during 2013. The reviewers noted that the quality of documentation of post-operative care improved markedly during the period of the review. The recording of ward rounds on the high dependency unit and the paediatric intensive care unit was good. There was excellent documentation of daily nursing records, especially in relation to the input by the critical care outreach team with clear evidence of appropriate use of the clinical escalation tool, Paediatric Early Warning Score (PEWS) and the clinical communication tool, Situation, Background, Assessment, Recommendation (SBAR). An area of concern arose as sometimes the case notes referred to members of staff by their first name only. This is not good practice and meant that the reviewers could not always be sure about who was involved and what their role was. Additionally pain and sedation scores were not always recorded, with frequent gaps in some cases making it difficult to determine whether changes in analgesia had been effective. Despite this, there were some examples of good practice relating to pain management with involvement of the pain team and use of nurse controlled analgesia in the high dependency unit.

There was evidence of good post-operative monitoring of cardiorespiratory, neurological and renal status and regular microbiology screening, with timely referral to other teams such as neurology.

In one case, there was evidence of a mains power and generator failure during cardiac surgery involving the uninterrupted power supply to theatre 3, which necessitated quick responses and decisions to maintain patient safety. The child returned to the paediatric intensive care unit and went back to theatre the following day. This incident was fully investigated and an action plan established to review all power supplies to the trust site and ensure all critical theatre equipment had a backup supply. In addition, the business continuity plan has been reviewed to ensure that all critical equipment across the trust has a backup supply.

The cases reviewed indicated that some very difficult clinical problems were managed well and overall, the reviewers had no significant criticisms of any individual child’s care.

6.6 Parent/carer support

On the whole, communication with parents was well documented, and was seen to improve over the period between 2012 and 2014, particularly in relation to consent

which became more detailed. There was evidence of frequent verbal communication with parents, both face to face and by telephone, in the immediate post-operative period and if the child was unstable. However, in a few cases, the content of the documented communication was limited to statements such as ‘parents informed’ or ‘parents updated’. It is good practice to provide a brief summary of discussions, to enable the whole team to know what information has been provided to parents and avoid inconsistency in communication. In one case it was clear that a family was upset about inconsistent communication during their interaction with members of different teams. This was well documented by the clinical teams who recorded how they went to great lengths to address the family’s concerns, but the subsequent discussion with managers was not recorded. This could have included agreements about future communication, important for all members of the team, which should have been documented.

There was good evidence of effective support for families as they came to terms with their child’s illness and the treatment required, with referrals for additional support from the local and Welsh Cardiac Liaison Nurses, Play Specialist, Social Worker and the Chaplain. The reviewers felt that there was not as much evidence of families being given appropriate written information about diagnosis and management as they would expect, although more evidence that written material was provided was seen in later cases and in relation to bereavement support.

6.7 Discharge planning

There was good evidence of parental training and education where monitoring and alternative feeding was required by children at home. This training included assessment of competence, which was signed by trainer and parent. The areas covered by training included care of Hickman line, nasogastric feeding, monitoring on warfarin and enoxaparin and where necessary basic life support.

Discharge to referring centres was managed well, with good evidence of effective communication with the local clinical teams. Discharge summaries were detailed and there was evidence that parents were provided with copies of discharge letters. Discharge planning took into account the need for care closer to home, where ongoing hospital monitoring was required. Follow up was often in outreach clinics and not recorded in the Bristol records. There was evidence in several cases of good outreach nursing support maintaining contact with families after discharge and providing support and advice. This included liaison with the Welsh Cardiac Liaison Nurses to ensure support was in place prior to discharge. In only one case was discharge planning seen to be below the standard expected and this related to failure to include the recommendations of a speech and language therapist in discharge communication. It is important to ensure that input from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.

6.8 Outcome

The cases examined by the case note review were selected on clinical criteria and the expert panel acknowledges that this is only a small series of patients. For these reasons the outcome for this group of patients cannot be taken as necessarily representative of the outcomes for children receiving care in this service. While six of the children whose care we reviewed died, others with complex and difficult conditions had good outcomes. The reviewers did not regard the observed outcome in any case to be outside the range they would expect in any equivalent children's cardiac service.

It was not clear from the records what information the families received after a child's death in all cases. However, there was evidence of an increasing focus on effective bereavement support of families in the latter part of the period of the review, with excellent practice observed in these later cases.

The reviewers regard the child death reviews recorded on the children who died to be of high quality and they commented that they covered all the relevant issues. There was evidence of involvement of all teams within BRHC and between BRHC and other centres in relation to child death reviews.

7. Conclusions

Overall the expert panel found the standard of care provided, as evidenced by the cases reviewed, to be within the expected level of quality and comparable with other centres in the UK.

The clinical panel noted that the findings changed during the period under review with more extensive documentation towards the later part of this period and particularly after the opening of a dedicated high dependency unit towards the end of 2012.

There was evidence of good practice, especially in relation to documentation with some excellent examples in the high dependency unit and paediatric intensive care unit and in relation to child death reviews.

There was evidence of thorough investigation of incidents, with documented explanations and apologies to families, including appropriate reference to duty of candour. Action plans agreed as a result of incidents were seen to be monitored and actions completed.

The expert panel noted that the methodology of this review meant that the majority of cases reviewed were complex conditions. There were no concerns about the management of any individual case reviewed. Individual outcomes for the patients reviewed were within the expert panel's expectations.

The panel relied upon the published analysis by NICOR to assess the outcomes for the service as a whole. NICOR reported that the 30 day survival for children operated on at BRHC for all cardiac surgical procedures was within the expected range for the period reviewed.

The panel considered that the case notes they reviewed did indicate that there were a number of areas where improvements could be made which would enhance provision of services for and communication with children and families. They would recommend that the service reviews the following areas of practice:

- Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms.
- Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery.
- Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice
- Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records.
- Providing written material to families relating to diagnosis and recording this in the records.
- Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.

Appendix 1

Case not review: Terms of reference

The following terms of reference were drafted for discussion with the case note review team prior to commencing the case note review:

- To review 40 sets of case notes of children who underwent cardiac surgery, between January 2012 and January 2015, to identify any systematic problems with pre-operative, operative and post-operative care. These might be indicated by deviations from the planned care pathway, clinical incidents or episodes of deterioration in the child's clinical condition.
- To review cases in detail where problems are identified, to determine whether the care provided was appropriate based on the information available in the case notes.
- The planned pathway of care includes: pre-operative assessment and investigation, surgical intervention, post-operative care and follow up after surgery.
- To report in writing the results of the case note review identifying areas for improvement in care and areas of good practice.
- The report will be completed by the end of the summer of 2015.

Criteria for selection of cases

Cases will be selected based on the following criteria:

- Children will have completed a pathway of care from pre-operative assessment to post-operative care between January 2012 and January 2015
- Cases selected will cover the age range treated within the children's hospital
- The cases will be representative of all surgeons operating on children within the BRHC
- Cases selected will not include those being reviewed by the independent review team
- All cases will have included admission to PICU
- The team of experts will specify the range of congenital defects to be included
- Case notes will be randomly selected by the project lead and discussed with the case note review team prior to final selection.

Process for case note review

The case note review will be conducted using the following process:

1. A team of experts will be established in April 2015 to undertake the case note review. This will include a paediatric cardiac surgeon, a paediatric cardiologist, a paediatric intensivist and an experienced paediatric cardiac surgical nurse.

2. The process will be led by a Project Manager with experience in children's cardiac surgery. This person will be responsible for collating the information arising from the case note review and producing a report for CQC.
3. The case note review team/process will be supported by staff within CQC and the trust in Bristol. These individuals will prepare notes for review and arrange for records to be sent to the expert reviewers as required.
4. The review will consist of five stages:
    i) The review team will meet to agree terms of reference and the case note audit tool (to be provided)
    ii) Two members of the case note review team will review all 40 sets of notes on site at BRHC. All cases where problems are identified will be forwarded to the experts for more detailed review.
    iii) The expert reviewers will undertake a detailed examination of the selected case notes, based on the criteria identified in the case note audit form. Experts will review each case independently, recording findings on the audit forms, which will be returned to the project manager for collation.
    iv) The collated information will be discussed by the team to determine whether there are any problems in the care provided at BRHC.
    v) The report will be drafted and circulated to the experts for comment prior to being finalised and sent to CQC.

Appendix 2:

Clinical Cardiac Case Note Review Audit Form

Demographics

Case ID	*(Project case number between 1 & 45)*	**Date of birth**	
Gender		**Age in months**	*(at time of procedure)*

Admission details

Admission date	Ward HDU ICU (*circle appropriately*)	**Length of admission in**	(*days & hours*)
Source of referral	Foetal medicine or cardiology/ GP/A&E/OPD/NNU/External hospital/other (*please specify*)	**Type of admission**	Elective Emergency (*circle appropriately*)
Readmission within 30 days	Yes No (*circle appropriately*)	**Reason for readmission**	
Comments			

Diagnosis *(see local pathway at end of document)*

Primary Diagnosis		**Secondary diagnosis**	
Comorbidities		**Time of diagnosis**	Pre-natal Post-natal (*circle appropriately*)
Diagnostic procedures undertaken		**Compliance with local pathway**	Yes No (*circle appropriately*)
Evidence of explanation & discussion with parents/carer.	Yes No (*circle appropriately*)	**Evidence parents provided with written information**	Yes No (*circle appropriately*)
Referral to a Children's Cardiac CNS	Yes No (*circle appropriately*)	**Appropriate counselling support**	Yes No (*circle appropriately*)
Comments			

Preparation for procedures

Type of procedure	Open Closed (*circle appropriately*)	**Evidence of discussion at Joint Cardiac Meeting**	Yes No (*circle appropriately*)
Pre-operative clinic	Yes No (*circle appropriately*)	**Pre-operative preparation & visit to service**	Yes No (*circle appropriately*)
Pre-operative investigations complete	Yes No (*circle appropriately & list*)	***Pre-operative medication given as required***	Yes No (*circle appropriately*)
Pain management discussed (as appropriate)	Yes No (*circle appropriately*)	**Evidence of informed consent**	Yes No (*circle appropriately*)
Evidence of opportunity for parents /carers to ask questions.	Yes No (*circle appropriately*)	**Evidence procedure cancelled**	Yes No (*circle appropriately*) Reason: (*specify*)
Comments			

Procedure

Procedure undertaken		**Time taken**	(*hours & minutes*)
Bypass	Yes No (*circle appropriately*)	**Time on bypass**	
Cross clamp time		**Anaesthetic events**	Yes No (*circle appropriately & list*)
Surgical events	Yes No (*circle appropriately & list*)	**Recovery events**	Yes No (*circle appropriately & list*)
Comments			

Post-operative care

Evidence of appropriate monitoring	Yes No (*circle appropriately*)	**Pharmacological support appropriate to procedure**	Yes No (*circle appropriately*)
Pain relief provided with appropriate assessment of efficacy	Yes No (*circle appropriately*) Comments:	**Evidence that changes in cardiac status were managed appropriately**	Yes No (*circle appropriately*) Comments:
Evidence that changes in respiratory status were managed appropriately	Yes No (*circle appropriately*) Comments:	**Evidence that fluid balance was monitored and managed appropriately**	Yes No (*circle appropriately*) Comments:
Evidence that neurological status was monitored and managed appropriately	Yes No (*circle appropriately*) Comments:	**Evidence that haematological parameters monitored and managed appropriately**	Yes No (*circle appropriately*) Comments:
Evidence of explanations of care to parent/carer	Yes No (*circle appropriately*)	**Evidence of monitoring for signs of infection**	Yes No (*circle appropriately*) Comments:
Emergency events	Tamponade Yes No Cardiac arrest Yes No Chest opened Yes No Return to theatre Yes No Significant arrhythmia Yes No Other (please state) Yes No	**Effective management of emergency event(s)**	Yes No (*circle appropriately*) Comments:
Comments			

Parent/carer support

Evidence of regular discussion with parent/carer	Yes No (*circle appropriately*)	**Content of discussions recorded in child's records**	Yes No (*circle appropriately*)
Evidence of parental involvement in decision-making	Yes No (*circle appropriately*)	**Local accommodation provided**	Yes No (*circle appropriately*)
Access to CNS/ Psychologist/other outside the clinical team for support	Yes Not recorded (*circle appropriately*)	**Written information relating to pain relief and ongoing care provided on discharge from hospital**	Yes No (*circle appropriately*)
Evidence of bereavement support and counselling offered	Yes No (*circle appropriately*)	**Evidence of post-death follow up appointment**	Yes No (*circle appropriately*) Comment
Comments			

Discharge planning

Discharge summary: PICU **Hospital**	Yes No (*circle appropriately*) Yes No (*circle appropriately*)	**Copy of discharge summary to parents**	Yes No (*circle appropriately*)
Evidence of discharge planning	Yes No (*circle appropriately*)	**Information provided to parents/carers**	Yes No (*circle appropriately*)
Information provided to local hospital (*where appropriate*)		**Follow up review date planned**	Yes No (*circle appropriately*)
Date for review given to parent/carer	Yes No (*circle appropriately*)	**Evidence of provision of emergency advice**	Yes No (*circle appropriately*)
Comments			

Outcome

Outcome	(*circle appropriately*) Discharged home Discharged to local hospital for ongoing care Neurological deficit Palliative care Death Other (*specify*)		
Comment			
Overall comments			

Clinical records	**Completeness (comments)**	**Appropriately signed** Yes No (*circle appropriately*)	**Legible** Yes No (*circle appropriately*)
M&M meeting	**Case discussed** Yes No (*circle appropriately*)	**Conclusions drawn** Yes No (*circle appropriately*)	**Practice recommendations** Yes No (*circle appropriately*)
Comments			

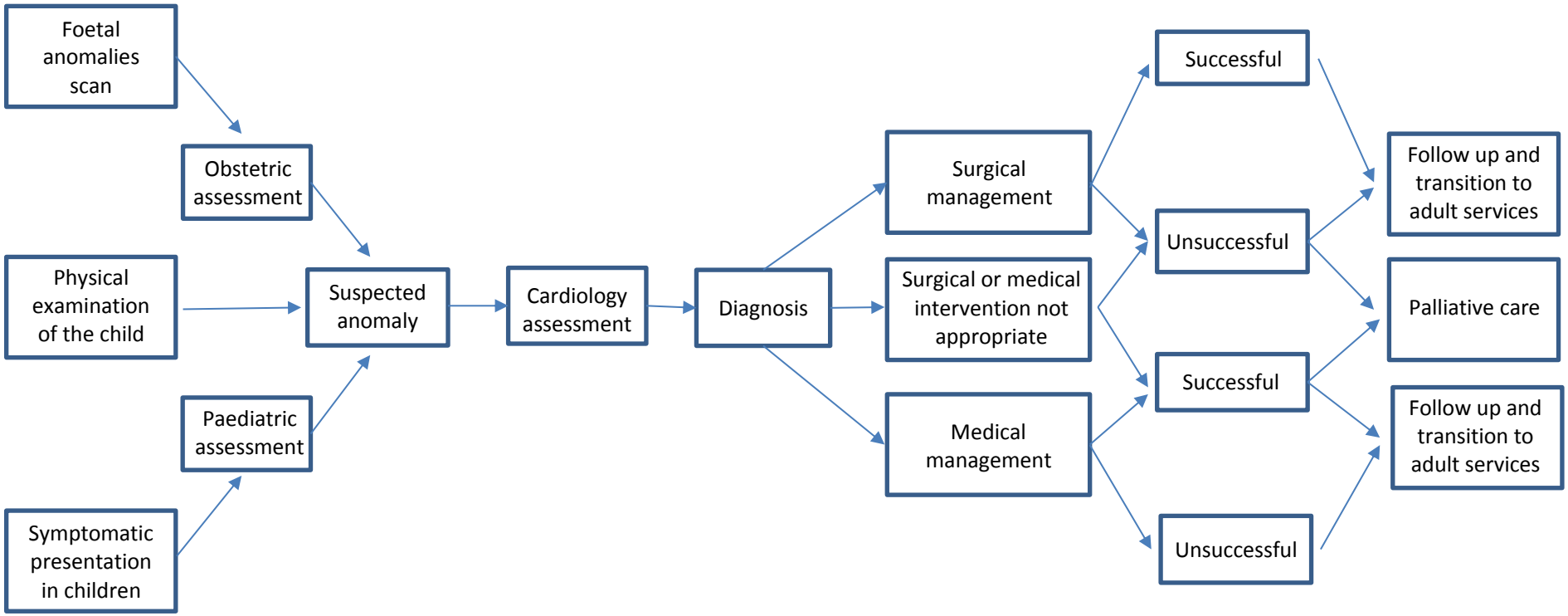
Signature---------- **Name----------**

Date----------

Appendix 3

The Congenital Heart Disease Pathway

The diagram below indicates the usual process a child's care will follow, from diagnosis, through to treatment and then to ongoing care.



University Hospitals Bristol NHS
NHS Foundation Trust
Trust Headquarters
Marlborough Street
Bristol, BS1 3NU
Email:robert.woolley@uhbristol.nhs.uk
Web-site: www.uhbristol.nhs.uk

Dear parents

On behalf of the Trust I'd like to express our gratitude to you for contributing to Eleanor Grey QC's review of children's heart services at our Children's Hospital. I know this could not have been an easy process to take part in.

I would also like to apologise to you for the things we got wrong. I am deeply sorry for when our care fell below acceptable standards, and for not supporting some of you as well as we could have. We know this must have added greatly to your distress at a very difficult time. For this we apologise unreservedly.

Parents have played an important role in bringing about significant changes in our practice and improving our care. We are committed to building on the work we have done so far by studying the recommendations in the reports on our services, and rapidly making improvements where we need to do so. We are also committed to strengthening our partnership with families and staff and continuing to work closely with the support groups that are already working alongside us. We know this is the basis of delivering safe and effective high quality care. I want to assure you that your contribution to the review will help us improve the services we provide and the way we support children and their families.

Because Eleanor Grey QC's investigation and work has been an independent process, conducted quite separately from the Trust, we don't know who contributed to the review. So I cannot directly contact you. But if you would like to contact me personally, please do so via ChiefExecutive@UHBristol.nhs.uk; via our LIAISE office on 0117 342 7444 (Monday to Friday, 10 am to 5 pm), or by letter to Trust Headquarters, Marlborough Street, Bristol. BS1 3NU. I would welcome the chance to arrange a time to say sorry in person. In addition, if you would like to register your interest in getting involved more closely with us and in helping us strengthen our partnership working with families please do so via these same contact points.

There is a small group of parents who also contributed to the independent expert case note review who have shared their individual reports with us. We want to fully consider these reports and will respond to these parents personally in the coming weeks.

Yours faithfully

Robert Woolley
Chief Executive

University Hospitals Bristol NHS
NHS Foundation Trust

The Report of the Independent Review of Children's Cardiac Services in Bristol

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(1) That any review of the Department of Health's Outlier policy (the policy followed by the NCHDA when its audits trigger alerts or alarms) should give specific attention to the need for publication of the responses to outlier alerts, and of any actions taken as a result.	Department of Health		
(2) That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data. **Initial Action** Framework for review of staffing requirements; - Changes in staffing during review period - Benchmark with other centres, linking with NCHDA recommendations - Review and report	Trust	Rebecca Dunn, Cardiac Services General Manager and Divisional Governance Lead	September '16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(3) That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	Trust	Carolyn Mills, Chief Nurse, Executive Lead Children's Services and Senior Responsible Office for Review Recommendation	
Completed Actions			
1. Current pathway of information that we give out to patients and families mapped including what we give, when and how. Gaps of information identified by team.			January '15
2. Creation of 4 new leaflets based on gap analysis exercise by team			January '15
3. Review of content of existing information by families via a listening event to identify any gaps and also accessibility of information.			February '15
4. Co-designed with families content of information leaflets and information on the website			February '15

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
Initial Action Draft new patient pathway including information and how to access, for review by cardiologists and cardiac surgeons in first instance and then link into next family listening event.			September '16
(4) That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth. **Initial Action** Correspondence from Network Manager and Network Clinical Director to Welsh Commissioners and University of Hospital of Wales to meet to discuss and agree process/pathway including method of monitoring its implementation.	South West and Wales Network	Dr Tometzki, Network Clinical Director	July '16
(5) The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol. **Initial Action** Network team to work with University Hospitals Wales and University Hospitals Bristol Clinical teams to review coordination between services. Define scope of exercise (based on initial meetings with Cardiff team may include: information and patient leaflets, IT and imaging links, discharge and repatriation processes and escalation, clinical leadership, attendance at meetings and job planning issues, clinical protocols and pathways, clinical governance processes).	South West and Wales Network	Dr Tometzki, Network Clinical Director	October '16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(6) There should be explicit recognition at a national level that children are 'lost to follow up' at points in time other than transition and transfer to other centres, which are the points explicitly reflected in the NCHD's current standard. The standard should be broadened, to recognise the matters of safeguarding which can arise for vulnerable children.	NHS England		
(7) The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments. **Initial Actions** 1. Submit an audit proposal following approval by cardiac clinical governance, to the audit facilitator for inclusion on the Children's annual audit plan. 2. Develop system for the regular reporting and review of follow up waiting lists at the monthly Cardiac Business meeting.	Trust	Rebecca Dunn, General Manager Cardiac Services and Divisional Governance Lead	 August'16 August'16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(8) The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective. **Initial Action** Review baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients to inform scope and focus of improvement plan for organisation of outpatient clinics.	Trust	Carolyn Mills, Chief Nurse, Executive Lead Children's Services and Senior Responsible Office for Review Recommendations	August '16
(9) In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary. **Initial Action** Benchmarking exercise and gap analysis with other units and site visits as appropriate - Combine with Network Visit, (e.g. to Southampton). Consider re visit of Leeds.	Trust	Ian Barrington, Women's and Children's Divisional Director	October '16
(10) NHS England should gather and/or publish, to the extent possible, the data necessary to assess the implementation of the NCHD standard, that tertiary centres	NHS England		

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
should employ one consultant cardiologist per half million people served, working flexibly across the Network.			
(11) That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC. **Initial Action** Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate.	South West and Wales Network	Dr Tometzki, Network Clinical Director	December '16
(12) That clinicians encourage an open and transparent dialogue with patients and families upon the option of recording conversations when a diagnosis, course of treatment, or prognosis is being discussed. **Initial Actions** 1. Policy/guidance to medical staff to ensure patients and families are given the option to record conversations exploring any legal/governance and reputational issues 2. Incorporate into children's consent pathway	Trust	Sean O'Kelly, Medical Director	November '16 December '16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(13) That the Trust reviews its Consent Policy and the training of staff, to ensure that any questions regarding the capacity of parents or carers to give consent to treatment on behalf of their children are identified and appropriate advice sought. **Completed Actions** 1. Review of current consent process by families via listening event 2. Co- design of new consent process with families 3. New consent process implemented apart from written risk information which is being agreed by surgeons **Initial Actions** 1. Evaluation of the Cardiac Consent pathway by families run by the Children Services psychology team 2. Written risk information surrounding surgery to be agreed by Cardiac Surgical Team and included as part of the consent process	Trust	Sean O'Kelly, Medical Director	February '15 February-December '15 March '16 March '16- to date September '16
(14) That the Trust reviews its Consent Policy to take account of recent developments in the law in this area, emphasising the rights of patients to be treated as partners by doctors, and to be properly informed about material risks. **Initial Action** Review the consent policy and training to address the issues raised.	Trust	Sean O'Kelly, Medical Director	January '17
(15) That a national protocol be agreed explaining the role of individuals and teams in paediatric cardiac surgery and cardiac catheterisations. Such a protocol should be shared at an early stage of the pathway of care, to ensure that all families are clear about how teams work and the involvement, under supervision of junior members of staff.	Department of Health		

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(16) As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other operators or team members. **Initial Action** A team to be established to review the children's hospital consent form.	Trust	Rob Tulloh, Cardiology Clinical Lead	September '16
(17) That the Trust carry out a review or audit of (i) its policy concerning obtaining consent to anaesthesia, and its implementation; and (ii) the implementation of the changes to its processes and procedures relating to consent. **Initial Action** 1. Review consent policy with respect to anaesthetic consent 2. Liaise with Royal College of Anaesthesia with regarding national policy	Trust	Sean O'Kelly, Medical Director	October '16 October '16
(18) That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services. **Initial Action** Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure	Trust	Rebecca Dunn, General Manager Cardiac Services and Divisional Governance Lead	August '16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(19) That NHS England should commission a review of Paediatric Intensive Care Services across England. We were conscious of the heavy strains placed on families by the limitations on the capacity of the Bristol PICU, during the period of this Review, and consider that this is likely to be a national issue that requires proper attention.	NHS England		
(20) That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support. **Completed Actions** 1. Appointment of additional bereavement support roles 2. Review of current pathway complete	Trust	Rebecca Dunn, General Manager Cardiac Services and Divisional Governance Lead	 June '16 June '16
Initial Action New End-of-life care and bereavement support pathway under development			September '16
(21) Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support. **Completed Actions (Trust)** 1. Cardiac Services psychology needs assessment complete 2. Submission made to commissioners for inclusion in 2016/17 prioritisation	Commissioners		 September '15 November '15

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
Initial Action (Trust) Revisit and update previous submission *(Louise Lloyd and Sue Dolby, Heads of Allied Health Professions Women's and Children's Division).*			November '16
(22) That the Trust review the implementation of the recommendation of the Kennedy Report that a member of the Trust's Executive, sitting on the Board, has responsibility to ensure that the interests of children are preserved and protected, and should routinely report on this matter to the Board. **Completed Actions** Refreshed accountabilities for the executive lead appointment for Children's services **Initial Action** Review current of arrangements and processes	Trust	Pam Wenger, Trust Secretary	April '15 September '16
(23) That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked. **Initial Action** Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety	Trust	Rebecca Dunn, General Manager Cardiac Services and Divisional Governance Lead	September '16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
incident reporting and management.			
(24) That urgent attention be given to developing more effective mechanisms for maintaining dialogue in the future in situations such as these, at the level of both the provider and commissioning organisations. **Initial Action** Discussion with commissioners on how best to achieve this.	Commissioners & Trust	Carolyn Mills, Chief Nurse, Executive Lead Children's Services and Senior Responsible Office for Review Recommendations (Trust)	October '16
(25) That when structural changes to the NHS are made, adequate resources are devoted to organising and archiving records in a way that will enable them to be retrieved and studied at a later date.	Commissioners		
(26) That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS	Trust	Carolyn Mills, Chief Nurse, Executive Lead	

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
England's Medical Directorate on this matter. Clear guidance should be given to patients or parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon. **Completed Actions** Links between Serious Incidents and other investigations policy written **Initial Action** Development of integrated process for managing complaints and investigations with guidance for families about the function and purpose of each element, how they may contribute, and how their contributions will be used in the report, along with information on support available to them.		Children's Services and Senior Responsible Office for Review Recommendations	July '16 October '16
(27) That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue. **Initial Action** Consider and explore sources of training available aiming to prevent breakdown in communications and stand-offs where possible	Trust	Sean O'Kelly	December '16
(28) That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or	Trust	Carolyn Mills, Chief Nurse,	

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
investigations which require it. **Initial Action** Revised complaints and concerns policy includes recommendations on independence, for review by the Senior Leadership		Executive Lead Children's Services and Senior Responsible Office for Review Recommendation	August '16
(29) That as part of the process of exploring the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation.	Trust	Carolyn Mills, Chief Nurse, Executive Lead Children's Services and Senior Responsible Office for Review Recommendation	
Initial Action Initial meeting with Trust Quality Team and Divisional team to discuss best approach.			September '16
(30) That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result	Trust	Carolyn Mills,	

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
of a complaint or incident involving them or their families and seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation. **Initial Action** Trust wide meeting organised to discuss best approach to involving complainants in devising solutions		Chief Nurse, Executive Lead Children's Services and Senior Responsible Office for Review Recommendation	July '16
(31) That the Trust should review the history of recent events and the contents of this report, with a view to acknowledging publically the role which parents have played in bringing about significant changes in practice and in improving the provision of care.	Trust	Carolyn Mills, Chief Nurse, Executive Lead Children's Services and Senior Responsible Office for Review Recommendation	
Initial Action Formal paper to the Board and evidence within the action plan.			July '16

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE (Initial Action)
(32) That the Trust redesignate its activities regarding the safety of patients so as to replace the notion of "patient safety" with the reference to the safety of patients, thereby placing patients at the centre of its concern for safe care. **Initial Action** Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide	Trust	Sean O'Kelly, Medical Director	December '16

Clinical Case Note Review: A review of pre-operative, peri-operative and post-operative care in cardiac surgical services at Bristol Royal Hospital for Children

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE
(1) Recording the percentage risk of mortality or other major complications discussed with parents or carers on consent forms **Initial Actions** 1. Written risk information surrounding surgery to be agreed by Cardiac Surgical Team and included as part of the consent process 2. Review of Trust consent policy	Trust	Sean O'Kelly, Medical Director	September '16 January '17
(2) Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery **Initial Action** Provide a formal report for transoesophageal or epicardial echocardiography performed during surgery that can be audited.	Trust	Rob Tulloh, Cardiology Clinical Lead	September '16
(3) Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Trust	Zoe Trotman, Ward 32 Manager	

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE
Initial Action Complete an audit on existing practise and report findings			September '16
(4) Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12) **Initial Action** Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records	Trust	Hazel Moon/Mark Gonninon, Head of Nursing, Women's and Children's Division	October '16
(5) Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3) **Initial Action** *Please refer to Cardiac Review recommendation 3*	Trust	Rob Tulloh Cardiology Clinical Lead and Andy Tometzki, CHD Network Director	

RECOMMENDATION	LEAD ORGANISATION	LEAD OFFICER	TIMESCALE
(6) Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed. **<u>Initial Action</u>** Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services	Trust	Louise Lloyd, Head of Allied Health Professional, Women's and Children's Division	October '16

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
08. Congenital Heart Disease Commissioning Standards									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: Paula Clarke, Director of Strategy and Transformation									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

NHS England have undertaken a robust national review of congenital heart disease (CHD) services. As part of this process, UH Bristol's ability to meet a set of "key requirements" has been assessed by a National panel.

The self-assessment process required Trusts to outline how they met each of the key requirements in detail and provide supporting evidence. They were also expected to lay out mitigations where gaps remained and/or plans to close the gaps. The process of assessment is further described in the attached report.

The panel have now confirmed University Hospitals Bristol will continue to be a Level 1 provider of CHD care for paediatric and adult patients, subject to the delivery of plans that enable the Trust to fully meet the required standards of care. It should be noted that this has not been the case for all existing providers and two surgical units are expected to close. Where NHS England have highlighted areas for further development/mitigation, an action plan to address these concerns has been developed. This action plan is included.

Key issues to note

Progress has already been made in several areas as outlined in the action plan.

A decision will be required by the Trust and Commissioners on the deliverability of an appropriate level of access to adult ECMO in emergency situations (4.4, B in the action plan), once an assessment of the clinical and financial service model has been undertaken by the Trust.

Recommendations
The Board is asked to receive the report for assurance.
Impact Upon Board Assurance Framework
Supports strategic priority 1, 3, 4, 5, 6, 7
Impact Upon Corporate Risk
Not applicable although a risk is held on the Division of Women's and Children's Risk Register

Implications (Regulatory/Legal)
Not applicable
Equality & Patient Impact
Securing the future of University Hospitals Bristol as a Level 1 Centre will enable patients based in South Wales and the South West to continue to receive CHD services as close to home as possible.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

NHS England

Paediatric Cardiac and Adult Congenital Heart Disease Standards Compliance Assessment: Report of the National Panel

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Description	This document provides a report of the self-assessment process carried out with current level 1 and level 2 congenital heart disease centres in England.
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Contact Details for further information	Will Huxter Senior Responsible Officer for the CHD Programme NHS England 105 Victoria Street, London SW1E 6QT www.england.nhs.uk

Document Status

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

NHS England is the direct commissioner of congenital heart disease (CHD) services, as prescribed specialised services. On 23 July 2015, the NHS England Board agreed new standards and service specifications for CHD services, with the expectation that in future all providers would meet the standards, leading to improvements in service quality, patient experience and outcomes. The Board agreed a go-live date of April 2016 to begin implementation of the new standards, embedded in contracts with providers, with a standard-specific timetable giving up to five years to achieve full compliance.

The standards are based on a three tier model of care with clear roles and responsibilities (and standards) for each tier. Networks will help local services to work closely with specialist centres, to ensure that patients receive the care they need in a setting with the right skills and facilities, as close to home as possible. The three tiers are:

> ***Specialist Surgical Centres (level 1)***: These centres will provide the most highly specialised diagnostics and care including all surgery and most interventional cardiology.
>
> ***Specialist Cardiology Centres (level 2)***: These centres provide specialist medical care, but not surgery or interventional cardiology (except for one specific minor procedure at selected centres). Networks will only include level 2 centres where they offer improved local access and additional needed capacity.
>
> ***Local Cardiology Centres (level 3)***: Accredited services in local hospitals run by general paediatricians / cardiologists with a special interest in congenital heart disease. They provide initial diagnosis and ongoing monitoring and care, including joint outpatient clinics with specialists from the Specialist Surgical Centre, allowing more care to be given locally.

The Board agreed proposals for commissioning the service and endorsed initial work with providers to develop proposals for ways of working to ensure the standards would be met. This work with providers commenced in April 2015, culminating in the submission of proposals in October 2015. Seven submissions were received, some from networks based on a single surgical centre, others from new multi-centre networks. The proposals were comprehensively assessed by a commissioner led panel, with clinician and patient/public representation. The panel advised that certain standards were considered particularly important for service quality, safety and sustainability:

- Surgeons should be part of a team of at least four, with an on-call commitment no worse than 1:3 from April 2016 and that each surgeon must undertake at least 125 operations per year. From April 2021 a minimum 1:4 rota will be expected.
- Surgery should be delivered from sites with the required service interdependencies. The standards specify which services should be on the same site, and the level of responsiveness required from these and other services. Some of the requirements for co-location are new, so hospitals have until April 2019 to meet them.

NHS England accepted the panel's assessment that, taken together, the initial provider proposals did not provide a national solution and giving more time was unlikely to yield a different outcome.

It was decided therefore that action should be taken to ensure that the April 2016 standards were met as soon as possible, with immediate action to ensure that appropriate short term mitigations are put in place in the meantime to provide assurance of safety. The process reported in this paper was endorsed by NHS England's Specialised Services Commissioning Committee (SSCC).

2 The assessment process

A further process to assess compliance with the standards was launched in January 2016. It set out 14 requirements organised into five themes:

1. Ensuring that paediatric cardiac / ACHD care is given by appropriate practitioners in appropriate settings
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake sufficient practice to maintain their skills
3. Ensuring that there is 24/7 care and advice
4. Ensuring that there is effective and timely care for co-morbidities
5. Assuring quality and safety through audit

Within the 14 requirements, this assessment covered 24 paediatric standards (and the corresponding adult standards) considered to be most closely and directly linked to measurable outcomes (including the surgical and interdependency standards previously highlighted) and to effective systems for monitoring and improving quality and safety.

Providers of CHD level 1 & 2 services were asked to provide evidence of their compliance with the April 2016 standards. As the standards are being introduced in a phased way to allow hospitals longer to prepare for the more demanding standards, consideration was also given to the ability of providers to reach the later requirements.

Where providers could not demonstrate that standards are met, they were asked to describe their plans to achieve the standards and the mitigating actions they proposed to take to provide assurance of the safety and quality of services until all the standards were met. An acceptable development plan was considered to be one that gave a high degree of assurance (in the view of NHS England) that the standard would be met within 12 months of the standard becoming effective.

This process was closely based on NHS England's usual approach when introducing a new service specification.

Additional information was needed in order to complete the process and this was requested in March 2016. These additional returns were assessed in April 2016.

Each set of returns was initially evaluated at a regional level by the NHS England specialised commissioning team, followed by a national panel review to ensure a consistency of approach. The national panel brought together NHS England staff from its national and regional teams with representatives from the Women and

Children's Programme of Care Board and the Congenital Heart Services Clinical Reference Group to provide wide ranging and senior clinical advice and patient and public perspectives. NHS England then gave each provider organisation the opportunity to comment on the factual accuracy of its assessment, so that the provider's comments could be taken into account before the assessment was finalised.

This report of the national panel's findings represents NHS England's assessment of compliance with the standards and the action it is proposing to take, subject to appropriate public involvement and/or consultation.

3 Specialist Surgical Centres (level 1)

3.1 Overall assessment

The detailed assessment of each centre, based on the evidence submitted is summarised here.

	Green	Green / Amber	Amber	Amber / Red	Red
	Meets all the requirements as of April 2016.	Meets most of the requirements as of April 2016 and has good plans to meet the rest within max. 12 months.	Should be able to meet the April 2016 requirements with further development of their plans.	Does not meet all the April 2016 requirements and is unlikely to be able to do so.	Current arrangements are a risk.
North			Alder Hey Leeds	Newcastle	Central Manchester
Midlands and East		Birmingham Children's	UH Birmingham	Leicester	
London		Great Ormond Street	Barts Guy's and St Thomas'	Royal Brompton	
South			Bristol Southampton		

We found that none of the centres met all the standards tested. This was not unexpected, as the standards were designed to ensure that all services were brought up to the level of the best of existing practice - to be stretching and drive improvement without being unrealistic.

The differences we found between centres, particularly between those rated green/amber and those rated amber/red were starker than the ratings alone may

imply. Those rated green/amber scored 12 out of 14 with only quite small and easily achievable improvements needed to move to a 100% rating. This contrasts strongly with the centre rated red which met only 6 of the 13 areas tested and where the required improvements would be extensive, and considered by the national panel not to be realistically achievable. Indeed it is this - our assessment of whether it is realistic to expect the providers rated amber/red to be able to meet those requirements where they fall short - that separates them from those providers rated amber (rather than a simple assessment of how many of the requirements are met).

The national panel's assessment confirmed that two elements of the April 2016 standards present a particular challenge and this was reflected in the assessments of those centres rated red and amber/red:

3.1.1 Minimum volumes of surgical / interventional activity for individual consultants and the minimum size of a surgical or interventional team.

During the process to develop the standards, surgeons told us that the number of operations they each carried out was the most important factor in achieving good surgical outcomes. Bigger teams are more resilient and better able to support the development of subspecialty practice. The standards require that each surgeon undertakes a minimum of 125 operations per year. This is a minimum threshold rather than a target. They also require that from April 2016 surgeons are part of a team of at least three, and from April 2021 part of a team of at least four. Although some centres significantly exceed the minimum required activity to support the required surgical teams, the national panel found that others (Manchester, Newcastle and Leicester) had not demonstrated that they met the minimum requirement:

- Manchester has fewer than 100 operations annually undertaken by a single surgeon, with interventional cardiology provided on a sessional basis. Appropriate 24/7 surgical or interventional cover is not provided. The national panel considered this to be a risk, and rated the centre red.
- Newcastle reported insufficient activity for three surgeons in 2014-2015. At the time of the national panel's assessment, Newcastle predicted that it would not perform 375 operations annually until 2016 - 2017. The national panel noted that the full standard (effective from 2021) requires a team of four surgeons rather than three, and considered that there was no realistic prospect of this being achieved during this period. Newcastle's response to the fact check indicated that activity in 2015 - 2016 had been higher than expected and had taken its activity to a level sufficient to support a three surgeon team. This is provisional data (as it is not yet validated by NICOR) but if confirmed, and sustained beyond one year, and if the activity was distributed appropriately between three surgeons, would meet the April 2016 requirement.
- Leicester reported insufficient activity for three surgeons in 2014-2015 and 2015-16. Leicester's response to the fact check indicated an expectation that the April 2016 requirement would be met over the three year period 2016-2019 and that it considered it was on target to achieve it in 2016-2017, though no additional data was supplied. Although Leicester described plans to increase activity, the national panel considered that this did not provide sufficient assurance to be confident that the requirements would be met during the next 12 months. The national panel noted that the full standard (effective

from 2021) requires a team of four surgeons rather than three, and considered that there was no realistic prospect of sufficient activity to support this requirement being achieved during this period.

While activity is expected to rise overall across the country, and repatriation of interventional activity from non-specialist centres will provide modest help, this will not resolve the problem that there is not enough activity nationally to support the number of centres now delivering the service.

3.1.2 Availability of advice, care and support from interdependent clinical services

The standards require that a range of other specialists needed by children with CHD must be able to deliver care at the patient's bedside at any time of day, seven days a week and 365 days a year. This is because many children with CHD have multiple medical needs. Co-location of specialised paediatric services is also considered important because it allows much closer working relationships to develop between paediatric cardiology specialists and the wider specialised paediatrics team. For hospitals where all of these services are not provided on the same site, this is more challenging:

- Leicester delivers care for children from a mainly adult hospital and the national panel found that assurance of 24/7 bedside care from a full range of paediatric specialists was lacking. Leicester's response to the fact check indicated an expectation that for a number of these the April 2016 requirement would be met by April 2017. The national panel noted that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time. Leicester does not currently meet these requirements and the national panel considered that it would not realistically be able to do so by 2019.
- Royal Brompton delivers care for children from a mainly adult hospital. While the national panel found that assurance of 24/7 bedside care from a full range of paediatric specialists was lacking, Royal Brompton submitted additional evidence in response to the fact check which provided this assurance. However, the national panel noted that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time. Royal Brompton does not currently meet these requirements and the national panel considered that it would not realistically be able to do so by 2019.
- Newcastle provided evidence to show that it is able to meet the April 2016 requirements. The national panel noted, however, that the full standards (effective from 2019) require co-location of a greater number of paediatric services, not just a 30 minute response time, and that the current arrangements at Newcastle would not meet these requirements.

3.2 Other issues

Care by CHD specialists

The standards require that surgery and interventional practice for CHD patients must only be undertaken by CHD specialists. Some level 1 centres told us in their submissions that this is not always the case, and doctors who are not recognised specialists in the care of CHD are sometimes involved. Some of the centres argue that this represents a legitimate approach because of their specialist skills. This needs to be urgently addressed with those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

Surgical and interventional practice

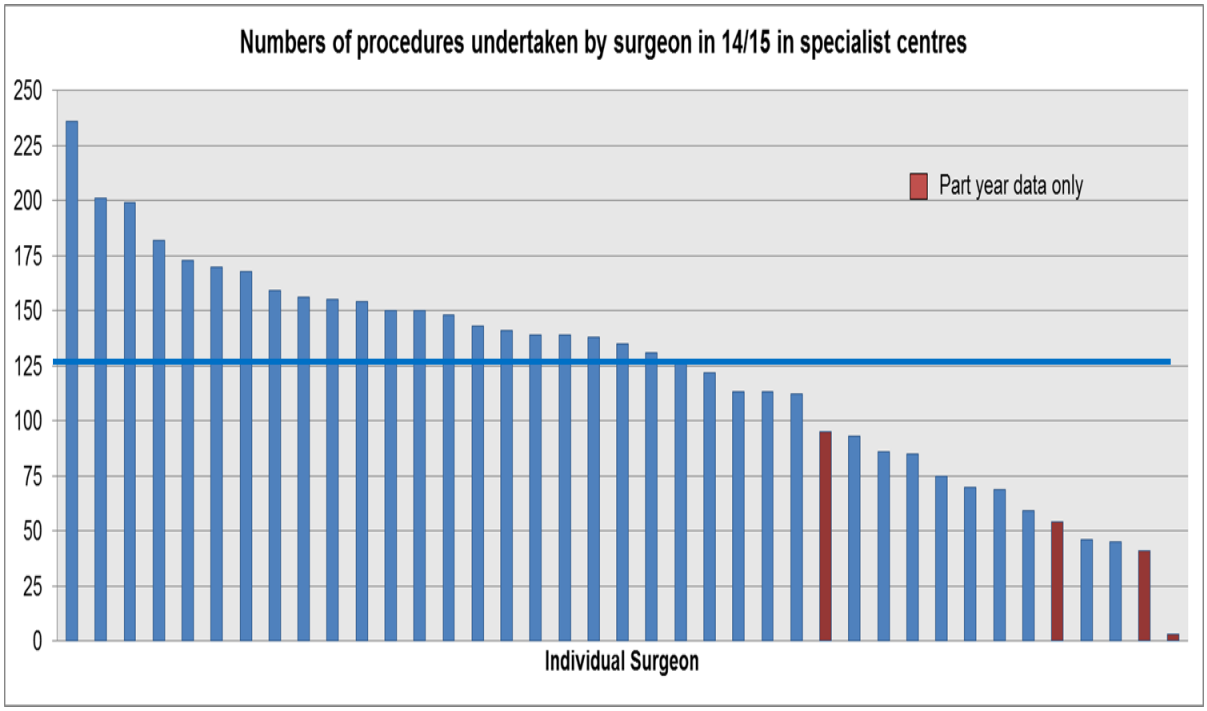
From the data supplied by the level 1 centres (figure 1 below) we can see that there are some surgeons whose activity levels fall below, and in some cases well below stated requirements. This is not just an issue for centres with low activity levels. It also occurs when centres have chosen to have too many practitioners or not to distribute activity in a way that achieves compliance with the standards. This needs to be urgently addressed by those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

Sometimes low activity was seen because of a change of staff, for example a cross-over between a retiring surgeon and their replacement. This is not considered a problem.

Taking the requirements for individual surgeon activity and for team size together, the implication of this is that in order to meet the standards each surgical centre will need a case load of at least 500 operations annually as a minimum. The Clinical Reference Group has previously advised that more than 500 cases would be needed at each centre because it would be operationally challenging to ensure that all surgeons reached the minimum activity required and every patient received their care from an appropriate surgeon if the unit's total activity was exactly 500 or only slightly above.

The evidence supplied shows that it is quite possible for surgeons to undertake 200 or more operations annually, emphasising the point that 125 operations per year is a minimum not a maximum. This is important in considering the efficient use of scarce resources as well as for consistency of outcome.

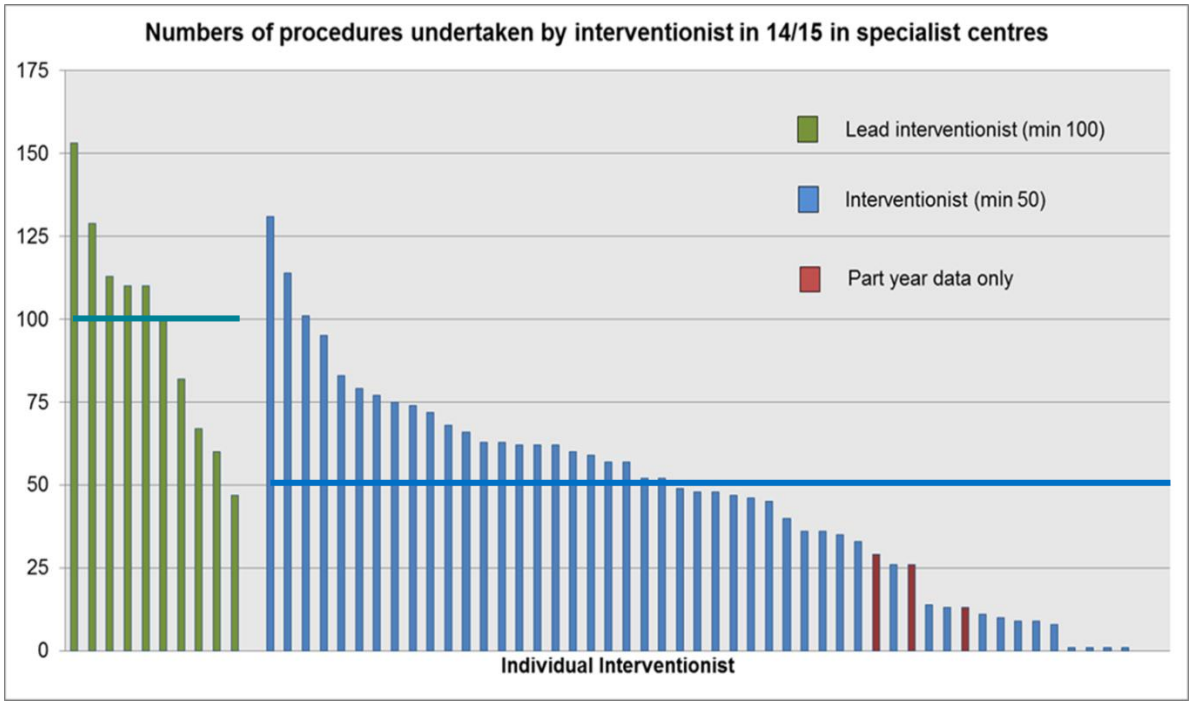
Figure 1: Number of procedures undertaken by individual surgeons in level 1 specialist surgical centres (2014-15)



From the data supplied by the level 1 centres[1] (see figure 2 below) we can see that these challenges are even more pronounced for interventional cardiology practice. There are many interventionists whose activity levels fall below, and in some cases well below, our requirement that lead interventionists undertake at least 100 procedures and other interventionists at least 50 procedures. As with surgery this results from a combination of factors including centres with too little activity, centres with too many practitioners and from poor distribution of activity within a centre. This needs to be urgently addressed by the centres concerned and NHS England regional commissioners will follow this up directly with the providers concerned.

[1] The individual interventionist activity numbers used here are those reported by each centre. Comparison with NICOR data shows that some of these include procedures which cannot be counted towards the volume required by the standards. While it is not possible from the data available to produce an absolutely definitive view of the number of procedures undertaken by each interventionist, whichever data source is used we see that a significant number of interventionists do not meet the minimum activity levels required by the standards. This is addressed in more detail in the individual centre reports.

Figure 2: Number of procedures undertaken by individual interventional cardiologists in level 1 specialist surgical centres (2014-15)



Ensuring there is 24/7 care and advice

The standards include adult care as well as children's services in order to ensure that excellent care is delivered to all age groups. Information from a number of centres showed that 24/7 care – both on-call and seven day working – is less robust for adult patients than for children. This needs to be addressed by those centres and NHS England regional commissioners will follow this up directly with the providers concerned.

The evidence supplied revealed that in a number of centres clinicians are on more than one duty rota at the same time. The national panel considered that while there could be circumstances when it would be acceptable for a clinician to be on more than one rota, this was not always the case. The key test was the likelihood that being on one rota would prevent the clinician from discharging their duties on the other rota. The national panel had particular concerns about out of hours arrangements that would require a member of staff with responsibilities for patient care on one to site to leave that site to attend a CHD patient on a different site. The national panel considered that where these arrangements involved more than one organisation this added to the risk that duty doctors could be faced with conflicting priorities.

While all centres described arrangements to provide advice 24/7 to patients, families and other health professionals, only some described clearly how they made sure staff knew how to handle requests for information and advice. Similarly only some centres had systems in place that ensured those seeking advice (patients, their families and other health professionals) knew how to obtain it.

An age appropriate environment

Around 80% of procedures (surgery and interventional) are undertaken in children so it is important to provide their care in an age appropriate environment where paediatric CHD care is delivered alongside other paediatric services – on the same site and with the ability to meet challenging response times. The evidence supplied showed that this is challenging for providers that deliver paediatric CHD care from specialist hospitals mainly focussed on adult services.

Many centres also found it challenging to articulate how they provided an appropriate care environment for patients with physical and/or learning disability, suggesting that this is an area where sharing best practice could be helpful.

Governance and improvement

The development of formal network governance arrangements and oversight of level 2 centres undertaking interventional cardiology in adults with CHD is a new requirement and progress so far is patchy. There is more to do for providers in establishing these arrangements and for NHS England in establishing which centres will continue to practise at level 2.

Many centres were able to describe clinical governance, audit and improvement activities though evidence of learning and action resulting from this activity was sometimes not available. As networks develop we expect this area to improve as the standards require networks to develop a robust and documented clinical governance framework that includes clinical audit; regular network meetings to discuss patient pathways, guidelines and protocols, mortality, morbidity and adverse incidents.

4 Level 2 centres and occasional practice

The standards do not permit occasional and isolated practice (small volumes of surgery and interventional cardiology being undertaken in institutions that do not offer sufficient specialist expertise in this field). Occasional and isolated practice has been of particular concern to patients and their representatives.

Our analysis showed that surgery and interventional cardiology procedures in CHD patients may have been happening at a number of non-specialist centres. The standards only permit this to continue in very specific circumstances[2]. Most non-specialist centres were not expected to wish to meet these requirements.

We asked all these centres to confirm whether CHD procedures had taken place and if they had, either to cease occasional practice or to take steps to meet the requirements of the standards, including minimum volume requirements. Most providers confirmed that the apparent occasional practice revealed by analysis of HES data was due to coding errors. In other cases, the practice had already stopped or steps were being taken to move this activity to an appropriate level 1 or level 2 centre.

The issue has not yet been resolved at a number of providers, either because no response has been received or because an application to work as a level 2 Adult

[2] Closure of atrial septal defects (ASDs) by interventional cardiology at level 2 ACHD centres can continue providing individual operators meet minimum volume requirements and the centre meets all the level 2 ACHD standards.

CHD centre is unlikely to be agreed. These will be followed up by NHS England regional commissioners to ensure that occasional and isolated practice is eliminated.

Some centres confirmed that they wished to be considered as level 2 (specialist adult CHD medical centres). Centres wishing to work in this way were assessed at the same time as the level 1 centres against the corresponding standards.

The detailed assessment of each centre, based on the evidence submitted, and after the fact check process described above had taken place, is summarised here.

	Green	**Green / Amber**	**Amber**	**Amber / Red**	**Red**
	Meets all the requirements as of April 2016.	Meets most of the requirements as of April 2016 and has good plans to meet the rest within max. 12 months.	Should be able to meet the April 2016 requirements with further development of their plans.	Does not meet all the April 2016 requirements and is unlikely to be able to do so.	Current arrangements are a risk.
North			Liverpool Heart & Chest		Blackpool; South Manchester
Midlands and East	Norwich & Norfolk*			Nottingham	Papworth
London					Imperial
South		Brighton	Oxford		

* Norwich & Norfolk was assessed as a medical only centre – it does not offer interventional ASD closures

NHS England's regional commissioners will discuss the arrangements at those providers assigned an amber/red or red rating with a view to ensuring that in future patients requiring ASD closure receive their care from an appropriate provider.

5 What happens next?

The issues we are grappling with are complex, but as commissioners we intend to see them through with a view to securing the best outcomes for all patients, tackling service variations and improving patient experience. That includes ensuring that all hospitals providing CHD care are able to meet the standards, or get as close as possible to them with satisfactory safeguards in place.

When we launched this assessment process with providers in December 2015 we advised them about how we intended to respond to the findings:

'…the outcome of the assessment may be one of the following:

- *NHS England continues to contract with a provider without conditions;*
- *NHS England will contract with a provider on the basis of a 'derogation' from the service specification (a time-limited agreement that providers can operate outside of the service specification, with an action plan to achieve compliance);*
- *If a provider does not meet the specification and is unlikely to be able to do so, we would need to discuss future service provision.'*

This report was considered by the Specialised Services Commissioning Committee (SSCC), a sub-committee of the NHS England Board, at the end of June. SSCC has recognised that the status quo cannot continue and that we need to ensure that patients, wherever they live in the country, have access to safe, stable, high quality services. SSCC also recognised that achieving this within the current arrangement of services would be problematic.

SSCC has determined that subject to appropriate public involvement and/or consultation, a change in service provision is appropriate and we expect that any such changes will be part of a managed process and that continuity of care for patients will be a high priority.

While the ability to meet the standards is an extremely important consideration as we seek to ensure that all patients benefit from the same high quality of care, it is not the only consideration. The NHS England board recognised this when it agreed the standards in summer 2015, setting out an intention to take into account and balance all the main factors, including: affordability; impact on other services; access; and patient choice; and not to treat the standards as though they existed in isolation.

Heart transplant services were not covered by the CHD standards as they have their own separate service specification. The national panel considered that the potential impact of any changes to CHD services on paediatric heart transplant and bridge to transplant services (which are only delivered by two providers - Newcastle and Great Ormond Street) would need careful consideration. In addition, adult CHD patients with end stage heart failure have limited access to heart transplant. The unit in Newcastle is recognised as delivering more care to this group than other adult heart transplant centres nationally.

For those providers where our assessment has shown that improvements are needed, we expect that agreed development plans and mitigations will become contractually binding by incorporation in provider Service Delivery Improvement Plans (SDIPs). NHS England regional service specialists will set out clearly the evidence required from providers to demonstrate that individual milestones of the agreed action plan have been met, and will meet with providers regularly to monitor progress, at least quarterly.

6 Ongoing approach to assuring standards compliance

We have a comprehensive process for ensuring that providers will meet all of the standards:

- CHD networks will be established with a specific focus on quality and improvement both operational (for example through the network MDT for rare, complex and

innovative procedures) and developmental (through network audit and improvement activities and clinical governance meetings). Patients and families will have an important role in the operation of the new CHD networks.

- Where providers need more support to achieve the standards we will facilitate arrangements to give access to support and advice from other providers. Where appropriate commissioners will provide project support.
- Our work with the CRG on the clinical dashboard and with NICOR on the national audit, and the new patient reported outcome measurement (PREM) tool we have commissioned will make available a much broader range of information about services to guide improvement activities and performance management.
- Regional commissioners will work through STPs and CCOGs to ensure that level 3 services are appropriately commissioned and play a full part in networks.

Meanwhile we are continuing to deliver a very active programme of work to support the implementation of the standards, including a new implementation group. This new group brings together clinicians from across the service with an interest in CHD, service and network managers, patients and their representatives and commissioners to work together on the challenges of meeting the whole span of standards, and to share best practice.

NHS England Review of UHB's self-assessment against the new CHD standards, key requirements

Action plan to achieve full compliance:

Measure	Requirement	NHSE Commentary – key points	Development plan/mitigations required	Lead	Time scale	Progress/comments	RAG
1. Ensuring that paediatric and adult CHD care is given by appropriate practitioners in appropriate settings.	1.1 All paediatric cardiac and adult CHD surgery, planned therapeutic interventions and diagnostic catheter procedures to take place within a Specialist Surgical Centre (exceptions for interventional and diagnostic catheters in adults noted below).	Refers to arrangements with Cardiff to provide oversight to their level 2 service. A written agreement will be established once the pathway has been confirmed within Quarter 1 of 2016/17. Must inform commissioners if timescale not going to be met.	Work-up and finalise written Service Level Agreement with Cardiff.	CM	Sep-16	Meeting with Cardiff adults team 19/7. Will be deliverable but will be quarter 2 due to current gaps in management in Cardiff to facilitate work and sign off agreement. Commissioners to be informed of realistic timescale.	
2. Ensuring that those undertaking specialist paediatric cardiac / ACHD procedures undertake sufficient practice to maintain their skills.	2.2 Cardiologists performing therapeutic catheterisation in children/young people and in adults with congenital heart disease must be the primary operator in a minimum of 50 such procedures per year (a minimum of 100 such procedures for the Lead Interventional Cardiologist) averaged over a three-year period.	Discrepancy between data used by NHSE England sourced from NICOR vs UHB data on numbers.	Need to unpick discrepancy with NICOR, and involve commissioners in discussions as necessary.	OW	Sep-16	Currently working with NICOR to understand discrepancy. Thought to be around their inclusions/exclusions of certain types of procedures. UHB is confident in total numbers of interventions that were submitted to NHS England.	

		UHB must develop a plan to manage interventional workload to meet the required numbers during 16/17 and appropriate mitigation in the meantime. Must also monitor activity and inform regional commissioners if at any point we consider it likely one or more of our interventionists will not meet the requirement.	Once discrepancy understood and final numbers agreed, the paediatric and adult teams need to work through projected activity by clinician and agree a plan to increase activity if/where required. If unable to ensure interventionists meet required numbers, need to inform commissioners and ensure appropriate mitigations.	RD/RT, AH/SC	Mar-17	Will progress once data is understood as per the above.	
3. Ensuring that there is 24/7 care and advice.	3.5 Patients and their families can access support and advice at any time	Bristol's plan to offer patients direct access to the on-call ACHD consultant or Specialist Registrar out of hours was considered realistic. The service is currently revising patient information to reflect this extended service and intends to implement this by September 2016. Bristol must inform regional commissioners if at any point they consider it likely that this timetable will not be met.	Service is in place. Information on patient letters heads to be changed to further highlight access to patients.	RB	Sep-16	Posters have gone up in BHI advertising process to patients. Letters in process of being changed. No concerns around delivery.	

4. Ensuring that there is effective and timely care for co-morbidities.	4.1 Specialist Surgical Centres must have key specialties or facilities located on the same hospital site. Consultants must be able to provide emergency bedside care (call to bedside within 30 minutes).	A) No 24/7 bedside paediatric gastroenterology. Bristol should regularly audit the effectiveness of the proposed mitigating arrangements (24/7 on-site support from general paediatrics, paediatric surgery and paediatric anaesthetists to provide first line care for gastroenterological emergencies with informal access to the lead paediatric gastroenterologist for advice) were considered acceptable by the panel) and report the results within their network and to regional commissioners.	Audit to be established and outputs reported to Network and Commissioners.	RT/RD/CS	Sep-16	Likely to be v small numbers/none. Discussions in progress around audit methodology. No concerns about delivery.	
		B) Adult ECMO (for Adult CHD). UHB does not have this service. Trust developing robust clinical and financial service model in 16/17. Need to describe current arrangements for providing this support to adult CHD patients requiring perioperative extracorporeal life support, plans and effective mitigation that could be produced. Commissioners to review, agree and monitor implementation of plan.	There is currently no adult ECMO service offered by the Trust. The Trust is progressing a cost/benefit analysis to inform further dialogue with commissioners with a focus on provision of “rescue” ECMO.	AB/ Commissioners	Dec-16		

		C) Vascular and interventional radiology. Provide a detailed description of care with Southmead and evidence commitment to achieve 30 minute call to bedside.	Work with Southmead to produce written description of care and evidence of commitment to meeting 30 minute call to bedside.	AH/ RD/ AT/ MB	Sep-16	Contact made with North Bristol team to create written document and evidence commitment to timely care.	
5. Assuring quality and safety through audit.	5.1 Specialist Surgical Centres must participate in national audit programmes, use current risk adjustment tools where available and report and learn from adverse incidents.	A) Bristol's NICOR data more at variance with NICOR than other centres. Further discussion required over nature of discrepancy and whether it affects validity of returns.	See 2.2 above.	OW	Sep-16	See 2.2 above	
		B) Continue to develop network arrangements.	Continue with Network plans.	CM/ AT	Mar-17	Manager, Clinical Director and Administrator in post. Nurse start date Oct. Board launch event took place in June - 58 stakeholders involved. Regional meetings occurring. No concerns around delivery.	

CM – Caitlin Marnell, AT - Andy Tometzki, RB – Radwa Bedair, CS - Chris Spray , OW – Olga White, AH – Alastair Haigh, ST – Steph Curtis, RD - Rebecca Dunn, AB - Alan Bryan, MB - Markus Brooks (North Bristol Trust), RT - Rob Tulloh

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public to be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
09. Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital.									
Sponsor and Author(s)									
Sponsor & Author: Robert Woolley, Chief Executive									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

This report describes progress in the delivery of the recommendations of the report of an independent investigation commissioned from Verita into events following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

Key issues to note

The Trust commissioned an independent investigation from Verita in December 2015 into the management response to allegations about staff actions and behaviours in relation to the death of a baby on the paediatric intensive care unit in April 2015, at the age of 2 months.

Verita produced their report on 16 June. Verita concluded that the Trust had missed a number of significant opportunities to engage proactively with the family after their baby's death, to be more open and candid with the family, to understand the seriousness of their allegations and to give them clear answers to a number of their questions. Despite the Trust believing that it had endeavoured to respond fully to their concerns, the Trust failed to get an appropriate grip of the complaint and lost the trust of the family as a result.

The Chief Executive wrote to the family on 17 June, giving unreserved apologies for the failings identified by the Verita investigation.

The Trust has accepted Verita's findings in full.

Recommendations

- note Verita's finding that there is no conclusive evidence to prove or disprove the charge of a conspiracy to cover up what happened in the care of the baby
- note that internal investigations have identified no intention to deceive and no cover-up on the part of Trust staff involved
- note the progress made in delivery of the recommendations of the Verita Report and particularly the appointment of a senior clinical leader, independent of the Division of Women's and Children's Services, to work with the family to ensure that their remaining questions are fully understood and a plan developed with the family to address the issues raised
- invite a further progress report at its September meeting.

Impact Upon Board Assurance Framework
This report is relevant to strategic priority 1 (we will consistently deliver high quality individual care, delivered with compassion) and the related risk of failure to act on feedback from patients, staff and our public.
Impact Upon Corporate Risk
Reputational risk applies.
Implications (Regulatory/Legal)
It is expected that the Trust's progress with delivery of the report recommendations will be monitored by regulators and commissioners.
Equality & Patient Impact
This report has implications for the Trust's approach to incident investigation, complaint handling and bereavement support in the case of a child death.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

INDEPENDENT INVESTIGATION INTO THE MANAGEMENT RESPONSE TO ALLEGATIONS ABOUT STAFF BEHAVIOURS RELATED TO THE DEATH OF A BABY AT BRISTOL CHILDREN'S HOSPITAL

1. INTRODUCTION

This paper reports progress in delivering the recommendations of the report of an independent investigation commissioned from Verita into events following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

2. BACKGROUND

The Trust commissioned an independent investigation from Verita in December 2015 into the management response to allegations about staff actions and behaviours in relation to the death of a baby on the paediatric intensive care unit in April 2015, at the age of 2 months.

Verita provided their report to the Trust on 16 June. We understand that it was provided to the family at the same time.

Verita concluded that the Trust had missed a number of significant opportunities to engage proactively with the family after their baby's death, to be more open and candid with the family, to understand the seriousness of their allegations and to give them clear answers to a number of their questions. Despite the Trust believing that it had endeavoured to respond fully to their concerns, the Trust failed to get an appropriate grip of the complaint and lost the trust of the family as a result.

The Chief Executive wrote to the family on 17 June, giving unreserved apologies for the failings identified by the Verita investigation and advising them that the report would be published on the Trust website the same day.

We posted the report on the Trust public website on 17 June.

3. TRUST RESPONSE

The Trust has accepted Verita's findings in full.

Action to address the findings of the Verita report has been taken in a number of ways:

- the formal recommendations from the investigation are being addressed as described in the next section;
- the Medical Director will share wider learning across the Trust from related internal investigations, in order to guide staff who are meeting with parents after a serious incident so that parental expectations concerning how information and explanation will be received may be met consistently. A new guidance note was presented to the Clinical Quality Group on 7 July and approved for incorporation into the Trust's Staff Support and Being Open Policy (Duty of Candour), with a dissemination plan;

- the Trust Board reviewed the detailed findings to establish whether other action beyond that described in this report was required. The Board took assurance that all appropriate steps were in hand but intends to seek further assurance in September.

4. VERITA RECOMMENDATIONS

Annex 1 sets out detailed progress to date against the recommendations in the Verita report.

The Board is particularly asked to note Verita's conclusion that the Trust has failed to provide the family with clear answers to a number of their questions and their recommendation that further efforts are made to understand their remaining questions by identifying a senior individual to work with the family to ensure that their remaining questions are fully understood and a plan developed with the family to address the issues raised.

The Trust has recently offered the services of Mr Alan Bryan, Consultant Adult Cardiac Surgeon and Clinical Chair of the Specialised Services Division, to act as an intermediary who is independent of children's services, supported by Ms
Sue Dolby, Consultant Clinical Psychologist. The family have agreed to be contacted by Mr Bryan to discuss this process further.

Terms of reference for this work have been shared with the family, as follows:

1. To constitute a Trust team, this will be led by a Senior Trust Clinician and will comprise of a nominated Trust assistant and secretarial support, who will take the minutes of the meeting.

2. To engage with [the parents] so that a meeting can take place at an agreed time and location.

3. To meet with [the parents] and identify those questions they consider as remaining to be addressed, given all previous Trust responses. 4. To confirm the outstanding questions, agree the approach for dealing with each question and clarify the desired outcome with [the parents].

4. To seek responses from the representatives of the Trust and the Division of Women's and Children's and to present these responses to the Trust and the family within an agreed time frame

5. To agree this plan with [the parents].

5. CONCLUSION

The Trust Board is recommended to:

- note Verita's finding that there is no conclusive evidence to prove or disprove the charge of a conspiracy to cover up what happened in the care of the baby;
- note that internal investigations have identified no intention to deceive and no cover-up on the part of Trust staff involved;

- note the progress made in delivery of the recommendations of the Verita Report and particularly the appointment of a senior clinical leader, independent of the Division of Women's and Children's Services, to work with the family to ensure that their remaining questions are fully understood and a plan developed with the family to address the issues raised;
- invite a further progress report at its September meeting.

Robert Woolley
Chief Executive
21 July 2016

ANNEX 1

STATUS OF RECOMMENDATIONS OF INDEPENDENT INVESTIGATION INTO THE MANAGEMENT RESPONSE TO ALLEGATIONS ABOUT STAFF BEHAVIOURS RELATED TO THE DEATH OF A BABY AT BRISTOL CHILDREN'S HOSPITAL

Recommendation	Owner	Status
R1 The trust must, as a matter of urgency, establish who reviewed Ben's pseudomonas results on 17 April and establish what action they took as a result.	Medical Director	**COMPLETE.** This has been follow up with the trainee doctor concerned. Action was not taken or required because appropriate antibiotics had already been prescribed. This finding was formally communicated to the family by letter on 3 June 2016.
R2 The trust must review its Child Death Review (CDR) process to ensure families are supported appropriately throughout. There needs to be clear guidance for families regarding what to expect from pre-CDR meetings and clinicians should be supported to be open and honest with the family, while acknowledging that the CDR meeting is the forum where diagnosis, care and treatment will be explored in greater detail. This review should take place within the next three months.	Chief Nurse	**IN PROGRESS.** The Division of Women's and Children's Services have reviewed the CDR process and established: • revised processes – standard operating procedure for CDR process went through Divisional Quality and Assurance Committee in April and is now in 6 month trial (complete) • use of PAS for recording CDR documentation (complete for all PICU patients and to be implemented in oncology and NICU by October 2016) • formal responsibility for monitoring and management to be assigned to the divisional Quality and Assurance Committee (complete) • Speciality Governance meetings to have all Root Cause Analysis and CDR actions as a standard agenda item (complete) • support to families to be significantly enhanced following introduction of new bereavement team posts (complete) • written guidance for families regarding what to expect from CDR process (complete) • working group, 'Support to families following the death of a child', to write guidance to ensure all families know what support Is available and to ensure staff deliver this in standardised way across the hospital no matter where a child may die. Completion date: September.
R3 The trust should share with Ben's family further findings from the investigation undertaken by the deputy medical director into the allegation that deliberate attempts were made by trust staff to falsify records of the CDR feedback meeting on 22 July 2015. The trust should do this to demonstrate that a robust investigation has been undertaken. The trust should take great care to ensure that any further information provided to the family adequately addresses their concerns.	Director of Workforce	**NOT YET ACTIONED.** The Trust's duty of confidentiality to its staff means the report itself cannot be released. Advice received is that as much as can be appropriately extracted for release was given to the family by the Medical Director in his letter of 1 April. It is proposed that further consideration of ways to address this recommendation be undertaken as part of the programme of work in response to R9. Completion date: TBC

R4 The trust must ensure that any newly developed guidance (for example the new process for managing formal complaints and the checklist following the death of a child) includes a ratification and review date. This should be implemented immediately.	Chief Nurse	**COMPLETE.** Instruction issued that all BRHC documentation to conform to corporate Procedural Document Framework standards for ratification and review. Follow-up audit is planned for completion by 31 August 2016.
R5 Before undertaking internal investigations (formal or informal), the trust must ensure that all staff involved are clear about the purpose of the investigation and the intended audience. The trust may need to review its investigation guidance in order to support staff conducting investigations.	Director of Workforce/ Chief Nurse	**COMPLETE.** Relevant policies revised to reinforce need for consideration of investigation purpose and intended audience. Separate guidance note for managers conducting investigations has been drawn up.
R6 The trust must ensure that staff are suitably trained in order to carry out investigations which are evidence-based, robust, proportionate and suitably independent.	Director of Workforce/ Chief Nurse	**COMPLETE.** Relevant policies have been reviewed to reinforce learning from this review. Revised training for senior leaders has been developed (and senior leader training scheduled for August 2016).
R7 Staff charged with conducting investigations should ensure they are clear what guidance governs their investigation and what process should be followed. They should ensure their approach is sufficiently independent and proportionate. This will include considering whether, for example, it is necessary to draft terms of reference, conduct formal interviews etc.	Director of Workforce	**COMPLETE.** Over-arching guidance note for managers conducting investigations is in place and will inform training under R6.
R8 The trust needs to ensure that it has a robust safeguarding system to ensure that results taken are still reported and flagged to the clinical team in the event that the patient has died.	Chief Operating Officer	**IN PROGRESS.** New standard operating procedure (SOP) is in development to clarify existing practice regarding the reporting and communication of laboratory results for all patients. This includes the appropriate process for dissemination of information within departments when results are received. The SOP will be presented at the Trust's Service Delivery Group in August 2016 and communicated via Divisional Boards in September 2016. A retrospective audit utilising incident forms will be completed in October 2017.
R9 Senior managers need to take steps to ensure that Ben's parents' outstanding questions are appropriately addressed. A senior individual should be appointed to work with the family to ensure that their remaining questions are fully understood and a plan developed with the family to address the issues raised.	Medical Director	**COMPLETE.** A senior clinician, independent of children's services, has been appointed to work with the family to understand the family's remaining questions and develop a plan with them to address the issues.

Recommendations from independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital: status report July 2016.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July at 11:00 in the Conference Room,
Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
10. Quality and Performance Report

Sponsor and Author(s)
Report sponsors: • Overview and Access – Owen Ainsley, Interim Chief Operating Officer • Quality – Carolyn Mills, Chief Nurse and Sean O'Kelly, Medical Director • Workforce – Sue Donaldson, Director of Workforce & Organisational Development **Report authors:** • Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards.

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

Impact Upon Board Assurance Framework
Links to achievement of the standards in NHS Improvement's Risk Assessment Framework.

Impact Upon Corporate Risk
As detailed in the individual exception reports.

Implications (Regulatory/Legal)
Links to achievement of the standards in Monitor's Risk Assessment Framework.

Equality & Patient Impact
As detailed in the individual exception reports.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

July 2016

Executive Summary

Progress in improving performance against the access standards slowed this month. Whilst the 92% national standard for the percentage of patients waiting under 18 weeks Referral to Treatment (RTT) was achieved at month-end, the total number of long waiters increased. There was a small deterioration in performance against the A&E 4-hour standard, although the trajectory continued to be met. Disappointingly, performance against both the 6-week diagnostic waiting times standard and the 62-day GP cancer standard deteriorated in the period, further details of which can be found below. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, along with noteworthy successes for June.

The growth in the number of patients arriving and being admitted via the Trust's Emergency Departments increased from 3% last month to 6% this month. The level of growth in emergency activity was highest at the Bristol Children's Hospital, which despite this achieved the 95% national standard for the percentage of patients admitted, discharged or transferred within 4 hours of arrival in the Emergency Department. Although the number of delayed discharges in the BRI stayed broadly similar to the levels seen in May, the number of patients that had stayed in hospital for more than 14 days was lower at the end of June. However, bed occupancy within the BRI increased back to its former high levels, resulting in a deterioration in flow and 4-hour performance.

Although the number of elective admissions increased in June, the elective waiting list is now at the highest level it has been for a year. This follows several months of growth in outpatient referrals. This growth in outpatient referrals has led to an increase in the number of patients waiting over 18 weeks on Non-admitted RTT pathways. The impact on RTT of the rise in the elective waiting list is still to be felt, and in combination with higher than planned number of over 18 week Non-admitted pathways, poses a significant risk to continued achievement of the 92% RTT national standard if this heightened level of demand cannot be met. The 99% diagnostic waiting times standard continued to be failed as forecast, although the breadth of under-performance was greater than expected. A number of diagnostic modalities have experienced high levels of demand which have not been able to be met by additional waiting list initiatives due to poor uptake. This has also impacted on the Trust's ability to reduce the number of routine endoscopy patients waiting over 6 weeks following a high number of endoscopy lists lost as a result of the junior doctor industrial action, and the repeated failure to recruit a locum endoscopist. Finally, there was a further deterioration in performance against the 62-day GP cancer waiting times standard. This underperformance is largely being driven by factors outside of the Trust's control, including increases in late referrals from, or delayed pathway at, other providers, and high levels of patient choice to defer diagnostic tests or treatment. Delayed reporting of histopathology results following the transfer of the service to North Bristol Trust is expected to be confirmed on final report as contributing to a further month's disappointing performance against the 62-day GP standard in June. This and other system risks continue to be flagged to NHS Improvement and commissioners.

There were relatively few changes in performance against the range of quality indicators that sit within the Trust's Summary scorecard, but also the wider range of quality metrics we report in our Safe, Caring & Effective Scorecard. There has been continued good performance against the core quality standard, with particular noteworthy performance against the rate of hospital acquired pressure ulcers, with the lowest level of grade 2 pressure ulcers in the Trust since robust reporting began in 2010. There has also been a further month of improved performance against the

indicators for timely reporting and investigation of Serious Incidents, but with more disappointing performance against the National Early Warning Scores (NEWS) acted upon for deteriorating patients, and management of Fracture Neck of Femur patients, both of which continue to be the focus of significant attention.

Whilst system pressures are lower than they were at the start of the year, they continue to provide context to the current workforce challenges, especially bank and agency spend and considerable focus is being placed on the reasons and necessity for each band and agency shift. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand. We also continue to work in partnership with other organisations within the community to mitigate these system risks, and improve the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

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

Care Quality Commission

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident & Emergency	Good	Not rated	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity & Family Planning	Good	Good	Good	Good	Outstanding	Good
Services for children and young people	Good	Outstanding	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	**Requires improvement**

NHS Choices

Website

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

Site	User ratings	Recommended by staff	Open and honest	Infection control	Mortality rate (within 30 days)	Food choice & Quality
BCH	5 (4.5) stars	OK	OK	OK	OK	✓ 98.4%
STM	4 stars	OK	OK	OK	OK	✓ 98.4%
BRI	3.5 stars	OK	OK	OK	OK	✓ 96.5%
BDH	3 (3.5) stars	OK	OK	OK	OK	Not avail
BEH	4 Stars	OK	OK	OK	OK	✓ 91.7%

Stars – maximum 5
OK = Within expected range
✓ = Among the best (top 20%)
! = Among the worst
Please refer to appendix 1 for our site abbreviations.
Last month's ratings shown in brackets where these have changed

NHS Improvement Risk Assessment Framework

The Trust did not achieve five of the standards in the NHS Improvement 2016/17 Risk Assessment Framework in the first quarter of the year, as shown in the table below. The 31-day first definitive and 31-day subsequent surgery cancer waiting times standards are expected to be confirmed as achieved for both May and June, but this was not sufficient to recover performance for the quarter as a whole.

Overall the Trust has a Service Performance Score of 4.0 against Monitor's Risk Assessment Framework, including the two 62-day cancer waiting times standards which are scored as a single standard. Although the A&E 4-hour standard and 62-day standards continue to not be met, Monitor restored the Trust to a GREEN risk rating in quarter 1 2015/16, following its review of actions being taken to recover performance against the RTT, Cancer 62-day GP and A&E 4-hour standards and an acceptance of the factors continuing to affect Trust performance, which are outside of its control.

NHS Improvement Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework: Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16*	Q1 16/17*	Q1 Draft	Notes	Q1 Draft Risk Assessment Risk rating
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	TBC**	✓	✓	✓	✓	TBC**	✓	Limit to the end of Q4 = 45 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	97.6%	✓	✓	✓	✓	98.3%	✓	31-day subs surgery/first will not be met due emergency pressues/lack of critical care beds in Q4.	Not achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	85.9%	✓	✓	✓	✓	90.1%	✘		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	98.1%	✓	✓	✓	✓	97.9%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	73.4%	✘	✘	✘	✘	73.9%	✘	62-day GP standard also lower than expected due to late referrals and histopathology delays.	Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	37.9%	✘	✘	✘	✘	47.2%	✘		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.3%	Not achieved	Not achieved	Not achieved	Achieved	92.3%	✓		Achieved
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	93.9%	✓	✓	✓	✓	94.7%	✘	See 31-day subs surgery note.	Not achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	94.5%	✓	✓	✓	✓	94.2%	✓		Achieved
6b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
7	A&E Total time in A&E 4 hours	1.0	95%	89.3%	✘	✘	✘	✘	89.3%	✘		Not achieved
8	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
	CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
				Risk Rating	GREEN	GREEN	GREEN	GREEN	To be confirmed	Triggers further investigation		

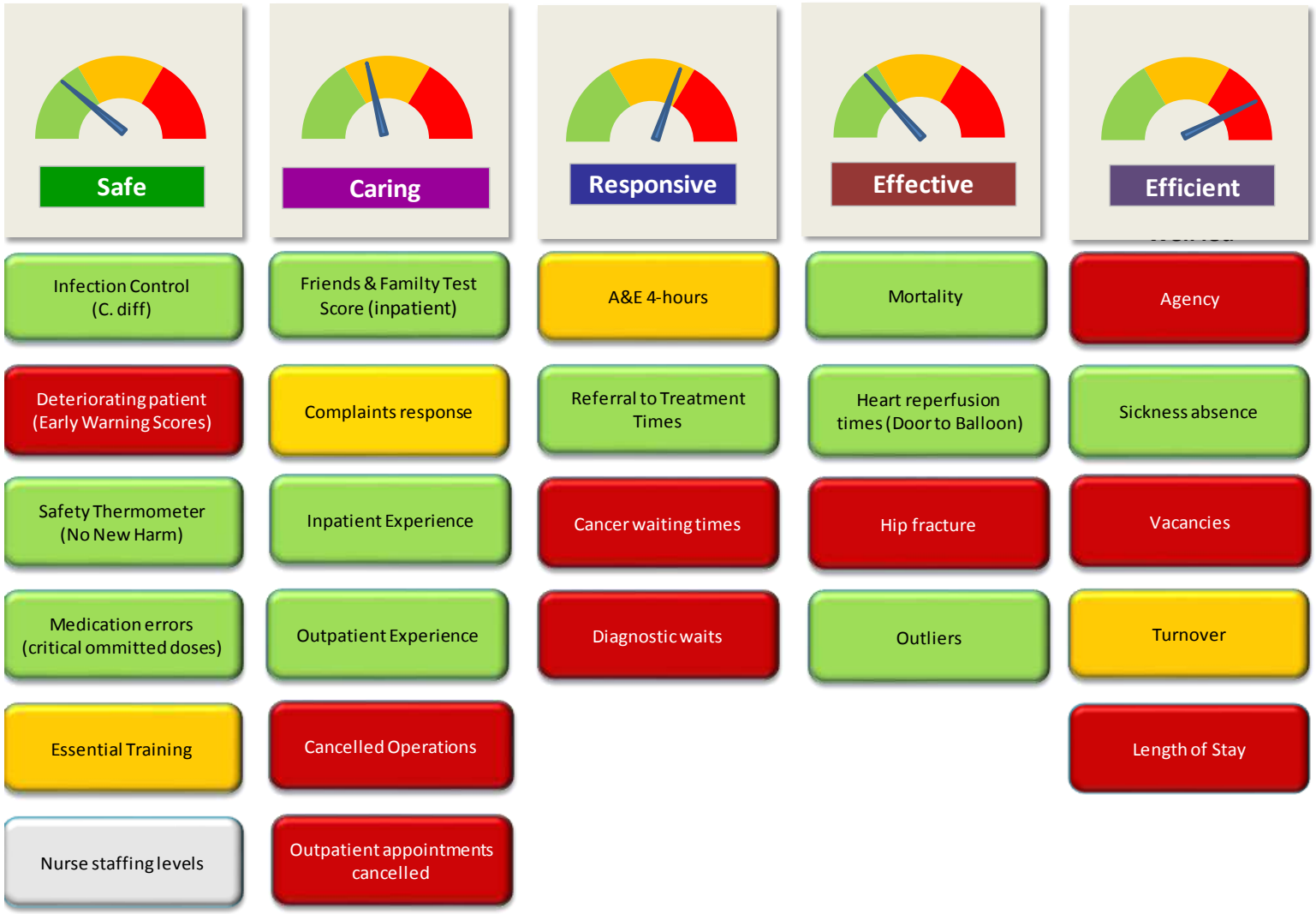
Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month period and is then failed in the subsequent nine-month period or for the year as a whole.

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

4.0
To be confirmed (see narrative)

Summary Scorecard

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



Key changes in indicators in the period:

GREEN to RED:

- Deteriorating patient
- Vacancy rate

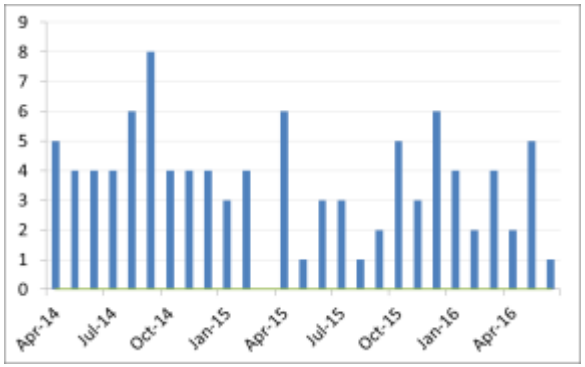
Un-rated to GREEN

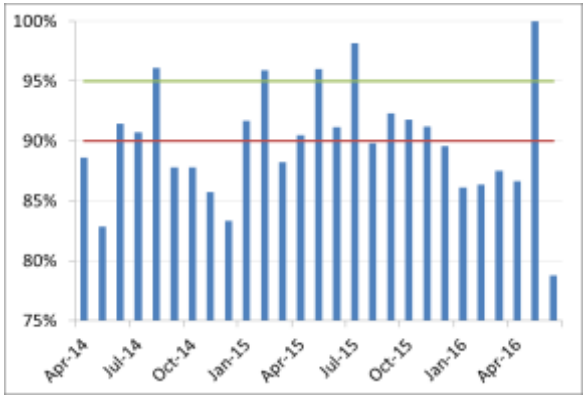
- Mortality (see SHMI report)

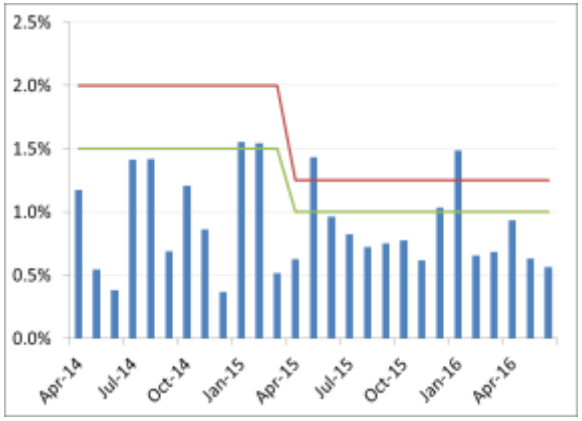
Overview

The following summarises the key successes in June 2016, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 2 2016/17.

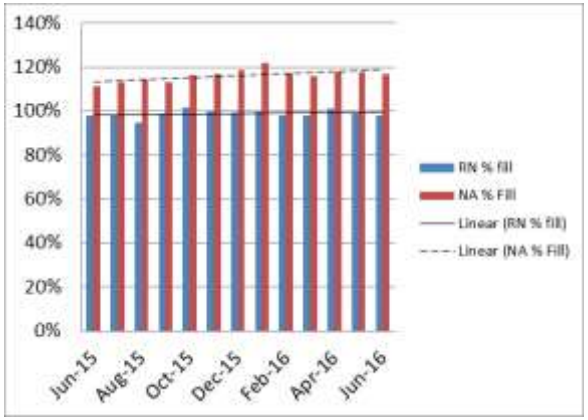
Successes	Priorities
• Improvement in the number of reported *Clostridium difficile* cases for June 2016, one compared to five in May; • Hospital acquired pressure ulcers: one grade 2 pressure ulcer in the Trust for June 2016, the lowest since robust reporting began in 2010; • Turnover is at the lowest level since August 2014, with in month reductions across every staff group except Estates and Ancillary; • Nursing and Midwifery agency usage, measured in FTE, is at the lowest level in six months; • Achievement of the RTT national standard; • Earlier than forecast recovery of cancer 31-day first definitive and subsequent surgery standards for May and June	• Improve performance in treating patients with fractured neck of femur; • There is a continued focus on the reduction of staff turnover and sickness absence with the development of action plans to support the achievement of the 2016/17 KPIs; • Delivery of planned Referral to Treatment (RTT) clock stop activity in July and August in order to continue to achieve the national RTT standard; • Implement a recovery plan for restoring performance against the 6-week wait diagnostic standard by the end of September.
Opportunities	**Risks & Threats**
• A new Staff Health and Wellbeing CQUIN was launched in May.	• Increase in the number of early warning scores not acted upon in June. The performance figure for was 79% compared with a 100% score in May; • Decrease in WHO surgical checklist compliance to 98.9% (40 breaches out of 3605 procedures). The decline has been in all divisions who reviewing reasons for this; • Changes in the requirements to achieve compliance in Information Governance and Fire Safety means levels of compliance have reduced levels. A recovery trajectory is being developed; • The rise in the elective waiting list, due to an increase in outpatient referrals, may put at risk future achievement of the RTT incomplete pathways standard, especially in the context of changes made to Waiting List Initiative payment rates and consequent poor uptake of additional theatre and outpatient sessions to provide core capacity or meet heightened levels of demand; • Delays in histopathology reporting, following centralisation of the service at North Bristol Trust, is impacting on performance against the cancer waiting times standards in June along with even higher levels of late referrals.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).</td>
<td>There was one case of Clostridium difficile (C. diff) attributed to the Trust in June. This was attributed to the Division of Surgery, Head & Neck.
<table>
<tr><th></th><th>C. difficile</th></tr>
<tr><td>Medicine</td><td>0</td></tr>
<tr><td>Surgery</td><td>1</td></tr>
<tr><td>Specialised Services</td><td>0</td></tr>
<tr><td>Women’s & Children’s</td><td>0</td></tr>
</table>
</td>
<td>Total number of C. diff cases
 

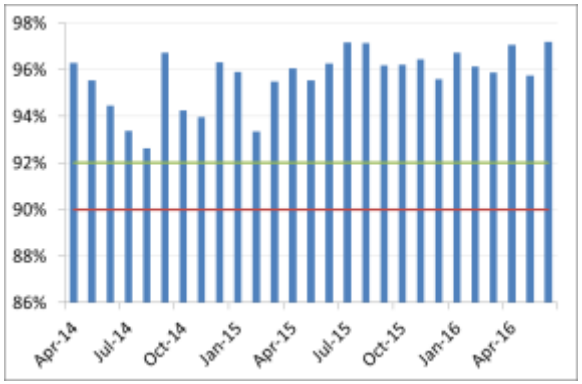
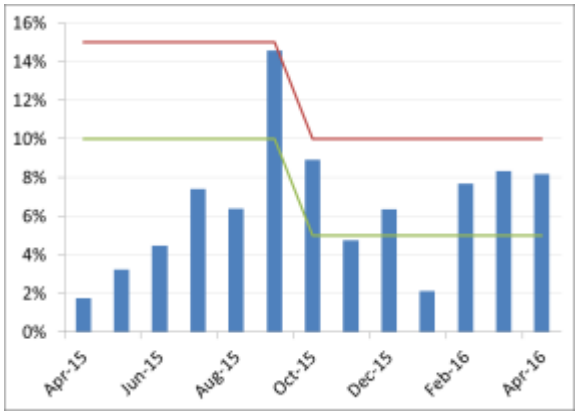
A total of 8 cases (unavoidable + avoidable) have been reported in the year to date against a limit of 45 (for April 2016 to March 2017).</td>
<td>The annual limit for the Trust for 2016/17 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. . The total number of cases to date attributed to the Trust is eight. Three cases have been assessed as unavoidable, one case assessed as avoidable and four cases have yet to be assessed
There have been no MRSA bacteraemia cases attributed to the Trust to date since August 2015</td>
</tr>
<tr>
<td>Deteriorating patient
National early warning scores (NEWS) acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.</td>
<td>Performance is June was 79% (seven breaches) against a three year improvement goal of 95%This is a reduction from May (100%). Reasons for the breaches are as follows:
Two patients were escalated appropriately ascertained by notes review, but this was not documented on the observation chart. One patient had observations repeated within 20 minutes which had reverted to normal parameters. Doctors had been previously made aware of and responded to elevated NEWS for two patients, but the escalation protocol was not followed on subsequent occasions. One patient was being cared for by an agency nurse, it has not been possible to ascertain why they were not escalated.</td>
<td>Deteriorating patient: percentage of early warning scores acted upon
 
</td>
<td>Three of the breaches occurred in the Division of Surgery Head & Neck and four in the Division of Medicine. Patient Safety Audit and Quality Improvement Nurses are now in post for 2016/17 to provide further support and education for clinical areas.
Actions being taken are described in the actions section (Actions 1A to 1F).</td>
</tr>
</table>

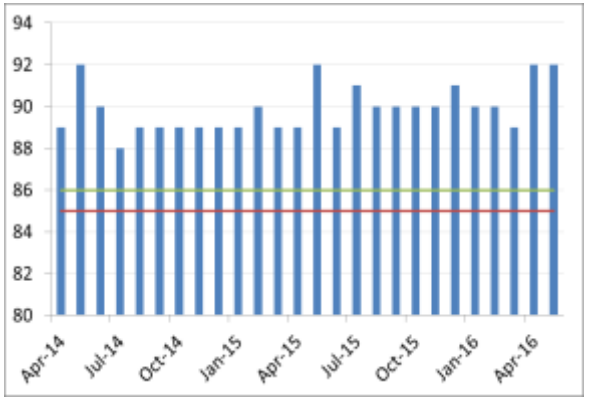
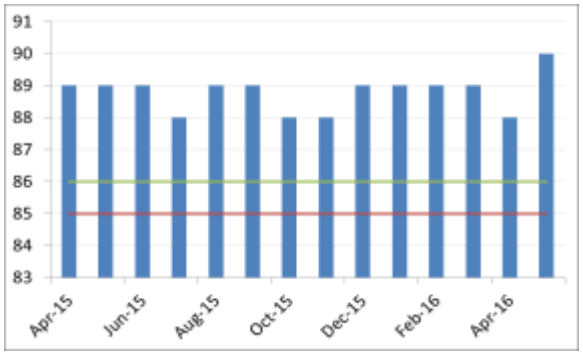
Description	Current Performance	Trend	Comments
Safety Thermometer – No new harm. The NHS Safety Thermometer comprises a monthly audit of all eligible inpatients for 4 types of harm: pressure ulcers, falls, venous-thromboembolism and catheter associated urinary tract infections. New harms are those which are evident after admission to hospital.	In June 2016, the percentage of patients with no new harms was 98.7 %, against an upper quartile target of 98.26% (GREEN threshold) of the NHS England Patient Safety peer group of trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The June 2016 Safety Thermometer point prevalence audit showed three new catheter associated urinary tract infections, two falls with harm, one new pressure ulcers and four incidences of new venous thrombo-emboli. Two of the incidences of venous thrombo-emboli were recorded in the Bristol Royal Hospital for Children which are being validated as this is unusual.
Non-purposeful omitted doses of listed critical medicines Monthly audits by pharmacy incorporate a review of administration of critical medicines: insulin, anti-coagulants, Parkinson's medicines, injected anti—infectives, anti-convulsants, short acting bronchodilators and 'stat' doses.	In June 2016, 0.56% of patients had one or more critical medications omitted. This is 6 patients out of a review of 1065 patients. The cumulative figure for 2016-2017 is 0.73% against an annual limit of 1%.	**Percentage of omitted doses of listed critical medicines** 	The monthly figures for 2016 show a continuing reduction in the number of omitted critical medications. Actions being taken are described in the actions section (Action 2)

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Achievement of the Green threshold for this indicator depends on all five categories of Essential Training achieving 90%. Overall compliance is 86% (excluding Child Protection Level 3). Compliance with each of the new reporting categories is provided below.
<table>
<tr><th>June 2016</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>86%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>88%</td></tr>
<tr><td>Annual (Fire & IG)</td><td>63%</td></tr>
<tr><td>Induction</td><td>95%</td></tr>
<tr><td>Resuscitation</td><td>79%</td></tr>
<tr><td>Safeguarding</td><td>88%</td></tr>
</table>
</td>
<td>This represents a new and more comprehensive way of reporting, and is not comparable with previous parameters for reporting. The graph below focusses on the most challenged category of essential training, Fire and Information Governance (IG).

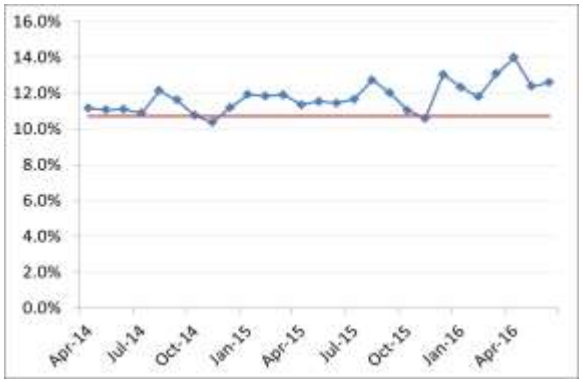

</td>
<td>Full details of the full range of Essential Training topics including a Divisional breakdown are provided in the appendix.
Action plan 3 provides details of the ongoing work to achieve compliance across all topics.</td>
</tr>
<tr>
<td>Nurse staffing levels unfilled shifts reports the level of registered nurses and nursing assistant staffing levels against the planned.</td>
<td>The report shows that in June the Trust had rostered 217,722 expected nursing hours, with the number of actual hours worked of 224,712.
This gave a fill rate of 103%
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>65,774</td><td>60,011</td><td>+5,763</td></tr>
<tr><td>Specialised Services</td><td>38,987</td><td>38,999</td><td>-12</td></tr>
<tr><td>Surgery Head & Neck</td><td>43,345</td><td>41,263</td><td>+2,082</td></tr>
<tr><td>Women’s & Children’s</td><td>76,365</td><td>77,449</td><td>-1084</td></tr>
<tr><td>Trust - overall</td><td>224,471</td><td>217,722</td><td>+6,749</td></tr>
</table>
</td>
<td>The percentage overall staffing fill rate by month


</td>
<td>Overall for the month of June 2016, the Trust had 98% cover for Registered Nurses (RNs) on days and 98% RN cover for nights. The unregistered level of 114% for days and 120% for nights reflects the activity in June. This was due primarily to Nursing Assistant (NA) specialist assignments to safely care for confused or mentally unwell patients in both adults and children. (Action 4).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for June 2016 was 97.2%. This metric combines Friends and Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. Division and hospital-level data is provided to the Trust Board on a quarterly basis and will be provided at the end of quarter 1.	**Inpatient Friends & Family scores each month** 	The scores for UH Bristol are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.	Following an agreed change, dissatisfied cases are now measured as a proportion of complaints responses and reported <u>two</u> months in arrears. This means that the latest data in the board quality dashboard is for the month of April 2016. As of 14th July 2016, four of the 50 complaints responses sent out in April had resulted in dissatisfied replies, i.e. 8% against a GREEN threshold of 5%. Two cases were in the Division of Surgery, Head & Neck and one each in the Divisions of Medicine and Diagnostics & Therapies.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our performance for 2015/6 was 9.1% compared to 11.1% in 2014/15. Informal benchmarking with other NHS Trusts suggests that rates of dissatisfied complainants are typically in the range of 8% to 10%. Actions continue as previously reported to the Board (Action 5).

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of June, the score was 90 out of a possible score of 100.
Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q4</th><th>Q1</th></tr>
<tr><td>Trust</td><td>90</td><td>90</td></tr>
<tr><td>Division of Medicine</td><td>86</td><td>87</td></tr>
<tr><td>Division of Surgery, Head & Neck</td><td>92</td><td>92</td></tr>
<tr><td>Division of Specialised Services</td><td>91</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>91</td><td>92</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>90</td><td>90</td></tr>
</table>
</td>
<td>Inpatient patient experience scores (maximum score 100) each month
 
</td>
<td>UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if patient experience at the Trust began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the score remains green. A detailed analysis of this metric (down to ward-level) is provided to the Trust Board in the Quarterly Patient Experience Report.</td>
</tr>
<tr>
<td>Outpatient experience tracker comprises four scores from the Trust’s monthly survey of outpatients (or parents of 0-11 year olds):
1) Cleanliness
2) Being seen within 15 minutes of appointment time
3) Being treated with respect and dignity
4) Receiving understandable answers to questions.</td>
<td>The scores for the Trust as whole were 90 in June 2016 (out of score of 100).
<table>
<tr><th></th><th>Quarter 4 2015/2016</th><th>Quarter 1 2016/2017</th></tr>
<tr><td>Trust</td><td>89</td><td>90</td></tr>
<tr><td>Medicine</td><td>87</td><td>93</td></tr>
<tr><td>Specialised Services</td><td>88</td><td>85</td></tr>
<tr><td>Surgery, Head & Neck</td><td>88</td><td>87</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>86</td><td>80</td></tr>
<tr><td>Diagnostics & Therapies</td><td>94</td><td>94</td></tr>
</table>
Scores are out of 100.</td>
<td>Outpatient Experience Scores (maximum score 100) each month
 
</td>
<td>UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust’s Quarterly Patient Experience Report.</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In June the Trust cancelled 61 (0.96% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th></th></tr>
<tr><td>Emergency patient prioritised</td><td>15 (25%)</td></tr>
<tr><td>No critical care bed available</td><td>14 (23%)</td></tr>
<tr><td>No ward bed available</td><td>12 (20%)</td></tr>
<tr><td>No theatre staff</td><td>6 (10%)</td></tr>
<tr><td>Other causes (8 different breach reasons - no themes)</td><td>14 (23%)</td></tr>
</table>
Two patients cancelled in May were readmitted outside of 28 days due to emergency pressures and other patients taking priority. This equates to 96.6% of cancellations being readmitted within 28 days, which is above trajectory and the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

National 0.8% standard is currently not forecast to be achieved again in July.</td>
<td>Although emergency pressures eased slightly within the period, cancellations due to emergency pressures still accounted for two-thirds of all cancellations of routine operations in the period. An action plan to reduce elective cancellations continues to be implemented (Actions 6A and 6B). However, please also see actions detailed under A&E 4 hours (8A to 8C) and outlier bed-days (13A to 13D).</td>
</tr>
<tr>
<td>Outpatient appointments cancelled is a measure of the percentage of outpatient appointments that were cancelled by the hospital. This includes appointments cancelled to be brought forward, to enable us to see the patient more quickly.</td>
<td>In June 12.6% of outpatient appointments were cancelled by the hospital, which is similar to the level of performance reported in May.
The Patient Administration System has a large number of different reasons for cancellation which can be selected by users. This creates confusion and impacts on the consistency of reporting of causes of cancellation. For this reason, a review of cancellations reasons has been completed and signed-off by the Outpatient Steering Group. This will now be implemented in Medway.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group. The improvement plan for this key performance indicator has now been refreshed, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 7A to 7F).</td>
</tr>
</table>

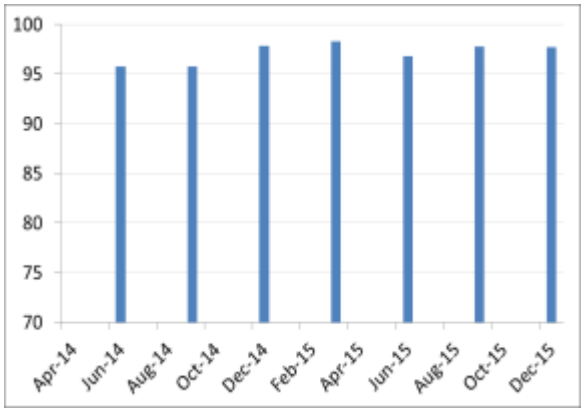
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in June. However, performance at 89.0% was better than trajectory (85.9%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Jun 2015</th><th>May 2016</th><th>Jun 2016</th></tr>
<tr><td>Attendances</td><td>5422</td><td>5834</td><td>5571</td></tr>
<tr><td>Emergency Admissions</td><td>1743</td><td>1842</td><td>1794</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5105
94.2%</td><td>5118
87.7%</td><td>4557
81.8%</td></tr>
<tr><th>BCH</th><th>Jun 2015</th><th>May 2016</th><th>Jun 2016</th></tr>
<tr><td>Attendances</td><td>3198</td><td>3475</td><td>3250</td></tr>
<tr><td>Emergency Admissions</td><td>710</td><td>830</td><td>803</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3073
94.9%</td><td>3261
93.8%</td><td>2824
95.1%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

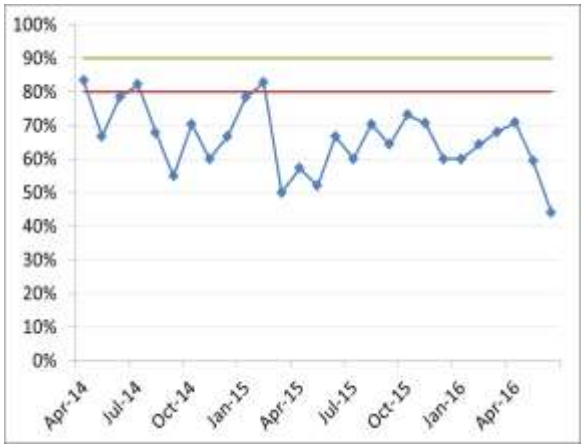
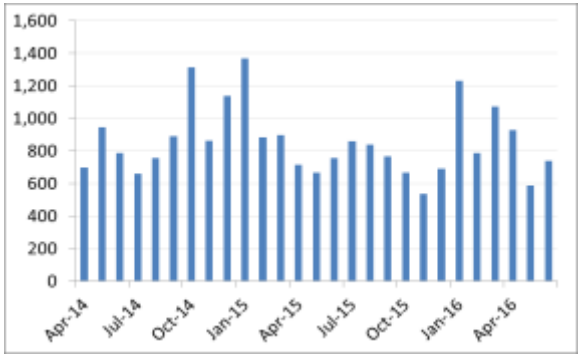
Trajectory target of 87.6% for July forecast to be met.</td>
<td>Overall levels of emergency admissions were 6% higher in June than in the same period in 2015, mainly due to high levels of admissions into the BCH. The number of adult patients on the Green to Go (delayed discharge) list increased from 58 at the end of May to 64 at the end of June. However, over 14 day stays have reduced. BRI bed occupancy has risen, for reasons that are not well understood. Actions continue to be taken to manage demand and to reduce delayed discharges (Actions 8A to 8C).</td>
</tr>
<tr>
<td>Referral to Treatment (RTT) is a measure of the length of wait from referral through to treatment. The target is for at least 92% of patients, who have not yet received treatment, and whose pathway is considered to be incomplete (or ongoing), to be waiting less than 18 weeks at month-end.</td>
<td>The 92% national standard was achieved at the end of June, with the Trust reporting 92.1% of patients waiting less than 18 weeks at month-end. The overall number of patients waiting over 18 weeks stayed at a similar level for the admitted but non-admitted pathways increased (see Appendix 3).
The number of patients waiting over 40 weeks RTT at month-end decreased in June from the May position, against the trajectory of zero.
<table>
<tr><th></th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>24</td><td>22</td><td>14</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0</td><td>0</td><td>0</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 
</td>
<td>There was an increase in the number of patients waiting over 18 weeks as a result of rising outpatient demand. The elective waiting list has now started to rise, which poses risks to continued delivery of the 92% standard. Delivery of the RTT trajectories is monitored weekly, with significant variances from plan escalated to Divisional Directors. The weekly RTT Operational Group oversees the management of longest waiting patients (Action 9).</td>
</tr>
</table>

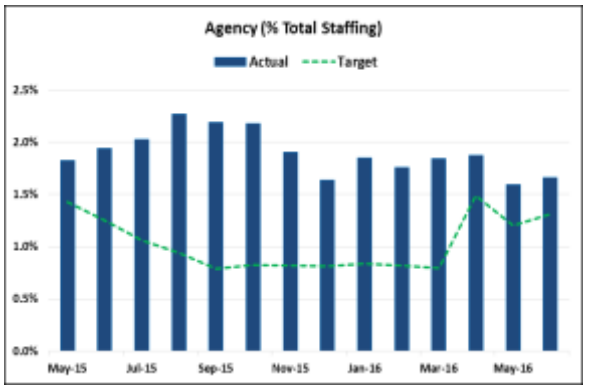
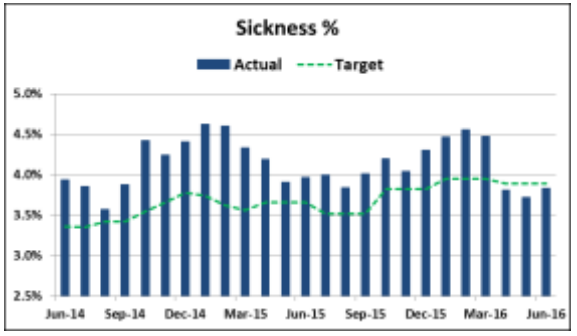
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>The Trust reported performance of 70.7% against the 85% 62-day GP standard in May. This is below the agreed performance trajectory for the month of 73.2%. Performance against the 90% 62-day screening standard was 35.3%. The main reasons for failure to achieve the 85% national 62-day GP standard are shown below.
<table>
<tr><th>Breach reason</th><th>May 16</th></tr>
<tr><td>Late referral by/delays at other provider</td><td>11.5</td></tr>
<tr><td>Medical deferral/clinical complexity</td><td>3.0</td></tr>
<tr><td>Patient choice</td><td>6.0</td></tr>
<tr><td>Delayed admitted diagnostic</td><td>2.0</td></tr>
<tr><td>Other reasons (4 different causes)</td><td>4.5</td></tr>
<tr><td>TOTAL</td><td>27.0</td></tr>
</table>
</td>
<td>Percentage of patients treated within 62 days of GP referral
 

There were 5.5 x 62-day screening pathway breaches out of 8.5 patients treated. The breach reasons were patient choice (2.5), delayed diagnostic (2) and clinical complexity (1).</td>
<td>Performance was worse than the trajectory this month, although the quarter to date trajectory was achieved for April and May combined. Performance was impacted by very high levels of late referrals and patient choice. Ideal timescale pathway review meetings are nearing completion (Action 10). Timescales for tertiary referral has been included in a CQUIN for 2016/17. The above areas of focus are part of the action plan signed-off by the Board.</td>
</tr>
<tr>
<td>Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.</td>
<td>The 99% national standard was not achieved at the end of June, with reported performance 96.3%. The number and percentage of over 6-week waiters at month-end, is shown in the table below:
<table>
<tr><th>Diagnostic test</th><th>Apr</th><th>May</th><th>Jun</th></tr>
<tr><td>MRI</td><td>13</td><td>13</td><td>49</td></tr>
<tr><td>Ultrasound</td><td>19</td><td>20</td><td>25</td></tr>
<tr><td>Sleep</td><td>3</td><td>24</td><td>47</td></tr>
<tr><td>Endoscopies</td><td>83</td><td>59</td><td>130</td></tr>
<tr><td>Audiology</td><td>2</td><td>1</td><td>30</td></tr>
<tr><td>Echo</td><td>3</td><td>4</td><td>43</td></tr>
<tr><td>Other</td><td>4</td><td>1</td><td>1</td></tr>
<tr><td>TOTAL</td><td>127</td><td>122</td><td>325</td></tr>
<tr><td>Percentage</td><td>98.3%</td><td>98.6%</td><td>96.3%</td></tr>
<tr><td>Trajectory</td><td>99.2%</td><td>99.2%</td><td>99.2%</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 6 weeks at month-end
 

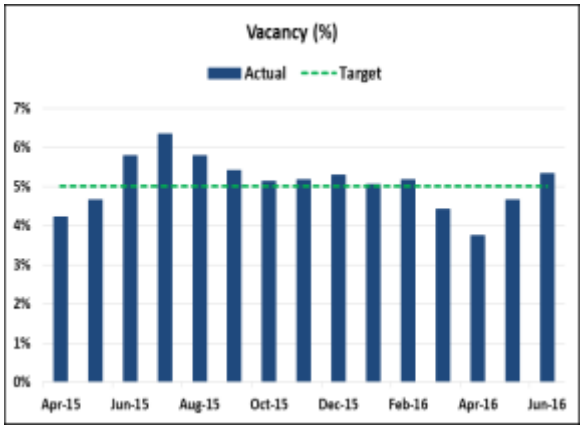
Achievement of the 99% standard is at risk for the end of July, with potential, although not certain, recovery for the end of September.</td>
<td>Disappointingly, this standard was failed across a number of diagnostic modalities, due to a range of reasons including spikes in referral volumes, an inability to flex capacity and unexpected losses of capacity for building works. Radiology as a whole is expected to achieve the 99% standard again in July. The number of Echo breaches should also reduce. However, the endoscopy backlog is forecast to rise. A recovery plan is being enacted. (Action 11A to 11C).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator is the ratio of the actual number of patients who died in hospital or within 30 days of discharge and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other risk factors. This is nationally published quarterly, six months in arrears.	Summary Hospital Mortality Indicator (SHMI) for December 2015 was 97.7. As reported last month, further discussions have taken place regarding mortality reporting and the impact of periodic rebasing. It has been agreed that we will report national SHMI which is available quarterly, but six months in arrears, and is rebased every publication providing a more accurate indication of our comparative mortality rates. Threshold have been set on the following basis: Red = SHMI above 100 and Lower Confidence Interval above 100 Amber = SHMI above 100 but Lower Confidence Interval below 100 Green = SHMI below 100	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	Our performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. No patterns of causes for concern have been identified. We will continue to track Hospital Standardised Mortality Indicator monthly to give earlier warning of a potential concern.
Door to balloon times measures the percentage of patients receiving cardiac reperfusion (inflation of a balloon in a blood vessel feeding the heart to clear a blockage) within 90 minutes of arriving at the Bristol Heart Institute.	In May (latest data), 27 out of 29 patients (93.1%) were treated within 90 minutes of arrival in the hospital. Performance for the year as a whole remaining well above the 90% standard at 97.0%.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In June 2016 we achieved 44.0% (11/25 patients) in Best Practice Tariff (BPT), against the national standard of 90%. Performance for the time to theatre within 36 hours, and review by an Ortho-geriatrician within 72 hours, was 72.0% (18/25 patients).
<table>
<tr><th>Reason for not going to theatre < 36 hours</th><th>Number</th></tr>
<tr><td>Lack of theatre capacity</td><td>6 patients - 5 went to theatre within 48 hrs (range 36 hours 17 minutes to 51 hours)</td></tr>
<tr><td>A specialist surgeon required</td><td>1 patient - due to very complex needs requiring a number of tests and procedures.</td></tr>
</table>
Patients admitted on Fridays or Saturdays are more at risk of breaching due to there being no regular weekend ortho-geriatrician cover</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>The percentage of patients going to theatre within the 36 hours has reduced due to a lack of theatre capacity. There has also been a significant level of long-term sickness within the ortho-geriatrician team. This has been partly covered with locums, but cover has not been consistent. Work has commenced between Medicine and Surgery, Head & Neck, to establish a future service model across T&O, and to ensure that consistent, sustainable cover is provided (Actions 12A to 12E).</td>
</tr>
<tr>
<td>Outlier bed-days is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.</td>
<td>In June 2016 there were 741 outlier bed-days against a Q1 monthly target of 815 outlier bed days. The target was met again this month
<table>
<tr><th>Outlier bed-days</th><th>June 2016</th></tr>
<tr><td>Medicine</td><td>407</td></tr>
<tr><td>Surgery, Head & Neck</td><td>263</td></tr>
<tr><td>Specialised Services</td><td>69</td></tr>
<tr><td>Women's & Children's Division</td><td>2</td></tr>
<tr><td>Total</td><td>741</td></tr>
</table>
Performance was maintained despite occupancy remaining high. There was a small deterioration in the Division of Medicine and more significantly in the Division of Surgery, Head & Neck, which experienced high demand during June.</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>This is reflective of improved patient flow across the hospitals and some reduction in level of demand.
Ongoing actions are shown in the action plan section of this report. (Actions 13A to 13D).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.</td>
<td>Agency usage increased by 6.4 FTE overall, moving from 1.6% to 1.7% of total staffing. However nursing agency as measured in Full Time Equivalent was at its lowest level (80 FTE) in six months. Nursing agency spend has reduced over the last six months, but changed little from May to June, because the average cost per shift rose, due to increases in premium cost areas such as paediatrics.
<table>
<tr><th>June 2016</th><th>FTE</th><th>Actual %</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>138.3</td><td>1.7%</td><td>1.3%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>3.3</td><td>0.4%</td><td>0.6%</td></tr>
<tr><td>Medicine</td><td>31.8</td><td>2.5%</td><td>2.3%</td></tr>
<tr><td>Specialised Services</td><td>22.6</td><td>2.4%</td><td>1.7%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>29.7</td><td>1.7%</td><td>0.7%</td></tr>
<tr><td>Women’s & Children’s</td><td>12.4</td><td>0.7%</td><td>1.0%</td></tr>
<tr><td>Trust Services</td><td>24.1</td><td>3.3%</td><td>2.3%</td></tr>
<tr><td>Facilities & Estates</td><td>14.4</td><td>1.8%</td><td>1.4%</td></tr>
</table>
</td>
<td>Agency usage as a percentage of total staffing by month
 
</td>
<td>The agency action plans continue to be implemented and the headlines are in the improvement plan (Action 14).
A summary of compliance with agency caps is attached in Appendix 2.</td>
</tr>
<tr>
<td>Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.</td>
<td>Sickness absence Trust-wide achieved the GREEN threshold, reducing to 3.8% (against the Trust target of 3.9%), meeting Divisional targets in 4 out of 7 Divisions.
<table>
<tr><th>June 2016</th><th>Actual</th><th>KPI</th></tr>
<tr><td>UH Bristol</td><td>3.8%</td><td>3.9%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>2.7%</td><td>2.8%</td></tr>
<tr><td>Medicine</td><td>4.0%</td><td>4.9%</td></tr>
<tr><td>Specialised Services</td><td>3.3%</td><td>3.5%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>4.0%</td><td>3.7%</td></tr>
<tr><td>Women's & Children's</td><td>3.6%</td><td>3.5%</td></tr>
<tr><td>Trust Services</td><td>3.2%</td><td>3.4%</td></tr>
<tr><td>Facilities & Estates</td><td>6.3%</td><td>6.0%</td></tr>
</table>
</td>
<td>Sickness absence as a percentage of full time equivalents by month
 

Please note: Sickness data is refreshed retrospectively to capture late data entry, and to ensure the data are consistent with what we finally submit for national publication.</td>
<td>Action 15 describes the ongoing programme of work to address sickness absence.</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.</td>
<td>Vacancies increased from 4.7%, to 5.3% (439.2 FTE) as a result of increased funded establishment (66.3 FTE increase) across a range of cost centres. Nursing and Midwifery vacancies increased from 4.8% to 5.5% (173.4 FTE) due to a 36.7 FTE increase in funded establishment.
<table>
<tr><th>June 2016</th><th>Rate</th></tr>
<tr><td>UH Bristol</td><td>5.3%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>5.4%</td></tr>
<tr><td>Medicine</td><td>6.7%</td></tr>
<tr><td>Specialised Services</td><td>7.1%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>6.3%</td></tr>
<tr><td>Women's & Children's</td><td>2.4%</td></tr>
<tr><td>Trust Services</td><td>8.0%</td></tr>
<tr><td>Facilities & Estates</td><td>3.6%</td></tr>
</table>
</td>
<td>Vacancies rate by month
 
</td>
<td>The recruitment action plan is summarised in Action 16.
Appendix 2 details progress in reducing specialist nursing vacancies where additional recruitment support has been provided. Ward D703, and Coronary Intensive Care Unit are close to trajectory. Heygroves Theatres have 9 Band 5 staff starting between August and October 2016 including cardiac scrub practitioners, which are particularly difficult to recruit.</td>
</tr>
<tr>
<td>Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory.</td>
<td>Turnover reduced from the refreshed May figure of 13.3% to 13.1% in June. Divisional targets were achieved in 2 out of 7 Divisions.
<table>
<tr><th>June 2016</th><th>Actual</th><th>Target</th></tr>
<tr><td>UH Bristol</td><td>13.1%</td><td>13.2%</td></tr>
<tr><td>Diagnostics & Therap.</td><td>12.6%</td><td>12.8%</td></tr>
<tr><td>Medicine</td><td>14.4%</td><td>14.2%</td></tr>
<tr><td>Specialised Services</td><td>12.7%</td><td>14.0%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>13.6%</td><td>13.9%</td></tr>
<tr><td>Women's & Children's</td><td>11.2%</td><td>10.8%</td></tr>
<tr><td>Trust Services</td><td>15.2%</td><td>15.4%</td></tr>
<tr><td>Facilities & Estates</td><td>13.9%</td><td>13.9%</td></tr>
</table>
</td>
<td>Staff turnover rate by month
 
</td>
<td>Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 17).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In June the average length of stay for inpatients was 4.14 days, a 0.02 day decrease on the previous month. Length of Stay remains above plan, and for this reason is RED rated. At the end of June the number of Green to Go delayed discharges was marginally higher than the same period last year (60 versus 54), but remains above the jointly agreed planning assumption of 30 patients. In June the percentage of over 14 days stay patients discharged was the same as in April, which was the highest level since April 2015. The high rate of discharge of long stay patients is consistent with the reduction seen in over 14 day patients in-hospital at month-end. The continued improvement in Length of Stay appears to be related to an underlying reduction in stays, and not simply due to fewer long stay patients being discharged in the period.	**Average length of stay (days)** 	Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan and additional exceptional actions being taken (Actions 13A to 13D).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Testing next version of revised escalation protocol in Division of Medicine. Baton bleep in place for on call medical registrars.	August 2016	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality & Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Further targeted teaching for areas where NEWS incidents have occurred.	Commenced February 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1C	Accessing doctor education opportunities to assist with resetting triggers safely	Commenced April 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1D	Further understand and address the reasons why not all nurses feel confident to escalate to more senior clinician through learning from NEWS incidents, through safety culture work. Also please see 1E below.	November 2016	As above	Sustained improvement to 95% by 2018.
	1E	Testing approach to point of care simulation training in adult general ward areas address human factors elements of escalating deteriorating patients and use of structured communication.	September 2016	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	1F	Awaiting confirmed outcome of application for further time for patient safety in doctors' induction to train new appointees on resetting triggers safely and human factors awareness of escalation conversations.	Outcome expected July 2016	As above	
Non-purposeful omitted doses of critical medication	2A	Feedback detailed results to Heads of Nursing to follow up the 8 omitted doses	July 2016	Ensuring detailed focus is maintained to avoid omitted doses	Maintain current improvement and sustain performance below 1%
	2B	Medication omitted, to be collated (by drug group) into a report that will be added to the Pharmacy Connect Front page.	August 2016	Ensuring detailed focus is maintained to avoid omitted doses	Maintain current improvement and sustain performance below 1%
Essential Training	3	Continue to drive compliance including increasing e-learning.	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	From August, trajectories will be monitored at a divisional level at monthly performance and Operations meetings.
		Detailed plans focus on improving the compliance of Safeguarding Resuscitation, Information Governance (IG) and Fire Safety.	Ongoing	Oversight of safeguarding training compliance by Safeguarding Board	
		Compliance reports have been produced which separate fire and IG, enabling divisions to proactively track those who are non-compliant. Additional enhancements have been made to target more appropriately, and this will be communicated to staff.	End July 2016	Oversight by Workforce and OD Group via the Essential Training Steering Group / Service Delivery Group	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Trajectories will be produced for Divisions to achieve compliance against fire (end of July) and IG (end of August) and these will be signed off by Service Delivery Group	End August 2016	Service Delivery Group/monthly and quarterly Divisional Performance Reviews.	
Monthly Staffing levels	4	Continue to validate temporary staffing assignments against agreed criteria.	Ongoing	Monitored through agency controls and action plan.	Action plan available on request.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Caring					
Dissatisfied complainants	5a	Response writing training continues to be rolled-out to Divisions	Ongoing	Completion of training signed-off by Patient Support & Complaints Team and Divisions.	Achieve and maintain a green RAG rating for this indicator.
	5b	Upon receipt of written response letters from the Divisions, there is a thorough checking process, whereby all letters are firstly checked by the case-worker handling the complaint, then by the Patient Support & Complaints Manager. The Head of Quality for Patient Experience & Clinical Effectiveness also checks a selection of response letters each week. All responses are then sent to the Executives for final approval and sign-off.	Ongoing	Senior Managers responsible for drafting and signing off response letters before they leave the Division are named on a Response Letter Checklist that is sent to the Executives with the letter. Any concerns over the quality of these letters can then be discussed individually with the manager concerned and further training provided if necessary.	
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited but now in pipeline before starting. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve	Ongoing To be confirmed – expected to be by quarter 4, when virtual ward up to full impact,	Monthly Divisional Review Meetings; Relevant Steering Group to be confirmed, but likely to be Cancer Steering Group, due to the recent impact on cancer	Improvement to be evidenced by a reduction in cancellations in Q1. Achievement of quality objective on a quarterly basis.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		ability to manage peaks in demand.	relieving ward bed pressures		
	6B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director of Operations.	As above.
Outpatient appointments cancelled by hospital	7A	Review and revise cancellation reasons available on Medway to improve consistency of reporting and improve the Trust's understanding of the root cause of cancellations.	End of July	Changes approved through Change Board and Medway revised.	See action 6C
	7B	Produce summary analysis of first month's use of the new cancellation codes, and test the reasonableness of the target thresholds currently set. This analysis will include a break-down of the reasons for cancellation, and the percentage of cancellations that relate to patients being able to book on the national Electronic Referral Service, beyond the period of notification for annual leave.	End August	Report provided for Outpatient Steering Group;	Outpatient Steering Group to identify any new actions arising from this analysis, which may alter performance trajectory.
	7C	Select six highest hospital cancellation specialities and investigate reasons for cancellations with frontline staff and Performance & Operations Managers. Share learning with all over specialities via the Outpatient	End of September	Report provided for Outpatient Steering Group	Amber threshold expected to be achieved by the end of October.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Steering Group.			
	7D	Send Trust Annual Leave Policy to all General Managers and ask them to confirm that the policy is being adhered to within their specialities.	End of June	Confirmation to go back to the Outpatient Steering Group in July	See action 6C
	7E	Using the new cancellations codes set-up on Medway, confirm that no leave is being agreed within six weeks (or timescale locally agreed).	End of September	Report provided for Outpatient Steering Group	See action 6C

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	8A	Commissioner-led task and finish group established in January, to understand drivers of increase in paediatric emergency demand and to identify possible demand management solutions.	Ongoing	Urgent Care Board	Achievement of recovery trajectory in Quarter 1 (achieved in each month to date).
	8B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of recovery trajectory in Quarter 2 (achieved in each month in Q1).
	8C	Working with partners to continue to mitigate any impact of recommissioning of domiciliary care packages providers and bed closures in other acute trusts See also actions 12A to 12D relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of recovery trajectory in Quarter 2 (achieved in each month in Q1).
Referral to Treatment Time (RTT)	9	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group.	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of the RTT Incomplete/Ongoing pathways standard (at risk for July due to rising demand).
Cancer waiting times	10A	Implementation of Cancer Performance Improvement Plan,	Ongoing	Oversight of implementation by Cancer Performance	Achieve monthly recovery trajectory submitted for

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		including ideal timescale pathways, and reduced waits for 2-week wait appointments (copy of plan provided to the Quality & Outcomes Committee as a separate paper in August; and Trust Board in September)		Improvement Group, with escalation to Cancer Steering Group.	2016/17
	10B	Escalate issues and seek assurance on North Bristol Trust's (NBT) plan to reduce delays in histopathology reporting post service transfer	Ongoing	Exec to Exec escalation complete; action plan provided.	NBT meeting the agreed Service Level Agreement standards.
Diagnostic waits	11A	Increase adult endoscopy capacity by recruiting to the Nurse Endoscopist post, completing the in-house training of a nurse endoscopist, booking additional waiting list initiatives and sessions through Glanso, and outsourcing as much routine work as possible to a private provider through the contract which has recently been agreed.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard by end of September.
	11B	GP with Specialist Interest undertaking additional Sleep Studies outpatient sessions (late June to September), to help address the bulge in demand; additional waiting list sessions also being undertaken.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	As above
	11C	Establish additional sessions for	Ongoing	Weekly monitoring by Associate Director of	Recovery of 99% standard for total Radiology (including

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Echo, Ultrasound and MRI.		Performance, with escalation to month Divisional Review meetings as required.	Ultrasound and MRI) by end July and Echo by the end of September.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	12A	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	Ready to trial in February with full implementation in June 2016 (deadline revised again from April 2016 to June 2016)	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured Neck of Femur (NOF) patients waiting, and all fractured NOF patients over 24 hours. IM&T needs to build a new system in order to be able to retrieve this information into the live tracker. Deadline slipped. Ongoing project in IM&T.	Improve in overall fractured neck of femur pathway
	12B	The Trust has commissioned the British Orthopaedic Association to conduct an external review of outcomes for fractured neck of femur patients.	July 2016	Report of external review. Draft report received June 2016. Comments made and returned to British Orthopaedic Association. Awaiting final report.	Draft report received June 2016. Comments made and returned to British Orthopaedic Association. Awaiting final report. Monitored by Clinical Effectiveness Group/Quality Intelligence Group.
	12C	Review and prioritise/action the recommendations of the British Orthopaedic Association Fractured Neck of Femur mortality review (review took place 10/11 May 2016 – awaiting report due within 3 weeks). Assess potential causes and mitigating actions for increased Fractured Neck of Femur	July 2016	Identifiable actions to take to improve the #NOF service for patients which is likely to lead to improved BPT performance	A meeting has taken place to outline some of the recommendations and possible actions, but we awaiting the final report before progressing.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		mortality			
	12D	Build and submit case for middle grade medical ortho-geriatric support (1.0 WTE 1-year fixed term with focus on quality/pathway work relating to Fractured Neck of Femur). This will enable consistent and regular ortho-geriatric cover across orthopaedic wards, and avoid breaches due to annual leave etc.	July 2016	Successful funding bid and subsequent recruitment to post.	Improvement in Best Practice Tariff indicators.
	12E	Build and submit case for specialist acute fracture nurse support (Band 6 permanent).	July 2016	Successful funding bid and subsequent recruitment to post.	Improvement in Best Practice Tariff indicators.
Outlier bed-days	13A	Reduce demand on beds to support optimal occupancy. Range of initiatives in place to reduce demand for acute services. Limited impact to and further significant initiative now being pursued – community virtual ward.	Ongoing Working to Q4	Oversight in fortnightly Urgent Care Working Group Urgent Care Working Group and System Resilience Group	Maintain modelled occupancy of 90% Plans for commencement of virtual ward project from late June
	13B	Weekly Patient Progress meeting continues to expedite early discharge with support of our partners. Divisions reviewing long stay patients.	Ongoing	Monitoring of Green to go list and new reporting of DTOC	Green to Go trajectory or no more than 30 patients. Currently working with partners to agree steps to meet this.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	13C	Ward processes to increase early utilisation of discharge lounge to facilitate patients from Acute Medical Unit getting into the correct speciality at point of first transfer	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge
	13D	'Plans for the Weekend' event took place to increase number of weekend discharges	Learning now embedded in into operating model.	Operating Mode Group	To increase number of weekend discharges and support reduction in length of stay

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	Sickness absence, vacancies and turnover are key to managing agency usage (see section 14, 15 and 16). Corporate actions to directly target agency expenditure are detailed below:		Oversight by Savings Board (Nursing Agency) and Medical Efficiencies Group (Medical Agency)	An annual workforce KPI of 1.1% for agency as a percentage of total staffing was agreed through the operating planning process. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews.
		Effective rostering: To reduce "lost time" - currently above funded establishment - ensuring annual leave, study leave, and sickness is planned and monitored appropriately. Actions include:			
		• Planning rosters six weeks in advance	Monitoring ongoing		
		• Roll out of e-rostering to outpatient areas	In progress, complete end of July 2016.		
		• Procurement of new rostering system with integrated acuity and dependency system to enable staff to be moved to areas of greatest need	Tenders closed June 2016. Pilot new system November 2016, go live April 2017		
		• Pending the new rostering system, a staffing dashboard is on trial to provide a cross trust overview of inpatient staffing	June 2016 to April 2017		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Controls: • Robust Escalation policy with clear sign off process and flow chart of questions to be asked before resorting to agency	Ongoing		
		• Operating plan agency trajectories monitored and tracked through divisional reviews	Monthly and quarterly reviews		
		Nursing Assistant one to one care: • The Enhanced Observation Policy is in place in all Divisions. An audit of the policy will commence in August 2016.	Audit commencing August 2016		
		• Funding for enhanced observation has been applied to budgets, enabling divisions to recruit additional staff to avoid agency usage.	Recruitment June – August 2016		
		Enhancing bank provision: • Close working with wards to support prompt payment for bank staff. • A direct booking process at ward level • Internal and external local marketing to develop an	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		increased pool of bank nurses			
		Agency Caps: • Executive working group set up to review compliance with NHS Improvement caps for maximum rates and develop strategies to reduce reliance on agency workers.	Ongoing		
Sickness Absence	15	**A dedicated lead**: To develop a sickness absence management plan to: • Review current strategies and develop impact assessment measures • Make further recommendations, supported by an action plan. Current actions include:	Action plan to Executive Directors on 29th June. Next steps to be agreed with Senior Finance/HR teams by end of July	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub Group	A KPI for 2016/17 of 3.9% has been set through the operating planning process.
		Pilot of self-certification for absences of 1-3 days: Targets the 11% of sickness which is for 3 days or less, and ensuring timely return to work interviews are undertaken.	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Supporting Attendance Policy: • Audit to ensure policy is fit for purpose and consistently implemented. • Full review of policy including simplifying content/ structure, sign posting and tools to assess attendance	July – end September 2016 July – end September 2016		
		Training for managers: Training review complete to ensure training meets the needs of managers and achieves improved competence/confidence	To commence October 2016		
		Resource allocation: Ensuring that the Employee Services resource is focussed appropriately and targeted at areas of greatest need.	Ongoing		
		Supporting Attendance Surgeries: Process to be reviewed as part of policy review in Q2. To support managers to expedite cases where possible	July – end September 2016		
		Musculo-skeletal: As a significant cause of absence, targeted actions include continued interventions by Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Staff Health and Well Being: Annual action plan, including the following: • Free on site health checks - target of reaching 2000 staff • "Work out at Work" – programme encouraging physical activity	January 2016 to January 2018 August 2016		
		Staff Health and Well Being CQUIN: Implementation plan has been developed, focussed on improving health and wellbeing. This includes funding to recruit an additional Occupational Health physiotherapist to increase capacity.	October 2017 (Peer review Bristol Clinical Commissioning Group) October 2016 to March 2017	CQUIN short term working group	
Vacancies	16	Recruitment action plan includes the following activities. **Marketing and advertising:** • Divisional Performance and Operations Meetings monitor performance against operating plan requirements and ongoing vacancies.	Review quarterly	Workforce and OD Group /Recruitment Sub Group.	Detailed trajectories are in place for key recruitment hotspots, including theatres; critical care, haematology and ancillary staff
		• Marketing activity plans are in progress, focusing on hard to fill posts including nursing and midwifery. A schedule to reflect planned activities will be completed in August, but will	Schedule completed end of August 2016	Divisional Performance and Operational Reviews	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		continue to be adjusted to respond to demand.			
		Service level agreements and KPIs for recruitment have been developed to measure performance and support improvement. The agreed KPI of 45 days for time to recruit will be tracked through divisional reviews against an improvement trajectory.	Reviewed quarterly		
		Business cases have been agreed for recruitment and retention initiatives in specialist areas - Heygroves Theatres, Ward D703 and CICU as an alternative to targeted overseas campaigns. Trajectories are shown in appendix 3.	Reviewed monthly		
Turnover	17	Key corporate and divisional actions include the following:	September 2016	Workforce and OD Group	The KPI target for 2016/17 has been set at 12.1%.
		Complete review of appraisal: To improve their quality and application, in response to feedback from the staff survey 2014, including: • Revised policy, in conjunction with staff side; • E-Appraisal working with our Learning and Development portal supplier;			

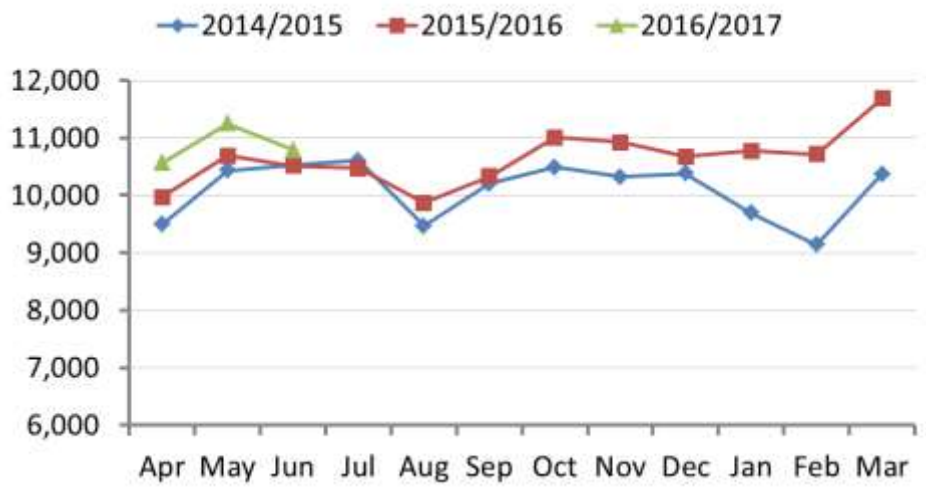
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• Engaging staff through feedback sessions (105 staff).			
		Targeted leadership and management development programme: Includes Healthcare Leadership Model training and Learning and Leading Together - target of 800 managers trained annually was met for 2015.	Second cohort of Leadership for supervisors will commence in October following a review of the first cohort	Transformation Board	
		Team building and local decision making: Work with Aston Organisational Development to develop team coaches, taking teams through a programme of work-based activities. Findings from the pilot will be evaluated to inform future roll-out.	September 2016 (Diagnostic and Therapies pilot Divisional Board)		
		Staff experience workshops: Divisions have incorporated actions with detailed milestones into their operating plans.	November 2015 - March 2017.	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	
		Training and Development Investment: £200k for divisional hot spots including ITU, Heygroves and Care of the Elderly to provide innovative training and development. Return on Investment report due September 2016.	End of September 2016	Senior Leadership Team/Workforce and OD Group /Divisional Boards	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Family and Friends Test: This survey asks "Would you recommend UHB as a place to receive treatment" and "Would you recommend UH Bristol as a place to work" distributed to all staff.	Results due end July 2016	Workforce and OD Group	
		Transformational Engagement and retention: A short life working group established to develop high impact projects to improve staff experience and improve retention in response to 2015 Staff Survey. The Group drafted plans for workshops during the summer across the trust to identify and develop expected behaviours of our leaders.	Senior Leadership Seminar 22nd June, Board Seminar 24th June Workshops summer 2016	Senior Leadership Team/Board	

Operational context

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

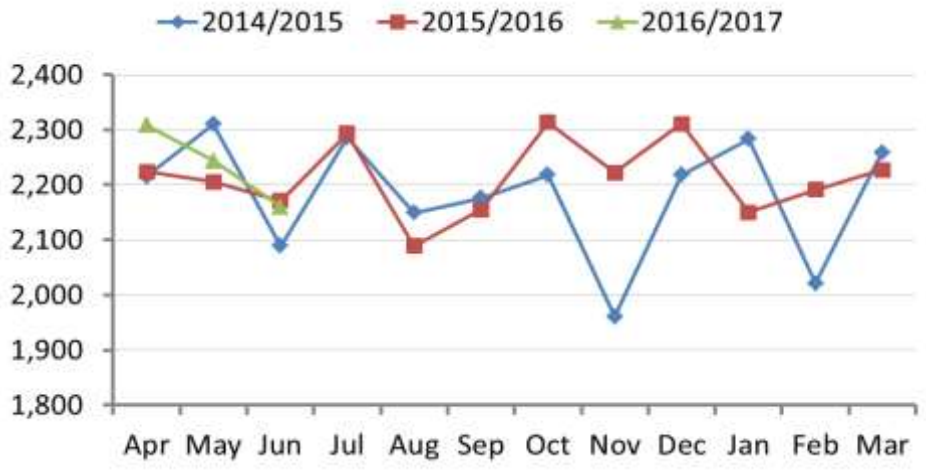
Emergency Department (ED) attendances



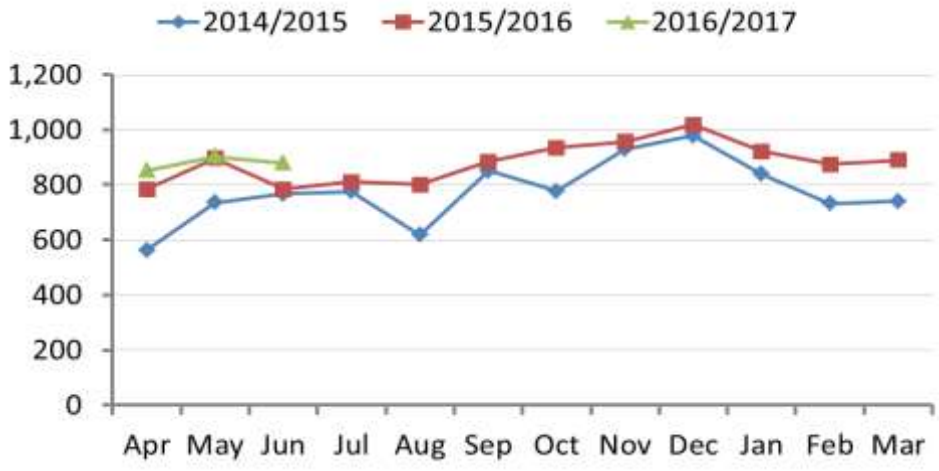
Summary points:

- Emergency attendances remains slightly above the same period last year; emergency admissions into the BCH are significantly above the same period last year (see the A&E 4-hour report);
- The number of elective admissions rose sharply, consistent with the pattern for this time of the year; as will be seen from the Assurance section, the number on the elective waiting list has however increased, which is thought to be a result of an increase in referrals seen in the last few months, as evident in the recently growing outpatient waiting list;
- The number of new outpatient appointments is consistent with the seasonal norm but above the levels seen in the last two months; this has helped slow the growth in the outpatient waiting list.

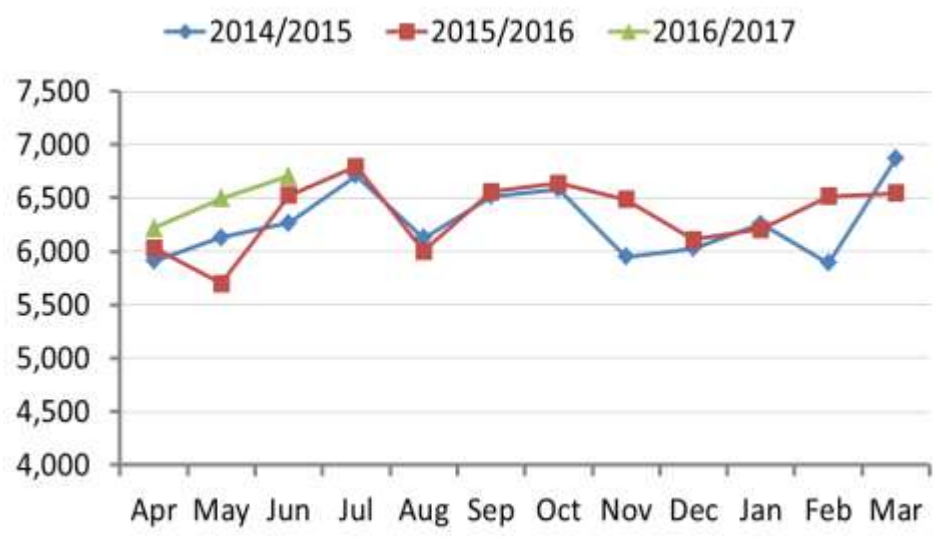
Emergency admissions (BRI)



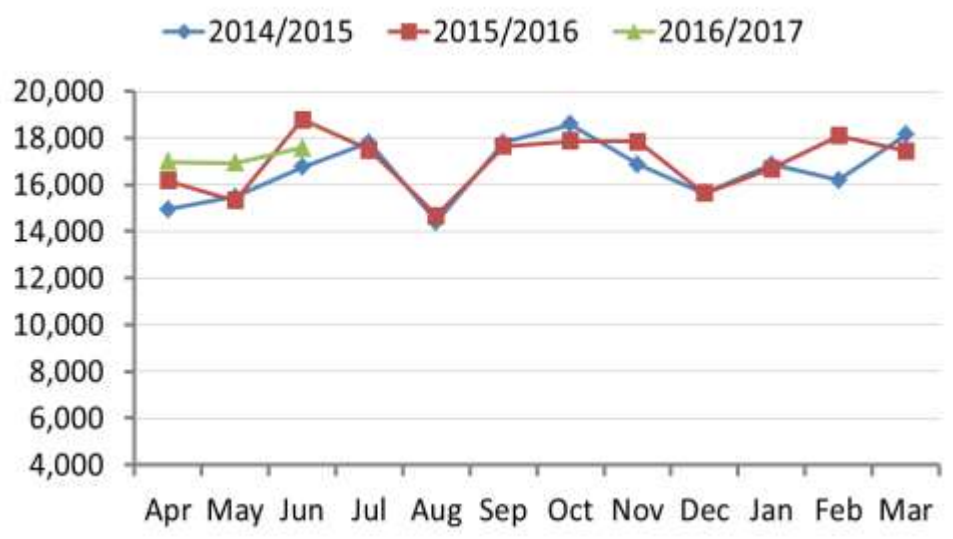
Emergency admissions (BCH)



Elective admissions



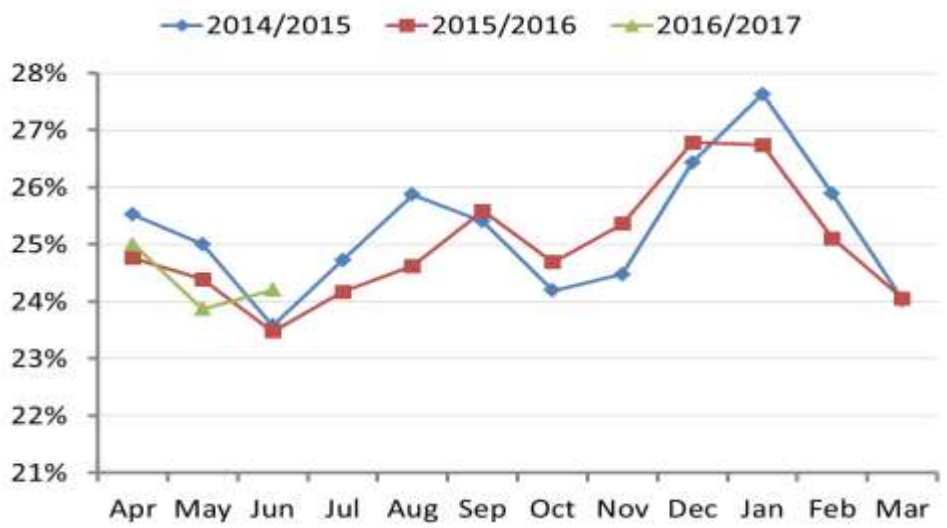
New outpatient attendances



Assurance and Leading Indicators

This section of the report looks at set of assurance and 'leading' indicators, which help to identify future risks and threats to achievement of standards.

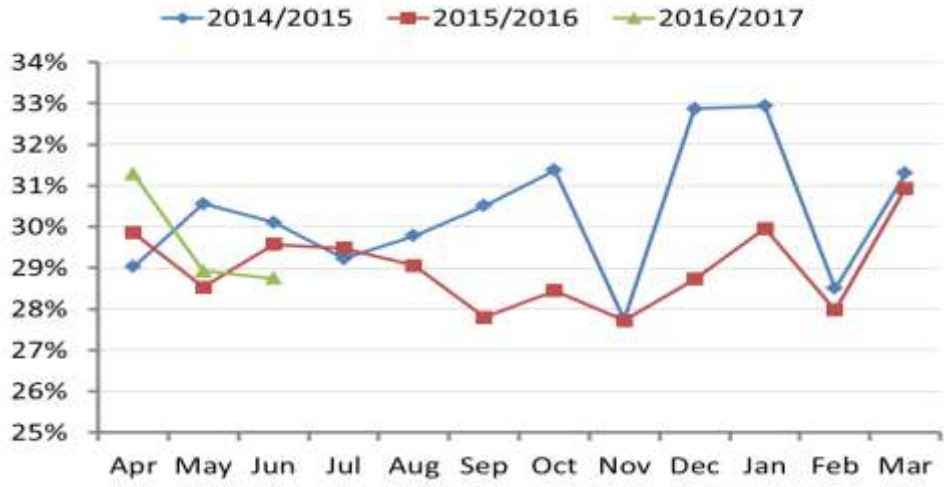
Percentage ED attendances resulting in admission



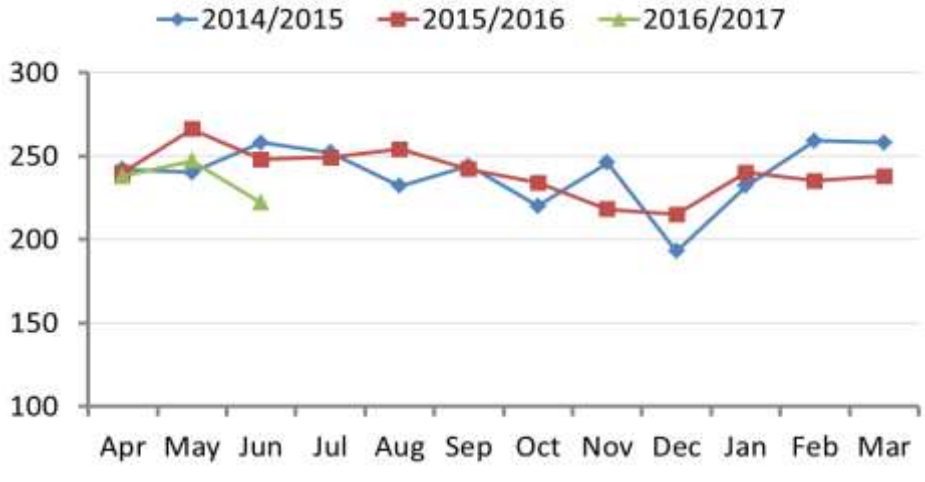
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission was above the seasonal norm in June; however, the percentage of patients admitted aged 75 years and over has continued to reduce;
- The number of delayed discharges remains similar to last year; BRI bed occupancy has, however, increased from May's level, which resulted in a slight deterioration in patient flow and 4-hour performance;
- The number of patients on the elective waiting list has increased despite a rise in elective admissions; the number of patients on admitted pathways waiting over 18 weeks RTT has not risen (see Appendix 3), but is expected to do so, with this recent rise in the elective waiting list, if the heightened demand to come cannot be met
- Numbers of patients referred by their GP with a suspected cancer has increased well above the seasonal norm which will create a bulge in demand for treatments.

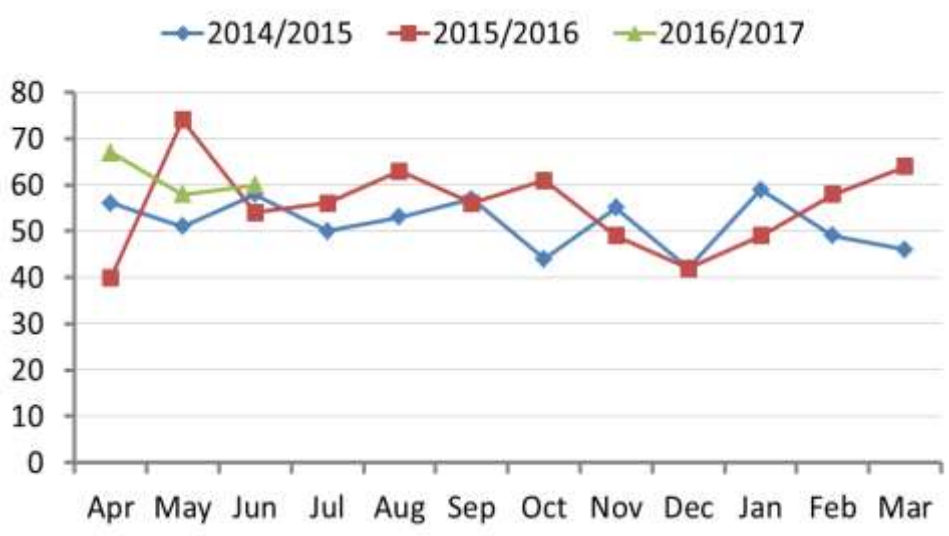
Percentage of Emergency BRI spells patients aged 75 years and over



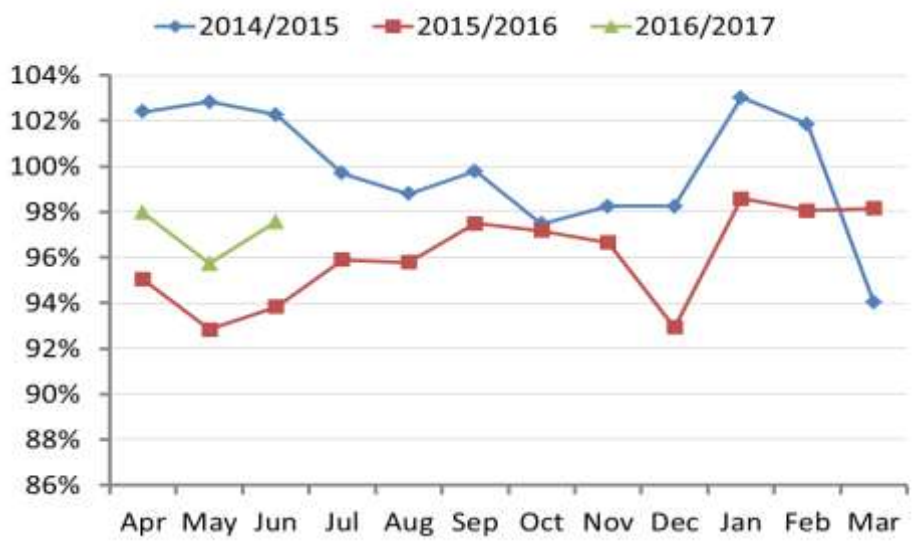
Over 14 day stays



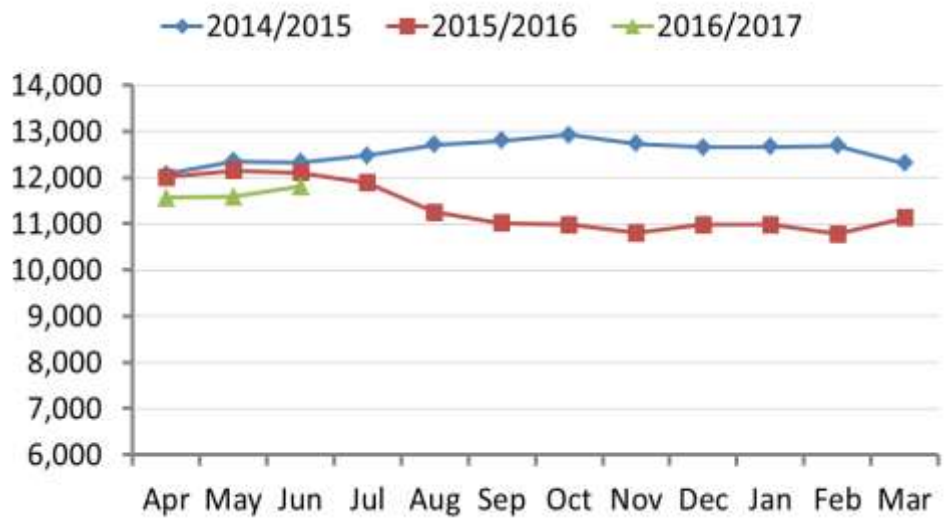
Delayed discharges (Green to Go)



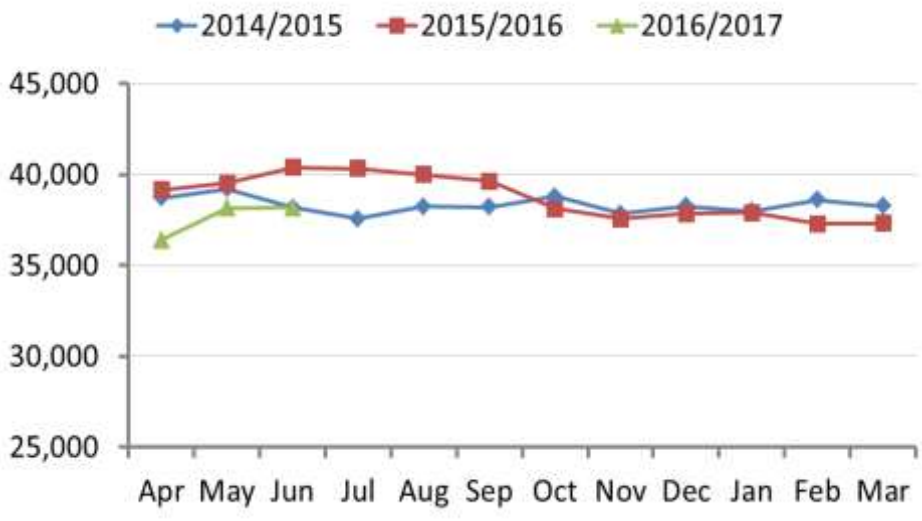
BRI Bed Occupancy



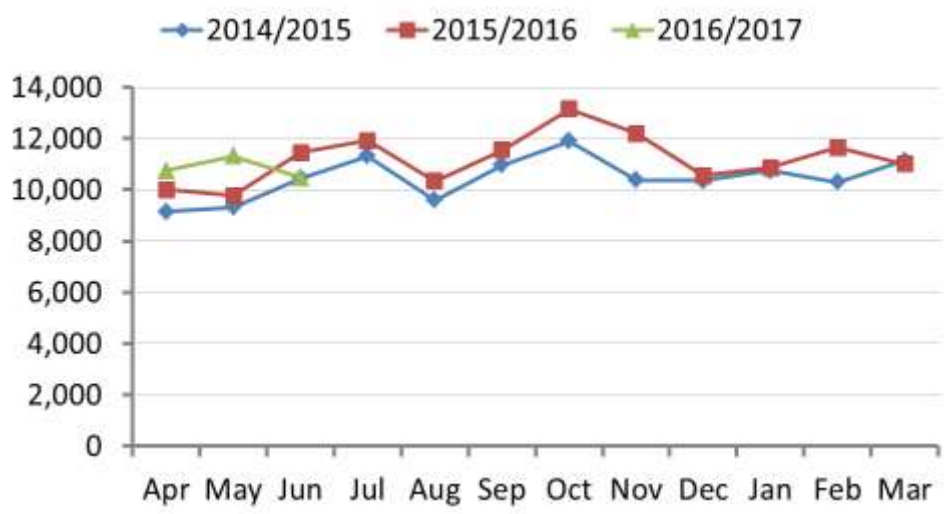
Elective waiting list size



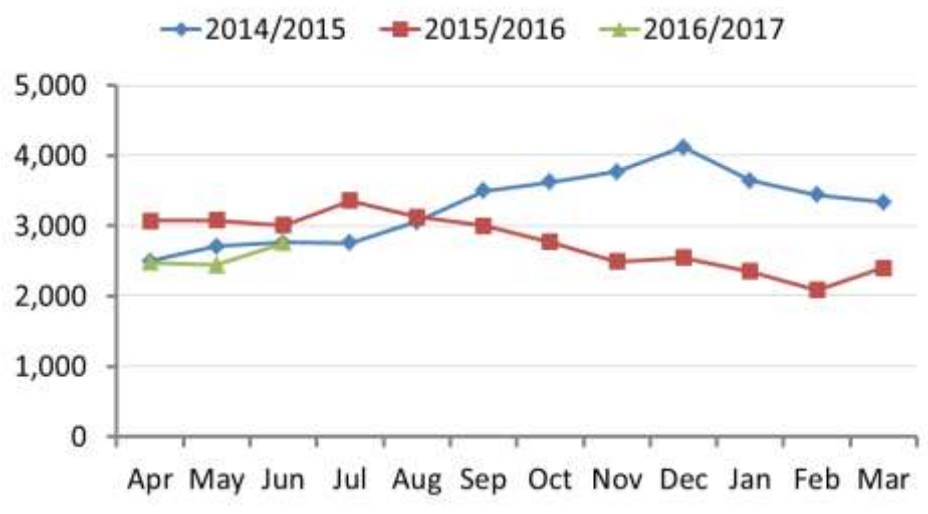
Outpatient waiting list size



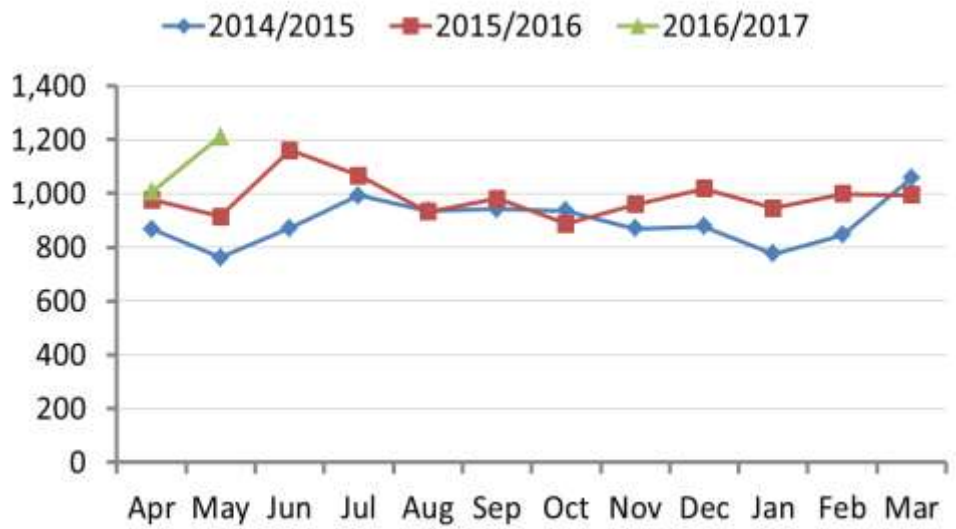
Number of RTT pathways stopped (i.e. treatments)



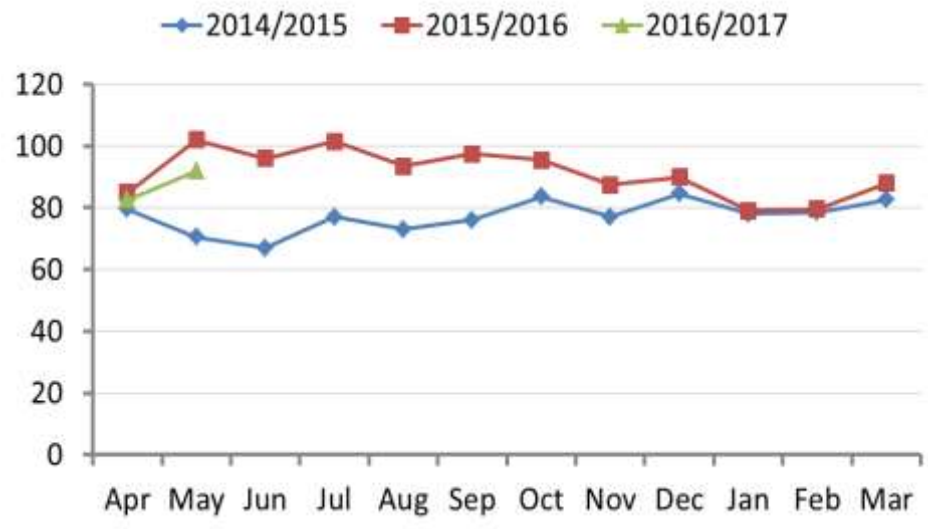
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	2	3	3	3	3	3	3	3	3	0	0	0	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	DA03	C.Diff Cases - Monthly Totals	40	8	3	1	2	5	3	6	4	2	4	2	5	1	6	14	10	8
	DA02	MSSA Cases - Monthly Totals	26	8	2	3	2	3	2	2	2	1	0	2	3	3	7	7	3	8
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	4	5	5	7	7	9	12	14	17	-	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	97.3%	97.7%	97.7%	97.9%	95.8%	98.1%	98.1%	96.4%	97.7%	96.8%	96.6%	97.3%	98%	97.8%	97.3%	97%	97.3%
	DB02	Antibiotic Compliance	87.6%	84.5%	88.3%	86.1%	82.3%	85.7%	86%	90.6%	86.5%	88.2%	86.1%	84.4%	85.3%	83.9%	85.7%	87.2%	86.9%	84.5%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	93%	95%	93%	93%	94%	94%	94%	95%	94%	95%	95%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	96%	97%	96%	97%	97%	97%	98%	98%	98%	98%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	94%	93%	94%	95%	95%	95%	95%	96%	95%	96%	96%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	13	3	8	4	4	9	5	6	4	10	3	8	2	15	18	20	13
	S02a	Number of Confirmed Serious Incidents	55	1	3	8	1	4	8	4	5	4	5	1	-	-	12	16	14	1
	S02b	Number of Serious Incidents Still Open	5	12	0	0	1	0	1	1	1	0	0	2	8	2	1	2	1	12
	S03	Serious Incidents Reported Within 48 Hours	84.1%	92.3%	100%	62.5%	100%	100%	44.4%	100%	100%	100%	100%	66.7%	100%	100%	80%	72.2%	100%	92.3%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	92.3%	-	-	-	-	-	-	-	-	-	66.7%	100%	100%	-	-	-	92.3%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	74.1%	100%	100%	100%	75%	85.7%	66.7%	60%	60%	63.6%	100%	100%	100%	100%	87.5%	72.2%	66.7%	100%
Never Events	S01	Total Never Events	3	0	0	1	0	0	1	1	0	0	0	0	0	0	1	2	0	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	2361	1023	1109	1143	1142	1149	1167	1190	1196	1226	1145	1216	-	3275	3458	3612	2361
	S06b	Patient Safety Incidents Per 1000 Beddays	44.72	45.9	39.35	42.91	45.47	43.98	45.34	46.17	44.59	48.19	46.64	44.93	46.85	-	42.55	45.15	46.43	45.9
	S07	Number of Patient Safety Incidents - Severe Harm	97	10	9	13	8	13	8	15	5	6	3	2	8	-	30	36	14	10
Patient Falls	AB01	Falls Per 1,000 Beddays	3.94	4.24	4.08	4.6	3.9	3.54	3.79	4.15	3.56	3.59	4.15	4.24	3.93	4.57	4.2	3.83	3.77	4.24
	AB06a	Total Number of Patient Falls Resulting in Harm	30	8	2	1	1	4	3	5	2	3	5	1	4	3	4	12	10	8
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.221	0.157	0.231	0.232	0.318	0.193	0.079	0.158	0.15	0.242	0.114	0.275	0.154	0.04	0.26	0.144	0.167	0.157
	DE02	Pressure Ulcers - Grade 2	61	11	5	4	7	4	2	4	3	6	3	7	3	1	16	10	12	11
	DE03	Pressure Ulcers - Grade 3	7	1	1	2	1	1	0	0	1	0	0	0	1	0	4	1	1	1
	DE04	Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.2%	99.2%	99.4%	99.3%	99%	98.4%	98.1%	97.4%	97.1%	95.6%	96.9%	99.3%	99.1%	99%	99.2%	98%	96.5%	99.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	95.8%	96.6%	95.2%	95.1%	94%	93.5%	94%	93.6%	96%	94.5%	94.8%	96.3%	96.6%	95.7%	93.9%	94.7%	95.8%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	88.5%	90.7%	86.6%	86.5%	91.5%	91.6%	93.2%	90.4%	89.9%	91.4%	83.6%	94%	86.3%	87.9%	92.1%	90.6%	88.5%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	-	80.8%	-	-	-	-	-	-	-	-	-	-	-	80.8%	-	-	-	80.8%
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.5%	100%	100%	100%	100%	99.8%	100%	99.9%	99.9%	100%	99.8%	100%	98.9%	100%	99.9%	99.9%	99.5%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Quarterly Totals 15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0.26%	1.32%	0.79%	1.75%	0%	1.39%	1.2%	1.28%	0.42%	0.41%	0%	0.51%	-	1.34%	0.91%	0.7%	0.26%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.73%	0.83%	0.73%	0.75%	0.78%	0.62%	1.03%	1.49%	0.66%	0.69%	0.93%	0.63%	0.56%	0.77%	0.8%	0.92%	0.73%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	97.7%	97.4%	96.4%	96.2%	97.3%	95.9%	97.9%	97.2%	96.7%	97.3%	97.1%	97.7%	98.3%	96.7%	97.1%	97.1%	97.7%
	AK04	Safety Thermometer - No New Harms	98.6%	98.8%	98.6%	98%	98%	98.9%	97.9%	99.1%	98.8%	98.9%	99.4%	98.9%	98.7%	98.7%	98.2%	98.6%	99%	98.8%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	89%	98%	90%	92%	92%	91%	90%	86%	86%	88%	87%	100%	79%	94%	91%	86%	89%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.6%	10.4%	11%	11.4%	13%	11.1%	9.6%	11%	9.6%	9.6%	8.1%	7.5%	7.2%	10.9%	11.2%	10.1%	7.6%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.9%	19.7%	17.9%	19.8%	19.1%	19.2%	22.1%	21.9%	22.3%	23.3%	23%	22.3%	23.4%	19.2%	20.2%	22.5%	22.9%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	2914	864	741	845	856	836	1002	911	926	990	971	952	991	2450	2694	2827	2914
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	103.9%	102.8%	100.5%	103.1%	105.8%	104.8%	104.8%	105.9%	103.2%	103.1%	104.7%	104%	103.1%	102.1%	105.1%	104.1%	103.9%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.4	-	-	-	97.8	-	-	97.7	-	-	-	-	-	-	97.8	97.7	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	89.8	-	90.7	87.9	90.1	97.3	94.4	76.3	96.7	97	94.9	-	-	-	89.6	88.9	96.1	-
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.65%	2.74%	2.89%	2.77%	2.83%	2.82%	2.87%	2.67%	2.66%	1.5%	1.74%	1.56%	-	2.8%	2.84%	2.27%	1.65%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	61.2%	57.3%	62.5%	62.4%	61.3%	63.9%	63.4%	62.7%	60.1%	62.5%	66.6%	61%	56.4%	60.7%	62.9%	61.8%	61.2%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	77.6%	76%	81.5%	85.7%	80.8%	76.5%	66.7%	76%	78.6%	80%	87.5%	74.1%	72%	81.3%	74%	78.2%	77.6%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	78.9%	80%	85.2%	78.6%	92.3%	94.1%	86.7%	80%	78.6%	84%	83.3%	81.5%	72%	81.3%	90.4%	80.8%	78.9%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	57.9%	60%	70.4%	64.3%	73.1%	70.6%	60%	60%	64.3%	68%	70.8%	59.3%	44%	65%	67.1%	64.1%	57.9%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	46.7	40.2	39.4	42.4	44.4	44.8	50.2	47.5	40.5	35.8	61.4	44.1	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	68.6%	43.8%	67.4%	62.2%	57.5%	59.5%	56.8%	62.5%	77.4%	60.6%	69.2%	67.6%	-	59.2%	57.9%	66.1%	68.6%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	88.4%	93.8%	95.3%	93.3%	90.2%	91.9%	91.9%	91.7%	96.8%	84.8%	88.5%	88.2%	-	94.2%	91.3%	91.1%	88.4%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	63.4%	58.8%	100%	75%	54.5%	62.5%	47.1%	71.4%	80%	80%	58.3%	68.8%	61.5%	73.5%	52.8%	77.3%	63.4%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	94.8%	83.3%	92.5%	91.1%	97.6%	97.2%	95%	93.4%	94.7%	96.7%	94.5%	95.8%	94.1%	88.8%	96.6%	94.9%	94.8%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	97.5%	90%	92.3%	93.2%	98.4%	96.9%	98.4%	95.7%	96.3%	96.8%	96.8%	97.8%	98.1%	91.8%	97.9%	96.2%	97.5%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	97.2%	80%	100%	88.9%	100%	83.3%	100%	100%	100%	100%	95.2%	100%	100%	88.9%	91.3%	100%	97.2%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	92.3%	76.9%	70%	100%	72.7%	72.7%	-	93.8%	100%	75%	-	-	80.6%	84.2%	96.2%	75%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9588	2258	858	839	768	666	537	692	1231	788	1072	930	587	741	2465	1895	3091	2258

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	91	90	90	90	90	91	90	90	89	92	92	90	90	90	90	91
	P01g	Patient Survey - Kindness and Understanding	-	-	93	95	94	94	95	94	95	94	93	96	96	94	94	94	94	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	88	89	89	88	88	89	89	89	89	88	90	90	89	88	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.2%	39.4%	20.5%	10.4%	19.8%	19.3%	20.4%	20.6%	21.9%	22%	26.3%	35.2%	42.4%	40.5%	17.1%	20.1%	22.7%	39.4%
	P03b	Friends and Family Test ED Coverage	13%	14.6%	12.3%	14.7%	17.8%	15.9%	16.4%	13.9%	15.8%	16.7%	12.3%	14.8%	13.5%	15.5%	14.9%	15.4%	14.9%	14.6%
	P03c	Friends and Family Test MAT Coverage	22.7%	20.5%	22.1%	18.3%	14.6%	25.3%	20.2%	20.3%	15.7%	24%	33.7%	16.2%	26.3%	19%	18.5%	21.8%	24.3%	20.5%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	96.6%	97.2%	97.2%	96.2%	96.2%	96.5%	95.6%	96.7%	96.1%	95.9%	97.1%	95.8%	97.2%	96.8%	96.1%	96.2%	96.6%
	P04b	Friends and Family Test Score - ED	75.4%	77.5%	78.1%	77.3%	76.6%	72.2%	76.2%	80%	77.7%	73.7%	71.5%	80.2%	78.1%	74.4%	77.2%	75.9%	74.4%	77.5%
	P04c	Friends and Family Test Score - Maternity	96.6%	97.2%	98.7%	97.1%	96.3%	98.2%	96.9%	97.7%	94.9%	97.6%	95.8%	96.6%	98.9%	95.5%	97.6%	97.6%	96.2%	97.2%
Patient Complaints	T01	Number of Patient Complaints	1941	520	207	168	185	182	148	116	143	183	150	176	146	198	560	446	476	520
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.262%	0.315%	0.302%	0.279%	0.267%	0.219%	0.19%	0.225%	0.268%	0.221%	0.272%	0.218%	0.296%	0.298%	0.227%	0.238%	0.262%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	76.2%	87%	80.9%	83.3%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%	81.6%	73.1%	73.8%	83.9%	56.5%	74.6%	76.2%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	90.9%	98.1%	93.6%	95.8%	80.4%	81%	90.5%	91.5%	84.6%	100%	87.8%	92.3%	92.9%	96%	84.5%	91.8%	90.9%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	8.16%	7.41%	6.38%	14.58%	8.93%	4.76%	6.35%	2.13%	7.69%	8.33%	8.16%	-	-	9.4%	6.83%	5.74%	8.16%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	1%	1.04%	0.46%	0.83%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	0.78%	0.73%	1.42%	1%
	F01a	Number of Last Minute Cancelled Operations	713	183	62	25	50	40	51	39	68	71	108	63	59	61	137	130	247	183

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Quarterly Totals 15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	92.3%	90.2%	90.5%	90.7%	91.1%	92%	91.8%	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%	90.4%	91.6%	92.6%	92.3%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3357	3128	3004	2772	2491	2544	2349	2083	2397	2480	2442	2753	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	0	0	0	1	0	0	0	2	0	0	0	0	0	1	0	2	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	60	45	38	28	25	22	15	15	14	26	24	22	14	111	62	55	60
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	245	188	172	118	96	81	86	75	68	77	80	80	85	478	263	220	245
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	94.5%	97.3%	95.4%	96.8%	97.5%	95.8%	94.8%	93.7%	98%	96.6%	94.3%	94.7%	-	96.5%	96%	96.1%	94.5%
	E01c	Cancer - Urgent Referrals Stretch Target	93%	93%	-	66.3%	-	-	-	-	-	-	-	-	-	64.2%	68%	-	-	-	-	66.3%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	93.9%	96.7%	96.7%	97.3%	98.7%	98.6%	97.8%	98.5%	97%	97.7%	91.3%	96.2%	-	96.9%	98.4%	97.8%	93.9%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	97.6%	99.1%	98.1%	98.6%	99.1%	100%	98.9%	96.1%	100%	99%	96.5%	98.9%	-	98.6%	99.3%	98.3%	97.6%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	85.9%	89.1%	100%	97.6%	97.9%	100%	98%	97.6%	97.9%	95%	76.2%	94%	-	95.6%	98.5%	96.9%	85.9%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	98.1%	96.1%	98.4%	96%	96.1%	97.6%	97.4%	97.9%	96.7%	98.6%	97.9%	98.4%	-	96.8%	97%	97.8%	98.1%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	73.4%	83.7%	80.7%	81%	79.1%	82.3%	86.7%	84.2%	74.2%	84.7%	76.4%	70.7%	-	81.9%	82.6%	81.1%	73.4%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	37.9%	76.9%	70%	85.7%	14.3%	71.4%	50%	50%	60%	70%	41.7%	35.3%	-	78.4%	51.9%	64.6%	37.9%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	81.9%	80.8%	86.7%	91.2%	93.6%	92.7%	100%	81%	92.9%	100%	75.9%	87%	-	87.6%	95.7%	92.1%	81.9%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	1%	1.04%	0.46%	0.83%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	0.78%	0.73%	1.42%	1%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	183	62	25	50	40	51	39	68	71	108	63	59	61	137	130	247	183
	F02c	Number of LMCs Not Re-admitted Within 28 Days	11	11	76	27	7	4	2	5	3	2	1	6	12	23	2	2	13	10	19	27
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.43%	1.32%	0.65%	0.74%	1.17%	1.67%	1.18%	1.86%	1.36%	1.68%	1.35%	1.82%	1.14%	0.91%	1.34%	1.63%	1.43%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	263	79	35	45	73	99	66	105	80	99	79	112	72	159	238	284	263
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	71.2%	73.2%	76%	76%	75.7%	78%	81.8%	75%	59.4%	63%	83.8%	55.2%	-	74.7%	78.7%	66.7%	71.2%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	97%	92.7%	100%	92%	89.2%	95.1%	95.5%	92.5%	93.8%	85.2%	100%	93.1%	-	94.5%	93.4%	90.9%	97%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	97.68%	98.83%	98.63%	99.01%	99.59%	99.37%	99.2%	98.69%	99.11%	99.2%	98.34%	98.55%	96.25%	98.83%	99.39%	99.01%	97.68%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.9%	13%	11.6%	12.7%	12%	11%	10.6%	13%	12.3%	11.8%	13.1%	14%	12.4%	12.6%	12.1%	11.5%	12.4%	13%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	41	59	48	54	41	30	19	33	31	34	23	22	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	19	11	11	12	10	4	5	5	10	3	6	4	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	37	52	45	50	39	33	42	49	48	59	48	50	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	19	11	11	11	10	9	7	9	16	8	10	10	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.18	4.15	3.97	4.51	4.2	4.11	4.12	4.04	4.03	4.3	4.23	4.16	4.14	4.21	4.14	4.13	4.18

RESPONSIVE (continued)

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	15/16	16/17 YTD	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	89.32%	95.51%	94.95%	91.69%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	94.04%	90.23%	83.47%	89.32%
		This is measured against the national standard of 95%																				
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	90.43%	89.32%	95.51%	94.95%	91.69%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	94.04%	90.23%	83.47%	89.32%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	87.4%	83.17%	93.78%	93.44%	87.75%	89.34%	89.43%	86.83%	75.72%	79.13%	75.11%	79.8%	87.73%	81.8%	91.71%	88.55%	76.61%	83.17%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	90.56%	94.01%	96.02%	94.97%	93.81%	93.12%	84.97%	86.7%	89.12%	84.67%	85.59%	93.02%	93.84%	95.11%	94.9%	88.18%	86.39%	94.01%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	99.48%	99.37%	99.84%	99.61%	99.77%	99.23%	99.83%	99.71%	99.83%	99.6%	98.94%	99.33%	99.54%	99.24%	99.74%	99.59%	99.44%	99.37%
		This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																				
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	12	1	0	0	0	0	0	0	6	0	6	0	1	0	0	0	12	1
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	96.4%	100%	99.6%	96.7%	98.4%	99.6%	99%	98.8%	99.3%	97.5%	96.2%	98.2%	94.7%	98.8%	99%	98.5%	96.4%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	93.2%	93.4%	91.6%	92.8%	93.2%	94.1%	93.8%	92.7%	92.9%	94.1%	93.3%	94.2%	92.1%	92.6%	93.7%	93.2%	93.2%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	52.8%	57.5%	60.4%	53.2%	52.8%	49.8%	53.1%	52.6%	45.3%	45.8%	55.2%	51.7%	51.7%	57%	51.9%	47.8%	52.8%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.7%	99.1%	99.2%	98.7%	98.8%	99%	98.9%	98.7%	98.6%	98.6%	98.8%	98.9%	98.5%	99%	98.9%	98.7%	98.7%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.6%	2.9%	2.5%	2.9%	2.7%	3.1%	3.5%	3%	3.7%	3.1%	3%	2.4%	2.3%	2.8%	3.1%	3.3%	2.6%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.2%	2.3%	2%	2.3%	2.4%	2.4%	2.2%	2.6%	2.7%	2.5%	2.1%	2%	2.5%	2.2%	2.3%	2.6%	2.2%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	248	38	36	92	96	86	104	236	153	140	62	72	114	166	286	529	248

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Sickness	AF02	Sickness Rate	4.2%	3.8%	4.2%	3.9%	4.1%	4.3%	4.2%	4.4%	4.6%	4.6%	4.5%	3.9%	3.7%	3.8%	4.1%	4.4%	4.5%	3.8%
		For 2015/16, the Trust target for the year is 3.7%. Divisional targets are: 3.0% (DAT), 5.5% (FAE), 4.1% (MDC), 3.7% (SPS), 3.5% (SHN), 3.9% (WAC), 2.6% (Trust Services, excl FAE)																		
		Different targets were in place in previous years. There is an amber threshold of 0.5 percentage points above the target. These annual targets vary each quarter.																		
Staffing Numbers	AF08	Funded Establishment FTE	8258.8	8304	8096.3	8110.8	8128.9	8168.6	8197.6	8199.8	8224.1	8229.4	8258.8	8241.7	8239	8304	8128.9	8199.8	8258.8	8304
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8315.7	8069.3	8149.2	8253.7	8249.7	8198	8180	8233.9	8246.6	8319.4	8339.7	8277.5	8315.7	8253.7	8180	8319.4	8315.7
	AF13	Percentage Over Funded Establishment	0.7%	0.1%	-0.3%	0.5%	1.5%	1%	0%	-0.2%	0.1%	0.2%	0.7%	1.2%	0.5%	0.1%	1.5%	-0.2%	0.7%	0.1%
		Green is below 0.5%. Amber is 0.5% to below 1% and Red is 1% or above																		
Bank Usage	AF04	Workforce Bank Usage	350.9	394.7	395	399.2	446.2	377.6	339.3	336.1	342.8	361.7	350.9	337.2	370	394.7	446.2	336.1	350.9	394.7
	AF11A	Percentage Bank Usage	4.2%	4.7%	4.9%	4.9%	5.4%	4.6%	4.1%	4.1%	4.2%	4.4%	4.2%	4%	4.5%	4.7%	5.4%	4.1%	4.2%	4.7%
		Bank Percentage is Bank usage as a percentage of total staff (bank+agency+substantive). Target is an improvement trajectory going from 4.7% in Apr-15 to 2.7% in Mar-16																		
Agency Usage	AF05	Workforce Agency Usage	153.4	138.3	163.5	185.2	193.1	180	156.1	134	152.1	144.9	153.4	156.4	131.9	138.3	193.1	134	153.4	138.3
	AF11B	Percentage Agency Usage	1.8%	1.7%	2%	2.3%	2.3%	2.2%	1.9%	1.6%	1.8%	1.8%	1.8%	1.9%	1.6%	1.7%	2.3%	1.6%	1.8%	1.7%
		Agency Percentage is Agency usage as a percentage of total staff (bank+agency+substantive). Target is an improvement trajectory going from 1.6% in Apr-15 to 0.8% in Mar-16																		
Vacancy	AF06	Vacancy FTE (Funded minus Actual)	361	439.2	507.9	465.1	436	416.4	420.1	431.3	412	422.3	361	305.8	380	439.2	436	431.3	361	439.2
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	5.3%	6.3%	5.8%	5.4%	5.1%	5.2%	5.3%	5.1%	5.2%	4.4%	3.8%	4.7%	5.3%	5.4%	5.3%	4.4%	5.3%
		For 2015/16, target is below 5% for Green, 5% or above for Red																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	148	135	147	398	227	146	148	120	137	154	148	229	191	135	227	120	148	135
	AF10	Workforce Turnover Rate	13.4%	13.1%	13.7%	13.7%	13.6%	13.7%	13.9%	13.8%	13.9%	13.6%	13.4%	13.6%	13.3%	13.1%	13.6%	13.8%	13.4%	13.1%
		Turnover is a rolling 12 months. It's number of permanent leavers over the 12 month period, divided by average staff in post over the same period. Average staff in post is staff in post at start PLUS stafff in post at end, divided by 2.																		
		Green Target is an improvement trajectory going from 13.6% in Apr-15 to 11.5% in Mar-16.There is an Amber threshold of 10% of the Green threshold (i.e. 15% in Apr-15, falling to 12.7% in Mar-16)																		
Training	AF20	Essential Training Compliance	91%	-	90%	90%	89%	91%	91%	91%	92%	92%	91%	-	-	-	89%	91%	91%	-
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		
Essential Training 2016/17	AF21a	Essential Training Compliance - Three Yearly Training	-	88%	-	-	-	-	-	-	-	-	-	-	88%	88%	-	-	-	88%
	AF21b	Essential Training Compliance - Annual Training	-	63%	-	-	-	-	-	-	-	-	-	-	56%	63%	-	-	-	63%
	AF21c	Essential Training Compliance - Induction	-	95%	-	-	-	-	-	-	-	-	-	-	96%	95%	-	-	-	95%
	AF21d	Essential Training Compliance - Resuscitation Training	-	79%	-	-	-	-	-	-	-	-	-	-	78%	79%	-	-	-	79%
	AF21e	Essential Training Compliance - Safeguarding Training	-	88%	-	-	-	-	-	-	-	-	-	-	88%	88%	-	-	-	88%

Appendix 1

Glossary of useful abbreviations, terms and standards

Abbreviation, term or standard	Definition
BCH	Bristol Children's Hospital – or full title, the Royal Bristol Hospital for Children
BDH	Bristol Dental Hospital
BEH	Bristol Eye Hospital
BHI	Bristol Heart Institute
BRI	Bristol Royal Infirmary
CQC	Care Quality Commission
DNA	Did Not Attend – a national term used in the NHS for a patient failing to attend for their appointment or admission
DVLA	Driver and Vehicle Licensing Agency
FFT	Friends & Family Test This is a national survey of whether patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. There is a similar survey for members of staff.
Fracture neck of femur Best Practice Tariff (BPT)	There are eight elements of the Fracture Neck of Femur Best Practice Tariff, which are as follows: 1. Surgery within 36 hours from admission to hospital 2. Multi-disciplinary Team rehabilitation led by an Ortho-geriatrician 3. Ortho-geriatric review within 72 hours of admission 4. Falls Assessment 5. Joint care of patients under Trauma & Orthopaedic and Ortho-geriatric Consultants 6. Bone Health Assessment 7. Completion of a Joint Assessment 8. Abbreviated Mental Test done on admission and pre-discharge

GI	Gastrointestinal – often used as an abbreviation in the form of Upper GI or Lower GI as a specialty or tumour site relating to that part of the gastrointestinal tract
ICU / ITU	Intensive Care Unit / Intensive Therapy Unit
LMC	Last-Minute Cancellation of an operation for non-clinical reasons
NA	Nursing Assistant
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
RAG	Red, Amber Green – the different ratings applied to categorise performance for a Key Performance Indicator
RCA	Root Cause Analysis
RN	Registered Nurse
RTT	Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times.
STM	St Michael's Hospital

Appendix 2

Breakdown of Essential Training Compliance for June 2016:

All Essential Training

	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Three Yearly	**88%**	90%	86%	88%	89%	90%	87%	85%
Annual (Fire and IG)	**63%**	78%	55%	62%	66%	59%	63%	61%
Induction	**95%**	97%	97%	95%	96%	95%	95%	94%
Resuscitation	**79%**	78%	N/A	80%	80%	80%	83%	78%
Safeguarding	**88%**	92%	86%	91%	89%	89%	90%	82%

Safeguarding Adults and Children

	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Safeguarding Adults L1	**90%**	95%	88%	91%	86%	90%	91%	90%
Safeguarding Adults L2	**88%**	93%	79%	92%	92%	90%	86%	80%
Safeguarding Adults L3	**65%**	100%	-	68%	75%	64%	75%	20%
Safeguarding Children L1	**90%**	92%	89%	92%	86%	88%	91%	-
Safeguarding Children L2	**87%**	87%	76%	90%	89%	88%	86%	89%

Child Protection level 3

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Core	**76%**	73%	56%	-	53%	100%	79%
Specialist	**71%**	-	-	-	-	100%	71%

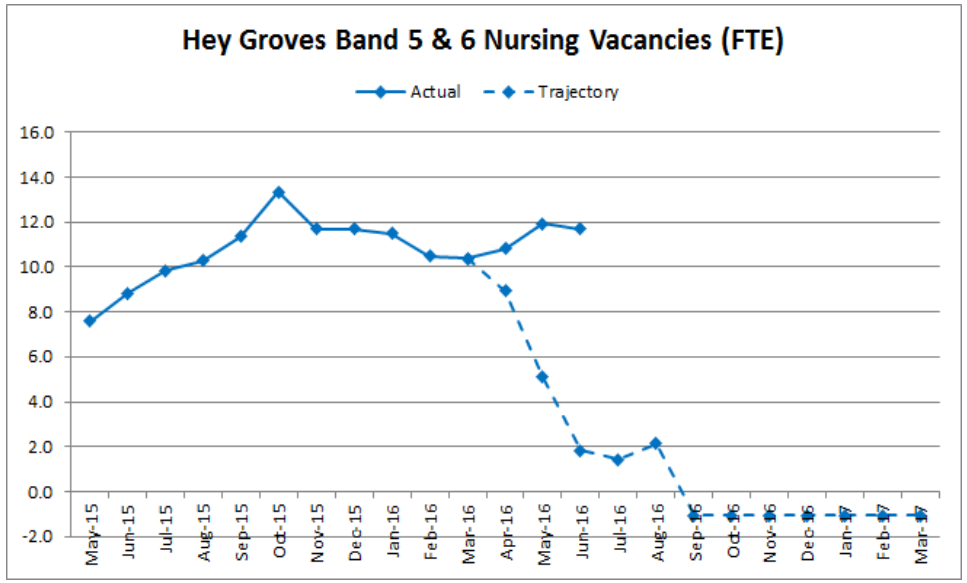
Appendix 2 (continued)

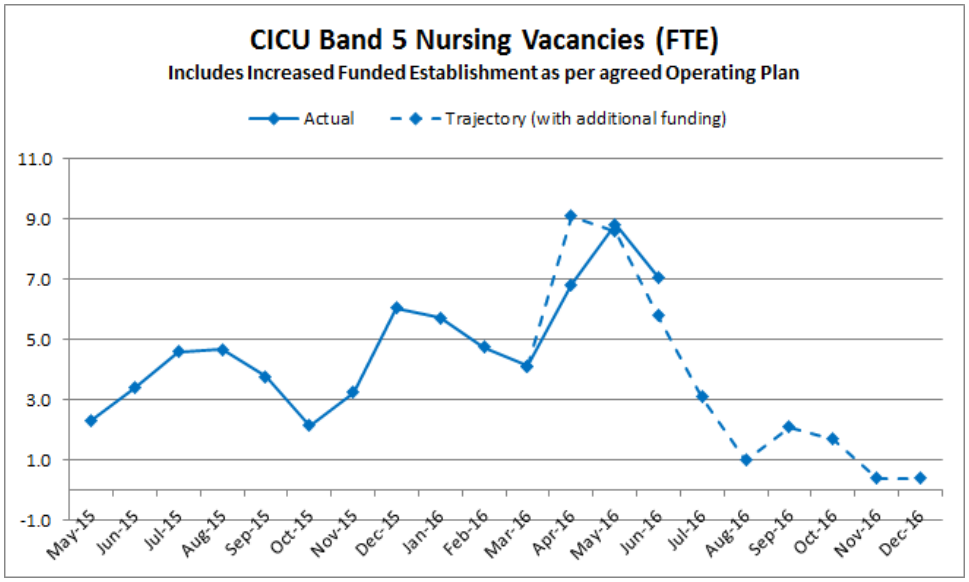
Agency shifts by staff group for June 2016

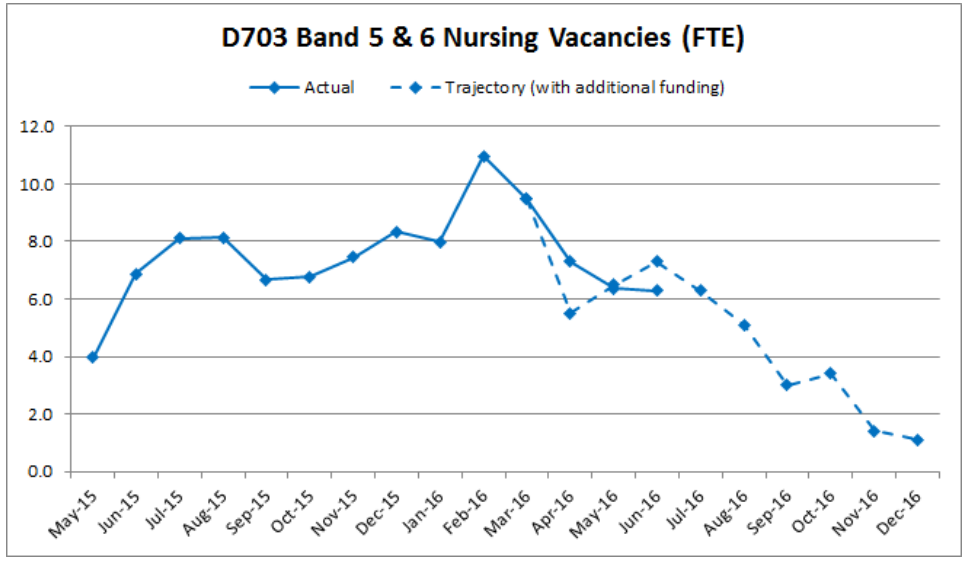
Staff Group	Non framework (but within price cap)	Above price cap (but within framework)	Non framework and above price cap	Within framework and price cap	Grand Total
Admin and Clerical				397	397
AHP and Healthcare Scientist				208	208
Facilities and Estates		16	1	49	66
Healthcare Assistant /Other		172		7	179
Medical and Dental		962	195	9	1166
Nursing and Midwifery		32			32
Grand Total		**1182**	**196**	**670**	**2048**

Currently reporting covers Temporary Staffing Bureau bookings only (see appendix 2). During 2016, reporting will be extended to cover all data.

Recruitment compared with trajectory for Heygroves Theatres, CICU and Ward D703







Appendix 3

Access standards – further breakdown of figures

A) 62-day GP standard – performance against the 85% standard at a tumour-site level for May 2016, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Breast†	100%	-	94.6%
Gynaecology	62.5%	85%	77.4%
Haematology (excluding acute leukaemia)	50.0%	85%	85.0%
Head and Neck	60.0%	79%	58.9%
Lower Gastrointestinal	48.1%	79%	70.5%
Lung	68.6%	79%	69.2%
Sarcoma*	100%	-	67.1%
Skin	92.3%	96%	95.7%
Upper Gastrointestinal	52.0%	79%	71.2%
Total (all tumour sites)	**70.7%**	**85.0%**	**81.3%**
Performance for internally managed pathways	**76.1%**		
Performance for shared care pathways	**56.0%**		
Monthly trajectory target	**73.2%**		

*3 or fewer patients treated in accountability terms

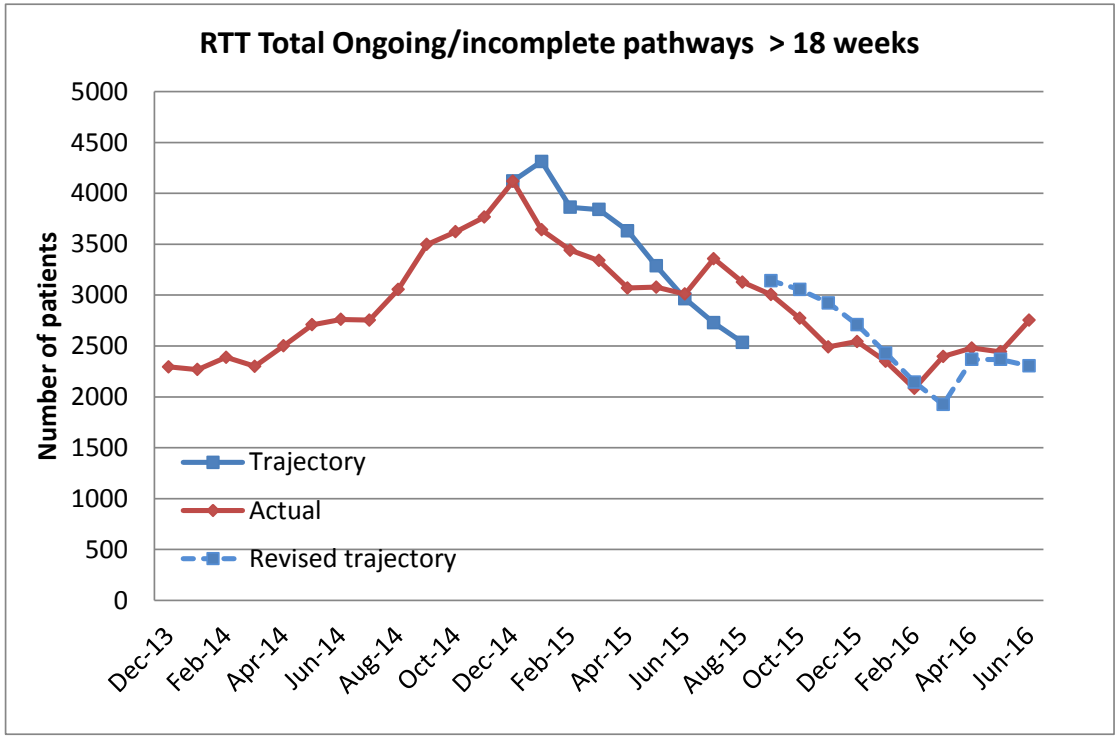
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

B) RTT Incomplete/Ongoing pathways standard – numbers and percentage waiting over 18 weeks by national RTT specialty in June 2016

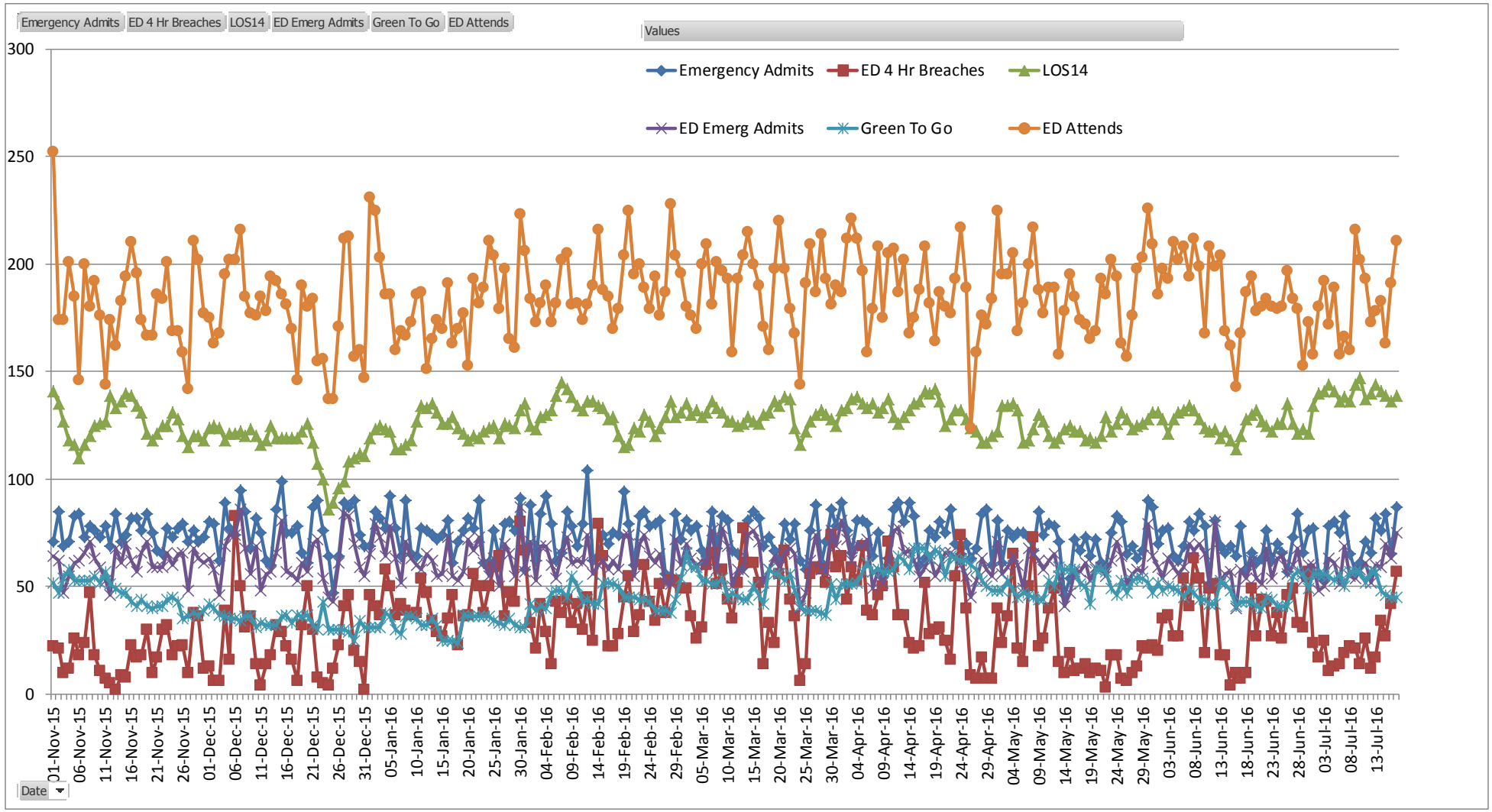
RTT Specialty	Ongoing Pathways Over 18 weeks	Ongoing Pathways	Ongoing Performance
Cardiology	234	2,023	88.4%
Cardiothoracic Surgery	8	265	97.0%
Dermatology	112	2,302	95.1%
E.N.T.	67	2,492	97.3%
Gastroenterology	49	565	91.3%
General Medicine	0	65	100.0%
Geriatric Medicine	2	189	98.9%
Gynaecology	127	1,480	91.4%
Neurology	35	379	90.8%
Ophthalmology	175	4,709	96.3%
Oral Surgery	202	2,726	92.6%
Other	1,658	15,130	89.0%
Rheumatology	5	501	99.0%
Thoracic Medicine	22	927	97.6%
Trauma & Orthopaedics	57	1,051	94.6%
Urology	0	1	100.0%
Grand Total	**2,753**	**34,805**	**92.1%**



	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Non-admitted pathways (target/actual)	1811/1634	1689/1632	1498/1470	1313/1222	1190/1460	1330/1479	1330/1480	1330/1796
Admitted pathways (target/actual)	1130/857	1023/912	931/879	832/861	735/937	935/1001	935/962	935/957
Total pathways (target/actual)	2923/2491	2710/2544	2430/2349	2145/2083	1925/2397	2265/2480	2265/2442	2265/2753
Target % incomplete < 18 weeks	91.1%	91.7%	92.4%	93.2%	93.9%	92.6%	92.6%	92.8%
Actual target % incomplete < 18 weeks	92.0%	91.8%	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%

Appendix 3 (continued)

BRI Flow metrics



University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
12. Quarterly Report on the Achievement of Quality Objectives									
Sponsor and Author(s)									
Sponsor: Sean O'Kelly, Medical Director **Authors**: Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose In May 2016, the Board approved the Trust's Quality Report for 2015/16, which included a number of specific quality objectives for 2016/17. Progress towards achieving these objectives is tracked by the Board, in the monthly quality dashboard (where appropriate). Key issues to note As detailed in the report.									
Recommendations									
The Board is recommended to receive the report for assurance.									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
26/7/16				20/7/16	Clinical Quality Group, 7/7/16

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Quarter 1 update on Corporate Quality Objectives**

Report to: **Trust Board**

Author: **Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**

Date: **18th July 2016**

Introduction

In May 2016, the Board approved the Trust's Quality Report for 2015/16, which included a number of specific quality objectives for 2016/17. Progress towards achieving these objectives is tracked by the Board in the monthly quality dashboard (where appropriate), and also via more detailed quarterly updates, the first of which is presented here.

Please note: this report is based on confirmed data for April/May and provisional data for June at the time of writing.

Quarter 1 performance

We said we would:	Q1 progress (RAG)	Year-end prediction (RAG)
1. To reduce the number of last minute cancelled operations	Amber	Amber
2. To ensure patients are treated on the right ward for their clinical condition	Green	Green
3. To improve timeliness of patient discharge	Amber	Amber
4. To reduce appointment (in-clinic) delays in outpatients, and to keep patients better informed about any delays	Red	Amber
5. To improve the management of sepsis	Not rated	Green
6. To ensure public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible	N/A	Green
7. To reduce the number of complaints received where poor communication is identified as a root cause	Green	Green
8. To ensure inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen	Amber	Green
9. To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted	Amber	Green
10. To increase the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving	Amber	Green
11. To reduce avoidable harm to patients	Green	Green
12. To improve staff-reported ratings for engagement and satisfaction	Amber	Green

Quality objectives

Objective 1	**To reduce the number of last minute cancelled operations**
Rationale and past performance	We set this objective for the last two years, but did not achieve our goal. Our target in 2015/16 – as per 2014/15 - was to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent. In 2015/16, we achieved 1.03 per cent.
What do our patients say?	"Any operation is a big deal but when it's cancelled and, in my case, cancelled twice the impact is devastating - I had cancer and was really worried this would affect the success of the operation when it finally happened."
What will we do?	We will embed a revised standard operating procedure across all our divisions and amend our escalation plan to ensure that everyone is aware of the current Trust-wide state-of-play relating to cancellations and that decisions to cancel are recorded through escalation 'Silver meetings'. Our divisions will review the reasons why operations are cancelled at the last minute and will agree a plan which sets out specific actions to reduce cancellations further related to the cause of breach. Given that the most common cause for cancellation is lack of a ward or critical care bed, most of these actions will be linked to the more general actions to support flow.
Measurable target/s for 2016/17	The indicator will be the number of operations cancelled on the day of operation/admission for non-clinical reasons. Our goal is to achieve last year's target – 0.92 per cent.
How progress will be monitored	Through divisional reporting and oversight at the Emergency Access Performance Improvement Group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	(June data not available at the time of writing) The Trust achieved small but encouraging reductions in last minute cancelled operations in April (63 cancellations; 1.08%) and May (59 cancellations; 0.96%). Overall year-to-date performance 1.02%. Divisions have been asked to review their recent performance; a refreshed action plan is being developed. It is clear that hospital occupancy levels and emergency demand are the largest triggers for poor performance in this area.
RAG - Q1 performance	Amber – we have made improvements but have not achieved our target
RAG - End of year prediction	Amber

Objective 2	**To ensure patients are treated on the right ward for their clinical condition**
Rationale and past performance	We set this objective for the last two years, but did not achieve our goal. Our target in 2015/16 was to have no more than 9,029 outlier bed days in total; we achieved 9,588.
What do our patients say?	"I went into hospital to have a mastectomy. After surgery I was put on a ward for the elderly where nurses did not know how to help which was not a good experience but it also knocked my confidence in the staff looking after me."
What will we do?	We will continue our work focussing on improving flow through our hospitals and, by doing so, improving occupancy. In 2016/17, we will roll out our ward

	processes to all wards and implement our new out of hospital acute model of care (Orla Healthcare) which has biggest single contribution to make to occupancy.
Measurable target/s for 2016/17	As in 2015/16, the indicator will be the total number of bed days patients spent outlying from their correct specialty ward. Our goal is to achieve last year's target – no more than 9,029 outlier bed days in total, with seasonally adjusted quarterly targets.
How progress will be monitored	Through divisional reporting and oversight at the Emergency Access Performance Improvement Group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	Our target was not met in April, when there with 930 outlier bed days against a target of 815. Occupancy levels improved in May and the hospital achieved improved patient flow. This improvement was reflected in May's performance: 587 outlier bed days against a target of 815. The Trust also met its target in June (741 against a target of 815) despite higher bed occupancy. Overall, in Q1, the Trust recorded 2,258 outlier bed days against a target of 2,444.
RAG - Q1 performance	Green – we achieved our Q1 target
RAG - End of year prediction	Green

Objective 3	**To improve timeliness of patient discharge**
Rationale and past performance	Despite huge efforts, we have yet to achieve our goal of increasing the number of discharges before noon. This impacts on the number of cancelled operations, as they cannot start if a bed hasn't been identified, as well as being a source of frustration for patients who may spend many hours awaiting their discharge.
What do our patients say?	"I was required to wait for a letter of discharge I saw the doctor at approximately 8.30am. My letter of discharge was given to me at 3pm." "I think the discharge process could be a lot more organised."
What will we do?	We will continue to embed our ward processes in order to promote timely discharge with an emphasis on pre-day planning of pharmacy requirements, patient transport and discharge letters. We will pilot new models of discharge including therapist such as physiotherapists and occupational therapists being able to discharge patients based on agreed criteria.
Measurable target/s for 2016/17	As in 2015/16, our target will be for at least 1,100 patients per month to be discharged between 7am and 12noon. Our target is also to increase the number of patients discharged at weekends by 20 per cent.
How progress will be monitored	Via transformation board
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	During Q1 we have continued to roll out and embed the ward processes work. The schedule of workshops with multi-disciplinary ward teams has continued, and follow up on actions agreed has also been maintained.

	Alongside this, we ran a successful event called “Plans for the Weekend” which provided a good understanding of the progress we have made with discharge and weekend planning, and the areas we will address to support improvement in weekend discharges. All of this learning is being taken into the next phase of our Operating Model programme, for which detailed plans are now being developed. In April, May and June, we achieved 971, 952 and 991 discharges respectively [between 7am and 12 noon]. This is consistent with improvements made in 2015/16. Achievement of our target continues to be dependent upon on engagement with multi-disciplinary teams across the Trust.
RAG - Q1 performance	Amber – we sustained improvements achieved in 2015/16 but did not met our target
RAG - End of year prediction	Amber

Objective 4	**To reduce appointment (in-clinic) delays in outpatients, and to keep patients better informed about any delays**
Rationale and past performance	We set this objective last year and have more work to do.
What do our patients say?	“Staff treated me well and with respect, but my appointment time was delayed, and no-one informed us of this until my wife asked at the reception desk. Then we had a 90 minute delay, but the sign over the desk area indicated no delays.”
What will we do?	We will complete Trust-wide implementation of our new standardised layout for information boards in outpatient departments and a standard operating procedure will be embedded to ensure teams proactively inform patients about any delays. Associated work reviewing clinic productivity and utilisation will lead to improved booking practices and scheduling to help minimise delays. Each quarter, we will also carry out a ‘15-step’ senior management walk around to ensure our redesigned clinic status boards are being used correctly.
Measurable target/s for 2016/17	We will ask patients about their experience using our monthly survey, setting minimum targets which would represent a statistically significant improvement on our patient-reported performance in 2015/16. The questions we will use and our minimum target scores are as follows: • How long after the stated appointment time did the appointment start? (78%) • Were you told how long you wold have to wait? (50%) • Did you see a display board in the clinic with waiting time information on it? (55%) In addition to asking patients about their experiences, we will also develop our own real-time objective measurement of clinic running times (currently being piloted in the Bristol Dental Hospital).
How progress will be monitored	Reports to outpatient steering group
Board sponsor	Chief operating officer

Implementation lead	Associate director of operations
Progress during Q1	No improvement seen in patient reported scores through Q1 to date. Funding has been confirmed for improvements to the patient information boards, adopting a standardised design and markers (minimising handwritten content). The boards will look more professional and will be easier for staff to update: we hope to see an improvement in engagement of the nursing and administration teams once these are in place. Work on the Outpatient Standards continues.
RAG - Q1 performance	Red – patient feedback scores have not improved
RAG - End of year prediction	Amber

Objective 5	**To improve the management of sepsis**
Rationale and past performance	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these, some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis nationally are thought to contribute to the number of preventable deaths from sepsis. Locally, we have identified – through mortality reviews and incident investigations into deteriorating patients – that we can improve our management of patients with sepsis. Therefore, this is one of the sub workstreams of our patient safety improvement programme for 2015 to 2018, and is a continuation of a quality objective we set ourselves in 2015/16.
What do our patients say?	"During my three months after suffering sepsis, the treatment I received was first class, the doctors and surgeons saved my life. I would like to put on record that all staff at BRI are fantastic." "The ward did not recognise how unwell my wife was (viral sepsis) and at first did not manage her symptoms very well."
What will we do?	Continuation and development of activities described in section 2.1.1 of this report.
Measurable target/s for 2016/17	Our goal is to achieve the national sepsis CQUIN: timely identification and treatment of sepsis in emergency departments, and acute inpatient settings.
How progress will be monitored	Monitoring by the National Early Warning Scores (NEWS) implementation / deteriorating patient group, and the Patient Safety Group; additional monthly CQUIN reporting to the Trust's Clinical Quality Group
Board sponsor	Medical director
Implementation lead	Adult services – Dr J Bewley, consultant in intensive care Children's services – Dr W Christian, consultant in paediatric medicine (standing down)
Progress during Q1	*Adult services* Financial support for sepsis nurse recruitment has been secured for 2016/17. The sepsis nurses will now be embedded within the patient safety group to develop joined up care for the deteriorating patient across the Trust. The team of 2 WTE nurses will all be in post by the beginning of August 2016 to enable education and training to develop. NICE Sepsis guidelines are being published in July 2016 so Trust guidelines will be updated shortly after this. In the meantime, sepsis education has continued in ED, AMU and the Surgical Trauma Assessment Unit for nursing and medical staff. Data collection has

	continued as per the CQUIN for 2015/16 to ensure that sepsis performance has been maintained at last year's level. Data will be gathered in Q2 for CQUIN monitoring purposes. *Children's services* Screening of potentially septic patients in the BRHC emergency department continues to improve following improved awareness of the CQUIN amongst medical and nursing staff. This has been achieved through educational study days, self-directed learning resources on the Children's Emergency Department (CED) intranet workspace and feedback through the CED governance newsletter. The next step to continue this improvement will to be automate the screening process at triage using the information inputted on the Medway triage proforma to ensure that all children meeting the screening criteria at triage are automatically flagged if their observations meet the criteria. We have also introduced a rolling programme of rapid audit cycles within the CED assessing our ability to meet our standards. One of these audits will specifically look at sepsis screening and antibiotic delivery. It is important to note however that the CQUIN for sepsis has now been broadened to include inpatients. This means that a hospital-wide strategy for the screening of potentially septic children and young people will need to be developed. The patient safety team are in the process of developing this and are currently seeking to identify a clinician from BRHC to lead on a whole-hospital approach to this issue.
RAG - Q1 performance	Not rated as CQUIN data is not being gathered until Q2
RAG - End of year prediction	Green

Objective 6	**To ensure public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible**
Rationale and past performance	The objective forms part of the Trust's previous two year commitment to improve key aspects of communication with patients. The issue was raised via the Trust's consultation on quality priorities.
What will we do?	We will: • Produce guidelines for all staff about the standard of information that should be displayed in public areas and advice on how to get support to produce it • Work with areas to professionally produce and print any materials that arise from this process • Continue to provide good quality corporate posters, publications and other materials for display in public areas – ensuring they communicate key information and messages.
How progress will be monitored	A monthly walk round public areas by a member of the communications team to take down any materials that do not meet the standard and to identify where new materials need to be professionally produced.
Board sponsor	Deputy chief executive
Implementation lead	Head of communications
Progress during Q1	Work on this objective is due to commence in Q2.
RAG - Q1	N/A – work will commence in Q2

performance	
RAG - End of year prediction	Green

Objective 7	**To reduce the number of complaints received where poor communication is identified as a root cause**
Rationale and past performance	Identified by Trust Board as an improvement area – we know that failures in communication account for a significant proportion of complaints received by the Trust.
What do our patients say?	"The information relayed by doctors was vague and the language that they used was jargon." "My experience was a very positive one and this has not been the case in some other hospitals I have used. The big difference was UH Bristol provided clear, timely communication."
What will we do?	Analysis of complaints data reveals that in 2015/16, the Trust received a total of 320 complaints relating to the following categories: - Telecommunications and failure to answer phones (97) - Administration including waiting for correspondence (64) - Communication with patients and relatives (159) In 2016/17, we will be rolling out the changes to patient letters described in section 2.1.1 of this report. We will also be running a transformation project to improve the quality of telephone communications. Finally, during quarter 1, we will conduct further analysis of complaints previously received within the 'communication with patients and relatives' category, to see whether common themes and opportunities can be identified.
Measurable target/s for 2016/17	Our target is to achieve a reduction in complaints received in the categories described above.
How progress will be monitored	Reports to patient experience group
Board sponsor	Chief nurse
Progress during Q1	*Patient Letters Project* After a considerable amount of work to ensure that letters meeting our local quality standard are delivered through Medway and Synertec, a pilot is going 'live' in two areas at the beginning of June (BHI outpatients and Surgery Head & Neck inpatients). This will be followed by a pilot of Easy Read letters, to commence by the end of August. We are currently planning for how to scale up this work to all areas across the Trust. *Telephone communications* During Q1, we have undertaken some analysis of complaints data about telephone communications, and met to consider the scope of work in response to this. There are many contributory factors which include the training, responsibilities and organisation of staff who receive incoming telephone calls, the switchboard technology and directory information available, and the wide variation in practice across areas. Some work is underway including further development of our appointment centre and development of our administration teams. During Q2, we will refine our plans

	to ensure we target the key issues for patients. *Analysis of complaints* Further analysis of complaints in the category of "communication with patients and relatives" (as described above) in 2015/16 has identified six potential 'hot spots' around the Trust. In Q2, we will look in more depth at these complaints and consider whether further targeted supportive actions are indicated.
RAG - Q1 performance	Green – we have made good progress around scoping and planning for this objective
RAG - End of year prediction	Green

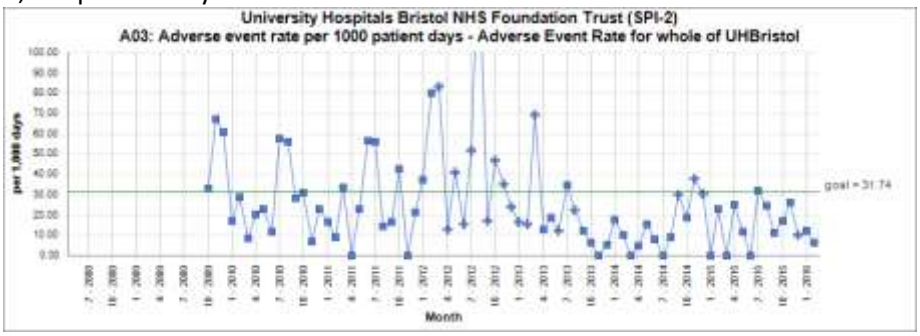
Objective 8	**To ensure inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen**
Rationale and past performance	Identified in discussion with Involvement Network as an important marker of positive patient experience when in hospital.
What do our patients say?	"I was kept informed at all times, from the cleaners to the doctors, and had excellent treatment" "I would like to see more communication between doctors and patient keeping them informed of what is happening with treatment."
What will we do?	During the first half of the year, we will carry out targeted 'Face to Face' interviews with inpatients to gain a clearer understanding of their needs and expectations around being kept informed, the ways in which patients are kept informed, and opportunities to do this better.
Measurable target/s for 2016/17	To be determined by chief nurse and medical director following scoping work described above
How progress will be monitored	Reports to patient experience group
Board sponsors	Chief nurse and medical director
Implementation lead	To be determined by chief nurse and medical director following scoping work described above
Progress during Q1	Scoping work on this objective is due to commence in Q2, however in Q1 we have gathered baseline data from patients, the results of which are encouraging: only 4% of patients told us that hospital staff had not kept them informed about what would happen next and when this would happen.
RAG - Q1 performance	Amber – early patient-reported data suggests that practice is already good in this area
RAG - End of year prediction	Green

Objective 9	**To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted**
Rationale and past performance	This is a key national standard which has the potential to make a significant difference to patients with disabilities who are cared for in our hospitals. Fits with the Trust's ambitions to do more to meet the needs of patients from

	defined equalities groups, which will form part of the Trust's quality strategy.
What do our patients say?	"Some nurses didn't know my child was disabled." "This operation was for my 15-year-old son who is deaf. We never got help from anyone who could sign to him and, if I wasn't there, he would have been lost. No-one could talk to him. They knew that he was deaf."
What will we do?	We will develop and implement a Trust-wide plan to address the requirements of the standard.
Measurable target/s for 2016/17	To be agreed
How progress will be monitored	To be determined as part of development of Trust-wide plan
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	A gap analysis has been completed. An AIS steering group has been convened and has met for the first time, agreeing terms of reference and actions required to move this work forward. Currently working on the detailed actions and resources required to systematically identify, record and respond to patients' communication needs.
RAG - Q1 performance	Amber – a Trust steering group has been convened and detailed planning has commenced; however the Trust is behind the national timescale for implementation
RAG - End of year prediction	Green

Objective 10	**To increase the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving**
Rationale and past performance	All trusts perform relatively poorly on this measure in the National Inpatient Survey; UH Bristol particularly so, because our current surveys are geared largely towards asking patients to reflect on their care post-discharge. In 2016/17, we will implement a new system of routinely capturing and responding to patients' experiences of care whilst they are in hospital. This will form an important part of our new strategy for improving patient experience, which will be focussed on the theme of responsive care.
What do our patients say?	"Please remember that you (midwives/doctors etc.) do this daily, patients don't, so don't forget to take a moment however busy you are, to mean it when you ask a patient if they are okay and listen. Too often the question is asked but the reply is unheard."
What will we do?	During 2016/17, we will procure a new in-hospital patient feedback system to run alongside our existing post-discharge survey. This will enable staff to routinely ask patients about the quality of care they are receiving whilst they are still in hospital, at point of care, as part of a wider theme of delivering responsive care. In the meantime, during the first half of the year, we will carry out targeted 'Face to Face' interviews with inpatients to gain a clearer understanding of their needs and expectations around being asked about quality of care and raising anything they are unclear or concerned about.
Measurable target/s for 2016/17	To achieve significantly improved scores in this measure in the 2017 National Inpatient Survey (by virtue of when the survey takes place), but in the meantime, to see consistent progress through our own monthly survey.

How progress will be monitored	Reports to patient experience group
Board sponsor	Chief nurse
Implementation lead	Patient experience programme manager
Progress during Q1	A tender specification for a new patient feedback system is in the process of being written, based on work carried out by a pre-tender working group and feedback from a recent workshop for matrons. The plan is for work on the specification to be completed during July. In parallel to developing the tender specification, 'deep dive' activities are being planned to gain a better understanding of patients' expectations, i.e. what patients understand by the question "were you asked about the quality of your care whilst you were in hospital?". This will involve our *Face2face* interview team.
RAG - Q1 performance	Amber – a system specification is being developed and we are planning patient involvement activity to better understand patients' expectations
RAG - End of year prediction	Green

Objective 11	**To reduce avoidable harm to patients**
Rationale and past performance	Reducing avoidable harm is a stated aim of our 'Sign up to Safety' Patient Safety Improvement Programme 2015-2018 and aligns with our vision 'to be among the best and safest places to receive healthcare' and the national 'Sign up to Safety' campaign's aims and objectives. Avoidable harm reduction is a longer term goal over several years. In our previous Safer Care Southwest Patient Safety Improvement Programme 2009-2015, we set an improvement goal to reduce our adverse event rate by 30 per cent. The graph below shows that over a five year period we achieved our goal to reduce our adverse event rate to below 31.74 per 1,000 patient days and sustain this. 
What will we do?	We will broaden the scope of our adverse event rate audit tool to include additional types of adverse events not previously included. We will test this new tool during quarter 1 of 2016/17. We predict that the new tool will initially increase our adverse event rate so we will use it to establish a new baseline over quarters 2 and 3 and will then set an improvement target of 50 per cent reduction to be achieved over the next three years.
Measurable target/s for	Completion of testing of the new audit tool in quarter 1 and establishing a new baseline by the end of quarter 3. Setting a new improvement goal of 50

2016/17	per cent reduction in quarter 4.
How progress will be monitored	Progress will be monitored through quarterly reports to our Patient Safety Programme Board and our non-executive Quality and Outcomes Committee.
Board sponsor	Medical director
Implementation lead	Head of quality (patient safety)
Progress during Q1	We have completed three PDSA (plan, do, study, act) cycles to test the new audit tool in March, April and May 2016. We started to use the new audit tool in June 2016 to look for adverse events for a sample of patients who were discharged in April 2016. We have therefore achieved our Q1 milestones. We will use the audit tool for the next six months and will be in a position to set a new baseline at the end of Q3. Progress will be reported into out Patient Safety Improvement Programme Board.
RAG - Q1 performance	Green – we achieved our Q1 milestones
RAG - End of year prediction	Green

Objective 12	**To improve staff-reported ratings for engagement and satisfaction**
Rationale and past performance	Although our 2015 staff survey results were better than the previous year, we still need to make considerable improvements if we are to achieve our ambition of being rated as one of the best teaching hospitals to work for.
What will we do?	Our plans for 2016/17 include: a focus on improving two way communication between staff and management; recognition events and team building; a review of the Trusts appraisal process; training programmes for line managers; health and wellbeing initiatives, with a specific focus on stress related illness, reduction in staff seeing errors and near misses and an increase in reporting where they are seen to increase lessons learned from the reporting; a piloted employee assistance programme; targeted action to address harassment and bullying; a revision and re-launch of the 'Speaking Out' policy; and support for staff forums and reverse mentoring.
Measurable target/s for 2016/17	Our target is to achieve improvements in the following areas of staff-reported experience: • Staff Friends and Family Test scores (this asks whether staff would recommend the Trust as a place to work and receive treatment) • Overall staff engagement (a 'basket' of measures covering staff motivation, involvement and advocacy) • The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month We will measure improvement via our annual all-staff census (this takes place in the third quarter of the year). We will also track progress via our quarterly Friends and Family Test survey (different staff groups are surveys each quarter: scores for each quarter are directly comparable to the equivalent survey 12 months previously).
How progress will be monitored	Divisional Board meetings and Trust Board
Board sponsor	Director of workforce and organisational development

Implementation lead	Divisional directors supported by corporate human resources
Progress during Q1	The Trust's divisions are continuing to develop action plans in response to the findings of the 2015 NHS staff survey. This process involves collaborative working between staff and management, and the template for the action plans includes minimum standards which the divisions are expected to achieve. In Q1, a number of divisions held management/staff workshops and away days to share and discuss the results of the staff survey, building on existing staff engagement plans Achievements in Q1: • Changes to appraisal policy have been signed off and a detailed appraisal improvement programme is in place (new appraisal goes 'live' in September) • A dedicated project lead has been appointed for sickness absence • Stress & Wellbeing workshops concluded 31 May 2016 • Working during pregnancy workshops; series 6 complete • Staff Health and Wellbeing implementation plan in progress; concludes March 2017 • Money Advice Service appointments offered to staff, students and volunteers • Workplace Wellbeing Charter – 8 standards completed for external assessment and accredited June 2016 • Happiness Pulse survey ongoing • On-line assessment and resource tool developed by Happy City in collaboration with academics at the University of Bristol and other experts in the field of wellbeing • Promotion of new free initiatives for staff: prospective lunchtime art / sketch club, Qi Gong and 'Tamizh' language taster sessions • Two modules of the resilience program for newly qualified nursing staff concluded June 2016
RAG - Q1 performance	Amber – good progress has been made in Q1, however improvements in staff experience have yet to be confirmed in survey data
RAG - End of year prediction	Amber

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
13. Research and Innovation Report									
Sponsor and Author(s)									
Sponsor: Sean O'Kelly, Medical Director **Author:** Diana Benton, Head of Research and Innovation									
Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓
Executive Summary									
Purpose: The purpose of this report is to provide an update on performance and governance for the Board. Key issues to note: See executive summary.									
Recommendations									
The Board is recommended to receive the report for **assurance.**									
Impact Upon Board Assurance Framework									
This links to the Board Assurance Framework strategic priority 4 and principle risk 5.									
Impact Upon Corporate Risk									
None.									
Implications (Regulatory/Legal)									
None.									
Equality & Patient Impact									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		
Date the paper was presented to previous Committees									
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**				

Executive Summary

Performance:

During the first quarter of 2016/17 we project that we will have sustained our performance initiating research, as reported to the NIHR under our research contract. Submitted data indicate that our percentage of studies meeting the 70d benchmark will remain steady at above 90%, although we await formal feedback once review of the data has been carried out. Our quarter 4 2015/16 performance in delivering commercial trials to time and target was lower than expected. During the Q3 analysis, different data have been included, which has affected the percentage of studies defined as delivering to time and target; this affects a number of other trusts too.

We are showing approximately the same level of activity as we were in 2015/16 for total recruitment. For weighted recruitment we are closing the gap and expect to be at the levels of 2015/16 by the end of the calendar year. This is in spite of an adjustment to the weightings allocated to band 1, 2 and 3 studies (a measure of complexity), which favours band 2 studies more strongly now. However, due to the model in use for allocation of funding, we expect to see a cut in our delivery funding in 2017/18 as the high recruiting study of 2014 is removed from the calculations used to allocate funding. Planning for this potential situation is under way. We continue to look to open studies that suit our clinical pathways and are beneficial to our patients, whilst building up relationships within and outside the region, expecting they will result in longer term collaborations if we deliver as expected. We work as a network of partners and will continue to run the most complex trials here in UHBristol as a tertiary centre, expecting that more straight forward research will be opened up in primary and secondary care, as well as here, when appropriate.

Partnerships:

The panel interview for the Biomedical Research Centre bid took place on 21st July. This was a bid prepared and submitted as a partnership with the University of Bristol. We expect to hear the outcome in September.

Governance and training:

The final quarterly submission of progress against actions following the MHRA inspection has been submitted and the action plan is now closed. With the appointment of our Research Projects Manager to post we are focusing on supporting regulatory and financial aspects of our sponsored trials to ensure we are meeting our obligations.

Innovation:

R&I staff are participating in a multidisciplinary trust wide group, led by the Director of Strategy and Transformation, to develop proposals around the trust's management of improvement and innovation.

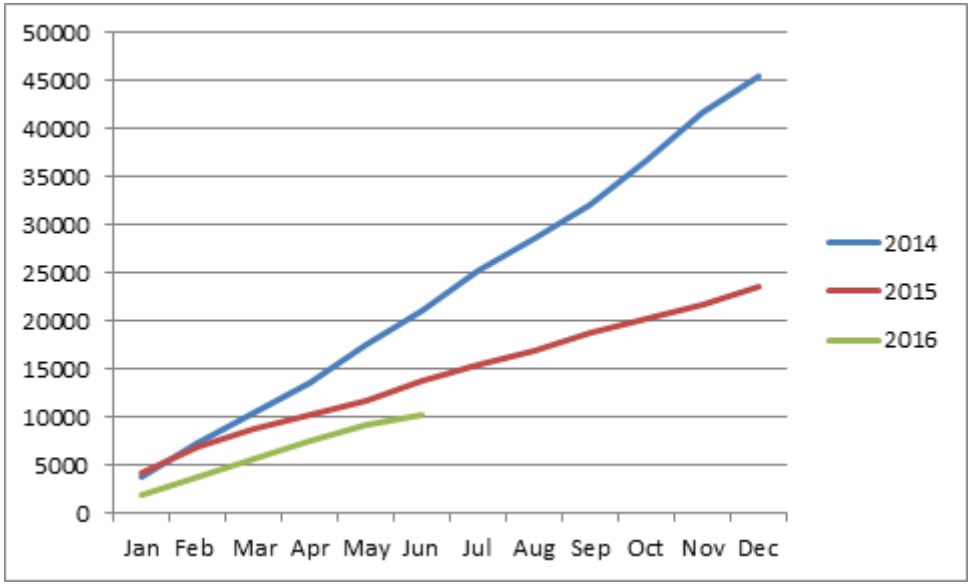
Overview

Successes	Priorities
• Full bid for Biomedical Research Centre developed and submitted, with interview having taken place on 21st July. This was a significant collaborative piece of work with the University of Bristol. • Appointment to new post supporting financial and regulatory oversight of our sponsored trials has taken place and a programme of work to support that research is now ongoing, adding assurance to our processes • Performance in initiating and delivering research has been maintained over the previous successive 4 quarters • Governance/oversight mechanism now set up in Division of Medicine has led to increased visibility and engagement in research.	• Following outcome of the Biomedical Research Centre bid process, ensure readiness to set up the Centre in the form appropriate for the value of the award. The outcome will be known in September, and funding will commence in April 2017 if we are successful. • Continue to support researchers through the recent implementation of changes to research approval systems by the Health Research Authority in order to ensure they are not deterred from carrying out research. • Carry out engagement work with research staff to ensure they feel connected to and supported by the trust. • Implement proposed KPIs in divisions in order to give good visibility of the research being undertaken.
Opportunities	**Risks and Threats**
• Work with NIHR to ensure reporting of our performance is appropriate and feed back when new HRA systems are not working as expected, impacting on our reported performance. • Undertake work with neighbouring trusts, in particular NBT, to identify areas of research/studies already being carried out that can be opened in UHBristol. Identify areas where we can improve our performance to time and target in both commercial and non commercial research. These will increase availability of research to our patients and efficiency with which we deliver research. • Move for division of medicine research unit out of Old Building in Autumn will reinvigorate research in the division and stimulate new relationships as researchers from surgery and medicine are co-located. This will build on work ongoing between the R&I team and divisional management teams (see successes).	• Recruitment levels for the first half of the year are lower than at the same time last year. This is very likely to impact on our share of the delivery funding, the cut for which will be taken in October. Planning is ongoing to prepare for a potential reduction in delivery funding in 2017/18. • Lower levels of RCF than expected, paired with existing financial commitments into 2016/17 to support staffing of two large trials has reduced funding available for small grant pump-priming schemes. This may impact in future years on NIHR grant successes. • Ongoing issues with new system for approving research has increased burden of work as studies work through the new system. The impact will be slower setup times, which are likely to affect trusts across the country. • If NIHR BRC full bid is unsuccessful or successful on a significantly smaller scale than expected, this may affect existing cardiovascular and nutrition research teams and will impact on trust RCF allocation longer term.

Performance Overview

This section provides information about performance against key performance indicators. All KPIs are financial or drive the income we receive.

a) Cumulative weighted recruitment into NIHR portfolio studies in 2016. NB. There is a 6 week lag of data from the portfolio.



Please note there has recently been an amendment to the weighting ratio by the NIHR co-ordinating centre. The graphs have been updated accordingly.

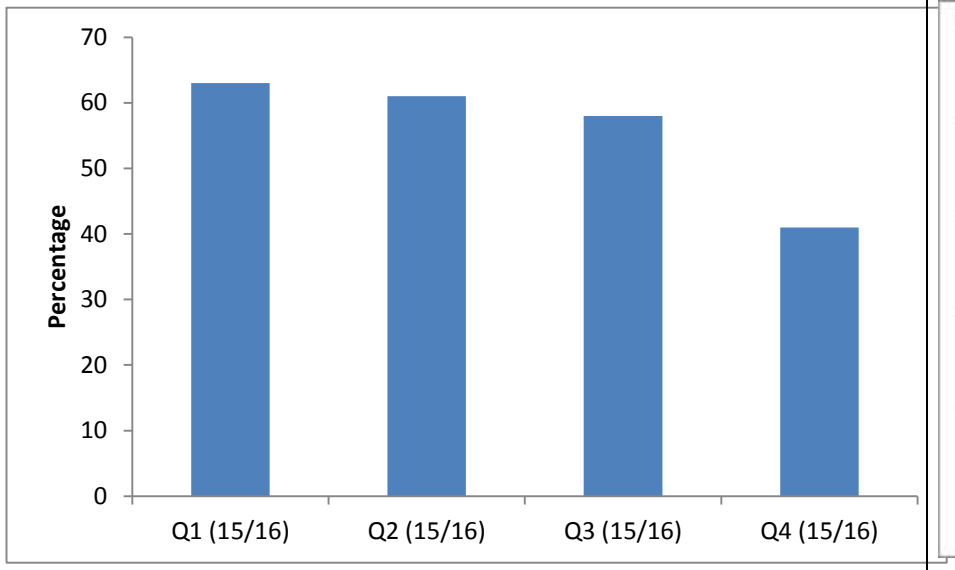
b) Performance in meeting the 70 day first patient first visit benchmark adjusted by NIHR in comparison to other Trusts

NIHR PID report- latest received Q4 15/16

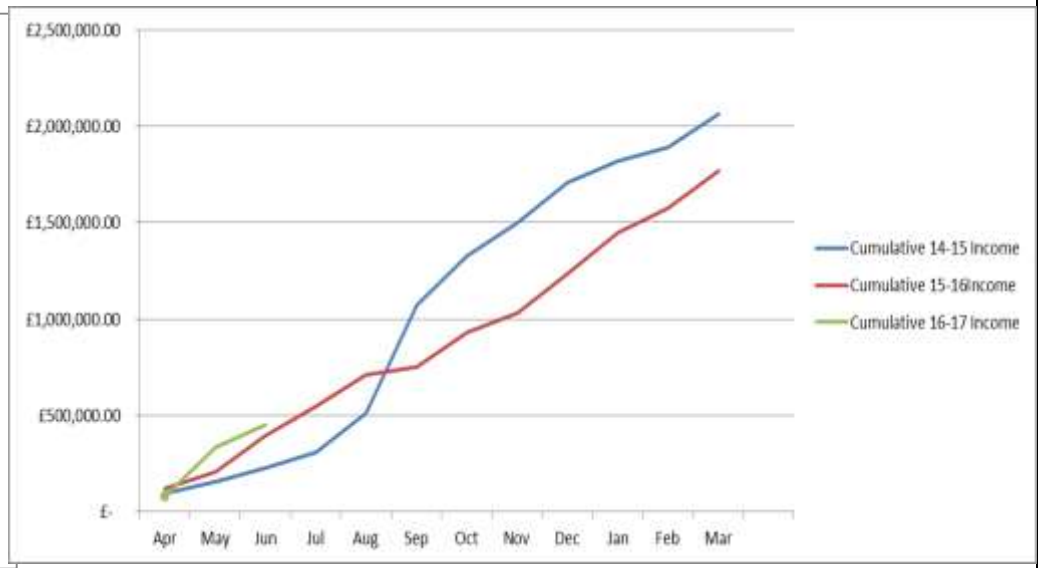
Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
95%	87%	92%	91%

Green: >81.4% (Upper Quartile)
Red: <70.7% (Median)

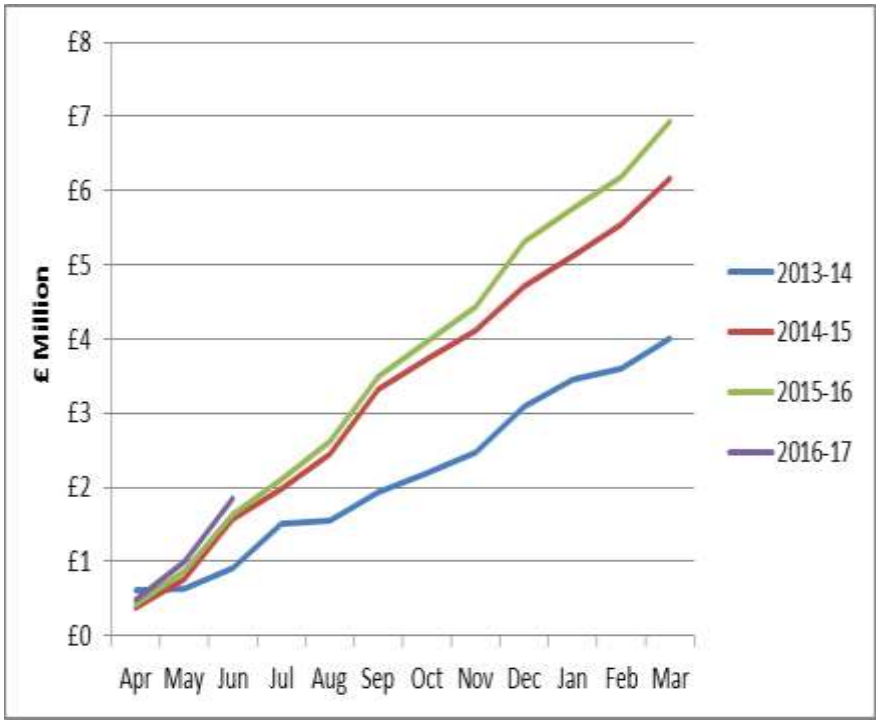
c) Percentage of commercial studies recruiting to time and target



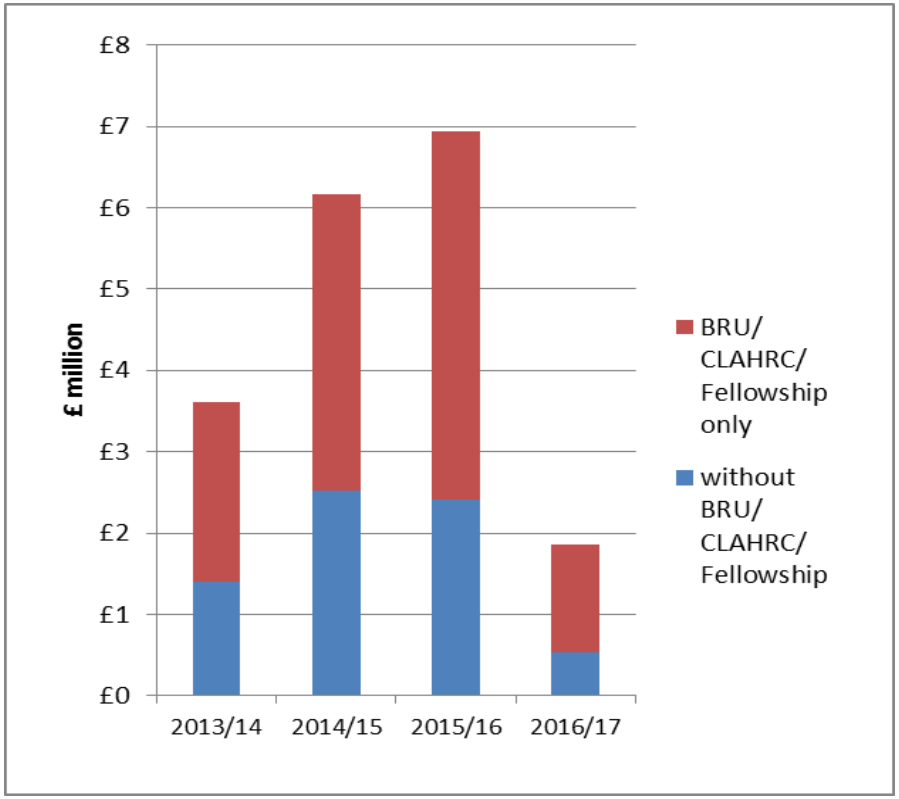
d) Monthly commercial income



NIHR monthly grant income – year on year comparison



NIHR grant income – drives research capability funding.



Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
14. Education Annual Report									
Sponsor and Author(s)									
Sponsor: Alex Nester, Acting Director of Workforce and Organisational Development **Author:** Kay Collings, Head of Education									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose: This annual report describes the activity and assurance for how UH Bristol delivered against its education and teaching priorities during 2015/16. The report demonstrates that there is a vast number of education and teaching programmes delivered across the Trust to ensure the experience of all our learners and staff and contributes to providing exceptional care for our patients. Key issues to note: During the reporting period, UH Bristol have supported learners to achieve 95% - 100% exam pass rates for final year medical, dental and non-medical students, and in the main learner satisfaction across all professional areas is good to excellent. Education and Professional leads from across the Trust have contributed to the development of this report.									
Recommendations									
The Trust Board is asked to receive this report for assurance.									
Impact Upon Board Assurance Framework									
Strategic Priority 3 : We will strive to employ the best staff and help all our staff fulfil their individual potential									
Impact Upon Corporate Risk									
None.									
Implications (Regulatory/Legal)									
None.									
Equality & Patient Impact									
None.									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				20 July 16	WF&OD Group 11 July 16

University Hospitals Bristol NHS
NHS Foundation Trust

EDUCATION ANNUAL REPORT

APRIL 2015 – MARCH 2016

CONTENTS

1. EXECUTIVE SUMMARY

1.1 Introduction

Reflecting on the 2015/16 period in this annual report, it has been a very busy and challenging year coupled with some very exciting new developments for education and training at UH Bristol. The purpose of this report is to evidence the high level context and background to how UH Bristol delivered against its education and teaching priorities during 2015/16. The report demonstrates that there are a vast number of education and teaching programmes delivered across the Trust to ensure the experience of all our learners and staff is of high quality and contributes to providing exceptional care for our patients. The report also identifies future priorities, reflecting an ever changing national context. Over the last 12 months considerable effort has been put in to raising the profile of Education at UH Bristol including:

- The development of a new Education, Learning and Development Strategy for 2015 – 2020 (signed off by the Trust Board in June 2015)
- Strengthening of the governance arrangements, in particular the establishment of a new Education Group which reports to the Senior Leadership Team
- The restructuring of the corporate Teaching and Learning Team
- Increased dialogue with key partners and stakeholders, including the University of Bristol, University of West of England and Health Education South West

Whilst UH Bristol continues to experience service pressures impacting internally on the ability for all staff to attend essential training and continued professional development, overall 2015/16 was an extremely successful year for UH Bristol learners, with 100% pass rates achieved in undergraduate medical, dental and dental care professional final exams, and non-medical pass rates averaging 95% - 100% across the various specialties. Evaluation of learner placements are in the range ‘good to excellent’ in the main and areas requiring improvements have action plans in place to address the short fall. Improvements to the way placements are evaluated for pre-registration nursing, midwifery and allied health professional and health care scientist learners were introduced in 2015 resulting in more accurate and valuable feedback for both the University and the Trust. Capacity increased in some areas e.g. pre-registration nursing and midwifery and undergraduate medical placements, and mentor and educational supervisor feedback from learners and Higher Education Institutions such as Universities of Bristol and the West of England are extremely positive, with some areas receiving nominations and successfully achieving educator and mentor of the year awards.

Several more placement areas with Clinical Nurse Specialist and Research Nurses have been opened up at UH Bristol in the last 12 months, utilising both single placement and rotational placement models to good effect. There will be more of these placement allocations in the next 3-6 months; this not only provides pre-registration nursing students with more varied placements reflecting patient pathways of care, but gives significant insight into the valuable roles delivered by Clinical Nurse Specialist and Research Nurses across the Trust, thus supporting the Trust’s efforts to improve recruitment and retention especially within nursing, midwifery and allied health professional roles.

Health Education England launched their education quality framework as a part of a suite of quality products that will be implemented across Health Education England from April 2016. The quality framework covers all learner groups within the healthcare system with a focus on the quality of work based placements. The framework sets out responsibilities for local placement providers and is monitored and measured through robust quality assessment visits and self-assessment written evidence.

The education contract between the South West NHS organisations and Health Education England, known as The Learning and Development Agreement (LDA) was assessed in 2015/16 through the new quality framework processes.

UH Bristol have been awarded 96% and rated green, although 6 other Trusts scored maximum 100% in this newly developed quality assessment, UH Bristol was informed that the scoring system is in its infancy stages and requires further refinement. UH Bristol is confident that our action plans to achieve 100% in the 2016/17 quality assessment will ensure we achieve 100% next time. Areas requiring improvement are:

- Adjustments to study leave forms for doctors to ensure applications are aligned with individual training plans.
- Accepting prior knowledge and skills of all new starters to prevent repeating subjects at induction.

A recent Quality Assurance visit by the General Medical Council to the undergraduate and postgraduate medical education functions at UH Bristol and the University of Bristol, resulted in a an excellent feedback review. There were commendations for the level of student support and teaching provided by the Trust and University administration and consultant staff, and there was similarly notable praise for the support by the Trust Board for medical education. There was however concern that Core Medical doctors in training are at risk of not meeting their learning outcomes if they are unable to attend mandatory training sessions and outpatient clinics as required in the curriculum, and this is being addressed by the Director of Medical Education and specialty education lead within the division of Medicine.

1.2 New Roles

UH Bristol continues to experience difficulties filling medical rotas and vacant nursing, allied health professionals and healthcare scientist positions, which is problematic both regionally and nationally. These ongoing challenges have led us to focus on the introduction of new roles through the transformation of the healthcare workforce. UH Bristol has been investigating the benefits of the Physicians Associate role to support the doctor's in training rota to enhance patient care and enable the foundation and core medical doctor's to attend valuable and compulsory education and teaching sessions; the Associate Nurse role has currently been the focus of a national consultation process, and the main findings have now been published by Health Education England together with plans for the introduction of the new role by January 2017. A programme of work will be undertaken in partnership with stakeholders through a series of 4 geographical workshops.

The development of new roles in HealthCare Science (HCS) is also underway, with the introduction of brand new HCS apprenticeships at level 2 and development of apprenticeships at level 4. UH Bristol's Lead Healthcare Scientist has led a southwest forum to develop awareness of apprenticeships and the opportunities for new degree level apprenticeships to fund in service training of HCS practitioners, previously funded by a regional training budget.

The forum contributes to the apprenticeship trailblazer project led by the Chief Scientific Officer at HEE which is currently seeking national approval for a Level 5 and 6 HCS apprenticeship. Forum members are working with the University of the West of England to extend their distance learning BSc in Healthcare Science to a wider range of HCS specialisms. It is hoped that approval for the University to be an accredited provider of higher and degree apprenticeships will be in place by September 2017, with a view to resolving the gap expected to be left by an ageing workforce in this specialist area over the next 3 – 5 years.

In response to the government's pledge to register 3 million apprenticeship start-ups by 2020. UH Bristol has spent 2015/16 focussing on introducing apprentices Trust wide with a view to implementing the role in April 2017.

Two working groups have been set up to consider the impact of the government levy and workforce target, which are being introduced to encourage organisations with pay bills over £3 million and a large workforce, to invest in the training of the support worker and encourage the employment of young people, in particular from disadvantaged backgrounds. UH Bristol is keen to invest in the development of this staff group and a strategy and process for the introduction of apprenticeships is currently under review.

Another new role to be implemented in July 2016, following UH Bristol's involvement in the Bristol Better Care project, is the wellbeing partner apprentice, developed to work across 3 health and social care sectors including UH Bristol, Bristol City Council and clinical commissioning group. UH Bristol will be welcoming 3 apprentices to follow a similar education programme to that of our nurse assistants, whilst understanding the patient journey from home/care home, hospital treatment and discharge. It is hoped these new roles will enhance our workforce and provide opportunities for young people to work in various healthcare settings across the community.

Finally, the Education Group regularly review the progress against education objectives. The Education Delivery Plan (Appendix 1) was agreed by the Board in January 2016 and good progress is being made against the 2016/17 objectives to deliver the Education strategy. Education activity reports by specialist area are available by request. Much activity has been delivered ensuring teaching and learning continues to underpin the mission and vision of the Trust.

2. NATIONAL AND LOCAL CONTEXT

Nationally and regionally 2015/16 has been a challenging year, however despite the announcement of changes within Health Education England that continue to be developed, and the need to make further financial savings across the NHS, some exciting new initiatives have emerged that impact favourably on education for UH Bristol staff and patients.

2.1 Stakeholder/Partnership working

We continue to have excellent working partnerships with our local Higher Education Institutions and in particular the Universities of Bristol and the West of England, and we are committed to continue working constructively with them. The following examples highlight some of the positive outcomes of collaborative working in 2015:

- The recent development of a joint strategic partnership board and education sub group between UH Bristol and the University of Bristol, has resulted in 2 collaborative projects being identified for 2016/17; developing more flexible modules on the Teaching and Learning for Healthcare Professionals that address leadership and research for UH Bristol staff, and the inclusion of medical students in the Trust's Widening Participation programme with Health Education England.

- The General Medical Council quality assurance visit to the Trust and University of Bristol Medical School took place earlier in the year, and was the first time both organisations were visited as a joint exercise. Both organisations received highly commendable feedback for their teaching and support for students.

- Recent partnership working with colleagues from Health Education South West, acute, community and primary care has enable an improved process for allocating Health Education England funded Continuing Professional Development (CPD) modules.

2.2 South West Genomics Medical Centres and funded MSc provision

Following a collaborative process in 2015/16, the South West now has two Genomics Medicine Centres: one based around Exeter and a brand new centre based around Bristol. These two centres are part of the 13 which will assist in the delivery of the unique, innovative and world-leading 100,000 Genomes project. These 13 NHS Genomics Medical Centres are on their way to bringing genomic diagnostics throughout the NHS in England to the benefit of patients.

To support this ambition, Health Education England in the south west has worked with education providers to secure national funding to support 65 fully-funded Genomics MSc degree training places for a one year full time, or two year part time programme. The programme is being led by Exeter University, in partnership with others in the south west, and is suitable for doctors and senior non-medical staff; especially those who work in cancer care or with rare diseases. UH Bristol is currently scoping the interest within the trust to take up this exciting opportunity.

2.3 Health Education England

From 1 April 2015, Health Education England was abolished as a Special Health Authority and established as an Executive Non-Departmental Public Body. This change of position will provide the education, training system and functions that they already support, with more stability and consistency with other stakeholders in healthcare and public health organisations. The direct commissioning of education and training will no longer be the responsibility of Health Education England; however they will continue to build on existing opportunities to work with organisations and Higher Education Institutions to support the provision and placements of education for the future NHS workforce.

Local Education and Training Boards will be reduced from 13 to 4 nationally with the emergence of Sustainability and Transformation Planning groups (STPs). Much of Health Education England's work will be carried out in partnership with the STPs with a major focus on upskilling current staff to support initiatives such as Making Every Contact Count; new roles such as Physicians Associates and Associate nurses; new ways of working to support improved staff flexibility and the embracing of research and innovation.

In April 2015, Health Education England launched its Talent for Care strategic framework: 'Get in, Get on, Go Further', for the development of the healthcare support workforce, this was followed with a subsidiary strategy called 'Widening Participation', to ensure the healthcare workforce represents the communities it seeks to serve, and to enable wider, larger scale, sustained and coordinated access for potential participants from all backgrounds and circumstances, seeking a career or employment in the health sector. UH Bristol has signed up to a Health Education England partnership to deliver a number of actions within the 'Talent for Care' and 'Widening Participation' strategies, and the employment of apprentices will form a major part of this strategy.

3. EDUCATION UPDATES

The following section provides an overview of activity in each education and training area during 2015/16.

It describes the activity and achievements from each of the Education Leads who contributed to the Education Plan and are members of the Education Group.

3.1 Medical Education

The General Medical Council visit to the Trust and University of Bristol Medical School took place in April 2016 as part of their regional visit to the South West.

UH Bristol was commended for the safe and supportive learning environment for undergraduate students; the supportive environment for educators; the strong educational governance structure and the supportive administration team. However, there was one area of concern for Core Medical Doctors in Training, who are at risk of not meeting their learning outcomes if they are unable to attend mandatory training sessions and outpatient clinics as required in the curriculum.

A full report will be received from the General Medical Council in autumn 2016 and an action plan will be developed by the divisional management team and medical specialty tutors with the support of the Director of Medical Education.

3.1.1 Medical Postgraduate Education

The medical education department have achieved 98% compliance against the General Medical Council key performance indicator for the accreditation of all educational and clinical supervisors within NHS trusts, and they are on track to reach 100% by the target date of end July 2016. The General Medical Council commended the Trust on their achievements to meet this target, with such a large number of education and clinical supervisors compared to similar trusts in the South West region.

In 2015/16, 2 medical staff from UH Bristol became the successful recipients of the Trainee and Trainer of the Year awards in Health Education South West School of Medicine.

- **Trainer of the Year**: General Internal Medicine (GIM) speciality: UH Bristol Dr Lindsay Dow
- **Trainee of the Year**: General Internal Medicine speciality: UH Bristol Dr Chloe Broughton

Both doctors were congratulated on the high quality of education, training and support offered to doctors in training in the South West. The postgraduate medical education department at UH Bristol has been fortunate enough to retain Dr Broughton for a further year in 2016/17, as she will be taking one of the undergraduate teaching fellow posts in the Trust.

This has been a successful year for two clinical education fellows in the Department of Ear, Nose and Throat (ENT). As well as being a useful additional service to the Division of Surgery, Head and Neck, they have also undertaken research into “Doctors and Patients as Partners in Learning” which they will be presenting at the Association for the Study of Medical Education (ASME) conference in July 2016. Due to their success, the Divisions of Surgery, Head and Neck and Specialised Services have agreed to fund several of these posts in 2016/17.

3.1.2 Medical Undergraduate Education

Enhancing the medical student experience at UH Bristol was a main focus for the medical education team during 2015/16, with positive outcomes reflected in improved local student feedback in all areas of the course delivered at the Trust. Embedding the Bristol Royal Infirmary based Clinical Teaching Fellows in Medicine and Surgery teaching in years 3 and 5 over the past 3 years, has proved invaluable to the positive feedback from students. The Clinical Teaching Fellows attract high-quality junior doctor candidates, and over the last 3 ½ years, there is a 100% record of progression to the career path of choice for each Fellow. One of the Clinical Teaching Fellows (Dr Stephanie Quinn) was shortlisted and achieved a commendation as one of only three individuals for the University of Bristol Faculty Teaching Award in June 2015.

3.2 Dental Postgraduate Education

In May 2015 an appointment of Education Lead for Dentistry was made following recommendations from the Dental Deanery Quality Assurance visit in January 2015. This positive development was highlighted at the recent Postgraduate Dental Deanery Quality Assurance revisit in June 2016, with praise for the post holder’s work to provide much needed leadership and direction.

It was evident that there has been a significant improvement in the development, structure and delivery of education and training throughout the specialties. A draft report of the Quality Visit outcome was received with a full and detailed report expected in the autumn.

Added to this success, 3 Dental Academic Clinical Fellows have received funding from national bodies to support further study to achieve a PhD, and of these, 1 Academic Clinical Fellow also ranked 1st of 29 candidates to enter Specialty Registrar training in national recruitment for Restorative Dentistry.

3.2.1 Dental Undergraduate Education

2015/16 has proved a challenging year for the Bristol Dental School. Despite some extremely positive responses in the National Student Survey, in particular the support and enthusiasm exhibited by the teaching staff, the Bristol Dental School has performed poorly against other dental schools, with disappointingly low scores for overall student satisfaction. Steps are being taken to address the issues experienced by the learners with the development of an action plan led by the head of school and dental tutors. However, notwithstanding these challenges, 100% pass rate was achieved in 5th year final exams with all students obtaining a dental foundation place in 2016.

4. NON-MEDICAL EDUCATION

4.1 Learning Resources

The Library has had a very successful year, achieving a 100% score in the Library Quality Assurance Framework, training 1200 staff, adapting to new and challenging demands and expectations, and growing to become the largest NHS Trust library in the South West. Steps have been taken towards complying with the criteria in the Knowledge for Healthcare Framework (2015), including locating and purchasing eBooks, which have become more popular with our users, and growing the outreach operation within UH Bristol from one to forty specialisms, and developing “synthesised literature searches.” The Library offers the most well-used critical appraisal and statistics face to face training sessions in the south west, and also has the highest percentage of users registered for electronic resources (31%). Key Performance Indicators have been reached and often exceeded in Literature Searching and Article Retrieval. The Library team was awarded ‘Highly Commended’ at the Trust’s Recognising Success Awards in November 2015.

4.2 Simulation Centre

Following the successful delivery of international simulation programmes in previous years, the Centre increased the number of courses delivered in 2015/16, with the addition of two Advanced Simulation Instructor Masterclasses in Cape Town, South Africa and a further two courses in Sri Lanka. As part of the European Erasmus Training project, the Centre welcomed eighteen clinicians from Turkey who undertook a range of practical and observational simulation activities to be implemented on return to their country.

A further exciting project enabled the Centre to support an international Simulation Fellow from a Christian Medical College in Vellore, India with the aim of promoting simulation activity on her return to India. Both experiences were highly evaluated and the Centre staff are working towards expanding their programme to support further international fellows in 2016/17.

With the new appointment of an adult mobile simulation trainer in 2015 , a structured quality ‘point of care’ training programme for staff in adult healthcare across the trust has now been implemented and will gain momentum over the coming months to reach the same objective level of success as the paediatric point of care programmes. The Centre has been working closely with the Patient Safety team to align their training to the ‘sign up to safety campaign’ which will address areas of concern around patient safety incidents.

4.3 Dental Care Professionals

The University of Bristol Faculty Quality Team visited the Diploma in Dental Hygiene and Therapy earlier in 2016; both programmes have recently undergone a major programme restructuring to conform to the General Dental Council's learning outcomes. The restructuring also incorporated a review of the assessments methods, to include more E assessments and Objective Structured Clinical Examinations (OSCEs). An E portfolio is under development, which will enable the tracking of all clinical activity. Both programmes received high praise, in particular around student support, student feedback and clinical facilities, with the final detailed report expected in July 2016.

The Dental Care Professional School achieved a 100% pass rate for the trainee dental nurse and student dental therapist's final diploma examination; student dental hygienists have yet to sit their exams., Also, a post registration Questions and Answers Book for Dental Care Professionals was published recently (Wiley Blackwell), and four of the authors are staff from the Dental Hospital.

4.4 Postgraduate Nursing, Midwifery and Allied Health Professionals

In 2015/16, UH Bristol were allocated a lower than requested number of funded postgraduate Continuing Professional Development (CPD) modules for nursing and allied health professionals to access at the University of the West of England. However collaborative working with the HESW and University of the West of England, has resulted in a further 100 modules being allocated to UH Bristol for access in 2016/17. This new partnership approach in decision making and strategic discussion has gone someway to ensuring that education for nurses and allied healthcare professionals in UH Bristol is aligned to meeting workforce development needs and supporting service delivery changes required by the transformation agenda.

Work has been undertaken nationally by Health Education England to develop preceptorship standards to support the transition of newly qualified staff that are new to the NHS. These standards will enable staff to develop the confidence and competence to function as an effective independent health professional, able to deliver high quality evidence based care for patients and service users. UH Bristol ran a pilot preceptorship programme that commenced in August 2015, which received very positive feedback from preceptees in terms of content, support and impact. A full evaluation of the pilot programme is being developed and due to be published in summer 2016.

4.5 Faculty of Children's Nurse Education

After a hugely successful first year in 2014/15, the Faculty of Children's Nurse Education has continued to grow and develop in the year 2015-2016, with the first cohort of nurses undertaking academic courses delivered by the Faculty Team being awarded their credits by Plymouth University.

The Paediatric High Dependency, Critical Care and Cardiac Modules continue to be well attended and evaluated with nurses coming not only from the South West region, but also Cardiff, Swansea, Southampton and Belfast to access the variety of courses offered.

As nurse recruitment remains high, with over 300 nurses having been recruited to the Children's Hospital since 2014, the Faculty's Clinical Education Team have ensured all new recruits have a place on the four day nurse orientation programme. A further two education days at 6 and 9 months ensures the nurses have additional skills and competence in intravenous drug administration and advanced tracheostomy and pain management.

All ward areas now have a clinical nurse educator in place supporting and developing clinical practice. This robust education package has been well evaluated and is acknowledged as being a vital element for nurse retention. The Faculty has exceeded planned delivery expectation and met both its key performance indicators and financial targets.

4.6 Pre-registration Nursing and Midwifery

The Trust's most recent pre-registration nursing and midwifery placement evaluations from the University of the West of England continue to be good, with a higher student response rate and overall satisfaction scores than in previous years. Students are overall extremely happy with the quality of placements at UH Bristol, with several clinical mentors being cited for their excellent support and activity. This is highlighted by the nomination of 5 of the pre-registration nursing and midwifery clinical mentors/teams by students for the 'Best Practice' prize, awarded by the University of the West of England. Samantha Burgess (Day Surgery & Endoscopy Unit SBCH was awarded winner in the Adult Nursing Category prize, with Emily Stirling (Radiography) winning the allied health professional prize.

4.7 Health Care Scientists

During 2015 a key focus was leading workshops for Healthcare Scientists across the Trust and the South West to highlight the potential for apprenticeships to assist services in filling vacancies through accessing the innovative distance learning BSc in Healthcare Science at the University of the West of England (which delivers the Practitioner Training Programme syllabus developed as part of the Department of Health's Modernising Scientific Careers programme). The University of the West of England has also developed course material for two further specialisms in Clinical Engineering and Neurophysiology as part of ongoing collaborative discussions with the Trust during 2015/16, and these will become available from September 2016.

During 15/16 Dr Reshat Reshat our Vascular Scientist Trainee achieved distinction and was awarded "Best CVRS student" in his year cohort.

4.8 Pharmacy

The regional training programme delivered by South West Medicines Information and Training (SWMIT) is considered to be one of the best in the country, delivering a pass rate of 100% across the region in 2015 which is well above the national pass rate of 74%.

Both pre-registration pharmacists at UH Bristol from this cohort successfully passed their pre-registration exam and qualified as pharmacists and have both been successfully employed within the department.

For the 2015/16 training year, funding was obtained for a third trainee whose post was split with the GP Practice at the Old School Surgery in Fishponds, Bristol. This was the first placement of its kind and was noted as an excellent innovation by the health minister at a national conference. UH Bristol Pharmacy was therefore involved in the development of a novel integrated training programme which has now been rolled out across England for the 2017 intake.

10 assistant technical officers (ATO's) are currently working towards their NVQ Level 2 in Pharmacy services, and a further two pharmacy technicians have commenced the NVQ Level 3 in 2016/17. Funding support from Health Education England for pharmacy technician training for 2016/17 has been increased to four places, which will support recruitment for future at UH Bristol.

4.9 Vocational Education

The Vocational education team is responsible for the development of nursing, and midwifery assistants and ophthalmology vision scientists across UH Bristol, through the delivery of a programme of education and training to achieve a Qualifications Credit Framework diploma in Clinical Healthcare Support. This training includes the completion of the national Care Certificate and the Essential Care programme. During 2015/16, 357 nursing/midwifery assistants attended one of the 24 induction programmes provided by the vocational education team, this includes 143 nurse assistants who joined the Trust Temporary Staffing Bureau.

Following internal stakeholder involvement and evaluations of the education programme for nursing assistants, 3 additional elements of training were agreed with the clinical areas, which will enhance the skills of the assistant, support the nursing workload and improve care for patients. These are:

- Capillary Blood Glucose monitoring- with the introduction of the new monitoring machines across UH Bristol the training has evolved to include registration of individuals as competent with the Medical devices department
- Fluid and Urine Management- including documentation, equipment and communication
- Paediatric principles of pain

The Care Certificate was implemented in July 2015 following the Francis Report and the Cavendish review. 89 of the 127 learners who undertook the Care Certificate in 2015/16 have successfully completed, with the remaining learners receiving the support to complete the certificate imminently. Currently the Care Certificate is not transferable between NHS Organisations, requiring fully trained care assistants joining the Trust to re-sit the certificate. However, recent affiliation with the Care Certificate consortium has led to a system of certificate transferability across the Southwest region with work ongoing to develop a quality assurance mechanism alongside supporting transferability.

4.10 Essential Training

Essential Training was more accurately re-defined in early 2016 as ‘any required training (statutory/mandatory) to which the Trust must report monthly compliance, averaged against a known and well-delineated target audience’.

There are now approximately 30 programmes considered ‘essential’ at UH Bristol, including Fire Safety, Information Governance, Manual Handling, Resuscitation etc. It is every individual staff member’s responsibility to ensure they are compliant with their Essential Training, and the Trust aims for compliance of 90% in each Essential Training programme.

In March 2016, overall compliance had increased to 91.1%, an increase of 4% since March of the previous year. Whilst compliance against essential training subjects varies between divisions, steps are being taken to encourage and support divisions to maintain compliance achievement and ensure staff are released to attend essential training. At least 18 Essential Training programmes are now available for staff via e-Learning updates; in the last year, staff have completed approximately 3900 eLearning programmes.

The Trust’s electronic Learning Management System allows individual staff to directly access their own training records, and keep abreast of training compliance, make instant bookings for face to face training, or immediately update training via E-Learning, and more recently managers can now view the training activities of their individual staff, to support appraisals and monitor essential training compliance more closely.

5. APPRENTICESHIPS

In 2015, the Government introduced an initiative to register 3 million apprenticeship start-ups by 2020. A national levy and workforce target are being introduced in April 2017, to encourage all large employers, including the public sector to become involved with apprenticeships. It is uncertain what the impact of these two initiatives will mean for UH Bristol until full guidance is published in September/October 2016.

In preparation for this work, the Trust has appointed an Apprenticeship Coordinator with start-up support financially from Health Education South West.

12 apprentices are already working in the Trust on programmes that have run successfully during 2015 – 2016, supported by external training providers. We have undertaken apprenticeship familiarisation sessions attended by 78 line managers and supervisors, and investigated the potential to become an employer/training provider for our existing Qualification Credit Framework nurse, midwifery and ophthalmology vision scientists, to convert into an apprenticeship pathway.

There are two working groups set up focussing on pay, terms and conditions and recruitment processes, including scoping the areas where apprenticeships could be beneficial in hard to recruit areas. A plan for the implementation of apprenticeships will be presented to the Senior Leadership Tem in July 2016

6. EDUCATION DELIVERY PLAN

The production of the Education Delivery Plan for 2016/17 (Appendix 1) has presented a number of opportunities and challenges. Historically education priorities have largely been determined and managed within each professional area with limited opportunity for sharing across the professional groups. The new way of working, culminating in one document has been well received by both education and service leads it provides greater opportunity for learning across the different groups; more multi-professional working; increased scope for development of new approaches to education and identification of new roles/ways of working; and a better understanding of the risks associated with education, including funding. However, given this step change in our approach to education, the high level plan will almost certainly need further refinement over time.

7. CHALLENGES

The changing landscape of the education agenda poses a number of challenges and this section describes these and the high level risks that will require a specific focus during 2016/17.

7.1 Medical Education

- As part of the government's comprehensive spending review in 2015/16, medical education income received from Health Education England to support salaries and education of doctors in training at UH Bristol has been reduced by 2%. This reduction in income poses a challenge to the administrative support, supervision and other necessary resources available within the team to support doctors in training and the increased number of teaching fellows appointed to enhance medical education provision and fill rota gaps.

- As part of Health Education South West's savings programme, funding provided to trusts for the development of Staff and Specialist Grade (SAS) doctors is currently under review. A possible 50% reduction in funding is expected for 2016/17.

- Meeting student expectations, who compare learning experiences across the Clinical Academies in other Trusts, continues to be a challenge year on year.

- Reduced Service Increment for Teaching (SifT) income to support medical undergraduate teaching continues to be a challenge when maintaining adequately funded and supported undergraduate teaching faculty.

- Dental Staff to student ratio is low, along with low numbers of patients, creating limited exposure to students, all of which are causes for the poor Student Survey outcome. The Dental School is keen to maintain discussions with the University and Trust staff to improve the situation.

7.2 Non-Medical Education

- The rising cost of journals, in particular the cost of the popular and vital point of care tool 'Uptodate.com' continues to add pressure to the Library resources budget and is a key concern. Consideration is being given to a cheaper alternative to 'Uptodate.com', whilst other solutions for the continuation of funding this journal are sought.

- The Trust received a red flag for 'access to educational resources' in the 2015 General Medical Council trainee survey, and as a result a benchmarking exercise was undertaken to compare UH Bristol library resources with other major Trust Libraries in the South West. Maintaining and developing high quality library services with spiralling British Library loans and journal subscription costs, will be a major challenge with limited resources.

- Earlier this year Health Education South West made the decision to end existing funding arrangements with the Trust to support Dental Nurse training from 2016/17; the programme will move to an Apprenticeship from August 2017.

- The shortfall in the number of Continued Professional Development modules for postgraduate nurses and allied healthcare professional and healthcare scientists versus the actual number allocated has been disappointing for staff wishing to progress their skills and knowledge in specialist areas. Not all divisions have been fortunate enough to support additional modules through their education budgets.

- A six week consultation on the proposal for introducing a new Nursing Associate Role to support Registered Nurses was launched in December 2015. The need for the new role was proposed within the Shape of Caring report and arose in part from the Cavendish Review. The role likely to be a band 4, will hold a care certificate plus additional skills and knowledge and work alongside Care Assistants and Registered Nurses. The new role is intended as an opportunity for those wishing to progress to become a Registered Nurse, with the aim of opening up opportunities to people from a wide variety of backgrounds.

  The main findings from the consultation have now been published by Health Education England together with plans for the introduction of the new role by January 2017. A programme of work will be undertaken in partnership with stakeholders, this work will include:

  - Developing the scope of practice
  - Identifying the skills, knowledge and competencies for the role
  - Develop a national curriculum
  - Establishing test sites
  - Support test sites to recruit 1,000 students for January 2017
  - Applying and embedding lessons learnt
  - Evaluating the role with key partners

- Understanding and preparing for the impact of the Apprenticeship Levy and Workforce Target due in April 2017 is challenging due to unanswered questions and guidance still to be published by the government. When looking at the development of employees, the Levy can only be used to fund new starter apprenticeships or new roles/skills for existing staff. It cannot fund salaries or continual professional development.

- For investment in education and training up to 2020, Health Education England will receive flat cash, this means that funds for education tariffs will also be set at flat cash, and does not take into account the rising cost of inflation in resources, material and salaries.

- With the advent of the clinical pharmacists in General Practice pilot, hospital pharmacy has now become the training ground for primary care in a similar way that it is for General Practice. Consequently, the trust is mindful that retention of staff may be influenced by the growth of this career path and the subsequent impact it will have on training resources.

- UH Bristol currently support over 30 undergraduate placements for pharmacy students from Bath University, which will significantly increase with the implementation of the integrated 5 year MPharm course, creating an increase in workload pressures within the pharmacy department.

8. HIGH LEVEL RISKS

Whilst UH Bristol continues to experience service pressures that impact internally on the ability for all staff to attend essential training and continued professional development, regional and national changes within the government and Health Education England, are a cause for concern to learners on placement at UH Bristol. Whilst some of the risks below have been placed on the Trust's risk register where appropriate, the majority of risks have only recently emerged and staff involved are participating in working groups to develop action plans that mitigate these risks.

- Clinical service pressures across the trust continue to pose a risk to the delivery of teaching and education for learners with increased difficulties releasing staff to attend programmes.

- Potentially the new contract for doctors in training and how it will affect both training and rotas continues to cause some concern. The medical education manager is part of the Trust's Implementation group.

- Following the Government confirming its intention to replace NHS bursaries with loans, discussions are underway between the Trust, Health Education South West and the University of the West of England to see how this will impact on placement up take and future recruitment for non-medical pre-registration staff groups such as dental hygienists and therapists, nurses, midwives and allied health professionals.

- Other Clinical Academies are developing increased capacity for medical undergraduate teaching and assessments, which may create some shift of activity away from the Bristol Trusts. This could jeopardise future student placement allocation and result in reduced Service Increment for Teaching (SifT) income.

- Library staff establishment is small with little opportunity for career progression, creating a high turnover and migration of staff to neighbouring Trusts. Staff development opportunities and potential restructuring of the team is being investigated.

- There is currently a gap of 88 Continued Professional Development modules for nursing and allied healthcare professionals from the original total requested. Divisions have some education resource to fund some but not all the deficit.

- The Trust does not have a robust system of centrally recording; identifying; or governing all essential specific to role training for staff, and currently this issue is on the Trust Risk Register. A working group met in May 2016, to specifically address this issue with a recommendation that essential specific to role training should be subject to an annual Divisional Training Needs Analysis.

9. FINANCIAL OVERVIEW

The Trust has continued to receive funding from Heath Education England via the Multi Professional Education and Training levy in support of its delivery of the Learning and Development Agreement. In 2015/16 this amounted to £35.2m (Appendix 2). During 2015/16 the Trust entered the third and final year, of the transition to the new Medical Service Increment for Teaching (SifT) tariff, receiving transitional support funding totalling £0.32m. This represents a reduction in Medical SIfT funding of £1.26m during the year as a result of the new tariff.

During 2015/16 the Trust Executive allocated £200k to improve recruitment and retention within the organisation. A significant proportion of this funding was utilised to improve training and induction programmes for staff across the Clinical Divisions.

The implementation of Health Education England's approach to the introduction of tariffs for education and costing Education and Training exercise has continued during 2015/16. Significant improvements have been made in data quality at a national level. The 2015/16 cost collection exercise contains one significant change in that in addition to the netting off of education income for the annual Reference Costs exercise a second, subsequent, submission will split the Trust costs between education and service. This is the first time that the level of expenditure between education and service has been measured and will allow an opportunity to assess the potential impact on service tariffs resulting from an introduction of education tariffs. However there is currently no firm timelines regarding the implementation of new education tariffs at this stage. The Trust continues to engage fully in the education cost collection exercise.

10. NATIONAL CHANGES - FUTURE IMPACT ON EDUCATION

In 2015/16, Health Education England was required to review its five year forward strategy and delivery plan, following the identification of barriers to provide a comprehensive service for the population it serves. These barriers include:

- The investment of more resources in preventing ill health
- The need to improve the quality of the services provided
- Removing unacceptable variation and delivering better outcomes for patients regardless of the locality

To deliver this ambitious programme, will require change in how the NHS operates in the short and long term, coupled with the need for the NHS to find £22bn in efficiency savings. Various mechanisms and structures have been created to take forward the work, with some immediate changes affecting the way education is planned, commissioned and debated at local and regional level.

10.1 Health Education England

Health Education England has recently presented plans to implement their Five Year Forward View and necessary engagement with external stakeholders to handle interim governance whilst they undergo an organisational change in 2016/17. The key changes agreed by the Health Education England Board are:

- The creation of four regional local Education and Training Boards, one of which will be in the South.

- The closure of the existing 13 local education training Boards (the local teams and offices in the South West will continue to operate as currently as will the role of the Health Education England Local Director).

- The dissolution of the current local Chair roles.

These changes will be implemented by 1 August 2016. Discussion and agreement of local arrangements for the transition, including the role of Health Education England in the South West in supporting the Sustainability and Transformation Plans, will be discussed at the local education and training board's governing body meeting in June.

10.2 Health Education England – Commissioning and training Plan

Following the organisational change and remit of Health Education England in 2016/17, education and commissioning plans and processes will be modified. Health Education England will not be commissioning any new pre-registration programmes after the 2016/17 intakes, and whilst the system of commissioning and funding is changing, Health Education England`s statutory duty to ensure the NHS has a ready supply of suitably qualified professionals aligned to its needs remains unchanged. This new system provides both opportunities and risks.

Whilst employers will be able to offer increased placements to meet their future needs, more attractive geographies may draw learners to other areas across the South West. Employers will be able to develop closer relationships with higher education providers both within and outside of their current area; however workforce planning may be more difficult if local commissioning arrangements are in place.

11. CONCLUSION/PRIORITIES FOR 2016/17

It is worth highlighting that our greatest strengths appear to lie in the positive experience learners' feedback in student surveys and the huge commitment of our staff to ensure this is the case. However, there is no room for complacency and there have been some specific areas of concern raised that we need to address. Equally, the landscape is shifting, as historical funding streams for education and the responsibility for commissioning education placements are changing or under review. We need to be responsive to these challenges and build on existing strengths. If we do this well, there are great opportunities in terms of our ability to attract and retain both students and employees; and also influencing the future of NHS education commissioning.

The delivery of the Education Plan objectives (Appendix 1) will be our main focus and key priorities over the next 12 months with the following additional objectives, which have evolved during 2015/16:

- To achieve 90% compliance in each essential training programme and, sustain this position year on year.

- To review current funding streams for Dental Hygienists and Dental Technicians and develop a plan that ensures continuity of this training.

- To ensure that the appointment of nine clinical education fellow posts (two in ENT, two in Haematology, two in Oncology, three in Trauma and Orthopaedics), are a success both in the provision of service to their respective departments and to conduct relevant and significant research and/or education.

- To research the possibility of the Trust supporting the funding and clinical placements of Physician Associate students at University of the West of England (University of the West of England), and thereafter providing permanent positions within the Trust to support the medical rota.

- To successfully implement the new curriculum for Foundation Doctors.

- To ensure that Core Medical Trainee (CMT) doctors have better access to local and regional teaching and that they have more opportunities to attend teaching in order for them to meet their curriculum outcomes, as indicated in the General Medical Council's interim report following their visit in April 2016.

- Maintain high quality learning experiences for medical undergraduates by recruiting enthusiastic educators in both middle grade and consultant/career grade roles. Encouraging Trust staff to take up educational roles at University of Bristol when opportunities arise, thus ensuring retention of education income.

- Keep abreast of implications of University of Bristol's new medical undergraduate curriculum (called MB21); due to be implemented in 2017. Greater emphasis on community medicine may result in reduced clinical placements in secondary care.

- Introduction of a full new education programme for Dental Core Trainees commencing at UH Bristol in September 2016.

University Hospitals Bristol NHS
NHS Foundation Trust

Education Plan

2016-2017

Education Plan high level generic objectives for all learners on placement 2016 – 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Deliver Health Education South West's Learning and Development Agreement contractual obligations for education and maintain levels of activity	• Secures equivalent or increased external funding (currently £34m) to support education each year • Maintains and improves stability and profile of education provision throughout the Trust.	• Achieve Green RAG rating in the Health Education South West outcome report	Education/professions Leads &Head of Education	April 2016
Improve the learner experience for students and trainees	• Individuals feel that UH Bristol is the best place to learn and best place to teach • Learners choose to work at UH Bristol post qualifying	• Learner satisfaction percentage for UH Bristol is same or higher than previous year. • A developed set of Key Performance Indicators that mirrors Universities of Bristol and West of England	All Education Leads	July 2016
Conduct a Trust wide Training review that is bottom up with patient and service needs and priorities assessed and matched to corporate and divisional education resources	• Ensures access to specific and relevant training for all staff to deliver service and patient needs. • Ensures training provision is reviewed and reflects operating plans and patient needs.	• Training requirements will be summarised and costed by division • Training provision is matched to funding available within divisional budgets	Deputy Director of Workforce and OD	September 2016 March 2017
Improve our relationships with key stakeholders to enhance our access education: • University of Bristol • University of the West of England • Higher Education colleges • Health Education South West • Clinical Commissioning Groups	• Strengthens ability for joint initiatives and excellent academic recognition across organisations and raises • Ensure skills development for current and future workforce • Raise Trust profile to be the best teaching hospital • Closer relationships result in joined up thinking and working.	• Secures financial investment to support continual professional development from external stakeholders e.g. Health Education South West and Clinical Commissioning Groups • UH Bristol presence on external partner working groups.	Head of Education	September 2016

Developed by Kay Collings Head of Education

***Education/Professional Leads** = Jayne Weare, Trish Hewitt, Helen Morgan, Mel Watson, Steve Brown, Sue Dolby, Rebecca Aspinall, Jane Sansom, Jane Luker, Sarah Bain, Tom Osborne, David Grant, Paula Tacchi

Education Plan high level objectives for Medical and Dental Postgraduates 2016 - 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Achieve positive evaluation from any external review of our medical and dental education environment. (General Medical Council review visit April 2016 and Health Education South West contract visit October 2016).	• Reduces risk of losing post graduate medical and dental core training places. • Secures continued funding to support education provision within the Trust for future years. • Trust has reputation of best place to learn and best place to teach	• Specialty medical and dental education leads communicate risks with an action plan against education quality, to the Medical and Dental Education Committee. • Medical and Dental Education Committee ensures education risks are communicated to Divisional management teams. • Continue to reduce red outliers in the General Medical Council trainee survey and increase the number of green outliers. • Any reports or suggestions of bullying and harassment are dealt with by the Director of Medical education and the Medical Director. • Any significant issues involving medical and dental trainees is communicated through the Director of Medical Education via: regular meetings with the medical director, The Medical and Dental education Committee, the annual Education Supervisors away day and the annual exception exit reports for revalidation.	Director of Medical Education	April 2016 (GMC Visit) October 2016 (HESW Visit)
Meet the General Medical Council & General Dental Council requirements to formally recognise and approve medical trainers (educational and clinical supervisors)	• Quality of education provision is maintained • Learners are supported by appropriately trained staff • Compliant with the Learning and Development Agreement • Improved placement quality leading to potentially more Health Education South West placements and safer staff numbers in vulnerable areas.	• 100% of medical and dental supervisors are accredited. • Educational roles are identified in medical job plans as Educational Programmed Activities (EPAs), including Educational Supervisors, Training Programme Directors and Specialty Medical Education Leads	Director of Medical Education	July 2016

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
To achieve a positive evaluation from the General Medical Council trainer survey	• Quality of education provision is maintained • Learners are supported by appropriately trained staff • Compliant with the Learning and Development Agreement • Improved placement quality leading to potentially more Health Education South West placements and safer staff numbers in vulnerable areas.	• Outcome is determined to be reduced number of outliers from GMC trainer survey • An action plan will be created and submitted to Health Education South West Postgraduate Medical Education by the deadline to address any outliers	Director of Medical Education	October 2016

Developed by Dr Rebecca Aspinall, Director of Medical Education

Education Plan high level objectives for Medical Undergraduates 2016 – 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
To implement a process to coordinate the recruitment of clinical teaching/education fellows, both undergraduate and postgraduate across UH Bristol	• This will ensure recruitment of high quality candidates and ensure a full complement of teaching/education fellows in UH Bristol.	• Standard process for recruiting teaching/education fellows is implemented	South Bristol Academy Dean and Director of Medical Education	March 2017
Achieve positive evaluation from the General Medical Council external review of medical undergraduate education at UH Bristol. (General Medical Council review visit April/May 2016).	• Reduces risk of losing undergraduate training placements • Secures continued funding to support education provision within the Trust for future years. • Trust builds reputation as best place to learn and best place to teach	• General Medical Council report is shared at Medical and Dental Education Committee • Detailed action plan following visit is created and submitted within agreed timeframe	South Bristol Academy Dean	October 2016

Developed by Dr Jane Sansom, South Bristol Academy Dean

Education Plan high level objectives for Dental Undergraduates and Dental Care Professionals 2016 – 2017

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Dental Undergraduates/ Bristol Dental School	Minimise the risk of a decrease in Dental Service Increment for Teaching funding to UH Bristol as a result of a national reduction in dental student placements	• Filling student numbers with overseas students will sustain funding levels and quality of education.	• Student numbers from overseas increase to mitigate funding loss. • Funding is maintained at current level (£9.9m) • Possible loss of up to £200k per year from 2015 to 2016	Lead to be identified by division of Surgery, Head & Neck	September 2016
Dental therapists, hygienists, nurses & technicians	Submit business case to Health Education South West to secure commissioning for all Dental Care Professionals (DCPs) training programmes 2016 onwards	• UH Bristol maintains its reputation as major teaching provider for DCPs • Sustained numbers of trained DCPs for recruitment purposes	• Funding available to support DCPs is sustained	Director of Dental Care Professionals School	June 2016
Dental nurses	To establish an appropriate apprenticeship training alternative to the current training model for Dental Nurses to start September 2017.	• Potential income generation for Trust by providing training programmes for trainee Nurses from General Dental Practice	• Apprenticeships in Dental Care Professionals visible within UH Bristol • An increase in numbers of trainee dental nurses/assistants to meet the workforce need	Director of Dental Care Professionals School	September 2017

Developed by Sarah Bain, Director of School for dental Care Professionals

Education Plan high level objectives for Nursing, Midwifery and Allied Health Professions 2016 – 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
To increase in the number of placement options for student placement capacity UH Bristol 2016/17 for nursing	• Potential to increase recruitment of nurses and Allied Health Professional's • Reduced pressure in some areas with high student numbers • Better experience for students	• Increased number approved placement options available	Deputy Chief Nurse Lead Allied Health Professional	September intake 2016
To deliver an improved experience of students specifically in any areas of variance identified via student placement feedback.	• Consistent high quality placement experiences Trust wide. • Centre of excellence for the South West.	• The number of positive placement evaluations • For areas where improvement is required clear actions identified to improve placement. • Positive evaluation by students following improvement actions being taken	Deputy Chief Nurse Lead Allied Health Professional	April 2016 July 2016 October 2016 January 2017
That 90% of mentors are up to date with mentorship training (rolling %).	• Students are mentored by knowledgeable up to date Mentors	• Live mentor update which demonstrates 90% compliance. • Positive feedback from placement evaluations regarding mentors role	Deputy Chief Nurse Lead Allied Health Professional	April 2016 July 2016 October 2016 January 2017
To ensure 'fair shares' allocation of Health Education South West CPD funding for 2016/17.	• Access to relevant speciality modules/numbers to support delivery of operating plan and meet national standards. • Supports staff retention.	• New methodology used by HESW and Commissioners to determine allocation to Trusts is based on a fair shares formula.	Deputy Chief Nurse Lead Allied Health Professional	March 2016
To align Health Education South West funded/ commissioned courses with organisational operating plans / priorities.	• Courses commissioned and allocated to the trust align with service delivery plans, outlined in Divisional Operating Plans • Supports staff recruitment & retention	• Access to modules which reflect professional and service delivery plans, outlined in Divisional Operating Plans	Heads of Nursing and lead Allied Health Professional (identification of need) Deputy Chief Nurse (negotiation with Health Education South West)	

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
To develop divisional ownership and understanding of: 1. Process for accessing allocated Health Education South West funded modules in 2016/17. 2. Process of accessing UH Bristol funded modules	• Clarity of understanding by Professional leads • Equitable access for staff across the Trust	• Access to modules which reflect professional and service delivery plans, outlined in Divisional Operating Plans	Head of Developing People capability	March 2016
To strengthen / formalise Faculty of Children's Educational Bristol Royal Hospital for Children (BRCH) relationship with the University of the West of England (UWE) / Child Health teams.	• Formalised relationship with UWE UH Bristol's local Higher Education Institution (HEI) provider. • Improved collaborative working	• Contract agreed and in place between the Faculty of Children's Nurse Education and UWE	Head of Nursing Bristol Royal Hospital for Children	TBC
To make the faculty of Children's Education self-funding.	• Faculty will be cost neutral to the Division and Trust	• Faculty will generate income to offset staffing and other costs.	Head of Nursing Bristol Royal Hospital for Children	By 2017
Develop opportunities for formalising links with non-medical consultant roles with the University of the West of England (UWE).	• Access to research centres, research mentorship, further training and networking opportunities with a focus on non-medical research. • Potentially increases research esteem for both organisations	• Formal links in place with some non-medical consultants.	Chief Nurse/Lead Allied Health Professional	June 2016
Develop the clinical nursing professor role within UH Bristol to maximise benefits to UH Bristol.	• Leadership of/ champions the development, coordination and implementation of a non-medical clinical research strategy, informed by a critical analysis of organisational priorities • Successful research grant applications related to the above, which bring recognition to UH Bristol and UWE • Leads a programme of clinical research	• Non-medical research	Chief Nurse	September 2016
To ensure no decrease in student numbers for UH Bristol when the bursary changes for student nurses are introduced in Sept 2017.	• No. of students out turning who are potential employees remains constant or increases.	• Student numbers/recruitment of new qualifiers does not decrease.	Chief Nurse/Deputy Chief Nurse	April 2016

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
To increase access to widening participation into pre-registration nursing and Allied Health Professional programmes undergraduate courses for existing NHS employees in *Agenda for Change* bands 1-4.	• Development and retention of our staff employed at bands 1-4. • The maintenance of education standards and learning programme quality outcomes.	• Increased No's of staff accessing these opportunities via HESW/or spot purchase by Trust.	Deputy Chief Nurse	March 2016
To understand the education & service implications for the newly announced nursing associate roles.	• Potential impact on widening the access opportunities/higher apprenticeships for nursing	• Clear Trust position on costs/benefits and potential commissioned numbers required.	Chief Nurse/Deputy Chief Nurse	2017

Developed by Carolyn Mills Chief Nurse, Helen Morgan, Deputy Chief Nurse and Jayne Weare, Head of Therapy Services

Education Plan high level objectives for Healthcare Scientists
2016 – 2017

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Health Care Scientists Bands 1-4	Develop apprenticeship frameworks with Health Education South West and local education providers to deliver the education and development required for the known workforce gaps in the Healthcare Science Services.	• Mitigation of risk of shortage of workforce supply in departments where there are a national shortage • Supports Health Education England's widening participation strategy • Trust department will be leader in region and nationally for piloting new apprenticeship frameworks	• Two trainee healthcare scientist practitioners enrolled on Higher/Degree apprenticeship by first intake September 2017	Diane Crawford, Lead Scientist	September 2016
Health Care Scientists	All Healthcare Science Departments to have at least interim accreditation with the National School of healthcare Science Education Governance strategy	• Quality training delivery • Sharing of learning across Healthcare science departments	• To have a Trust database holding all accreditation self-assessment records for all Healthcare Science departments involved in postgraduate training programmes	Diane Crawford, Lead Scientist	50% by September 2016 100% by September 2017

Developed by Diane Crawford Lead Healthcare Scientist and Melanie Watson, Deputy HCS Lead for Education

Education Plan high level objectives for Pharmacy
2016 – 2017

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Pre-registration pharmacists and technicians	For > 90% of pharmacy graduates and pharmacy technician students to successfully qualify having fully developed through a comprehensive and innovative training programme commissioned by HESW and delivered South West Medicines Information and Training (SWMIT) to enable the necessary training to be delivered.	• Suitably trained and experienced workforce. • Retained Pharmacists and Pharmacy Technicians in NHS, a proportion in UHBristol.	• For > 90% of pharmacy graduates and pharmacy technician students to successfully qualify. • Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: September 2016 September 2017
Post registration Pharmacy technicians	For at least 4 Pharmacy Technicians to achieve regional accreditation (through SWMIT programmes) in order to develop professional practice and provide safe and efficient Pharmacy services.	• Suitably trained and experienced workforce. • Retained Pharmacy Technicians in UHBristol.	• For at least 4 Pharmacy Technicians to achieve regional accreditation. • Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: September 2016 September 2017
Post registration Pharmacists	For at least 3 pharmacists to successfully complete diploma or masters programmes in clinical pharmacy and pharmaceutical technology and quality assurance specialties.	• Suitably trained and experienced workforce exhibiting delivery of patient benefits.	• For at least 3 pharmacists to successfully complete diploma or masters programmes. • Measurement: In year evidence of steady progress; end year 100% success; and excellent feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: September 2016 September 2017

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Pharmacist independent prescribing	For at least 3 Pharmacists per annum to successfully qualify as Prescribing Pharmacists.	• Suitably trained and experienced workforce to develop clinical pharmacy and patient focused services.	• For at least 3 Pharmacists per annum to successfully qualify as Prescribing Pharmacists. • Measurement: Tracking of student progress; end year success rate; and student feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: September 2016 September 2017
Pharmacy Assistants	Equipping all new Pharmacy Assistants with the knowledge and experience to deliver assigned services through commencing 100% of new Pharmacy Assistants on the NVQ2 programme within 6 months and completing 100% of the necessary modules within the required timeframes.	• Suitably trained and experienced workforce and effective skill mix.	• Commencing 100% of new Pharmacy Assistants on the NVQ2 programme within 6 months and completing 100% of the necessary modules within the required timeframes. • Measurement: Successful commencement and completion of relevant Quality Credit Framework modules in a timely manner. Evidence of development and excellent feedback from evaluations of training experience.	Director of Pharmacy	2 cohorts: September 2016 September 2017
Joint working with Bath University	Develop joint practice educator post with Bath University to commence in 2016	• Improved collaboration with Bath University School of Pharmacy resulting in higher level of clinical pharmacy training and development.	• Joint practice educator post with Bath University to commence in 2016. • Measurement: Final agreement of role and successful appointment of high calibre candidate.	Director of Pharmacy	By January 2017

Professional Area	Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
South West Regional Pharmacy Training Unit service delivery	South West Regional Pharmacy Training Unit (hosted by UHBristol) to be recognised by SW trust Chief Pharmacists as a high quality provider of the South West Pharmacy Training needs, and retains HESW commissioned services.	• Maintenance of high quality Pharmacy training services in the South West NHS.	• South West Regional Pharmacy Training Unit (hosted by UHBristol) recognised by SW trust Chief Pharmacists as a high quality provider of the South West Pharmacy Training needs, and retains HESW commissioned services. • Measurement: Positive response by South West Chief Pharmacists to the SWMIT annual report and for SWMIT to retain the existing HESW commissioned service level agreements.	Director of Pharmacy	September 2016 September 2017

Developed by Steve Brown, Director of Pharmacy

Education Plan high level objectives for Clinical Psychology
2016 – 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Increase the offer of specialist clinical health training placements for Doctorate Clinical Psychology trainees to 6 per annum	• Establish UH Bristol as a quality placement provider for doctoral trainee clinical psychologists • To aid future recruitment and retention of clinical psychologists	• 2016 - 17 Offer of 4 placements • 2017 – 18 Offer of 6 placements	Consultant Clinical Psychologist	September 2016 for 1st cohort January 2018 for 2nd cohort
100% of staff eligible to be clinical supervisors have completed clinical supervision training recognised by the British Psychological Society and	• Quality of education provision is maintained • Learners are supported by appropriately trained staff • Compliant with the Learning and Development Agreement contractual obligations	• 100% of eligible supervisors trained	Consultant Clinical Psychologist	January 2017

Developed by Sue Dolby, Consultant Clinical Psychologist

Education Plan high level objectives for Support Workers Bands 1 -4
2016 – 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Implement trust wide Apprenticeship programme for support workers (bands 1-4) as part of Health Education England's 'Widening Participation' and 'Talent for Care' strategies	• Planned, affordable workforce, skilled to deliver services, improved staff retention, reduced turnover • Raised profile of support worker roles within overall workforce • Enables succession planning to cover skills gap and manages impact of retiring workforce	• Robust plan in place to support implementation of apprenticeships within UH Bristol • A minimum of 30 apprentices will be registered by April 2016 to meet obligations as agreed with Health Education South West • Higher apprenticeship framework available in Healthcare Science	Head of Education	April 2017 September 2017
Review opportunities and entry routes for local young people into support roles with UH Bristol	• Trust is able to take advantage of all opportunities available to promote careers in clinical and non-clinical roles at schools and college career events. • Trust becomes a major employer of choice for younger people	• Active directory of Trust 'healthcare ambassadors' who can attend school and college careers events • Trust workforce better reflects the diversity of the local population we serve, using equality and diversity workforce data as guide. • Increased number of employees aged 16-24 above current position of total headcount 81 staff.	Head of Education	April 2016 April 2017 April 2017

Developed by Kay Collings, Head of Education

Education Plan high level objectives for Learning Resources
2016 – 2017

Objective/Aim	Impact	Measureable Outcome	Lead	Timescale
Adhere to criteria in Health Education England's Library Quality Assurance Framework (LQAF) and develop library based on HEE's Knowledge for Healthcare Framework	• Trust staff agree that UH Bristol provide the best resources, knowledge training, and study facilities in the South West • Conforms with LDA and SIFT requirements for a staffed, well-resourced library space	• Continue to achieve a score of 100% in LQAF • Instigate at least one new project directly related to Knowledge for Healthcare • Green flag for resources	Library Manager	July 2016
Increase visibility and impact of all current library services whilst maintaining quality and efficiency.	• More Trust staff become aware of essential evidence based medicine resources paid for by the Trust, and know where and how to access all resources. • More Trust staff practice evidence based medicine on a daily basis	• At least 80 users trained in knowledge skills per month • Grow outreach operation to 25 departments • Achieve 32% Athens registration • Target an average £2 cost per click of electronic resources	Library manager	December 2016
Develop library space in line with the needs of a modern library post Knowledge for Healthcare recommendations (2015)	• The Library will become increasingly digital, ensuring access for all Trust staff wherever they are • More PC space for medical students and nurses undertaking revalidation • Better use of physical facility, enabling more Trust staff to train in essential evidence based medicine skills	• Development of a "digital first" purchasing policy • A successful refurbishment of the library space, with at least 20% increase in capacity and a new training space.	Library Manager	June 2016 March 2017
Increase number of simulation based multi-professional education programmes within the Trust by 2 each year	• Enables improved opportunities of access to simulation training courses for trust staff and learners. • Can enhance delivery of patient care through skills development for staff and learners	• Increased of training programmes provided by two in the first year and by two in the second year and number of staff accessing the training	Director Bristol Medical Simulation Centre	September 2016 for first two September
Link Simulation Training to the Trust Patient Safety Agenda	• Provides staff with appropriate skills development to improve patient safety • Supports the reduction of patient safety incidents	• Production of a strategic plan to align simulation training to Patient safety objectives	Director Bristol Medical Simulation Centre	April 2017

Developed by Tom Osborne, Library Manager and David Grant, Chair of Bristol Medical Simulation Centre

EDUCATION, LEARNING AND DEVELOPMENT STRATEGY

Vison statement: To enable our staff to deliver exceptional patient care through our excellence in education and our culture of continuous learning and development

The vision will be characterised by:

- Trust commitment to ensure staff and learners develop the skills and behaviours needed for patients to experience high quality individualised, compassionate and dignified clinical care
- Patient focussed philosophy with staff acting as health and wellbeing advocates
- Effective partnerships with patients, with and between divisions and corporate departments
- Equality and diversity of opportunity
- Effective partnerships with universities and other NHS organisations, with Health Education South West, Bristol Health Partners, the West of England AHSN
- Ambition based on sound foundations with basic building blocks in place.
- Responsive, seamless education, learning and development team working within an effective hub and spoke model
- Multi-professional opportunities to further enhance effective team working used whenever possible
- Modern environments that enable learning in different settings including in clinical practice and via different media
- Cross cutting themes and values woven through all education, learning and development
- Staff responding positively to research, innovation and evidence based changes in practice
- Taking opportunities to showcase our specialist education, learning and development skills e.g. point of care learning

Education, Learning and Development strategy outcomes:

- Outcome 1 – Local and regional education leadership

  UH Bristol will expand its role and reputation within the education, learning and development system and wider systems as an effective regional leader, partner, and collaborator.

- Outcome 2 – Innovative learning and working

  We will work in new ways with patients and education partners, using modern methods of delivery, blended approaches and technology to transform our education and teaching approach

- Outcome 3 – Education - Best place to teach, best place to learn

  With our university and education partners we will help attract the best learners to Bristol due to the diverse and specialist learning placements we have as well as the excellence of our teaching. We will achieve our LDA obligations, improve learner experience, enhance the reputation of the Trust as a teaching trust and enable future staff recruitment.

- Outcome 4 – How does the Trust value my learning and development

  Staff will recognise how our Trust values them through equipping them to safely discharge their roles and deliver high quality care with compassion, and helping them towards their potential, through opportunities to gain improved knowledge as well as fulfilling career development.

- Outcome 5 – Multi-professional by default

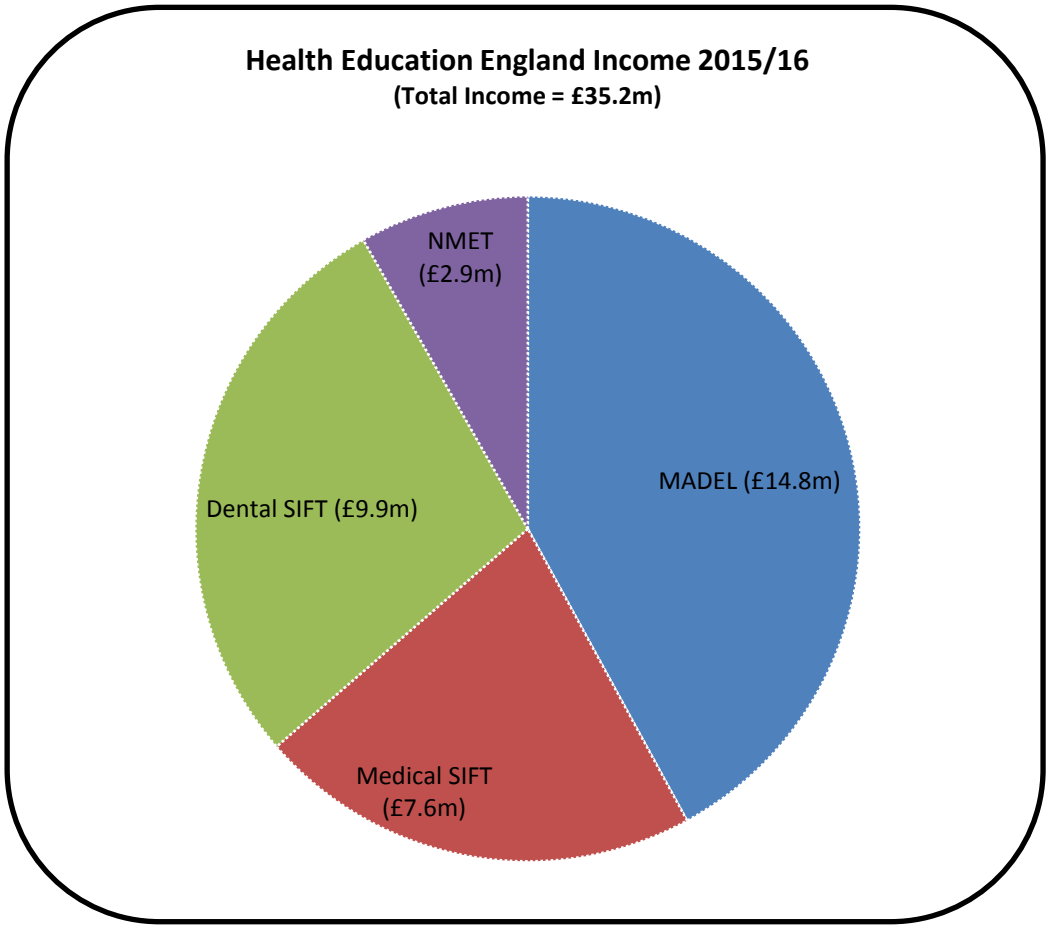
  We will use multi professional relationships, working and solutions as our standard way of learning, maximising opportunities for learning and problem solving as a team.

- Outcome 6 – Effective governance of high quality education, learning & development

  Education, learning and development will be governed with processes in place from ward to Board, including flow of information and KPIs reporting on the two audiences. This will contribute to the sound governance of the Trust and enhance our profile and reputation for education, learning and development.

APPENDIX 2

UH BRISTOL EDUCATION INCOME ALLOCATION 2015/16



Key to chart above:

MADEL	Medical and Dental Education Levy (Medical and Dental postgraduates)
SIFT	Service Increment for Teaching (Medical and Dental undergraduates)
NMET	Non-Medical Education and Training

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public to be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
15. Equality and Diversity Annual Report 2015/16									
Sponsor and Author(s)									
Sponsor: Alex Nestor, Acting Director of Workforce and Organisational Development **Author**: Teresa Sullivan, Interim Equality & Diversity Project Lead									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The Equality & Diversity Annual Report for 2015/2016 highlights successes during the past year, performance in regulatory areas, and the Trust's commitment to promoting a culture of inclusion for patients and staff through plans for the future, including the strategic objectives for 2016 - 2019.

The Equality & Diversity Sub-Group of the Workforce and OD Group are responsible for overseeing the production of the Annual Report. The report has also been presented to the Senior Leadership Team.

As part of the Trust's annual cycle of business, the Equality and Diversity Annual Report is now being presented to the Board for assurance that the Trust is discharging its responsibilities within the Equality Act, as part of which the Equality objectives have been reviewed and revised.

Following submission of this annual report, the Board received a presentation from Yvonne Coghill, NHS England Director, WRES (Workforce Race Equality Standard), outlining the priorities of WRES, following the commitments set out in the NHS Five Year Forward View.

The Board reviewed the UHB WRES data, local comparators and committed to focus on improving the WRES outcomes across the indicators within the WRES.

SLT, held on 20 July 2016, also supported this approach and have asked the E&D group to strengthen the 2016/17 strategic objectives to reflect this focus.

Key issues to note

The Board is asked to:

1. Note the contents of this report
2. Support the SLTs recommendation to strengthen the E&D strategic objectives for the WRES

Recommendations

The Board is recommended to receive the report for assurance prior to publication on the Trust's website.

Impact Upon Board Assurance Framework
Strategic Priority 3 : We will strive to employ the best staff and help all our staff fulfil their individual potential
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
The Equality & Diversity Annual Report supports the fulfilment of the Trust's duties under the Public Sector Equality Duties, in line with the Equality Act 2010.
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
26/07/2016				20/07/2016	WF&OD Group 11/07/2016

University Hospitals Bristol NHS
NHS Foundation Trust

Equality and Diversity Annual Report

2015 - 2016

1. INTRODUCTION

University Hospitals Bristol NHS Foundation Trust provides services to the socially and ethnically diverse population of Bristol, as well as to service users from our neighbouring counties, and specialist services for the wider south-west.

Each of our patients and members of staff is a unique individual with different needs and aspirations. The Trust aims to recognise and celebrate these differences by providing an environment which is inclusive for patients, carers, visitors and staff.

The Trust is fully committed to adherence to the Equality Act 2010, and undertaking action under the Public Sector Equality Duties (PSED) as defined within the Act. We are also eager to emulate the national focus as expressed in the NHS Five Year Forward Plan:

"*The Five Year Forward View sets out a direction of travel for the NHS – much of which depends on the health service embracing innovation, engaging and respecting staff, and drawing on the immense talent in our workforce.*

We know that care is far more likely to meet the needs of all the patients we're here to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination. These new mandatory standards will help NHS organisations to achieve these important goals."[1]

This Annual Report will highlight our successes during the past year, our performance in regulatory areas, and our commitment to promoting a culture of inclusion for patients and staff through our plans for the future.

2. BACKGROUND

The key areas of our legal and regulatory obligations are set out below.

Equality Act 2010 and the Public Sector Equality Duty (PSED)

The Equality Act 2010 replaced previous anti-discrimination laws with a single Act. It gives the NHS and its organisations opportunities to work towards eliminating discrimination and reducing inequalities in care. The Public Sector Equality Duty applies to public bodies and others carrying out public functions, and requires these organisations to publish information to show their compliance with the Equality Duty. The information (including strategic Equality & Diversity objectives) must show that the organisation has had due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between people who share a protected characteristic and people who do not;

[1] Simon Stevens, Chief Executive of NHS England

- foster good relations between people who share a protected characteristic and people who do not share it

The protected characteristics covered by the Equality Act and PSED are:
Age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race (including ethnic or national origins, colour or nationality
Religion or belief (including lack of belief)
Sex
Sexual orientation

The Trust's information in relation to its members of staff and its service users is published on the UH Bristol Website, and is included at Appendix A of this report.

Measures to improve equality

The Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard requires organisations to publish information against a number of indicators of workforce equality, and to demonstrate progress against them. The WRES highlights any differences between the experience and treatment of White staff and Black & Minority Ethnic (BME) staff in the NHS with a view to closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
The Trust published its first set of results in July 2015, which are available on the Trust's website.

The Equality Delivery System (EDS2)

The EDS2 is a toolkit which aims to help organisation improve the services they provide for their local communities and provide better working environments for all groups. There are four goals within the EDS2:

Goal 1 – Better Health Outcomes
Goal 2 – Improved Patient Access and Experience
Goal 3 – A Representative & Supported Workforce
Goal 4 – Inclusive Leadership

The goals are divided into eighteen outcomes. For most of these outcomes, the key question is "How well do people from protected groups fare, compared with people overall?"

The Trust is continuing with the extensive piece of work required to grade its performance against these goals and outcomes (and to have the self-assessment commented on by internal and external stakeholders.)

The Accessible Information Standard[2]

[2] SCCI1605 Accessible Information – the 'Accessible Information Standard' – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

During the last year**,** the Accessible Information Standard was developed in response to the requirements of the Equality Act 2010 to take steps or make "reasonable adjustments" in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled, and specific duties under the Care Act 2014 with regard to the provision of information - "Information and advice provided under this section must be accessible to, and proportionate to the needs of, those for whom it is being provided."

It is particularly relevant to individuals who are blind, people who are deaf, the Deaf community (whose first or preferred language is British Sign Language), individuals who are deafblind and/or who have a learning disability, although *it should support anyone* with information or communication needs relating to a disability, impairment or sensory loss.

The Standard was considered by the Trust's Equality and Diversity Group in September 2015, who recommended that views should be sought from the Trust's Service Delivery Group due to the potential impact on a significant number of Trust services, patients and potential impact on contract commitments.

A briefing paper was sent to the Trust Executive in December 2015 designed to give an overview of the Accessible Information Standard which must be fully introduced within all NHS Trusts by July 2016. The paper sought clarification from the Trust's Executives on initial project planning questions in order to ensure the broad remit of the standard is effectively implemented across all sites and services in UHBristol.

The Trust has included successful implementation of the AIS as one of its Quality Objectives for 2016/2017. An update on progress against this objective will be included in next year's report.

3. UPDATE ON EQUALITY ACTIONS

After many years of driving the Equality & Diversity agenda, the Trust's Equality & Diversity Lead moved on to another role within the Trust during the year. This and other changes in personnel have meant the Equality & Diversity Group agreed to realign some of its priorities.

The Trust's Senior Leadership Team agreed a revised action plan for 2015/16 which sets out the key programmes of work in progress or due to be undertaken and demonstrates the Trust's on-going commitment to elements of the extensive Equality & Diversity agenda. It supports major national and local equality and diversity needs such as the Equality Delivery System and the Workforce Race Equality Standard (WRES) as well as the Trust Staff Engagement agenda, and has been used to inform our revised strategic objectives for 2016 - 2019. The full Action plan, including our progress to date, is provided at Appendix B of this paper.

As part of the delivery of the Action plan, here are some examples of what we did -

Development of an online Equality & Diversity Training Programme

It was acknowledged that the existing on-line training needed to be refreshed and updated, so other externally provided packages were explored before a decision was reached to develop an in-house package.

A set of scenarios and questions were developed and tested with the Equality & Diversity Group in December 2015. Recommendations from the Group included a maximum time taken to complete the training (30 minutes), and a preference for more work-based scenarios. Amendments were made, and the slides were developed into an on-line tool in January 2016. Testing with a member of the Training Team indicated that a re-working would improve staff's experience of the training package. Revised deadlines for completion

of this work have been agreed by the Trust's Equality & Diversity Group and will go live in the autumn.

Benchmarking against other Trusts - learning from, and sharing, best practice where: disciplinary rates are similar and where apparently disproportionate disciplinary action by ethnicity or other protected characteristics is being tackled

Benchmarking and analysis of disciplinary outcomes by ethnicity was included in WRES Action Plan July 2015. A report was commissioned by the E&D Project Lead and completed in April 2016. The report includes benchmarking of last year's WRES data for this indicator and examines possible reasons for the disproportionate number of disciplinary cases involving BME staff, together with recommendations to address this. The report has been shared with the E&D Group and the Workforce & Organisational Development Group.

Review and refresh the Equality Objectives for the Trust to give us a clear, measurable framework for our activities.

The Trust's strategic Equality Objectives covered 2012-2014. Last year's E&D Annual Report said "A further set of objectives for 2015 – 2018 will be developed by the Trust's Equality & Diversity Group using evidence and key priorities from a range of sources including the Workforce Race Equality Standard, the 2014 Staff Survey results and the EDS2 self-assessment."

Revised objectives were developed and agreed by the E&D Group, and are included later in this report.

4. SOME SUCCESS STORIES for 2015 / 2016

The Trust is constantly striving to improve the outcomes and experience for all of our patients, carers and visitors as well as the working environment for our staff. Here are some examples of the wide range of initiatives being undertaken to create an inclusive and supportive environment for all, and support the Equality and Diversity regulatory duties.

Patients Living with Dementia

For those patients living with a Dementia, the Trust has engaged in several projects this year. The new build and refurbishment projects have helped improve the environment for patients, encompassing Dementia friendly aspects in all areas, including work within the out-patient departments. Increased patient engagement through the use of activity boxes has been successfully implemented in two ward areas, with plans to roll out boxes across the adult wards. We continue to support those who are carers for someone with Dementia, through the Dementia Support café and individual face to face contacts. The Trust is actively supporting a campaign to encourage open visiting for carers.

Disabled Children's Working Group / Bristol Parent Carers

The Disabled Children's Working Group includes health professionals and representatives from voluntary services, as well as parents of children with disabilities. It provides a resource for Trust level groups to consult in relation to policy, strategy and guidelines which may impact on children and young people with disabilities, and meetings include information sharing on service developments, wider healthcare agendas (including the Local Offer and changes resulting from the Children and Families Act), and reviewing feedback from patients and the public.

During 2015/16, the Group has supported the Trust in opening a Changing Space in the Bristol Royal Hospital for Children for young people using outpatients and held a training day for nursing staff on disability awareness. The group also repeated the popular 'You Said, We

Did' engagement event at At Bristol, to seek views and provide information to both regular users and local families with children with additional needs. Priorities for 2016/17 include working with Bristol City Council on Aim for the Stars, a self-assessment tool to ensure that services are SEND (Special Educational Needs and Disability) friendly.

The Group promotes and supports the work of the local parent carer support groups, including Bristol Parent Carer, Our Voice Counts (North Somerset) and South Gloucestershire Parents and Carers, who offer support to parents or guardians caring for a child with special needs, disabilities or a life limiting condition.

Staff Health & Wellbeing Initiatives

Over the past year, a significant volume of work has been undertaken to map and consolidate the wide range of workplace health and wellbeing initiatives in place and to ensure there are no barriers for any group or individual in accessing all available services. We are proud of our achievements in delivering inclusive wellbeing provision to staff, students and volunteers from across the Trust and we continue to actively build on this work. It is not possible to include all of the schemes the Trust has been involved in this year, so examples which link directly with two of the protected characteristics are given below.

Working During Pregnancy Workshops

Over 100 members of staff attended the three series of Workshops run between November 2014 and February 2016, with another series taking place between March and June 2016. The workshops provide pregnant workers with support to enable them to remain at work during pregnancy and provide a range of information and tips on pregnancy, maternity and childcare. Feedback from the Workshops included:

- Very helpful and speakers very nice
- Found it really useful – looking forward to the next 3.
- Really helpful to have chance to ask questions and get advice face to face. Thank you!
- Friendly atmosphere

Over 40s NHS Health Check

To complement the provision of free onsite health checks for all staff members who would like one, the Trust has also provided the opportunity for employees aged between 40 and 74 to have a free over 40s NHS health check with a Health Checks Outreach Worker onsite. The project started in April 2016, and some of the feedback is given below.

- A fantastic opportunity to do this at work. I would not have gone to my GP to have this done. Information was explained clearly to me and gave me a good insight into my own health. Thank you.
- I think this is a good routine for me to learn and understand - I want to try to become healthy.
- Useful to be able to have the health check at the workplace. GP practice doesn't offer.
- Very interesting and helpful. Made things easier having the Health Check in my workplace.

Raising Awareness of the Equality & Diversity Agenda

Following publication of the Snowy White Peaks of the NHS Report in October 2014, NHS England developed a set of measures designed to examine the composition of senior leadership teams, including Boards, across the NHS in England. The Standard also requires information to be published about the relative likelihood of Black & Minority Ethnic (BME) staff being appointed from the recruitment process and entering a formal disciplinary process, as well as Staff Survey findings detailed in a later section.

A well-received presentation to the Senior Leadership Team about Equality & Diversity at the Trust included a section on the experiences of staff from protected groups as reported in the National Staff Survey. Groups discussed how we continue to raise awareness of equality and diversity issues across the organisation, and suggested that Staff Champions should be identified.

Work with the local community

Work Experience & the Bristol Helping Young People into Employment (HYPE) Programme

The Trust's Work Experience programme has placed over 300 students from local schools and colleges across the Trust over the last year. All students are interviewed so that their personal aims for their placement can be fully understood, and to ensure their time with us is curriculum based, structured, and offers a wide range of activities across the Trust's many different healthcare settings.

As well as school career fairs, we have also attended several public careers fairs at local shopping centres and colleges in conjunction with Bristol City Council and The University of West England. This has provided the opportunity to not only promote the Trust to students but also to offer advice to our local community.

The last year has also seen a highly successful 'NHS Take Over Day' allowing young people from local schools to come into the Trust and shadow a range of staff from a number of professions, giving them insight into the NHS and the vast number of role opportunities on offer.

Through Skills for Health, a number of staff ambassadors have been trained how to share their profession / role with young people. As a 'Future You Industry Ambassador' this will empower us as a Trust to inspire, inform and support young people into science, technology, engineering and mathematics (STEM) based careers in industries such as life sciences and healthcare.

The Human Resources Service Centre team this year has actively supported the Bristol HYPE programme commissioned by Business West offering tailored work placement support to young people struggling to find employment. With personal support from Job Coaches, this has helped the individuals experience working in a team, some basic administrative duties and to gain some confidence in the responsibilities of having a job.

Volunteering at University Hospitals Bristol NHS Foundation Trust

Volunteering at University Hospitals Bristol NHS Foundation Trust is open to all people aged 17 and over. Volunteers take on a variety of roles supporting patients, staff and visitors, which include:

- Playroom volunteers in Bristol Royal Hospital for Children
- Ward befrienders and mealtimes volunteers on adult wards in the Bristol Royal Infirmary, Bristol Heart Institute and South Bristol Community Hospital,
- 'Meet & Greet' / Reception volunteers in the Bristol Royal Infirmary, Bristol Eye Hospital and Bristol Heart Institute
- Peer support volunteers in Cardiac Outpatients, SMART (Self-Management & Recovery Training) Recovery Group
- Information and patient support in the Cancer Information & Support Centre, Bristol Haematology and Oncology Centre.

Volunteers do not need to have any qualifications or work experience to apply; experience of providing care for a family member or having received healthcare services themselves can give volunteers valuable skills which they can bring into our hospitals.

Volunteers have been supported in various ways to enable them to access volunteering opportunities including interviewing in the presence of a support worker, arranging several visits to volunteering areas for a volunteer with autistic spectrum disorder, providing one to one training for a volunteer with physical disabilities, working with local charities and voluntary organisations to assist their peer support volunteers coming into the hospitals.

Bristol Zero Tolerance Pledge

Bristol Zero Tolerance is an initiative set up by Bristol Women's Commission working towards Bristol becoming a city free from gender-based violence, abuse, harassment and exploitation. Bristol is the first city in England to take on this challenge and, as a major employer in the city, the Trust is one of the organisations which has been asked to pledge its support to the initiative.

Organisations are asked to commit to taking at least one action to support this initiative. The pledge was signed by Sue Donaldson (Director of Workforce & OD), on behalf of the Trust, in July 2015. On 3rd May 2016, we renewed our pledge to the Bristol Zero Tolerance Initiative. In re-signing the Zero Tolerance Pledge, the Trust commits to continue to raise awareness of the issues facing victims of gender based violence and the support available to them.

5. PATIENT EXPERIENCE

The Patient Experience Group is the Trust's lead group in relation to the 'Patient Experience' element of the NHS model of Quality (i.e. Patient Safety, Patient Experience, Effectiveness and Outcomes). The core function of PEG is to drive implementation of the Trust's Patient Experience and Involvement Strategy and ensure that the Trust meets its 'duty to involve', as set out in Section 242 of the NHS Act 2006 - so that patients and service users are involved in certain decisions that affect the planning and delivery of NHS services if a service is changing from the service-user's perspective.

Improvements made in the last twelve months

The following examples are steps undertaken by the Trust to learn from patients and carers about how best to provide the services that they need.

- *Involvement Network* . The UH Bristol Involvement Network was established in October 2015 to offer an easy way for our diverse patient and carer groups to take part in conversations about how our services develop. The Involvement Network was instrumental in informing the Trust's priorities for the coming year.

- *STITCH - Services and Trusts Integrated to Transform Care in Self-Harm*. We continued to support this user led experience based co-design project working with patients who self-harm harm presenting in the BRI Emergency Department. There are quarterly steering group meetings: the service users/patients are delivering teaching to Emergency Department staff on self-harm. In addition, a new patient leaflet and personal support plans have been introduced.

- *Paediatric cardiac surgery.* Consultants and doctors have continued to work with families of children who have had cardiac surgery through our "Listening Events" to

fully understand their experience of the care they received and how improvements to that care can be made.

- *Cystic Fibrosis.* Patients with Cystic Fibrosis have been involved in decisions about changes to the ward environment and patient information.
-
- *South Bristol Community Hospital.* A community event took place at the South Bristol Community Hospital with ten local community based organisations in south Bristol as part of our work to promote health and well-being in this part of Bristol.

- *Children's Mental Health Liaison Project*. Service users and other stake holders have been involved in developing a mental health Liaison team for the children's Hospital (Children's Liaison Psychiatry Team).

- *Diverse Sex Development family meetings*. Ways in which families can become involved in shaping "Diverse Sex Development family meetings" to offer support to children who are born with one of a number of conditions that affect how the body is sex differentiated have been explored.

- *Adult Congenital Heart Disease.* An event took place for children aged 15+ to meet the Adult Congenital Heart Disease team as part our transition to adult services planning process.

- *Patient letters:* Patients and carers have been engaged in conversations about a review of the quality of correspondence patients receive from the Trust including appointment letters.

Looking ahead, during 2016/17 the Patient Experience Team will be:

- Engaging patients of no fixed abode who attend our Emergency Department and who are subsequently admitted to hospital in conversations about their care and discharge.
- Engaging families and carers of patients, and where appropriate patients themselves, in conversations about the end of life care for patients with dementia.
- Engaging service users of Dhek Bhal in conversations that will inform the Trust's Carers Strategy.
- With other local providers and NHS England we are investing in a Patient and Community Leadership Programme to develop a new approach to working collaboratively with patients about our plans for the future.

The Patient Experience Group also receives reports based on the findings of national and local patient surveys.

Monthly Inpatient Experience Surveys (2015-16)

A report presenting a breakdown of overall patient-reported care ratings by the protected characteristics collected in UH Bristol's monthly inpatient survey (age, sex, ethnicity, sexuality, religion, and disability) was presented to the Patient Experience Group in June 2016. Analysis performed by the Patient and Public Involvement Team aims to identify trends in the data to prompt further discussion about equality and diversity issues in the delivery of care at UH Bristol. The full report is included at Appendix D, and the key findings are outlined below.

The survey data shows that across all of the demographic variables considered, the proportion of patients rating UH Bristol's care as "excellent", "very good", or "good" is typically 95% and above.

Wherever possible, a further breakdown was carried out to show the percentage of respondents stating that their care was “excellent”. Although the data is less reliable when this is done (i.e. differences seen between groups are more likely to be due to chance), some interesting findings emerge. The following demographic groups are less likely to report their experience as being “excellent”:

- Women
- Black / Black British ethnic group
- Asian / Asian British ethnic group
- Older patients aged 87+
- Patients with a disability

The findings suggest that although overall satisfaction with care is generally high across all demographic groups, certain groups are less likely to report the very highest quality experience. The survey cannot identify the underlying reasons for this, but they are likely to reflect a complex mixture of demographic, health, cultural, personal-perception, and equalities factors.

Certain groups of patients tend to be under-represented in self-completed survey data (e.g. patients with cognitive impairments, communication difficulties, learning disabilities). Often these are the patients who would also tend to report more negative experiences of NHS care[3]. UH Bristol’s Patient Experience and Involvement Team has established links with a range of patient and community groups, and regularly supports Patient and Public Involvement activity with groups of patients who may not engage with surveys. Some examples during 2015/16 include:

- Patients who self-harm
- People in recovery for addictive behaviour
- People receiving palliative care
- Carers
- Patients with Learning Disabilities

Patient Complaints

In 2015/16 the Trust’s target was that the volume of complaints received should not exceed 0.21% of patient activity – in other words, that no more than approximately 1 in 500 patients would complain about our service. We achieved 0.25% compared to 0.26% in 2014/15.

Patients’ ethnicity, age, gender, religion and civil status are recorded on the Trust’s patient administration system, Medway and until 31st January 2016, this information was transferred across to the Ulysses Safeguard system, which is used to record all complaints. The Trust moved over to a new complaints system, Datix, on 1st February 2016 and the protected characteristics available to complete on Datix do not match those on Medway and this meant that we were unable to report on these protected characteristics in Quarter 4 of 2015/16. A solution to this is currently under investigation by Datix and the Trust’s Risk Management Team, although we are able to report here on the data gathered in Quarters 1, 2 and 3.

- Just over half the complainants were female (54%);
- 36% were aged 65 years or above;
- The overwhelming majority of people who complained, and whose ethnicity is recorded, were White British (70%);
- Of those whose religious status was recorded, just under 50% were Christian and 32% claimed to have no religious affiliation.

[3] For example see: http://www.cqc.org.uk/content/review-learning-disability-services-1

- 39% of those whose civil status was recorded were married or in a civil partnership and 28% were single.

The Patient Support and Complaints Team routinely asks for the patient's ethnic group, age and gender if this data is not available on Medway. In addition to English, the Trust's 'How can we help?' leaflet is available in several of the ethnic languages most commonly spoken by residents of Bristol, including Somalian, Chinese, Polish and Hindi.

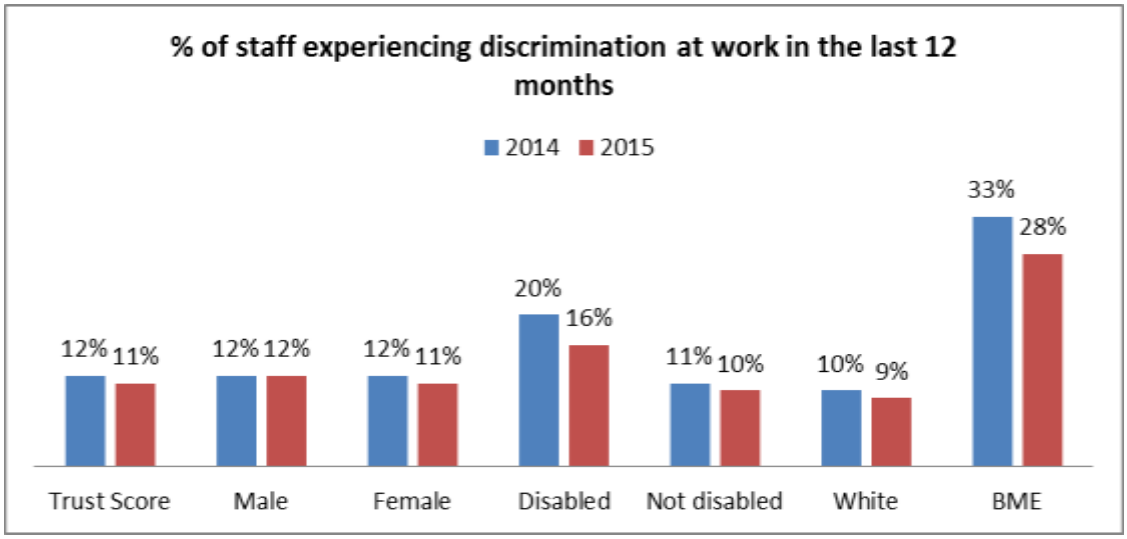
6. STAFF EXPERIENCE MEASURES

Staff Survey Results – Key Findings

The Annual National Staff Survey questionnaires were sent on a census basis to all substantively employed staff across University Hospitals Bristol NHS Foundation Trust and 3,625 staff responded – a response rate of 44%.

The Staff Survey included two Key Findings specifically relating to Equality and Diversity: The percentage of staff experiencing discrimination at work in the last 12 months (from patients, service users, managers and colleagues), and the percentage believing the organisation provides equal opportunities for career progression/promotion.

The graph below shows the results for the first of these findings, comparing 2015 and 2014 results.



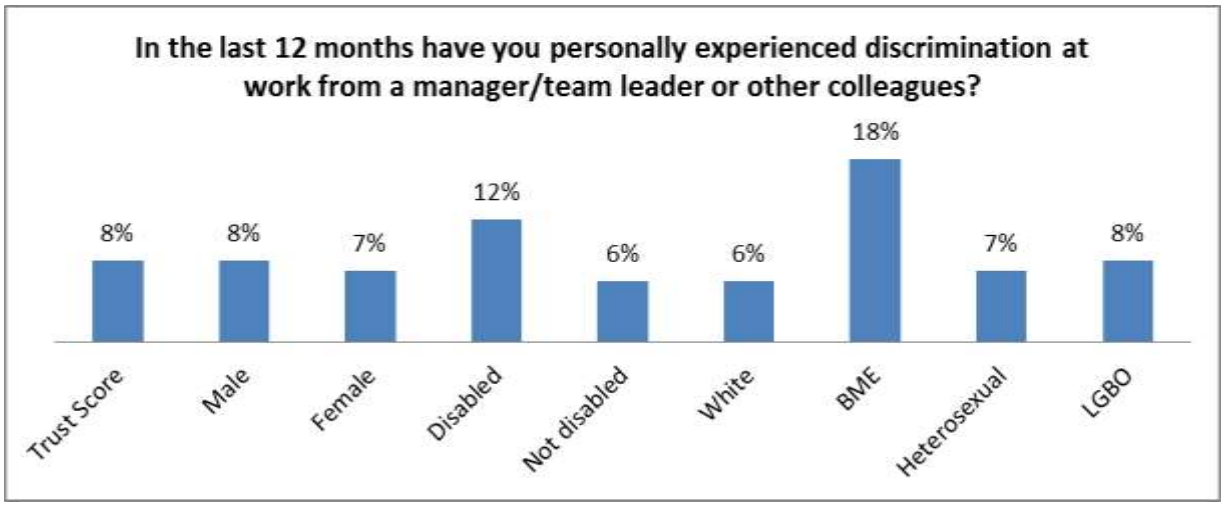
(The national average score for acute trusts in 2015 was 10%. The best score was 5%.)

Whilst the results show that there has been a small improvement since last year, and discrimination experienced by any of our staff is not acceptable, the levels of discrimination experienced by disabled and Black and Minority Ethnic staff are of greater concern.

The Trust aims to provide a working environment for staff which is free from harassment, bullying and discrimination. The Equality & Diversity Group is exploring how best to communicate our expectations of the behaviours associated with the Trust Value of Respecting Everyone to both staff and patients and service users.

Experience of discrimination from colleagues is highlighted by the response to another staff survey question – one which is also used as part of the Workforce Race Equality Standard. This graph shows the percentage of different groups which answered "Yes" to the question

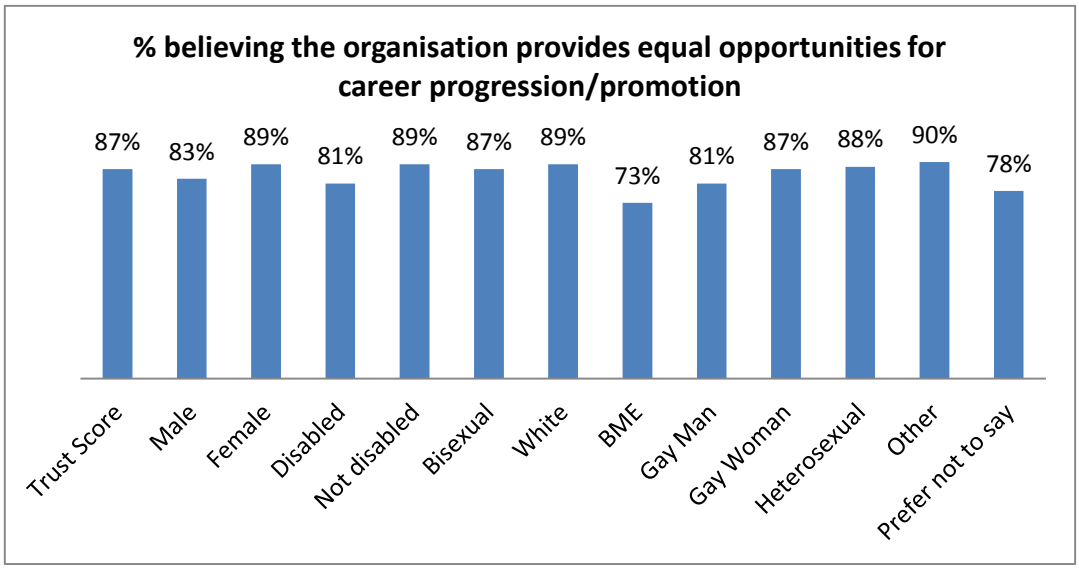
"In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?"



(Note: Transgender is not given as an option for identifying in the staff survey returns, hence LGBO (Lesbian, Gay, Bisexual, Other)

Divisional responses, as set out in actions from their Operating Plans, include work to encourage team-building and foster a culture of inclusion as one of the ways in which this is being addressed. The coming year will also see the reworking of the Trust's Tackling Bullying & Harassment at Work policy to place the emphasis on a culture of dignity and respect at work.

Also included in the measures for the Workforce Race Equality Standard is the comparison between White and BME staff who believe that the organisation provides equal opportunities for career progression or promotion. This key finding was also explored for staff in other protected characteristics:



The overall Trust score is comparable with the 2015 average for other acute trusts – also 87%. However, disabled staff and staff from BME backgrounds clearly perceive that there are more barriers to progression within the organisation.

The findings for BME staff are included in the Workforce Race Equality Standard Report, together with planned actions to address, including an audit from Audit south West of

recruitment practices and processes to identify any unconscious bias or barriers to employment or promotion within the Trust.

Provisions to support an equal playing field in succession planning and development programmes for potential future applicants from diverse backgrounds for Senior Manager and Board positions form part of the Trust's Equality & Diversity Action Plan. Part of the Trust's Workforce & OD Strategy is to ensure the Trust has a workforce which reflects the diversity of the community it serves at all levels of the organisation and across all staff groups. This is underpinned by an agenda focussed on Developing Leadership and Management Capability, and work will be undertaken to ensure that this agenda is fully committed to providing equal opportunities for staff from all protected groups.

Some of the key areas which have been identified as requiring improvement Trust-wide have also been examined to see how the feedback as expressed in the staff survey from staff in protected groups compared with the overall response.

The findings highlighted that the experience of disabled staff compares badly with staff from other groups. For example, scores for effective team working and motivation at work were markedly lower. The Trust will explore ways to further understand and improve the experience of disabled staff through Divisional Staff Engagement Plans and work with the Trust's Staff Forum for staff living and working with disability, illness or impairment (LAWDII).

In contrast, responses from gay men and staff from BME backgrounds indicate that they are more highly motivated than staff from other groups, and more satisfied with the quality of work and patient care they are able to deliver. (These are two of the key areas identified for improvement overall.)

Two areas in which the Trust scored most favourably compared with other acute trusts were the percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (Trust score was 13%, national average was 14%), and the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (Trust and national average 28%).
The percentage BME staff (19%) experiencing physical violence is noticeably higher.
The percentage of women (30%), disabled staff (34%) and BME staff (30%) experiencing harassment, bullying or abuse compares unfavourably with the Trust score.

And yet, BME staff are highly motivated and are more likely to recommend the Trust as a place to work or receive treatment (3.93 with 5 as the highest score) than their white colleagues (3.79).

These findings were presented to the Senior Leadership Team on 4th May, and provided some interesting insights into how staff experience differs. Other comparative scores from the National Staff Survey are included in the Trust's Annual Report and Quality Account.

Workforce Race Equality Standard (WRES) – 2015 Report

There are nine WRES indicators which are used to highlight any differences between the experiences of White staff and Black & Minority Ethnic staff in the NHS. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on Boards.
NHS organisations were required to submit and publish their first set of data last summer, together with their action plans outlining the practical approach needed to continuously improve their respective organisation with regard to workforce race equality.

The Trust successfully reported against all but one of the required metrics in July 2015. (The report and action plan, including progress against the actions, is included at Appendix C). Although some progress has been made against the agreed action plan - including a better understanding of possible reasons for the greater likelihood of BME staff entering the formal disciplinary process - several actions have not yet been followed to their conclusion.

A major barrier to assessing whether BME and White staff access non-mandatory training equally - and therefore whether steps are needed to address inequity of access - is the fact that although this training is recorded locally it needs to be added to the central Learning Management System to enable extraction and reporting against protected characteristics. Although reporting in the preferred format for Indicator 4 will not be possible again this year, it might be argued that the Staff Survey findings more accurately reflect staff experience of access to non-mandatory training.

Other planned actions (for Indicators 1 and 9 in particular) were also included in the Equality & Diversity Action Plan, progress against which is shown in Appendix B.

Workforce Race Equality Standard (WRES) – 2016 Report

The WRES is included in the 2016/17 NHS standard contract for NHS provider organisations and it also features in the new 2016/17 CCG Assessment and Improvement Framework.

The milestone date for organisations to report on their WRES data this year is 1st August 2016. Work is in progress to collate and report on the data for this year's report against the nine metrics which are indicators of workforce equality.

The information available for the indicators to be published this year shows little change in the make-up of the Trust's workforce. Although BME staff are still relatively more likely to enter the formal disciplinary process, the likelihood has decreased and actions have been suggested to further address this.

7. STAFF FORUMS

The Trust currently has three Staff Forums. The Lead for each Forum is a member of the Trust's Equality & Diversity Group, and they have contributed to this report.

Lesbian, Gay, Bisexual & Transgender (LGBT) Forum 2015-16

The forum is for Lesbian, Gay, Bisexual and Transgender members of Trust staff and supporters within UHBristol. We are a safe space for staff to discuss issues and assist in advising HR on staff policy relating to LGBT issues within the organisation.

The forum was founded in 2012 after the Pan-Avon LGBT forum disbanded. Over the last four years we have been building the number of staff attending steadily and advertise meetings via the Trust internal weekly news email. We feedback and work closely with HR on issues that affect our LGBT staff as well as working to promote equality within the Trust. Our Forum chair recently gave a well-received talk to the Trust Senior Leadership Team on his experience of working for the trust and the wider challenges LGBT face in the workplace.

Our aims for the next year are to continue to promote the forum and build attendance numbers at meeting by working with the other staff forums to produce a poster to be displayed around the trust about the staff forums available. We will be continuing to work with HR and the Equality & Diversity group over the next year to raise the profile of the forum and support staff across the trust. Through our forum we have been able to feedback good

patient experiences throughout the trust. We are also working towards a greater understanding of the issues faced by LGBT patients by assisting our staff though training available.

Black & Minority Ethnic Workers (BME) Forum 2015 -2016

The Black and minority ethnic workers (BME) Forum is a network of UH Bristol staff from multi-disciplinary backgrounds across the Trust. It endeavours to support, involve and develop its members of diverse cultural backgrounds to achieve their optimum professional levels within their work environment. The forum is open to all Black, Asian and Minority Ethnic workers within UH Bristol.

Last year was quite a challenging year for the BAME group, with a change of leadership and support as former members and colleagues moved on. However, the work of the forum continues and regular meetings have been scheduled throughout the year, and advertised through the Trust's weekly news email. In June 2015 two members of the BAME group attended the NHS BME Network Conference in London, which was a great success. The conference gave the opportunity to link up with BAME staff based in North Bristol Trust and it is hoped to work together in the near future.

The objectives for 2016-2017 are to develop strategies to encourage BAME staff to become more actively involved in forum meetings, including the re-design and re-launch of the BME Forum using leaflets and posters for distribution to BAME staff through different channels including Newsbeat, noticeboards and staff areas (and possibly made available at corporate inductions); and refresh the BAME page(s) on HR Web. We will also refresh the type and frequency of meetings, with three core group meetings per year and an Annual General Meeting. The Forum will also revisit the Reverse mentoring scheme.

Living & Working with Disability, Illness or Impairment (LAWDII)

The Trust LAWDII Forum (living and working with disability, illness or impairment) enables staff and volunteers with physical, sensory or mental impairments to raise awareness of any issues they may have encountered at work. The LAWDII Forum is made up of UH Bristol staff with visible and non-visible disabilities and impairments. The group was formed in 2015, and they meet on a regular basis to provide extra support to staff living and working with disability, injury or illness.

During the past year, the group has looked specifically at ways to enable staff with dyslexia to work to their full potential by providing aids such as reading rulers and coloured overlays. With the help of the Trust's Information Management &Technology department, members of staff can be offered a log-in screen in the colour which works best for each individual, and other ways in which information technology can help have been investigated.

During 2016-2017, LAWDII aims to raise its profile throughout the Trust, encouraging managers to become involved and holding another open session. It will also pursue the possibility of the installation of a software package designed to support members of staff with dyslexia.

8. PLANS FOR THE FUTURE

OUR EQUALITY & DIVERSITY STRATEGIC OBJECTIVES

The Trust's Strategic Equality & Diversity Objectives for 2016 – 2019 have been developed by the Trust's Equality & Diversity Group, informed by key priorities from a range of sources including the Workforce Race Equality Standard, the National Staff Survey results and the EDS2 self-assessment, and supported by the Equality & Diversity Action Plan.

It is vital that the objectives have an impact on the Trust's continuing commitment to improve both patient and staff experience. They must also be underpinned by deliverable action plans and be supported by the Senior Leadership of the Trust.

What are our objectives for 2016 – 2019?

To improve access to services for our local communities

This will be measured by:

Achievement of one of the Trust's Quality Objectives for 2016/17:
"To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted."

Completion of the EDS2 self-assessment. In particular the Better Health Outcomes and Improved Patient Access & Experience Goals, which will provide evidence of good practice and identify areas for improvement.

Completion of a review of the processes for patient monitoring data, seeking to reduce numbers of not declared/not known, and increase information collected for all protected characteristics. (Increased information will better able to Trust to provide services aligned to the needs of the local communities.)

To improve the opportunities for members of our diverse communities to gain employment with and progress within the Trust.

This will be measured by:

The outcomes and recommendations from reviews of the Trust's recruitment processes for potential unconscious bias, and the criteria for appointments - including ensuring executive search agencies are committed to diversity in their processes.

Benchmarking against other Trusts – learning from, and sharing, best practice where succession planning and development programmes are in place to support an equal playing field for potential future applicants for senior manager and Board positions from diverse backgrounds.

Reporting and analysing all staff training data.

Completion of the EDS2 self-assessment – Representative and Supported Workforce Goal, which will provide evidence of good practice and identify areas for improvement

To work towards a more inclusive and supportive working environment for all of our staff.

This will be measured by:

The results of the National Staff Survey.

Actions on recruitment and training information as above.

Completion of the EDS2 self-assessment – Representative and Supported Workforce Goal, which will provide evidence of good practice and identify areas for improvement.

Actions from Staff Engagement Action Plans – Trust-wide & Divisional, and the Workforce Race Equality Action Plan.

Development of a resource pack on Equality & Diversity for managers and leaders to access via HR Web.

Progress against all of the objectives will be reported to the Trust's Equality & Diversity Group and onwards to the Trust's Workforce & OD Group. Progress during 2016/17 will be reported in next year's Annual Report.

CONCLUSION

As described in the introduction, this report has highlighted some successes, the Trust's performance in regulatory areas, and out plans for continuing to promote a culture of inclusion.

A wide range of inclusion activities have been undertaken during the past year, and the amount of information gathered from formal and informal routes shows that the Trust is strengthening existing links and forging new ones with local communities and hard to reach groups. However, we still need to work towards a greater understanding of the barriers to providing excellent healthcare to all people with characteristics protected by the Equality Act 2010.

We have learnt from the results of the 2015 Staff Survey and the Workforce Race Equality Standard reporting that not all of our staff have an equally positive experience of working for the Trust, and this is something which we will continue to work to improve.

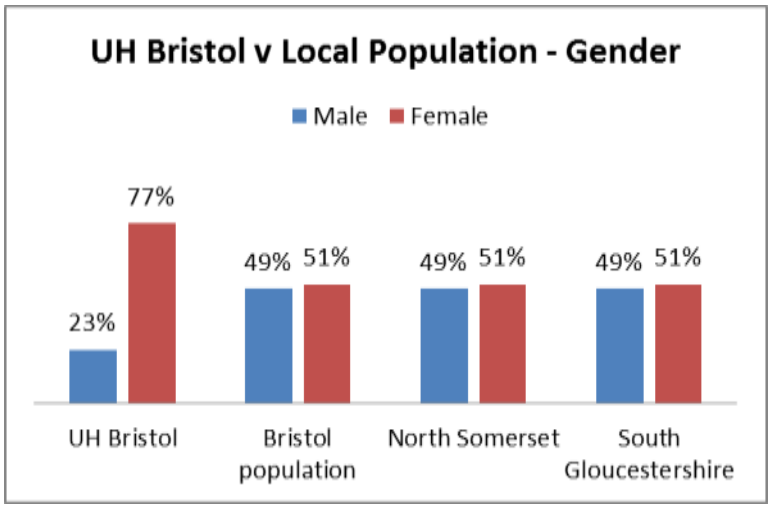
It is recognised that the Trust has made insufficient progress towards delivery of the EDS2, therefore a priority for the forthcoming year will be to complete the assessments for identified areas before rolling out the programme of assessment Trust-wide
We are confident that the work towards achievement of the revised strategic Equality & Diversity Objectives, underpinned by the Equality & Diversity Action Plan and the WRES Action Plan, will enable the Trust to ensure it continues to improve patient care and experience and to work towards a more inclusive and supported working environment for all of its staff.

Local Population, Workforce, and Patients – a snapshot

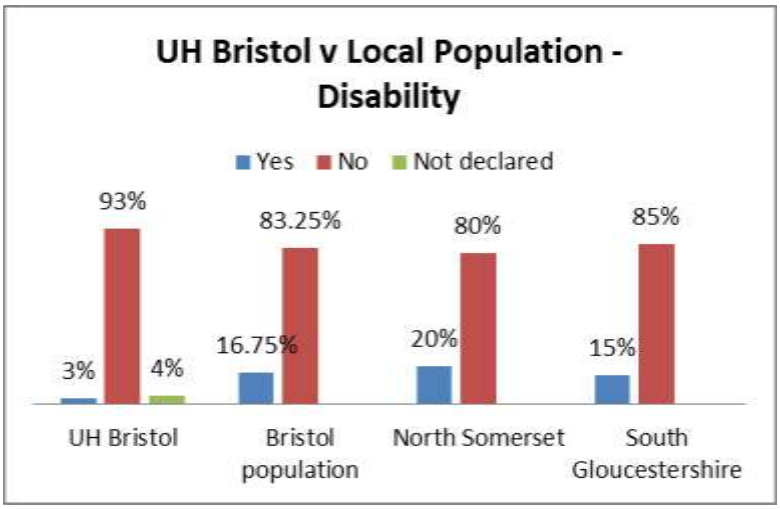
More detailed demographic breakdowns are included at Appendix A

Local Population

Sex: 77% of UH Bristol staff are female, compared with 51% of the local population (but note that it is usual for NHS organisations to have a higher proportion of female staff)

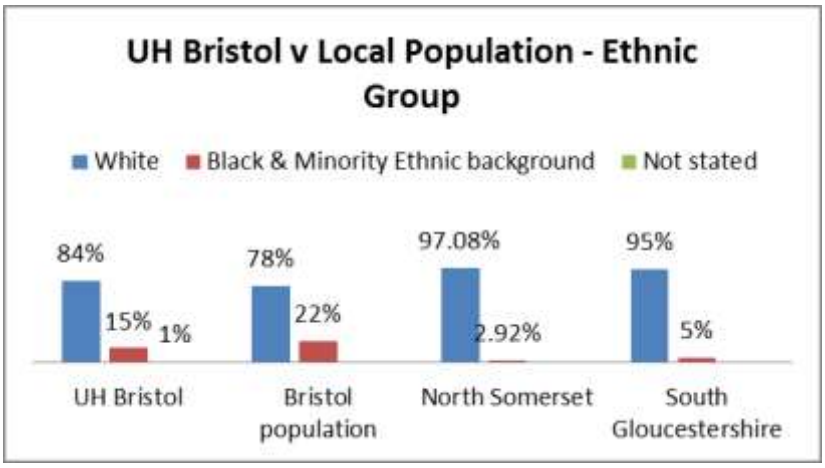


Disability: 3% of UH Bristol staff compared with 15 – 20% of local population

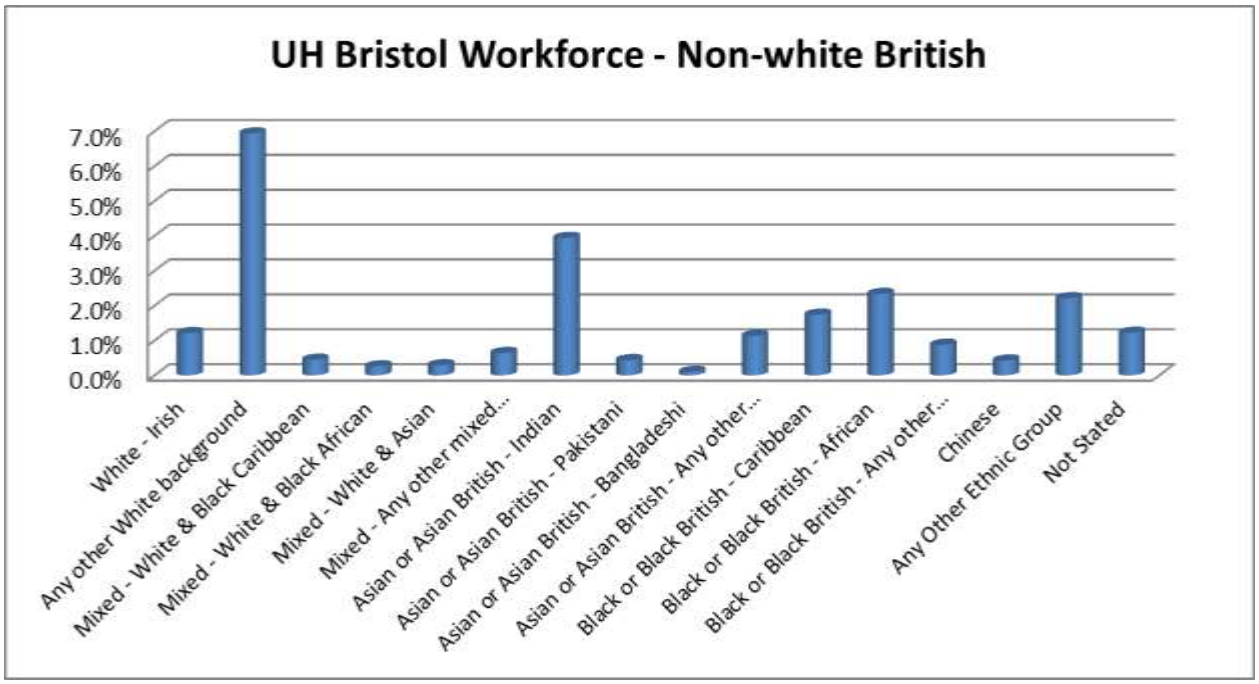


Race: 15% of UH Bristol staff are from a BME background, compared with 22% of the Bristol population

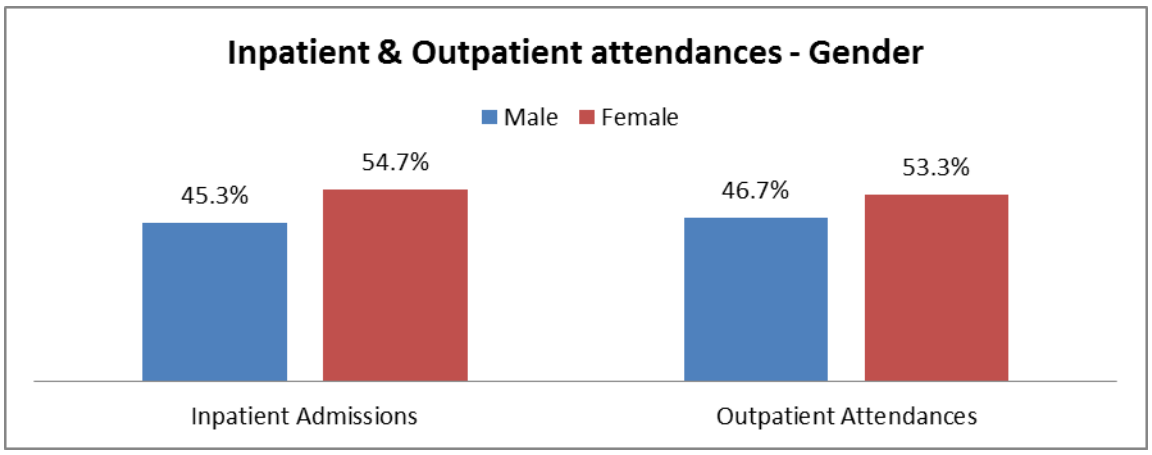
(76% of UH Bristol staff declare as White British)

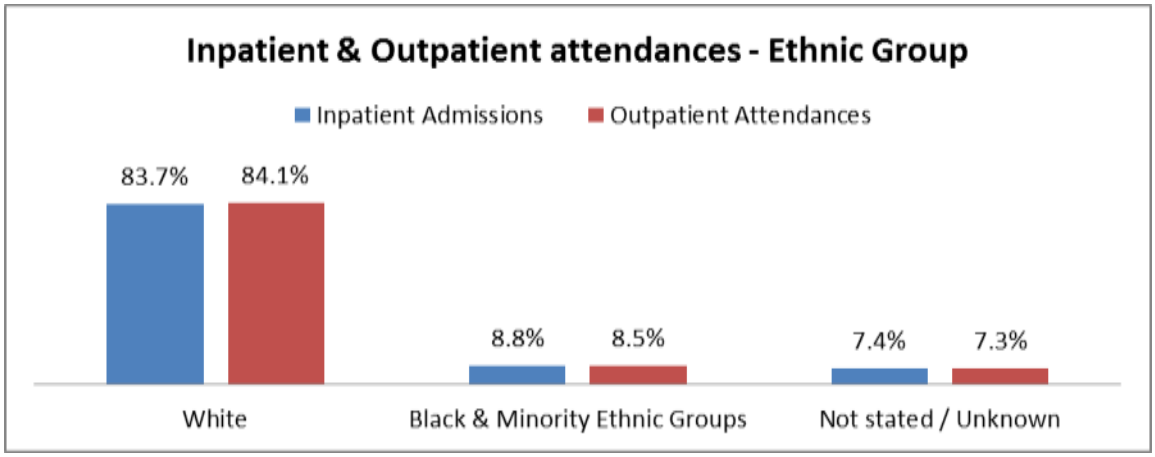


Our Workforce – Non-White British



Our patients and service users (data from January to December 2015)





Appendices

Appendix A UH Bristol Workforce Data

Appendix B UH Bristol Equality & Diversity Action Plan

Appendix C UH Bristol WRES Report and Action Plan 2015

Appendix D UH Bristol Inpatient Experience Survey Data

Acknowledgements

With thanks to colleagues across the Trust who have contributed to this report.

APPENDIX A

BACKGROUND EQUALITY DATA 2016

Equality legislation requires us to collect a range of pre and post-employment information, and information relating to patients accessing our services. The information below is an extract from the data which is available on the Trust's website. It is for the calendar year 1st January to 31st December 2015 unless otherwise stated.
In a change from previous reports, data for the previous year (in this case 2014) is included in the tables for information.

Staff in post (all substantive staff)

Age band	Headcount 31 December 2014	Headcount 31 December 2015	Proportion of Headcount December 2014	Proportion of Headcount December 2015
16 – 20	65	94	0.76%	1.06%
21 – 25	786	861	9.17%	9.67%
26 – 30	1,237	1,284	14.44%	14.42%
31 – 35	1,260	1,289	14.70%	14.47%
36 – 40	1,110	1,172	12.95%	13.16%
41 – 45	997	1,054	11.63%	11.83%
46 – 50	1,036	989	12.09%	11.10%
51 – 55	987	1,028	11.52%	11.54%
56 – 60	718	761	8.38%	8.54%
61 – 65	291	295	3.40%	3.31%
66 - 70	67	62	0.78%	0.70%
71 - 77	15	18	0.18%	0.20%
Grand Total	**8,569**	**8,907**	**100.00%**	**100.00%**

Disability	Headcount December 2014	Headcount December 2015	Proportion of Headcount December 2014	Proportion of Headcount December 2015
No	8,036	8,291	93.78%	93.08%
Not Declared	281	363	3.28%	4.08%
Yes	252	253	2.94%	2.84%
Grand Total	**8,569**	**8,907**	**100.00%**	**100.00%**

Gender	Headcount December 2014	Headcount December 2015	Proportion of Headcount December 2014	Proportion of Headcount December 2015
Female	6,646	6,896	77.56%	77.42%
Male	1,923	2,011	22.44%	22.58%
Grand Total	**8,569**	**8,907**	**100.00%**	**100.00%**

Ethnicity	Headcount December 2014	Headcount December 2015	Proportion of Headcount December 2014	Proportion of Headcount December 2015
White	7,269	7,476	84.82%	83.93%
Black & Minority Ethnic Groups	1,262	1,322	14.72%	14.84%
Not Stated	38	109	0.44%	1.22%
Grand Total	**8,569**	**8,907**	**100.00%**	

Religious Belief	Headcount December 2014	Headcount December 2015	Proportion of Headcount December 2014	Proportion of Headcount December 2015
Atheism	939	1,088	10.96%	12.22%
Buddhism	49	47	0.57%	0.53%
Christianity	3,493	3,542	40.76%	39.77%
Hinduism	84	102	0.98%	1.15%
Islam	143	155	1.67%	1.74%
Jainism	2	3	0.02%	0.03%
Judaism	10	6	0.12%	0.07%
Sikhism	18	18	0.21%	0.20%
Other	499	523	5.82%	5.87%
I do not wish to disclose my religion/belief	3,332	3,391	38.88%	38.07%
Undefined	0	32	0.00%	0.36%

Sexual Orientation	Headcount December 2014	Headcount December 2015	Proportion of Headcount December 2014	Proportion of Headcount December 2015
Bisexual	30	37	0.35%	0.42%
Gay	47	54	0.55%	0.61%
Heterosexual	5,567	5,981	64.97%	67.15%
Lesbian	34	35	0.40%	0.39%
I do not wish to disclose my sexual orientation	2,891	2,770	33.74%	31.10%
Undefined	0	30	0.00%	0.34%

Employee Relations Cases – reported formally under the Trust policy and recorded on the Case Management System

Harassment & Bullying Cases (reported formally under the Trust policy)

Gender	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
Female	20	16	77%	76%
Male	5	1	19%	5%
Group		1		5%
Not reported	1	1	4%	5%
Grand Total	**26**	**21**		

Disability	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
Yes	4	1	15%	5%
No	19	17	73%	81%
Group		1		5%
Not Declared/reported	3	2	12%	10%
Grand Total	**26**	**21**		

Ethnic Background	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
White	17	17	65%	81%
Black & Minority Ethnic background	7	6	27%	29%
Not Stated / not reported	2		8%	
Grand Total	**26**	**21**		

Grievance Cases (reported formally under the Trust policy)

Gender	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
Female	12	11	50%	65%
Male	9	6	37%	35%
Group	3		13%	
Grand Total	**24**	**17**		

Disability	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
Yes	4	2	16%	12%
No	17	15	71%	88%
Not Declared/Not reported/Group	3		12%	
Grand Total		**17**		

Ethnic Background	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
White	16	11	67%	65%
Black & Minority Ethnic background	5	6	21%	35%
Not Stated/Not reported/Group	3		12%	
Grand Total	**24**	**17**		

Disciplinary Cases (reported formally under the Trust policy)

Gender	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
Female	103	75	58%	60%
Male	75	50	42%	40%
Group	1		0%	
Grand Total	**179**	**125**		

Disability	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
Yes	11	3	6%	2%
No	154	118	86%	94%
Not Declared/Not reported/Group	14	4	8%	3%
Grand Total	**179**	**125**		

Ethnic Background	Number of cases Jan-Dec 2014	Number of cases Jan-Dec 2015	Proportion of cases 2014	Proportion of cases 2015
White	106	84	59%	67%
Black & Minority Ethnic background	72	41	40%	33%
Not Stated	1		1%	
Grand Total	**179**	**125**		

University Hospitals Bristol NHS
NHS Foundation Trust

UH Bristol Equality and Diversity Action Plan - Updated June 2016

Planned Actions *(Including remedial actions where discussed and agreed at June 2016 E&D Group)*	**Proposed Timescale** *(including revised timescales where agreed by E&D Group – June 2016*	**Facilitator**	**Comments /Progress** **As at June 2016**
TRAINING			
Development of an online Equality and Diversity Training Programme Programme written and benchmarked against best practice Programme uploaded and tested with user groups Programme rolled out *Remedial actions agreed by E&D Group – June 2016* *E&D Project Lead to produce revised draft* *Update of on-line tool* *Programme uploaded and tested with user groups* *Programme rolled out*	October 2015 November 2015 December 2015 *June 2016* *June/July 2016* *July/August 2016* *Autumn 2016*	Head of Reward (Equality & Diversity Project Lead - from March 2016)	To be carried out as part of the development and benchmarking of training in E&D. E-learning package written & tested with E&D Group December 2015. Slides developed into e-learning tool by the Teaching and Learning team January 2016. Feedback from the Training Team received which requires amendments to the package. Progress delayed – estimated date of uploading and rollout adjusted to Autumn 2016.
Develop resource pack on Equality and Diversity for managers and leaders to access via HR Web *Remedial actions agreed by E&D Group – June 2016* *Chairs of the three staff forums represented on the E&D Group undertake to review & make suggestions for updated content on the relevant pages/sub-pages of HR Web – including identifying what additional guidance would be of help*	December 2015 *June 2016*	Head of Reward (Equality & Diversity Project Lead - from March 2016)	E&D Group reviewing HR web pages. Recommendations and suggestions for updated content awaited. Progress delayed – estimated date of completion adjusted to September 2016.

E&D Project Lead to review and make suggestions for updated content on the other E&D pages/sub-pages of HR Web *Members of the E&D Group to investigate relevant additional information to add to the resource* *Content updated and refreshed pages publicised*	*July2016* *September/Oct 2016*		
Devise and run training and briefings/seminars for the Senior Leadership Team and Trust Board on 'Unconscious Bias' in recruitment (both internal and external) *Remedial actions agreed by E&D Group – June 2016* *Engage senior colleagues involved in recruitment in the discussion, so that there is greater understanding* *Engage senior colleagues involved in training in the discussion, to find out what is included in training for recruiting managers/resourcing staff, and what could be included about unconscious bias* *Follow up opportunity to deliver unconscious bias training to SLT – establish potential date and provider*	January 2016 *September 2016* *September 2016* *Oct – Dec 2016*	External Consultant/Director of Workforce and OD/Head of Service Centre	Equality Lead for NHS England & Director, Workforce Race Equality Standard scheduled to speak at Board Seminar in July 2016.
Development of a robust Trust wide system for collecting and analysing essential and non mandatory training data *Remedial actions agreed by E&D Group – June 2016* *E&D Project Lead to follow up outcome of initial meeting, agree on requirements and explore possible timeframes for implementation* *Head of Developing People Capability to add to the departmental risk register*	March 2016 *June – Oct 2016*	Assistant Director of Teaching and Learning/Head of Reward	Meeting held with HRIS Systems Development Manager to explore provision of data through existing system February 2016. Further definition of reports required needs to be supplied by E&D Project Lead. Progress delayed – estimated date of availability of essential training data adjusted to September 2016.

STAFF EXPERIENCE			
Review the Trust's recruitment processes for potential unconscious bias *Remedial actions agreed by E&D Group – June 2016:* *Revised timeframe is dependent on timing of delivery of Audit report* *Following delivery of the Audit report, the relevant actions within it are used to inform an update to this Action Plan* *Engage senior colleagues involved in Recruitment in the discussion, so that there is greater understanding*	October 2015 October 2016	Head of Service Centre	Audit South West undertaking an audit of Trust recruitment procedures – awaiting audit report
Review criteria for appointments including ensuring executive search agencies are committed to diversity in their processes *Remedial actions agreed by E&D Group – June 2016* *Engage senior colleagues involved in Recruitment in the discussion, so that there is greater understanding* *Discuss revised timeframe with Head of Service Centre*	October 2015 *December 2016*	Head of Service Centre	Review of WRES and Staff Survey data to inform this work.
Benchmarking against other Trusts - learning from, and sharing, best practice where : (i) disciplinary rates are similar and where apparently disproportionate disciplinary action by ethnicity or other protected characteristics is being tackled *The E&D Group agreed that the WRES Disciplinary report completes the first part of this action, and that other actions should be developed from the recommendations therein* (ii) succession planning and development programmes are in place to support an equal playing field for potential future applicants for Senior Manager and Board positions from diverse backgrounds.	November 2015	Head of Service Centre/Head of Reward /Assistant Director of Teaching and Learning (And Equality & Diversity Project Lead - from March 2016)	To be undertaken in partnership with staff side and E&D Sub Group membership. Data being gathered. *Benchmarking & analysis of disciplinary outcomes by ethnicity included in WRES Action Plan July 2015. Report completed April 2016 to be shared with E&D Group May 2016. Recommended actions to follow* Succession planning forms part

The E&D Group recommended that this should be taken into consideration as part of any Retention and Appraisal plans, and that identifying future leaders and succession planning should be integral to Workforce Plans and Divisional Business Continuity plans.			of Teaching and Learning 5 year Framework.
PATIENT EXPERIENCE			
Review processes for patient monitoring data seeking to reduce numbers of 'not declared/no known and increase information collected for all protected characteristics	July 2015	Director of IM&T/Deputy Chief Nurse/Head of Reward	E&D lead co-ordinating Diamond cluster approach on monitoring information. NOTE – this needs to be revisited
EQUALITY DELIVERY SYSTEM (EDS2)			
Completion of the EDS2 self-assessment and action plan *Remedial actions agreed by E&D Group – June 2016* *Divisional Operating Plans are examined to find out what actions are included to take the EDS2 forward. Also to establish the reporting mechanisms so that progress can be made.* *E&D Lead to revisit the work done on the pilot areas (Maternity Services & Radiology) so far and move them on to completion.* *E&D Project Lead to take stock of progress to date & complete the action plan (including all deadlines)* *Request a workshop session for the Staff Engagement Leadership Group to discuss & contribute to the self assessment of the outcomes for Goal 4 – Inclusive Leadership*	June 2015 *May/June 2016* *May/June 2016* *June/July 2016* *Sept - December 2016*	Head of Reward (Equality & Diversity Project Lead - from March 2016)	Self-assessment commenced but not completed due to incomplete information. Assessment being undertaken in Radiology and Maternity Services initially to then inform other divisions (see below) *Assessments being undertaken in Medicine* *Progress delayed. Estimated revised date of completion September 2016.*
Implementation of the EDS2 action plan *To follow completion of the pilot, with appropriately revised timeframes.*	October 2015 *Progress delayed. Estimated revised date of completion December*	Deputy Director of Workforce and OD/Head of Reward	Commenced pilot in two clinical areas (radiology and maternity services) to then inform Divisions.

	2016.		
Develop training and additional support for managers on EDS2 *To follow completion of the pilot, with appropriately revised timeframes*	December 2015 – January 2016	Head of Reward	To follow EDS2 pilot
Review the Trust's processes for undertaking and completing equality analysis. *Actions agreed by E&D Group – June 2016* *Benchmark against other trusts & recommend that best practice be adopted* *Obtain agreement & support from Equality & Diversity Group and Workforce & OD Group*	Ongoing *September 2016* *December 2016*	Head of Reward /Trust Secretary	*Estimated revised date of completion December 2016.*
Review and refresh the Equality Objectives for the Trust to give us a clear, measurable framework for our activities. *Suggested revised objectives discussed and agreed at June E&D Group.*	Annual review	Head of Reward	Completed
Devise a comprehensive Communications plan for the remainder of the financial year for both internal and external communications for EDS2. *Suggested remedial action:* *That this element of the Plan is revisited at a time when it is clear what will be included in such a communication plan.*	Ongoing *January 2017*	Head of Communications/Head of Reward	To follow EDS2 pilot
GOVERNANCE			
Develop and implement an integrated Equality and Diversity Strategy for service users and the Trust workforce. *Suggested remedial action not discussed at E&D Group June 2016:*	December 2016	Head of Reward	Review of Equality, Diversity & Human Rights Policy completed January 2016. *Clarification about the nature of*

To reword this action to clarify its aims: *"To ensure the Trust is fulfilling its obligation under the PSED, as exemplified by compliance with the requirements of the WRES, EDS2, AIS and other regulatory requirements."*			*the Integrated Strategy needed before one can be developed.*
MONITORING			
Design of, and agreement for, an Equal Pay Audit to be implemented across all staff groups	September 2016	Head of Reward /Assistant Director of Finance (Payroll Services)	Equal pay audit being undertaken by Audit South West

APPENDIX C

Workforce Race Equality Standard – Data and Progress against plan (Reported 2015)

Please note that the periods the workforce data refers to for the report published in July 2015 are Staff in post as at 31st December 2014; Disciplinary data from calendar years 2013 and 2014. Staff Survey data is from the 2014 national Staff Survey

For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.

1	**Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce**				
	Data for reporting year	*Data for previous year*	*Narrative*	*Action taken and planned*	*Progress against planned actions*
	4.1% BME of 409 staff in Bands 8-9 and VSM. 14.7% BME in overall workforce.	Not previously reported. 15.25% BME in overall workforce	Number of staff in senior roles does not reflect the diversity of the workforce.	Planned actions: • provide unconscious bias training • Audit Southwest review of recruitment process (part of E&D Action Plan) Review recruitment processes including advertising of non-executive posts	Progress against planned actions: Invitation extended to Yvonne Coghill to run session at July Board Seminar Audit Southwest report commissioned. Report due May/June 2016. Action outstanding – see E&D action plan
2	**Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts**				
	Data for reporting year	*Data for previous year*	*Narrative*	*Action taken and planned*	*Progress against planned actions*
	White staff 1.85 times more likely to be appointed from shortlisting than BME staff.	Not previously analysed.	Improved comparative data for 2014, whereas not able to compare previously	Planned actions: as above	As above.
3	**Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*** ***Note: this indicator will be based on data from a two year rolling average of the current year and the previous year**				
	Data for reporting	*Data for previous*	*Narrative*	*Action taken and planned*	*Progress against planned actions*

	year	*year*			
	3.6 times greater in 2014	2.8 times greater in 2013	Information shared with Trust Industrial Relations Group	Planned actions: • Undertake benchmarking with other trusts as part of Action Plan Scrutinise further for areas of disaggregation	Benchmarking & scrutiny included in report completed April 2016. Submitted to E&D Group for discussion and recommended actions May 2016 and WF&OD Group July 2016.
4	**Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff**				
	Data for reporting year	***Data for previous year***	***Narrative***	***Action taken and planned***	***Progress against planned actions***
	Data not available	***Data not available***	*Data is available from the 2014 National Staff Survey, which was conducted on a full census basis. (47% response rate.)*	***Planned action: Recording of data part of 2015 Action Plan***	*Delay in progress on reporting all training.*

	KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months				
	Data for reporting year	***Data for previous year***	***Narrative***	***Action taken and planned***	***Progress against planned actions***
	White 30% *BME 32%*	*White 28%* *BME 26%*	***Data for 2014 is from a full census survey (3,641 staff responded).*** ***Data for 2013 is from a sample survey. (439 of 850 staff responded)***	***Actions to tackle harassment & bullying form part of the Trust's Staff Engagement Action Plan***	*Recruitment campaign for additional H&B Advisors carried out autumn 2015. Revised Policy approved February 2016. To be reviewed within one year to ensure shift of focus towards values-based behaviours*

	KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months				
	Data for reporting year	***Data for previous year***	***Narrative***	***Action taken and planned***	***Progress against planned actions***
	White 26% BME 40%	White 26% BME 37%	**As above**	**As above**	*As above*
	KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion				
	Data for reporting year	***Data for previous year***	***Narrative***	***Action taken and planned***	***Progress against planned actions***

	White 90% BME 63%	White 91% BME 73	**As above**	***Planned actions:*** • ***Audit of internal promotion and recruitment process*** • ***All training information to be recorded for access opportunities*** • ***Further Reverse Mentoring programme***	Audit Southwest report commissioned. Report due May/June 2016. *Delay in progress on reporting on all training.*

	Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues				
	Data for reporting year	***Data for previous year***	***Narrative***	***Action taken and planned***	***Progress against planned actions***
	White 7% BME 22%	White 9% BME 24%	**Full census staff survey provided more complete data to enable better understanding**	**Planned actions:** • **Staff Engagement Action Plan** **Review all incident reports for better understanding**	*Full census survey conducted again in 2015 shows improved experience in this area for BME staff.* *Introduction of refreshed E&D training and other awareness training December 2016.*

9	Boards are expected to be broadly representative of the population they serve				
	Data for reporting year	***Data for previous year***	***Narrative***	***Action taken and planned***	***Progress against planned actions***
	Of the members of the Board who have declared their ethnicity, all describe themselves as White	Not previously reported	Board is not broadly representative of the workforce which has 14.7% BAME staff; neither is it representative of the local population	**Planned actions:** • **Review criteria for appointments ensuring executive search agencies are committed to diversity (part of the Trust E&D Action Plan)** **Work with the Membership Office to review diversity of Governors**	*Progress delayed. Remedial action in revised E&D action plan.*

Appendix D

Demographic analysis of UH Bristol's monthly inpatient survey (2015-16)

1. Purpose of this report

This report presents a breakdown of overall patient-reported care ratings by the demographic variables collected in UH Bristol's monthly inpatient survey (age, sex, ethnicity, sexuality, religion, and disability). A similar report was produced for the Patient Experience Group in 2014/15[4]. The analysis aims to identify trends in the data to generate further discussion about equality and diversity issues in the delivery of care at UH Bristol. Due to the complexity of the issues being considered in this report, and the fact that it draws on data from a survey this is not designed to measure these factors, the report cannot be used to *prove* whether differences exist between demographic groups. Further information about the data used in this report can be found in the Appendices.

2. Key findings

- Across all of the demographic variables that are considered in this report, the proportion of patients rating UH Bristol's care as "excellent", "very good", or "good" is typically 95% and above.
- Wherever possible, a further breakdown is provided to show the percentage of respondents stating that their care was "excellent". The following demographic groups are less likely to report their care as being "excellent" (to a statistically significant degree):
    - Women (Chart 1)
    - Black / Black British ethnic group (Chart 2)
    - Asian / Asian British ethnic group (Chart 2)
    - Older patients aged 87+ (Chart 3)
    - Patients with a disability (Chart 4)
- These findings suggest that although overall satisfaction with care is generally high across all demographic groups, certain groups are less likely to report the very highest quality experience. The survey cannot identify the underlying reasons for this, or determine whether the effects are "real" or an artefact of some other underlying factor.
- The trends seen at UH Bristol broadly mirror those at a national level[5], with two notable exceptions:
    - Nationally, the lowest satisfaction rates are among young adults and the oldest age groups – which is broadly true, though less marked, at UH Bristol. However, at a national level the older age groups still report relatively high satisfaction. At UH Bristol patients aged 87 and over are the least likely of all age groups to rate their care as "excellent".
    - At a national level the Black / Black British ethnic group have similar satisfaction levels to White British patients, but at UH Bristol the former are significantly less likely to rate the care as excellent.

[4] During 2014-15 additional demographic questions were added to the Trust's inpatient questionnaire. Previously only demographics held on Medway could be analysed.

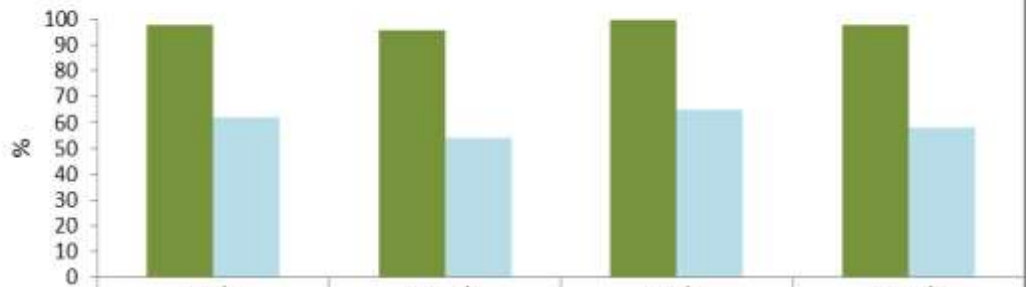
[5] See http://www.pickereurope.org/wp-content/uploads/2014/10/Multi-level-analysis-of-inpatient-experience.pdf

3. Overall inpatient care ratings by demographic group

Sex

Females are less likely to rate their care as "excellent" than males. The reasons for this are unclear, but it is in line with trends seen at a national level. The satisfaction scores in 2014-15 are essentially the same as in 2015-16, when margins of error in the data are taken into account.

Chart 1: overall care rating by sex (all data are percentages)

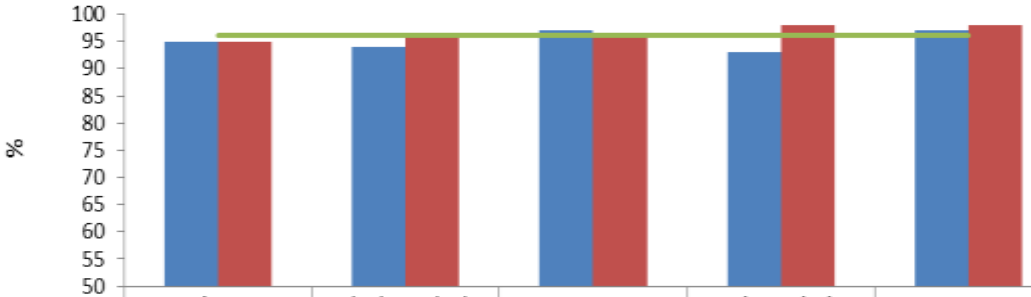


	Male 2014-15	Female 2014-15	Male 2015-16	Female 2015-16
% Excellent, very good, good	98	96	100	98
% Excellent	62	54	65	58

Ethnicity

None of the differences shown in Chart 2 reach statistical significance, therefore any variations seen should be considered a result of chance fluctuation in the data. However, Table 2 (over) shows the proportion of patients rating the care as "excellent", and here we do find significantly lower ratings from Black / Black British and Asian / Asian British groups. Chart 3 shows that, at a national level, Asian / Asian British patients also give less positive ratings. However, this is not the case for Black / Black British patients nationally where the scores are broadly in line with White British patients.

Chart 2: Inpatients rating their care as excellent, very good or good by ethnic group

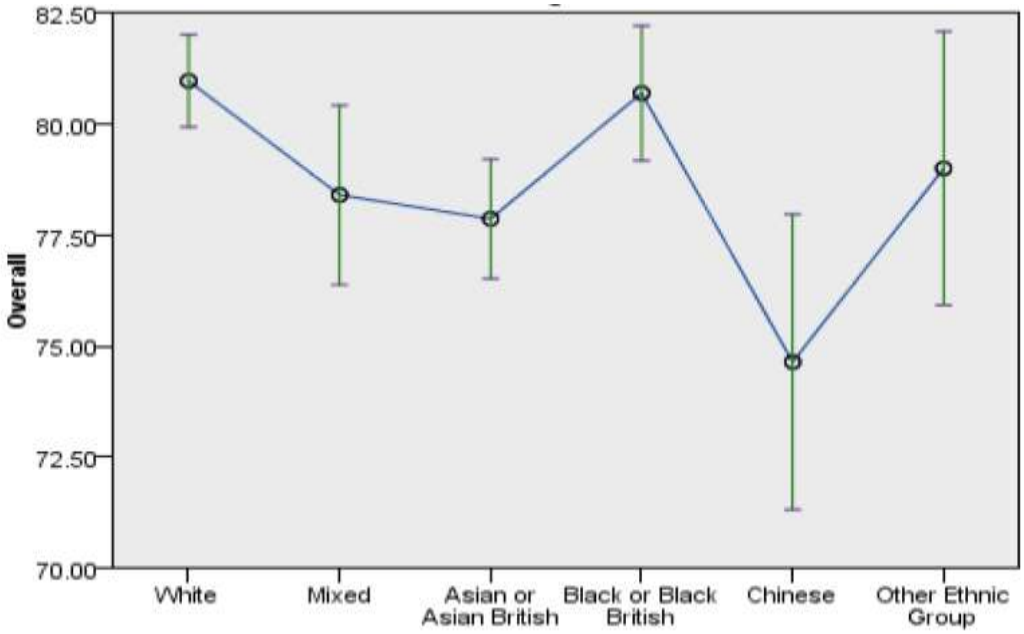


	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White
2014-15	95	94	97	93	97
2015-16	95	96	96	98	98
Average (mean)	96	96	96	96	96

Table 1: percentage of respondents rating the care as "excellent"

	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White
2014-15	47%	42%	53%	58%	60%
2015-16	51%	43%	65%	55%	62%

Chart 3: National-level patient satisfaction by ethnic group



Source: Picker Institute Europe (please note that the scoring system is not directly comparable to the one used in Chart 2 and Table 1. Also, there are insufficient responses in the UH Bristol survey to break the data down in to all of the groups shown in the Picker data)

Age

The care ratings shown in Chart 4 (over) also broadly correspond to trends seen at a national level (Chart 5), with scores steadily increasing with age and then dipping back again for the very oldest patients. Interestingly our data shows that 12-16 year olds buck this trend (the national surveys only collect data for patients aged 16 and over), as they give relatively high ratings of care.

Chart 5 (over) shows the trend at a national-level. It can be seen that there is much less of a decline in satisfaction for the oldest patient groups nationally, than is the case at UH Bristol. Although caution is needed when comparing Charts 4 and 5 because different scoring systems and age categories are used, it is still noticeable that UH Bristol's oldest patients are the least likely to rate their care as "excellent", whereas nationally this group are still relatively satisfied compared to younger patients.

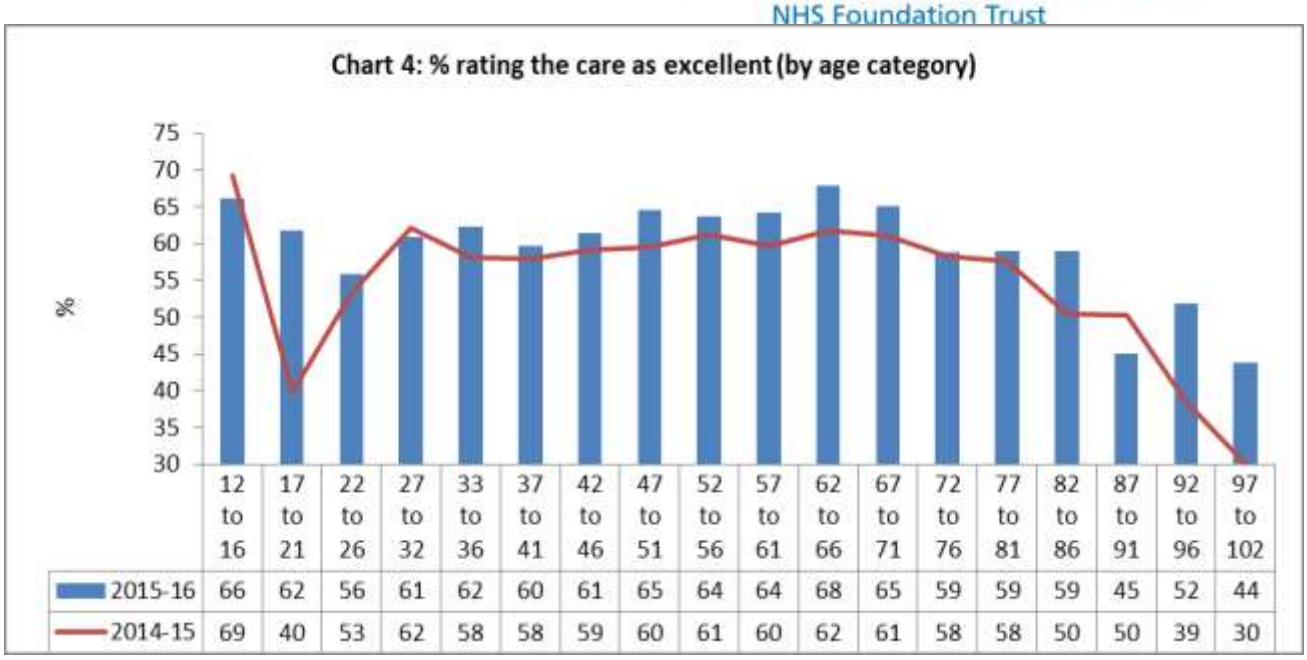
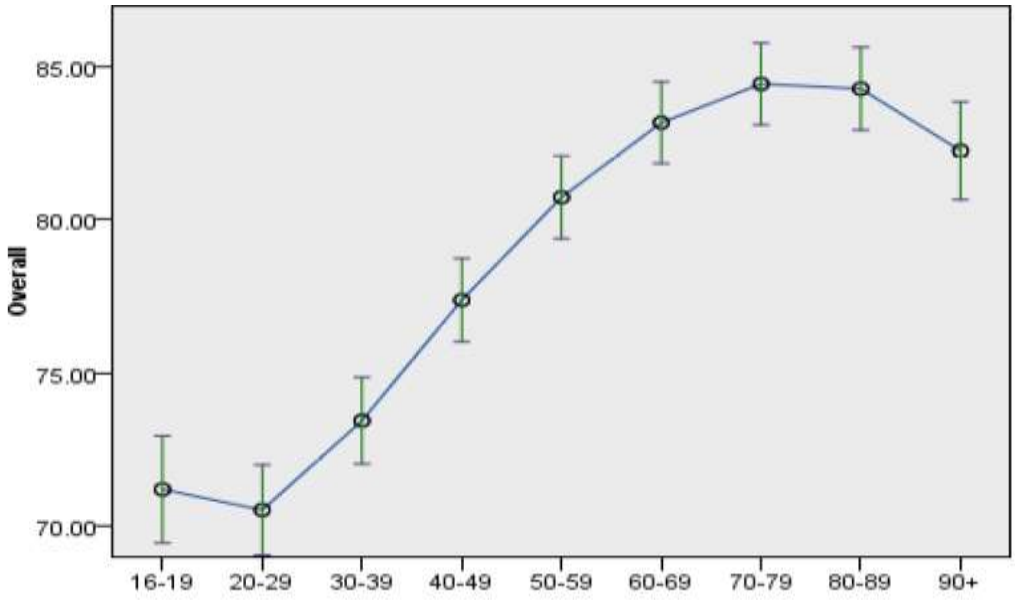


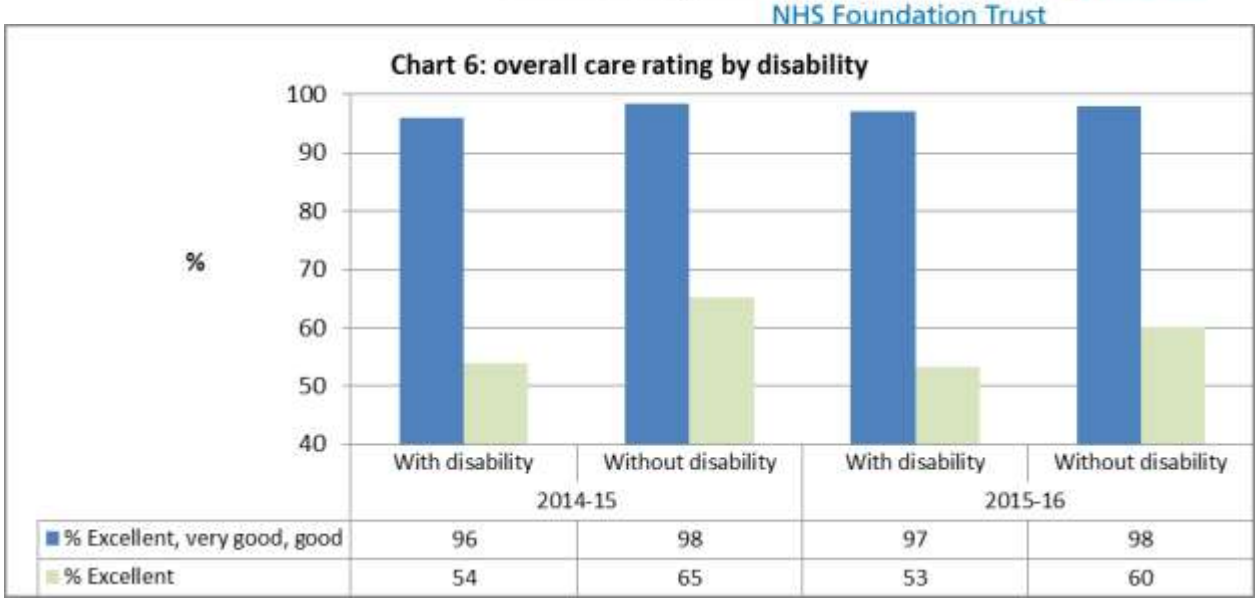
Chart 5: National-level patient satisfaction by age group



Source: Picker Institute Europe (please note that the scoring system is not directly comparable to the one used in Chart4. Also, it can be seen that the age categories used are different between Charts 4 and 5 – although the general trend can still be compared)

Disability

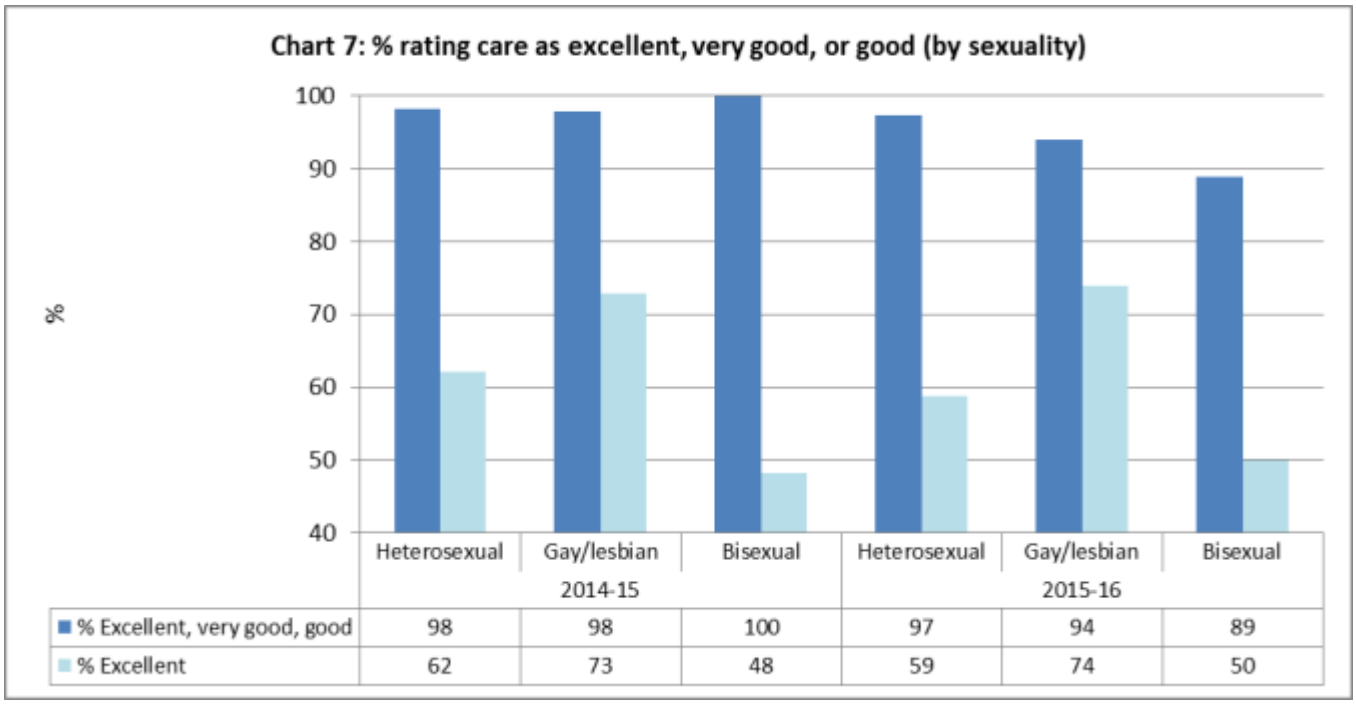
In our questionnaire patients are asked to state whether they consider themselves to have a disability. It can be seen in Chart 6 (over) that patients with a disability are less likely to rate their care as excellent.



	2014-15 With disability	2014-15 Without disability	2015-16 With disability	2015-16 Without disability
% Excellent, very good, good	96	98	97	98
% Excellent	54	65	53	60

Sexuality

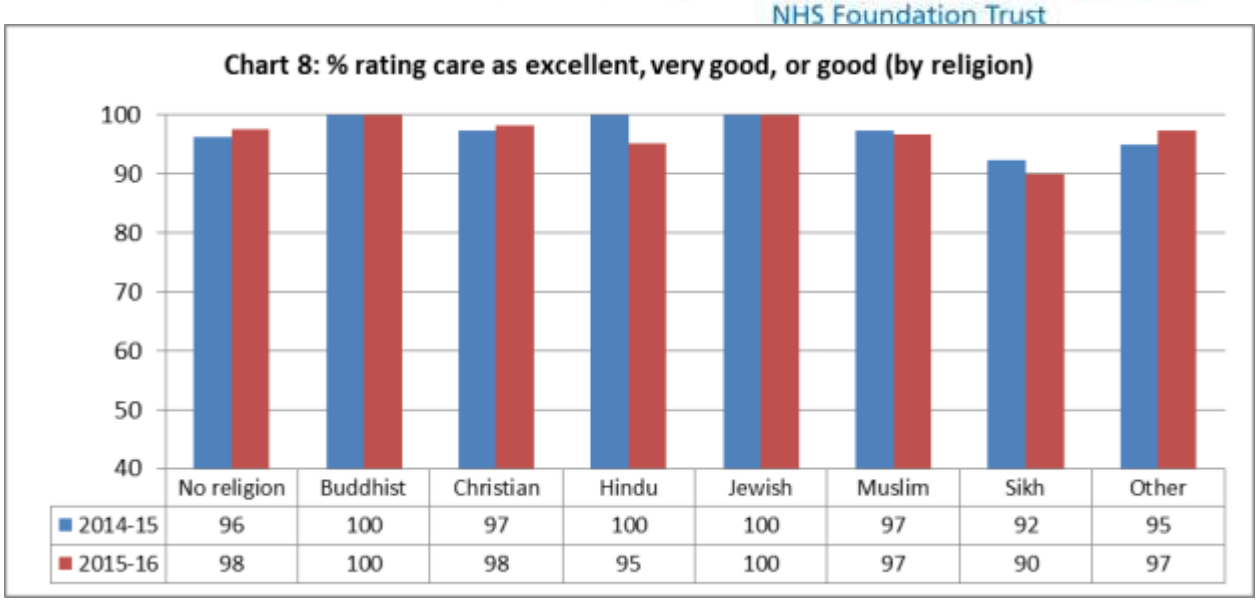
The sample sizes for the gay and bi-sexual groups are very small in Chart 7 and the difference in "excellent" ratings between bi-sexual and heterosexual respondents does not reach statistical significance (although the difference between bi-sexual and Gay/lesbian does). Nevertheless, it is interesting that the bi-sexual "excellent" ratings are low for the second year in a row. The reasons are again unclear and are particularly hard to untangle because this group of respondents are both relatively young (median age of 48 compared to 68 for the sample as a whole) and more likely to be female (63%) – both factors that are in themselves linked to lower scores.



	2014-15 Heterosexual	2014-15 Gay/lesbian	2014-15 Bisexual	2015-16 Heterosexual	2015-16 Gay/lesbian	2015-16 Bisexual
% Excellent, very good, good	98	98	100	97	94	89
% Excellent	62	73	48	59	74	50

Religion

Again the sample sizes are very low for some of the groups shown in Chart 8 and there is no statistically significant difference evident. The number of respondents in a number of these groups is too small to allow an analysis of the "excellent" category in isolation



	No religion	Buddhist	Christian	Hindu	Jewish	Muslim	Sikh	Other
2014-15	96	100	97	100	100	97	92	95
2015-16	98	100	98	95	100	97	90	97

4. A note on Patient and Public Involvement

Certain groups of patients tend to be under-represented in self-completed survey data (e.g. patients with cognitive impairments, communication difficulties, learning disabilities). Often these are the patients who would also tend to report more negative experiences of NHS care[6]. UH Bristol's Patient Experience and Involvement Team has established links with a range of patient and community groups, and regularly supports Patient and Public Involvement activity with groups of patients who may not engage with surveys. Some examples during 2015/16 include:

- Patients who self-harm
- People in recovery for addictive behaviour
- People receiving palliative care
- Carers
- Patients with Learning Disabilities

5. Conclusions

The data presented in this report does not in itself provide evidence of an "equalities and diversities" bias in the delivery of UH Bristol's inpatient care. Even where a difference is identified between demographic groups in this analysis, it is impossible to isolate the various factors that may be influencing the outcome, and therefore to identify where to target improvements. Nevertheless, the Patient Experience Group may wish to consider the key findings of this report and to identify potential opportunities to improve care.

Paul Lewis, Patient Experience Lead (surveys and evaluation), 8 June 2016

[6] For example see: http://www.cqc.org.uk/content/review-learning-disability-services-1

Appendix A – UH Bristol monthly inpatient survey

Methodology

Near the start of each month a random sample of UH Bristol inpatients (or the parents of children aged 0-11 years), who were discharged during the previous calendar month, are sent a patient experience questionnaire by post

The survey sample is drawn at random from across the Trust. As part of this process a sample of inpatients from Ward 32 is automatically generated

The UH Bristol survey largely adopts the methodology used in the Care Quality Commission's national inpatient surveys, with some adaptations to reflect the relative frequency of our survey (i.e. to prevent over-surveying patients) and our relatively rapid data turnaround times

All surveys have strengths and weaknesses and can only provide an *estimated* measurement. The results should always be treated with caution (particularly where a breakdown of the results produces small sample sizes) and should be corroborated with other robust data sources wherever possible

Further information about the survey can be obtained from

Sample sizes for selected demographic groups

This is a selection of data to provide an indication of the sample sizes used in this report (2015/16 year only):

Female	2898
Male	3066
Disability	1830
No disability	3887
Heterosexual	5151
Gay/lesbian	48
Bisexual	<30
No religion	1301
Buddhist	<30
Christian	4138
Hindu	<30
Jewish	<30
Muslim	59
Sikh	<30
Asian or Asian British	93
Black or Black British	105
Mixed	71
Other Ethnic Groups	47
White	5930

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
16. Complaints Annual Report 2015/2016
Sponsor and Author(s)
Sponsor: Carolyn Mills, Chief Nurse **Authors**: Tanya Tofts, Patient Support & Complaints Manager

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose The complaints annual report fulfils a statutory requirement for the Trust to publish a summary of complaints received during the year. The Board has previously reviewed the data included in this report via detailed quarterly reports, and in summary form via the Trust's annual Quality Report (Account). Key issues to note As detailed in the report.
Recommendations
The Board is recommended to note the report for assurance.
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
This report fulfils a requirement of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Equality & Patient Impact
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
26/7/16				20/7/16	

University Hospitals Bristol NHS
NHS Foundation Trust

ANNUAL COMPLAINTS REPORT 2015/2016

Author: Tanya Tofts, Patient Support and Complaints Manager - July 2016

Contents

Executive Summary

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by University Hospitals Bristol NHS Foundation Trust in 2015/2016. The report also records other support provided by the Trust's Patient Support and Complaints Team[1] during the year.

In summary:

- 1,941 complaints were received by the Trust in the year 2015/2016, averaging 162 per month. Of these, 647 were managed through the formal investigation process and 1,294 through the informal investigation process. This compares with a total of 1,883 complaints received in 2014/2015, an increase of 3%. During 2015/16, the volume of complaints received by the Trust as a proportion of patient activity was 0.25%: a marginal decrease on 2014/15, when 0.26% of patient episodes resulted in a complaint.

- In addition, the Patient Support and Complaints Team dealt with 597 other enquiries, including compliments, requests for support and requests for information and advice: a small decrease on the 619 enquiries dealt with in 2014/2015.

- The Trust had 15 complaints referred to the Parliamentary and Health Service Ombudsman in 2015/16, compared with 12 in 2014/15 and 17 in 2013/14. Nine of the complaints referred during 2015/16 were not upheld and one was partially upheld; the remaining five cases are still being considered by the Ombudsman (as at 07/07/2016).

- 35 complaints were re-opened due to complainants being dissatisfied with incomplete or factually incorrect responses. This compares with 84 in 2014/15: a 58% decrease.

- 75.2% of complaints (formal resolution) were responded to within the agreed timescale, a decrease on the 85.9% achieved in 2014/15 and lower than the 76% recorded for 2013/14.

- At the time of writing, 59 complainants have expressed dissatisfaction with complaints responses sent out during 2015/16. This equates to 9.1% of the total responses sent out.

[1] UH Bristol's integrated 'PALS' and complaints team

1. Accountability for complaints management

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

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

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

The Patient Support and Complaints Manager line manages a team which consists of one full time Band 6 Deputy Manager, three full-time and one part-time complaints officers/caseworkers (Band 5) and three part-time administrators (Band 3). The total team resource, including the manager, is currently 7.8 WTE.

2. Complaints reporting

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

- Percentage of complaints per patient attendance
- Percentage of complaints responded to within the agreed timescale
- Percentage of cases where the complainant is dissatisfied with the original response
- Headline Indicator Report providing further detail of all cases where the complainant is dissatisfied with our response.

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

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

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

3. Total complaints received in 2015/2016

In 2015/16, the Trust's target was that the volume of complaints received should not exceed 0.21% of patient activity – in other words, that no more than approximately 1 in 500 patients complain about our service. We achieved 0.25% in 2015/16, compared with 0.26% in 2014/15 and 0.21% in 2013/14 (see Figure 1). The total number of complaints received during the year was 1,941, an increase of 3% on the previous year. Of these, 647 were managed through the formal investigation process and 1,294 through the informal investigation process.

Compared with 2014/15, there was a decrease of 23% in the number of complaints managed through the formal investigation process and a 25% increase in the number of complaints managed through the informal investigation process. This is a positive change – we want to address concerns quickly and as close to point of care as possible.

A formal complaint is classed as one where an investigation by the Division is required in order to respond to the complaint. A senior manager is appointed to carry out the investigation and gather statements from the appropriate staff. These statements are then used as the basis for either a written response to, or a meeting with, the complainant (or sometimes a telephone call from the manager). The method of feedback is agreed with the complainant and is their choice. This Trust's target is that this process should take no more than 30 working days in total.

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

Figure 1 - Monthly complaints as a percentage of patient activity 2013/14, 2015/15 and 2015/16

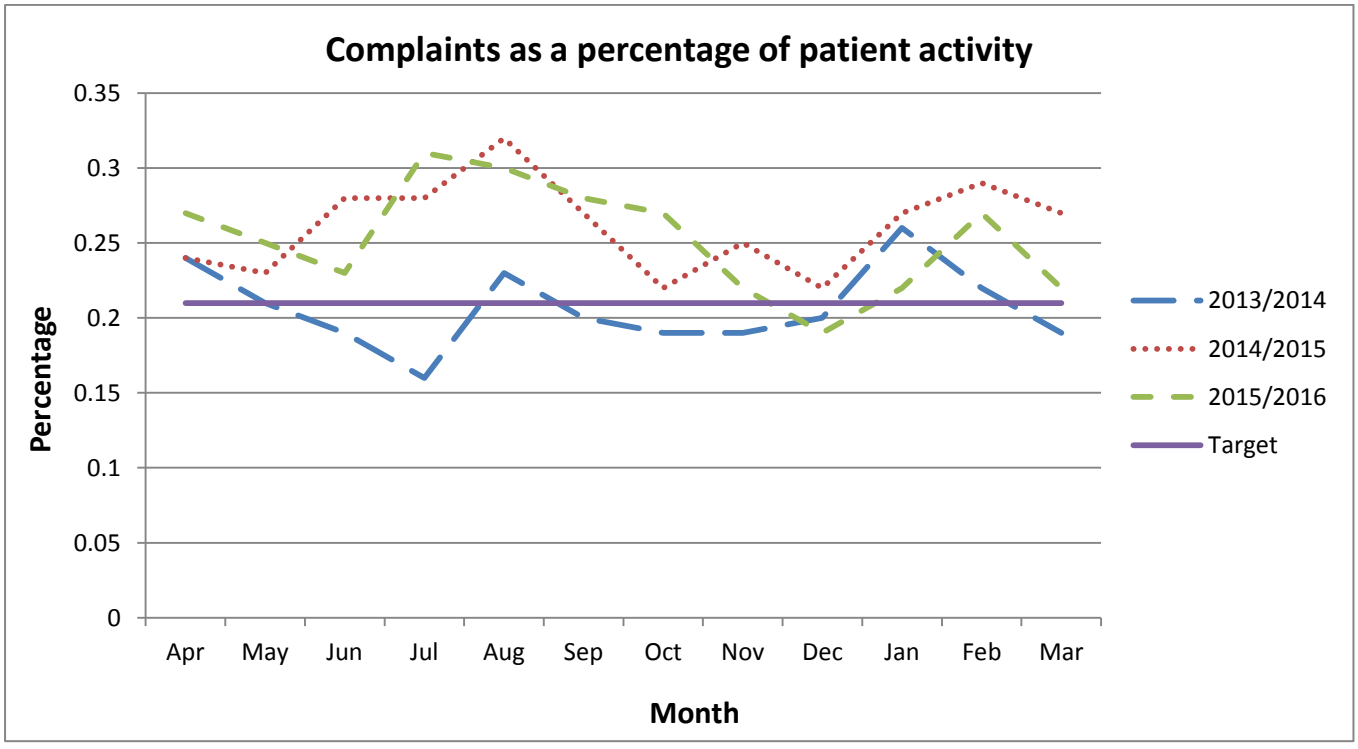


Table 1 below shows the number of complaints received by each of the Trust's clinical divisions compared with the previous year. Directional arrows indicate change compared to the previous financial year.

Table 1 - Breakdown of complaints by Division

Division	Informal Complaints 2015/2016	Formal Complaints 2015/2016	Divisional Total 2015/16	Informal Complaints 2014/2015	Formal Complaints 2014/2015	Divisional Total 2014/15
Surgery, Head and Neck	583 ↑	212 ↓	795 ↑	407 ↑	293 ↓	**700 ↑**
Medicine	244 ↑	162 ↓	406 ↑	174 ↑	176 ↑	**350 ↑**
Specialised Services	172 ↓	66 ↓	238 ↓	184 ↑	101 ↑	**285 ↑**
Women and Children	142 ↓	157 ↓	299 ↓	146 ↑	204 ↑	**350 ↑**
Diagnostics and Therapies	56 ↓	24↓	80 ↓	67 ↑	35 ↓	**102 ↑**
Trust Services (including Facilities & Estates)	97 ↑	26 ↓	123↑	61 ↑	35 ↑	**96 ↑**
TOTAL	**1294 ↑**	**647↓**	**1941 ↑**	**1039 ↑**	**844 ↑**	**1883 ↑**

Table 1 shows increases in the number of complaints received by Surgery, Head & Neck, Medicine and Trust Services (including Facilities and Estates) compared with 2014/15 and decreases in the number of complaints received by Specialised Services, Women and Children and Diagnostics and Therapies.

4. Complaint themes

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

Table 2 and Figure 2 show complaints received by theme, again compared to 2014/2015.

Table 2 - Complaint themes – Trust totals

Complaint Theme	Total Complaints 2015/2016	Total Complaints 2014/15	Total Complaints 2013/14
Access	40 ↓	56 ↑	44 ↑
Appointments and Admissions	661 ↑	656 ↑	472 ↓
Attitude and Communication	552 ↑	444 ↑	438 ↓
Clinical Care	469 ↓	528 ↑	372 ↓
Facilities and Environment	99 ↓	116 ↑	90 ↓
Information and Support	120 ↑	83 ↑	26 ↓
TOTAL	**1941 ↑**	**1883 ↑**	**1442 ↓**

In 2015/16, the total number of complaints received under the theme of Attitude and Communication increased by 24%. This theme covers such categories of complaints as attitude of medical staff, attitude of administrative staff, communication with patient/relative and communication (administrative).

Of the 552 complaints recorded under this theme, the largest sub-category was 'communication with patient/relative' (170), followed by 'failure to answer telephones' (90) and 'attitude of medical staff' (71). Some examples of the complaints categorised as 'communication with patient/relative' were: family members not being given enough information about the patient's treatment pathway; patients not receiving adequate explanation of their diagnosis or treatment; and patients not being contacted to be advised that their appointment or procedure had been cancelled and having a wasted journey to the hospital.

Complaints received in this category were spread across our hospital sites, with Bristol Royal Infirmary receiving 40% of all complaints relating to attitude and communication and Bristol Eye Hospital receiving 12.5%. The hospital departments receiving the highest numbers of complaints relating to attitude and communication were Bristol Eye Hospital Outpatients (52), Trauma & Orthopaedics (32) and Bristol Royal Infirmary Emergency Department (32).

Four of the six main complaints themes saw increases when compared with the previous year, although there was an encouraging 29% reduction in complaints relating to Access. This theme includes complaints about transport, visiting hours and services being unavailable.

In respect of Clinical Care, the total number of complaints received by the Trust decreased from 528 in 2014/15 to 469 in 2015/16. The largest numbers of complaints under this theme were in the category of 'clinical care (medical/surgical)' with 192 (234 in 2014/15).

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

There was a slight increase in complaints received about Appointments and Admissions. The highest numbers of complaints received by the Trust under this theme were in respect of cancelled or delayed appointments and operations 489 (504 in 2014/15).

5. Equalities data: monitoring protected characteristics

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

In February 2016, the Trust changed from Safeguard to a new Datix system for recording complaints. Unfortunately, the protected characteristics recorded on the Trust's Medway system do not match the fields within Datix. This is currently under investigation but means that for the purposes of this report, data is only available for the first three quarters of the year, i.e. April 2015 to December 2015.

Information about the age, gender, ethnicity, religious beliefs and civil status of patients who have made a complaint in Quarters 1, 2 and 3 of 2015/16 (or on behalf of whom a complaint was made) shows that:

- There was a broadly even distribution of complaints between men (677) and women (778)
- 36% of patients were aged 65 years or above

- The overwhelming majority of people who complained, and whose ethnicity is recorded (70%), were White British.
- 49% of complainants stated their religious affiliation as Christian.
- The civil status of the majority of complainants was Married/Civil Partnership (39%), followed by Single (27%)

6. Performance in responding to complaints

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

6.1 Proportion of complaints responded to within timescale

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

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

The Trust captures data about the numbers of complaints responded to within the agreed timescale. The Trust's performance target for this in 2015/16 was 95% compliance. Over the course of the year 2015/16, 75.2% of responses were responded to within the agreed timescale, a decrease on the 85.9% achieved in 2014/15 and lower than the 76% recorded for 2013/14.

The main reason identified for the reduction in the number of responses sent out within the agreed timescale is the extra scrutiny of response letters to ensure that they are of a consistently high quality. This has meant that more amendments are being made to response letters by the Patient Support and Complaints Team and by the Executive Team, which can in turn lead to delays in responses being posted to complainants.

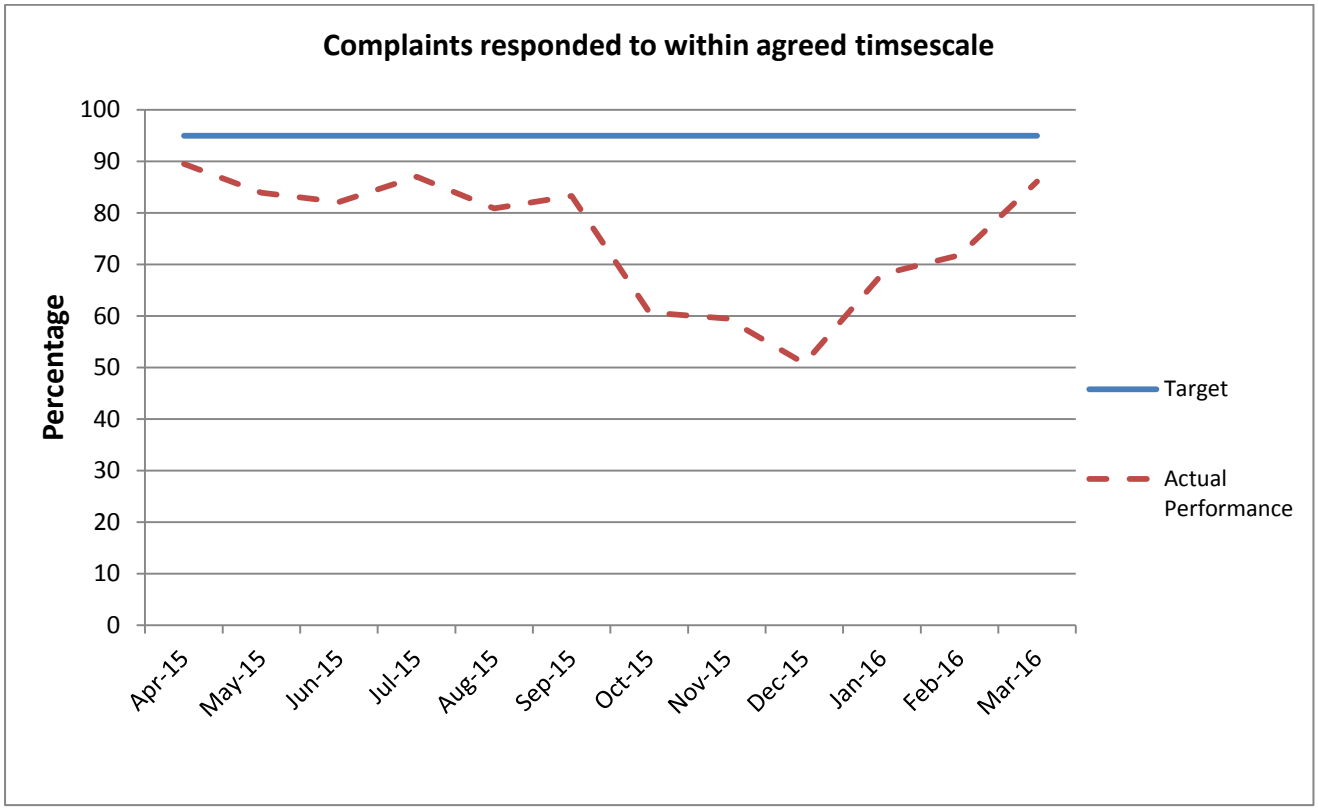
It is anticipated that the rate of responses being sent out on time will increase due to the following steps being taken:

- Training in how to write a good response letter continues to be rolled out Trustwide;
- The timescale for the review and sign-off process for complaint responses has been increased from four working days to seven working days, to allow more time for amendments to be made prior to responses being signed at Executive level;
- The Patient Support and Complaints Team must ensure that the response letter is checked and sent to the Executive Directors for sign-off within 24 hours of receipt from the Division (subject to weekends and Bank Holidays). The exception to this would be if the response has

been received from the Division very early, which allows additional time for the response to be checked if needed.

- All Divisions are now working to the same target of 30 working days.
- Longer deadlines are agreed with all Divisions should the complainant request a meeting rather than a written response. This allows for the additional time needed to coordinate the diaries of clinical staff required to attend these meetings.
- Finally, divisions have the option of seeking the agreement of the complainant to extend their deadline if additional time is required to complete the investigation.

Figure 3. Percentage of complaints responded to within agreed timescale



6.2 Numbers of complainants who are dissatisfied with our response

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

The total number of cases reported in 2014/15 where the complainant was dissatisfied with our response for this reason was 84, which represented 10% of all formal complaints received during the same period. However, with effect from 2015/16, the Trust changed the way in which it reported dissatisfied cases and now reports the number of complainants dissatisfied with our original response as a percentage of response letters sent out that month (as opposed to the number of dissatisfied responses received *in* a given month). At the time of writing, 59 complainants have expressed dissatisfaction with complaints responses sent out during 2015/16. This equates to 9.1% of the total responses sent out. Informal benchmarking against other NHS trusts indicates that a

dissatisfaction rate of 8-10% is typical. Nonetheless, our aspiration is for nobody to be unhappy with the quality of our original response.

7. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the way in which their complaint has been dealt with by the Trust and feels that local resolution of their complaint has not been satisfactory, they have the option of asking the PHSO to carry out an independent review of their complaint.

The Trust had 15 complaints referred to the Parliamentary and Health Service Ombudsman in 2015/16, compared with 12 in 2014/15 and 17 in 2013/14. Nine of these complaints were not upheld and one was partially upheld; the remaining five cases are still being considered by the Ombudsman (as at 07/07/2016). In respect of the one partially upheld complaint, the Trust has complied fully with the PHSO's recommendations.

8. Information, advice and support

In addition to managing complaints, the Patient Support and Complaints Team also deals with information, advice and support requests. The total number of enquiries received during 2015/2016 is shown below, together with the numbers from 2014/2015 for comparative purposes:

Table 3:

Type of enquiry	**Total Number 2015/2016**	**Total Number 2014/2015**
Request for advice / information	375	389
Request for support	24	43
Compliments	200	187
Total	**599**	**619**

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

- Their treatment and care
- Services which the Trust provides
- Signposting to other local or voluntary services
- Outpatient clinic appointments (patients may occasionally ask a member of the team to attend with them)
- Liaison for carers and patients who have additional support needs and complex health problems
- Communication with patients' healthcare teams to facilitate both parties being able to work together in the future.
- Assisting families who arrive in Bristol with a patient but do not live locally and require local orientation and signposting to further help about finding somewhere to stay.

Examples of typical enquiries about advice and information include:

- 'What is the waiting time for xxx procedure?'
- 'Who do I contact to discuss xxx?'
- 'Can I have my treatment at a different hospital/location?'
- 'Is it true that my operation has been cancelled due to cost cuts?'

- ‘I’m having an operation soon, who do I speak to about some concerns/questions that I have?’
- ‘I need a letter from my consultant in order that I can get my driving licence back.’
- ‘How do I make a complaint about my GP?’
- ‘My transport hasn’t arrived and I’m going to miss my appointment. Who do I contact?’
- ‘I’m on the ward and I need to know the password for the Wi-Fi.’
- ‘I was an inpatient last week and lost my glasses. What do I need to do?’

Examples of typical enquiries about support include:

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

9. Looking ahead

University Hospitals Bristol NHS Foundation Trust continues to be proactive in its management of complaints and enquiries, acknowledging that all concerns are a valuable source of information. One of the Trust’s nine key corporate quality objectives for 2015/16 was to improve the quality of complaints responses letters, and in turn to reduce the number of complainants who were dissatisfied with our complaints responses.

A further Trust quality objective for 2016/17 is to achieve a reduction in the number of complaints received relating to communication. Progress will be monitored by the Trust Board throughout the year.

The Trust’s complaints work plan for 2016/17 is available upon request.

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
17. National In-patient Survey Results 2015									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author**: Paul Lewis, Patient Experience Programme Manager									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose:

The national inpatient survey is a mandatory annual survey carried out by acute NHS trusts and is part of the Care Quality Commission's national survey programme. This agenda item provides an overview of the Trust's performance in the 2015 national inpatient survey and a response to the key issues identified. Two reports are provided:

1. A local analysis of the Trust's performance in this survey
2. The Care Quality Commission benchmark report that compares UH Bristol's results against the national average:

Key issues to note:

The headline results are as follows:

- UH Bristol was **below** the national average to a statistically significant degree on whether hand-wash gels were available for patients and visitors to use (although it should be noted that this was one of the Trust's best scores at 9.3/10, against a national average of 9.6).
- One score was **better** than the national average: privacy when discussing the patient's treatment or condition (9.0/10)
- All of the other 61 scores were in line with the national average

The 2015 National Inpatient Survey shows that patient-reported experiences of UH Bristol's inpatient care are generally positive – particularly in key aspects of patient experience such as cleanliness, privacy, dignity and confidence in the Trust's clinical staff. The Trust received a number of low scores that need to be improved. These related to "signposting" people to the complaints service, explaining potential medication side effects, and ensuring that patients are asked about the quality of their care whilst in hospital. These issues are already the subject of significant improvement activity. Whilst these specific issues are important, the wider context is of UH Bristol aspiring to move from being consistently in line with the national average to among the best performing trusts in the delivery of a positive patient experience. The Trust's new Quality Strategy, due to be received by the Trust Board in September 2016, will set out how this will be achieved - with a key focus being the development of a "customer service culture" at UH Bristol.

Recommendations
The Trust Board is asked to receive this report
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
26/7/2016				20/07/2016	

2015 National Inpatient Survey Results

1. Purpose of this paper

This paper provides an overview of the Trust's performance in the 2015 national inpatient survey and a response to the key issues identified.

2. Methodology

A questionnaire was sent by post to 1,250 adults (aged 18+) who attended UH Bristol during the latter half of July 2015. In total, 598 responses were received, a response rate of 50% (compared to a response rate nationally of 47%)[1].

In carrying out the sampling for the 2015 national inpatient survey, an error was identified in the way that UH Bristol drew the sample for the previous survey in 2014. This error resulted in the incorrect exclusion of patients with a referral code of "81" (referrals in from other trusts). A comparison of individual question scores between the 2014 and 2015 surveys is therefore not provided in the Care Quality Commission's benchmark report[2]. However, it is important to note that this error would not have materially affected UH Bristol's results.

3. Key results

The Care Quality Commission provides a benchmark report that compares UH Bristol's 2015 national inpatient survey results against the national average:

- UH Bristol was **below** the national average to a statistically significant degree on whether hand-wash gels were available for patients and visitors to use (although it should be noted that this was one of the Trust's best scores at 9.3/10, against a national average of 9.6).
- One score was **better** than the national average: privacy when discussing the patient's treatment or condition (9.0/10)
- All of the other 61 scores were in line with the national average

In the previous (2014) survey, UH Bristol performed in line with the national average on 57 out of 60 survey questions. The Trust again received a good but below-national average score on availability of hand gels (9.1/10). On two questions in 2014, the Trust performed better than the national average (relating to explaining the risks and benefits of operations and discussing post-hospital care needs with patients).

Additional analysis by the UH Bristol Patient Experience and Involvement Team is shown in Charts 1-3 (over). This provides a single overall performance measure by taking a mean score across all of the survey

[1] The response rate calculation takes into account any postal surveys that could not be delivered.
[2] In subsequent discussions between the Trust and the Care Quality Commission, it was agreed that a comparison was valid on all but ten survey questions. Unfortunately this could not be incorporated into the benchmark report, as it is a mass-produced report and cannot deviate from the standard format. On these ten questions, the Picker Institute found a significant difference between the way that the patients with an "81" referral code answered the questions compared to the rest of the sample. However, it should be noted that there were too few "81's" in the sample (around 7%) to make a material difference to UH Bristol's overall position relative the national average, and on none of these ten questions was there a statistically significant difference in the score between 2014 and 2015.

questions for each participating trust[3]. It can be seen that in 2015 UH Bristol performed between the national average and best quintile of trusts nationally (Chart 1), that this was also the case in 2014 (Chart 2), and that in 2015 UH Bristol occupied a similar position to this when directly compared to other large acute teaching trusts (Chart 3).

Chart 1: mean survey score for each participating trust - 2015

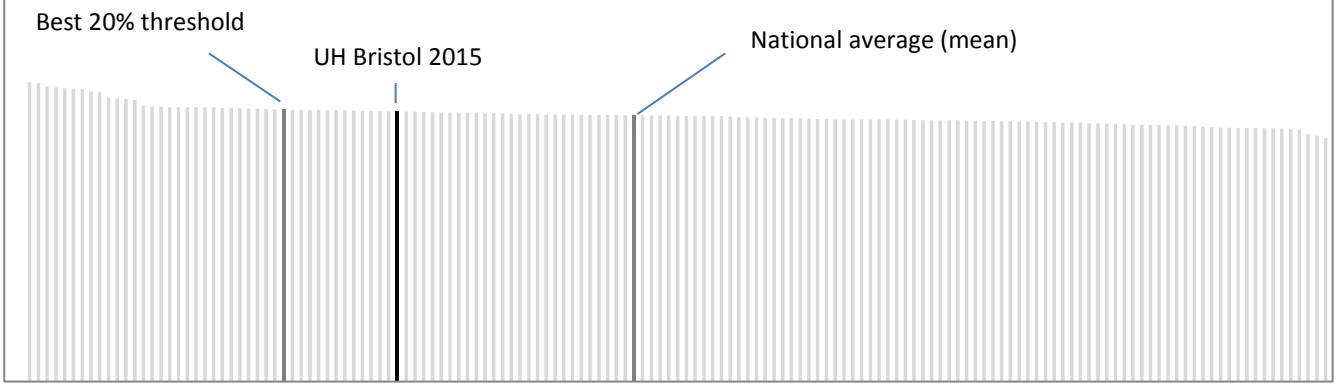


Chart 2: mean survey score for each participating trust - 2014

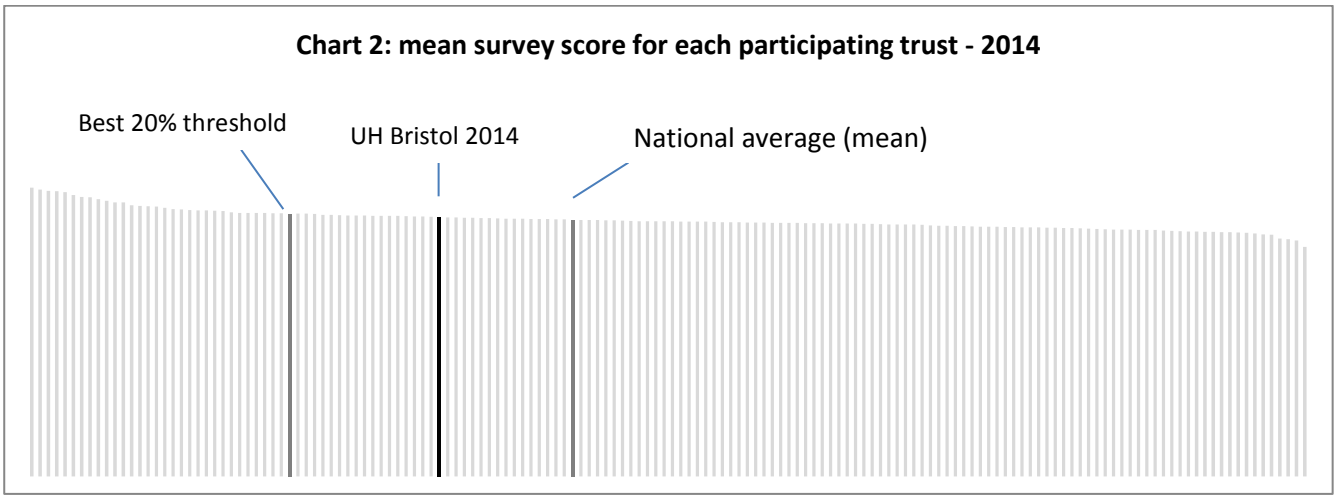
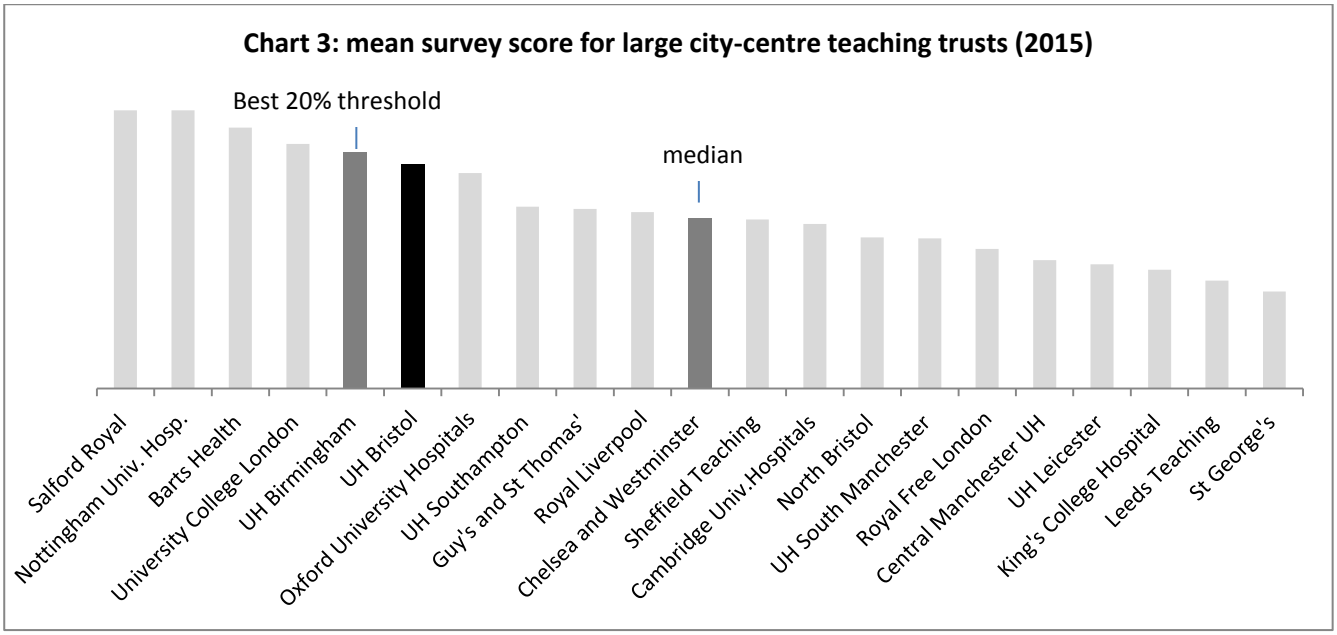


Chart 3: mean survey score for large city-centre teaching trusts (2015)



[3] This is not an official CQC classification. For information: UH Bristol's overall mean score in Chart 1 was 7.85/10, with the top quintile threshold being 7.90, and the national mean being 7.73.

4. Best UH Bristol scores and negative outliers

Table 1 shows UH Bristol's best scores in the 2015 national inpatient survey (a number of these scores are jointly in "third place"). It can be seen that these relate to themes around feeling safe, privacy and dignity, cleanliness, and confidence and trust in our doctors.

Table 1: UH Bristol's top survey scores (all scores are out of ten)

	UH Bristol Score	Best trust score nationally
Did you feel threatened during your stay in hospital by other patients or visitors? *(i.e. patients did not feel threatened)*	9.7	10.0
Were you given enough privacy when being examined or treated?	9.6	9.9
In your opinion, how clean was the hospital room or ward that you were in?	9.3	9.7
Were hand-wash gels available for patients and visitors to use?	9.3	9.9
Did you have confidence and trust in the doctors treating you?	9.3	9.8
Were treated with respect and dignity while you were in the hospital?	9.3	9.7

In section 3, we explained that although the Trust's score for availability of hand gel was one of its highest in the survey (as per Table 1), it was nonetheless lower than most other trusts. It is acknowledged that this is an important issue and that the score has been below the national average for two years in a row. However, some caution is needed here because the effect is marginal (within 0.03 of being classed as "average") and, in statistical terms, the higher and more concentrated a set of scores is, the lower the margin of error – so that, in this case, it only takes a small deviation from the average to be classed as statistically significant[4].

Table 2 also highlights three other questions (explaining medication side effects, seeing information about making a complaint, and being asked about the quality of care) which were in line with the national average, but were UH Bristol's lowest scores in absolute terms[5]. A response to the survey scores in Table 2 is provided in the next section of this report.

Table 2: UH Bristol negative outliers

	UH Bristol Score	Best trust score nationally
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.5	4.1
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.3	4.9
Did a member of staff tell you about medication side effects to watch for when you went home?	4.8	7.8
Were hand-wash gels available for patients and visitors to use?	9.3	9.9

[4]For this reason, and the fact that all trusts perform well on this measure, the Picker Institute is removing this question from the 2016 national inpatient survey.

[5] They were also the scores where UH Bristol was furthest away from the best trust score nationally.

5. Responding to the national inpatient survey results

The report shows that patient-reported experience of UH Bristol's inpatient care is generally positive and in line with national norms.

Actions are planned or already underway in respect of the four 'outlier' questions described in Table 2.

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

In line with key national and international guidelines[6], the placement of hand gel is targeted at points of care - which are primarily at the end of a patient's bed and immediately outside patient rooms / bays. Ward staff are responsible for ensuring that gels are available in these areas and hand hygiene audits are carried out monthly as part of the "Safety Thermometer".

It is not possible to determine the exact areas of the Trust where survey respondents felt that hand gels were not available. However, the Deputy Chief Nurse has requested that, as part of "Back to the Floor" in July and for all Matron visits to wards during July, staff talk to patients about this and check to ensure that hand gel is available and visible to visitors and patients. Findings will be discussed at the August meeting of the Nursing and Midwifery Council and any further appropriate actions considered in light of staff and patient feedback.

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

This is a consistently low score for all trusts and reflects the challenge of ensuring that this information is provided to patients in the right format at the right time. As noted in the recent Quarter 4 Patient Experience Report[7], the Trust's Pharmacy Department is currently overseeing two important improvement actions:

- A new on-line system ("MaPPs") produces bespoke patient information sheets for common medicines, and other helpful material including a summary chart of administration times[8]. This system is now available for ward staff to access.
- In collaboration with the West of England Academic Health Sciences Network, the Pharmacy Department has also implemented a new IT system ("PharmOutcomes") which allows community pharmacists to receive information about the medications that UH Bristol patients have been discharged with. The community pharmacist can then proactively engage / support patients using the most up to date and accurate medicines information. It is important to provide this additional support in the community, particularly as patients may not find it easy to take in information about medications during their hospital stay and / or at the point of being discharged.

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

This was identified as a theme in the recent inpatient Delivering Best Care week at the Trust[9]. The Trust's "Tell us about your care" posters, which highlight the various methods of providing feedback (including

[6] National Patient Safety Agency and World Health Organisation.
[7] Received by Trust Board in June 2016.
[8] MaPPs stands for: Medicines – a Patient Profile Summary. The Pharmacy Department had developed an "in-house" system that was a similar concept to MaPPs, but this proved very difficult to maintain and did not progress beyond the pilot stage.
[9] This involved an "inspection team" visiting each adult inpatient ward and assessing key elements of care provision that are likely to the focus of any future Care Quality Commission inspections.

making a complaint), are currently being printed for display on each ward and will be in place by the end of August 2016. The Trust's Welcome Guide, which is also a key source of information about making a complaint, is currently being updated and the new version will distributed to wards during Quarter 3 2016/17. This work is being coordinated by the Trust's Patient Experience and Involvement Team.

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

Improving UH Bristol's score on this question is a corporate quality objective for 2016/17[10]. The "Tell us about your care" posters described above form part of these plans, as they highlight a range of existing opportunities for patients to provide feedback about the quality of their care. During 2016/17, we will continue to improve these opportunities so that we gather patient feedback faster, closer to the point of care, and use it in a more timely and effective way to improve services.

However, our response to this question goes much further than this and begins to address the wider challenge posed by successive annual sets of what might be described as 'average to good' national inpatient survey results. Our aspiration is to achieve the best results in the country. We know this is possible because our maternity services achieved exactly that in their most recent CQC survey.

The Trust's new Quality Strategy will be presented to the Board in September 2016. This strategy will include plans for the procurement of a new trust-wide patient feedback system, towards the end of 2016/17, which we believe will deliver two significant step changes for the Trust. Firstly, it will introduce the widespread gathering of feedback from patients whilst they are still receiving care in hospital and, crucially, whilst our staff still have the opportunity to address any concerns patients might have. Secondly, we envisage that patient feedback will be shared with staff, patients and public in a highly visible way that reminds our staff that every encounter with a patient matters, facilitates positive competition and creates a strong sense of pride in customer service.

6. Summary

The 2015 National Inpatient Survey shows that patient-reported experiences of UH Bristol's inpatient care are generally positive, particularly in key aspects of patient experience such as cleanliness, privacy, dignity and confidence in the Trust's clinical staff. Our local analysis suggests that, overall, UH Bristol performs slightly above the national average in this survey - but not to an extent that moves the Trust "beyond the pack" to a statistically significant degree. Therefore the great majority of UH Bristol's scores (61/63) are classed as being in line with the national average by the Care Quality Commission. This general picture reflects UH Bristol's performance in the national inpatient survey over a number of years.

In the 2015 national inpatient survey the Trust received a number of low scores that need to be improved. In the main these issues had already been identified and are the subject of existing activity. For example, as a result of the recent Delivering Best Care week, improved "signposting" to the complaints service and other feedback channels will be put in place on each ward. Ensuring that patients are asked about the quality of their care is a Trust corporate Quality Objective for 2016/17, reflecting plans to implement new patient feedback systems. However, whilst these specific issues are important, the wider context is of UH Bristol aspiring to move from being in line with the national average to being among the best performing trusts. The new Quality Strategy, due to be received by the Trust Board in September 2016, will set out how this will be achieved - with a key focus being the development of a "customer service culture" at UH Bristol.

[10] We would not expect improvements to be reflected in the national survey results until 2017, as the 2016 national survey will reflect the experiences of patients seen in July – too soon for changes to have been implemented.

Patient survey report 2015

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

Survey of adult inpatients 2015

Making patients' views count

NHS patient survey programme
Survey of adult inpatients 2015

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve we take action to make sure this happens. We speak with our independent voice, publishing regional and national views of the major quality issues in health and social care.

Survey of adult inpatients 2015

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

The thirteenth survey of adult inpatients involved 149 (one trust was excluded from the national results due to errors when drawing their sample) acute and specialist NHS trusts. Responses were received from 83,116 people, a response rate of 47%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2015[1]. Trusts counted back from the last day of July 2015, including every consecutive discharge, until they had selected 1250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2015). Fieldwork took place between September 2015 and January 2016.

Similar surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2014. They are part of a wider programme of NHS patient surveys, which cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

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

Interpreting the report

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

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

This report shows the same data as published on the CQC website (http://www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

[1] 43 trusts sampled additional months because of small patient throughputs.

Standardisation

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

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

Scoring

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

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts. For example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q43 "During your stay in hospital, did you have an operation or procedure?" For full details of the scoring please see the technical document (see further information section).

Graphs

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

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

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

Methodology

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

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

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

Tables

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

Scores from last year's survey are also displayed. The column called 'change from 2014' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2014. A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test.

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

Notes on specific questions

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

All trusts

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?" Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the question's wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Q31: "In your opinion, did the members of staff caring for you well work together?" is a new question in 2015 and it is therefore not possible to compare with 2014.

Q53 and Q54: The information collected by Q53 "On the day you left hospital, was your discharge delayed for any reason?" and Q54 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q54 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q55: Information from Q53 and Q54 has been used to score Q55 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q56, Q57 and Q58: "Where did you go after leaving hospital?", “After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? and “When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing you care?” are new questions in 2015 and it is therefore not possible to compare with 2014.

Q58: This question does not contribute to the Section score for 'Leaving hospital' (Section 9), though is displayed for trusts where 30 or more respondents answered this question. In the instances where 30 or more respondents answered this question, the question score is displayed for the trust. If the row for Q58 is blank, this means that less than 30 responses were received for this question.

Trusts with female patients only

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

Trusts with no A&E Department

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

Further information

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

The results for the adult inpatient surveys from 2002 to 2014 can be found at:
http://www.nhssurveys.org/surveys/425

Full details of the methodology of the survey can be found at:
http://www.nhssurveys.org/surveys/833

More information on the programme of NHS patient surveys is available at:
http://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

Section scores

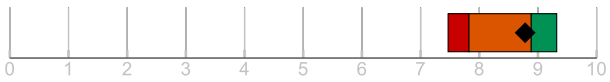
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

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

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



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

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

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

Q7. Was your admission date changed by the hospital?

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

Waiting to get to a bed on a ward

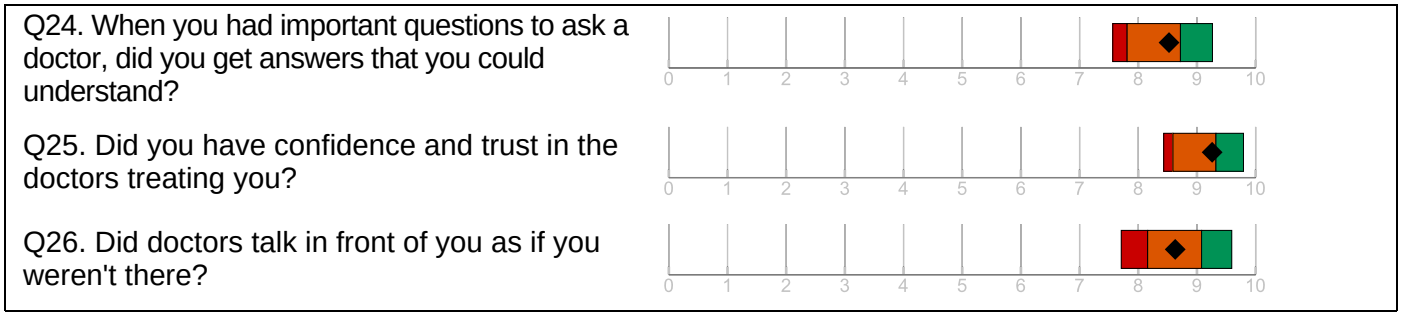
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

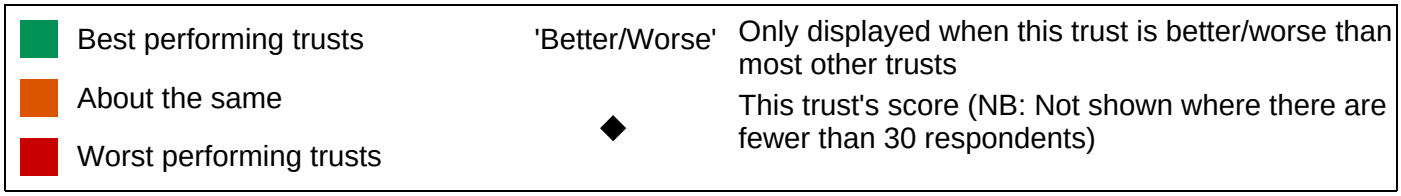
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Survey of adult inpatients 2015
University Hospitals Bristol NHS Foundation Trust

The hospital and ward

Doctors



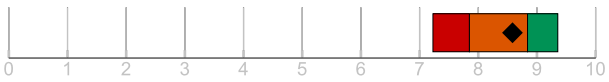


Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

Nurses

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



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

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

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

Care and treatment

Q31. In your opinion, did the members of staff caring for you work well together?

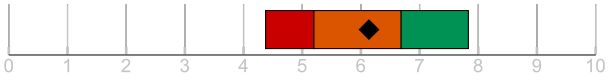
Q32. Did a member of staff say one thing and another say something different?

Q33. Were you involved as much as you wanted to be in decisions about your care and treatment?

Q34. Did you have confidence in the decisions made about your condition or treatment?

Q35. How much information about your condition or treatment was given to you?

Q36. Did you find someone on the hospital staff to talk to about your worries and fears?



Q37. Do you feel you got enough emotional support from hospital staff during your stay?

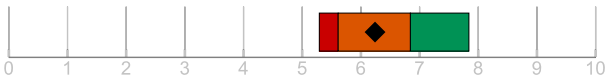
Q38. Were you given enough privacy when discussing your condition or treatment?

Better

Q39. Were you given enough privacy when being examined or treated?

Q41. Do you think the hospital staff did everything they could to help control your pain?

Q42. After you used the call button, how long did it usually take before you got help?



Best performing trusts

About the same

Worst performing trusts

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

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

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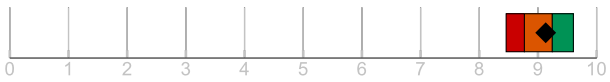
University Hospitals Bristol NHS Foundation Trust

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

Q44. Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?



Q45. Did a member of staff explain what would be done during the operation or procedure?

Q46. Did a member of staff answer your questions about the operation or procedure?

Q47. Were you told how you could expect to feel after you had the operation or procedure?

Q49. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?

Q50. Afterwards, did a member of staff explain how the operation or procedure had gone?

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

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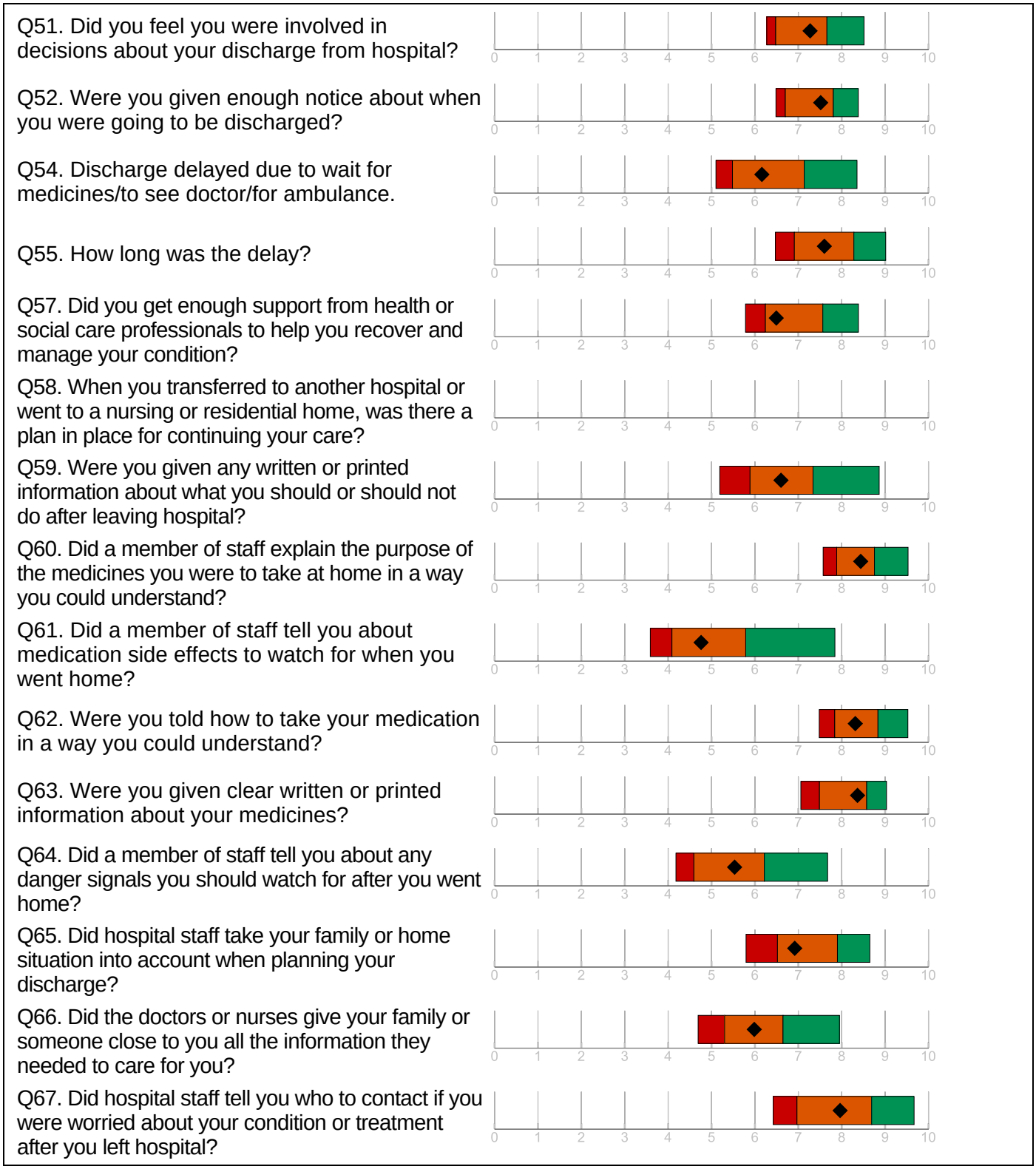
University Hospitals Bristol NHS Foundation Trust

Leaving hospital



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

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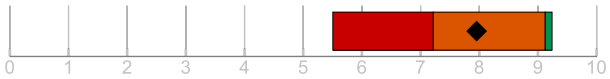
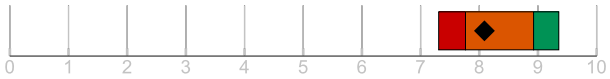
University Hospitals Bristol NHS Foundation Trust

Q68. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?



Q69. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



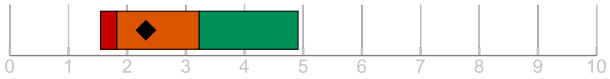
Overall views of care and services

Q70. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Q71. During your time in hospital did you feel well looked after by hospital staff?

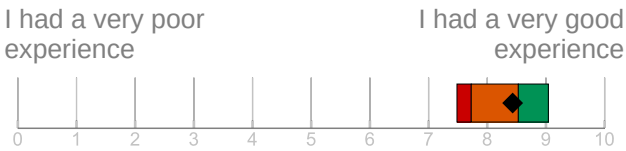
Q73. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q74. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Overall experience

Q72. Overall...



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

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	8.8	7.9	9.4			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.8	7.5	9.3	267		
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.9	8.1	9.5	296		
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.8	8.2	9.5			
Q6	How do you feel about the length of time you were on the waiting list?	8.3	6.9	9.4	244		
Q7	Was your admission date changed by the hospital?	9.0	8.5	9.9	244		
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.2	8.2	9.5	244		
Waiting to get to a bed on a ward							
S3	Section score	8.5	6.5	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.5	6.5	9.6	587		

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
The hospital and ward							
S4	Section score	8.5	7.7	9.1			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.2	7.9	9.8	397		
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.8	6.5	9.9	534		
Q15	Were you ever bothered by noise at night from other patients?	6.9	4.8	8.5	583		
Q16	Were you ever bothered by noise at night from hospital staff?	8.1	7.0	9.3	576		
Q17	In your opinion, how clean was the hospital room or ward that you were in?	9.3	8.2	9.7	583		
Q18	How clean were the toilets and bathrooms that you used in hospital?	9.1	7.7	9.5	566		
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.7	9.4	10.0	582		
Q20	Were hand-wash gels available for patients and visitors to use?	9.3	9.2	9.9	551		
Q21	How would you rate the hospital food?	5.9	4.5	7.9	545		
Q22	Were you offered a choice of food?	8.8	7.8	9.6	572		
Q23	Did you get enough help from staff to eat your meals?	7.9	5.9	9.2	146		
Doctors							
S5	Section score	8.8	8.1	9.5			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	8.5	7.6	9.3	538		
Q25	Did you have confidence and trust in the doctors treating you?	9.3	8.4	9.8	585		
Q26	Did doctors talk in front of you as if you weren't there?	8.6	7.7	9.6	586		
Nurses							
S6	Section score	8.6	7.5	9.4			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	8.6	7.2	9.4	526		
Q28	Did you have confidence and trust in the nurses treating you?	8.9	7.9	9.6	587		
Q29	Did nurses talk in front of you as if you weren't there?	8.9	8.0	9.6	588		
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	8.0	6.5	9.3	586		

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Care and treatment							
S7	Section score	8.1	7.2	8.9			
Q31	In your opinion, did the members of staff caring for you work well together?	9.1	8.0	9.7	576		
Q32	Did a member of staff say one thing and another say something different?	8.4	7.5	9.2	587		
Q33	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.9	6.6	8.9	584		
Q34	Did you have confidence in the decisions made about your condition or treatment?	8.7	7.8	9.4	590		
Q35	How much information about your condition or treatment was given to you?	8.4	7.2	9.4	592		
Q36	Did you find someone on the hospital staff to talk to about your worries and fears?	6.1	4.4	7.8	352		
Q37	Do you feel you got enough emotional support from hospital staff during your stay?	7.5	6.1	8.8	374		
Q38	Were you given enough privacy when discussing your condition or treatment?	9.0	7.9	9.4	584		
Q39	Were you given enough privacy when being examined or treated?	9.6	9.1	9.9	593		
Q41	Do you think the hospital staff did everything they could to help control your pain?	8.7	7.6	9.4	350		
Q42	After you used the call button, how long did it usually take before you got help?	6.2	5.3	7.8	314		

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.5	7.8	9.2			
Q44	Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	9.1	8.5	9.6	362		
Q45	Did a member of staff explain what would be done during the operation or procedure?	8.9	8.0	9.4	354		
Q46	Did a member of staff answer your questions about the operation or procedure?	8.8	8.1	9.5	330		
Q47	Were you told how you could expect to feel after you had the operation or procedure?	7.3	6.4	8.4	371		
Q49	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.9	8.3	9.6	310		
Q50	Afterwards, did a member of staff explain how the operation or procedure had gone?	8.1	6.8	9.2	372		

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Leaving hospital							
S9	Section score	7.1	6.1	8.4			
Q51	Did you feel you were involved in decisions about your discharge from hospital?	7.3	6.3	8.5	567		
Q52	Were you given enough notice about when you were going to be discharged?	7.5	6.5	8.4	588		
Q54	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.2	5.1	8.4	554		
Q55	How long was the delay?	7.6	6.5	9.0	549		
Q57	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.5	5.8	8.4	308		
Q58	When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care?	-	6.1	8.8			
Q59	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.6	5.2	8.9	575		
Q60	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.4	7.6	9.5	449		
Q61	Did a member of staff tell you about medication side effects to watch for when you went home?	4.8	3.6	7.8	388		
Q62	Were you told how to take your medication in a way you could understand?	8.3	7.5	9.5	398		
Q63	Were you given clear written or printed information about your medicines?	8.4	7.1	9.0	423		
Q64	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.5	4.2	7.7	437		
Q65	Did hospital staff take your family or home situation into account when planning your discharge?	6.9	5.8	8.6	388		
Q66	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.0	4.7	7.9	404		
Q67	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.0	6.4	9.7	538		
Q68	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.0	5.5	9.2	124		
Q69	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.1	7.3	9.4	292		

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015

University Hospitals Bristol NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Overall views of care and services							
S10	Section score	5.6	5.0	7.1			
Q70	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.3	8.5	9.7	586		
Q71	During your time in hospital did you feel well looked after by hospital staff?	9.2	8.3	9.7	586		
Q73	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.5	0.8	4.1	502		
Q74	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.3	1.5	4.9	446		
Overall experience							
S11	Section score	8.4	7.5	9.0			
Q72	Overall...	8.4	7.5	9.0	559		

↑ or ↓	Indicates where 2015 score is significantly higher or lower than 2014 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2014 data is available.

Survey of adult inpatients 2015
University Hospitals Bristol NHS Foundation Trust

Background information

The sample	This trust	All trusts
Number of respondents	598	83116
Response Rate (percentage)	50	47

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	52	47
Female	48	53
Age group (percentage)	(%)	(%)
Aged 16-35	6	6
Aged 36-50	10	10
Aged 51-65	24	24
Aged 66 and older	60	60
Ethnic group (percentage)	(%)	(%)
White	91	90
Multiple ethnic group	1	1
Asian or Asian British	2	3
Black or Black British	1	1
Arab or other ethnic group	0	0
Not known	5	5
Religion (percentage)	(%)	(%)
No religion	18	15
Buddhist	1	0
Christian	76	78
Hindu	1	1
Jewish	0	0
Muslim	1	2
Sikh	0	0
Other religion	1	1
Prefer not to say	3	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	94	94
Gay/lesbian	1	1
Bisexual	1	0
Other	1	1
Prefer not to say	4	4

Cover report to the Board of Directors meeting held in public
To be held on Thursday 28 July 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
18. Transforming Care Report									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive Author: Simon Chamberlain, Director of Transformation									
Intended Audience									
Board members	**X**	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose The purpose of this report is to update Trust Board on progress with Trust wide programmes of work under the Transforming Care programme. Key issues to note The report sets out the highlights of progress over the last quarter and the next steps.									
Recommendations									
The Board is recommended to receive the report for **assurance**.									
Impact Upon Board Assurance Framework									
Strategic Priority 4 : We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance				Information Management & Technology					
Human Resources				Buildings					
Action/Decision Required									
For Decision		For Assurance	**X**	For Approval		For Information			
Date the paper was presented to previous Committees									
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**				

Transforming Care Update

The purpose of this report is to update the Trust Board on progress with the Trust wide programmes of work within the Transforming Care programme. The Transforming Care priorities for 2016/17 were agreed by the Senior Leadership Team earlier in the year, and this update describes the progress over the last quarter in mobilising work against these. The Transforming Care priorities for 2016/17 are shown at appendix 1.

1. Our key programmes of work to improve patient flow (Unscheduled Care & Ward Processes and Planned Care) have been brought together into a single "Operating Model" programme. This recognises that the areas of focus across these pathways are become increasingly similar and the separate project structures were no longer of benefit.

2. The Ward Processes work delivered in 2015/16 has helped deliver a significant improvement in performance versus the quality objective of improving timely discharge. In the last three months 970 patients per month have on average been discharged before noon compared to 850 in the same period one year ago. The improvement is even more marked at individual ward level where the wards who adopted the Ward Processes work earliest have made most improvement – in some areas moving from below 20% to over 33% of discharges before noon over the last year.

3. This programme will continue into 2016/17 but closely integrated with the roll out of real time patient information and IT tools. The aim of the overall Operating Model programme is to bring together all of our process, behaviour, information and IT improvement work in order that we can fully exploit all of these improvements to better manage patient flow in real time. This will include the IT tools which were originated within the Planned Care programme, and over the next quarter we expect to see the first electronic ward whiteboard come into use on STAU, supported by the electronic pathway dashboard which is being rolled out initially across SH&N.

4. The opportunities to further improve were highlighted in the "Plans for the Weekend" event which we held in May. This event, inspired by our previous Breaking the Cycle events, focussed on preparations for and discharges across the weekend. The event was enthusiastically taken up by ward teams and again we were supported by our community health and social care partners. The event was successful in driving up weekend discharges. The post event "wash up" review showed how the Ward Processes good practice had become embedded, how teams benefited from it, and pointed to the further developments needed. The key learning

was the need to continue to improve the accuracy of patient status in our IT systems (which has been a particular focus of IT led work) – and in particular to improve use of Estimated Dates of Discharge. A cross-divisional clinical, IM&T and Transformation project team is now planning the detailed delivery of the next phase of our Operating Model work.

5. Our Theatre Transformation programme held a "Theatres Quality and Culture Week" in late April. The purpose of this event was to support theatres staff in delivering safe and high quality care by identifying barriers which they regularly encounter. The week was very well received by theatre staff who appreciated the strong engagement and focus on their issues which it provided. A wrap up event was supported by over 100 staff, and featured feedback on the findings of the week and team building activities. The learnings from the event have shaped the next phase of Theatres Transformation work which is focussed around three themes: team leadership, capability and communications; further improvements to scheduling to address list changes on the day; and the integration of the new Bluespier theatre management system to make the best use of data in scheduling and real time theatre management.

6. In our Children's Hospital, the changes driven by the 2015/16 Surgical Improvement programme have become widely adopted and have supported the hospital's growth in surgical activity over the last year. It is notable that over the same period the percentage of procedures cancelled or postponed has fallen. New tools and methods including new booking processes, the adoption of enhanced recovery pathways and increased adoption of IT tools have helped support this growth. The Children's teams have since completed a series of staff workshops to identify priorities for the next wave of transformation projects, which will include hospital out of hours, protecting surgical activity in winter, daily hospital management (including use of real time information), and support to regional partner hospitals.

7. In our Outpatients Transformation programme, workshops with staff have been held to review and update our Outpatients Standards – which set out best practice in preparing and managing outpatient clinics. These standards support both productivity improvement and patient experience in clinics and the update standards will be rolled out through the balance of 2016. The programme team has tested revised text message reminders in clinics with high DNA (Did Not Attend) rates. The trial reduced the number of DNAs by 15% over the trial period. We are planning to extend the scope of our central Appointments Centre which will further improve the quality of service to patients calling in to book or amend appointments. We have also tested real time information systems to give patients better information about clinic running times and give staff an early indication of developing delays.

8. We are rolling out an Admin Teams Transformation programme. This responds to feedback from patients on how admin staff can provide a better quality of service, but

also seeks to strengthen staff engagement and reduce turnover among these teams by ensuring we provide consistent training and development. Workshops with teams are ensuring that recruitment, training and development needs are well understood and linked to competency development, and improve the quality of service to patients complaints by focussing on areas such as call handling and delivering difficult messages.

9. This programme also aligns to our quality objectives of improving communications with patients. Through both training and improving call management we are addressing some of the causes of complaints around verbal/telephone communications with patients. Alongside this we are addressing written communications through the introduction of new standardised patient letters. These have now been extensively tested through reading panels and technical trials and will start to roll out, along with revised accompanying leaflets, this summer. Alongside this we have secured Information Governance support to initiate the use of email to send Medway originated appointment letters to patients and are now clearing the technical and logistical barriers to this.

10. A common factor through all of our transformation work is team and staff engagement – working closely with front line teams to support them in shaping change and addressing their local issues. Staff engagement is also supported by the roll out of the Happy App, the real time staff feedback tool we have developed and tested. This is gradually being rolled out across the Trust, with a further 20 teams expected to adopt it in June and July alone. The response and take up from staff has been very positive to date.

11. Alongside our large scale transformation programmes, a cross functional team is addressing how we promote and encourage innovation and improvement more broadly. Last year we ran a Bright Ideas competition to seek out and support good ideas from staff for improving our services. The competition was a success, with 36 entries from which four winners were selected. One of these – “A Good Night’s Sleep” led by Damien Leith was featured in the last edition of Voices”. We will run this competition again this year, but our Innovation & Improvement working group is developing how we can better support staff on a continual basis. Recommendations will be presented to the Transformation Board later in the summer, but will focus on two areas: How we find, prioritise and support the best ideas for improvement; and how we provide skills development opportunities to staff to our staff to build the capacity to take on and deliver change locally.

12. While the focus of much of our transformation work is internal, by leading in partnership with health community partners we are supporting the wider transformation of our local health system. We continue to lead cross agency work to improve discharge for patients with complex circumstances through the adoption of Discharge to Assess pathways which are becoming increasingly used. We are

developing the multi-agency Integrated Discharge Service based in the BRI through the appointment of a single, jointly appointed lead, and further team development and improvements to ways of working. Across Bristol we have been central to the work over the last quarter to renew the vision for the Better Care Bristol programme, which seeks to transform service more widely across our city. And our Transformation Board is addressing how we ensure our plans will align with and support the Sustainability & Transformation Programme across Bristol, North Somerset and South Gloucestershire

13. The latest update of progress on our programmes of work as provided to Transformation Board and the Senior Leadership Team is provided at Appendix 2

14. Next steps: Over the next quarter our focus will be on delivery of the changes planned for the year, in order that we can maximise our impact and improvement ahead of the winter period.

Simon Chamberlain
Director of Transformation
8th July 2016

Appendix 1: Transforming Care Priorities for 2016/17

Appendix 2: Progress update at July 2016

Transforming Care Programme report

Pillar	Details	Purpose	Status	Milestone review last month June	Key deliverables going forward	Planned Month	Benefits / Measures	Risks
Delivering best care	**Project:** Patient Communications **Exec lead:** Carolyn Mills **Project lead:** Alison Grooms	**Patient Letters** To improve and standardise the quality of all appointment letters that are sent by UHBristol to patients, guardians and carer (both electronically and non-electronically generated) in line with the Trust's Objective 5 - 'To improve how the Trust communicates with patients'.	G G A G	• KPI's for success agreed • SH&N Inpatient and Cardiology Outpatient letters sent to synertec for testing • Children's outpatient letters drafted • Inpatient and Outpatient leaflets approved and sent to synertec for testing and printing	• BHI and SH&N letter pilot commenced through synertec. • SH&N inpatient and Cardiology Outpatient easy read letters drafted and approved • Children's outpatient letter packs approved • Letters champion week follow up for pilot areas • Plan agreed for roll out of letter quality standards across Trust	Jul Aug Aug Aug	• To improve patient experience and reduce patient communication related complaints and DNA's	• Ability to resource the rewriting of letters Trust wide against the letter quality standards.
		Medway based email correspondence To provide our patients with the option of receiving their appointment letter via email instead of post, as preferred by many of our patients, especially those with visual impairment.	A G G	• VCP form submitted for validator staff • Decision on use of Synertec as interim measure for issuing emails and leaflets • Solution agreed for issuing patient leaflets	• Appointment of 3 Validator staff • Training of validators, receptionists and booking coordinators in SOPs for email correspondence. • Go-live coms in place prior to project launch • Email collection commenced	Aug Aug Aug Aug	• To provide our patients with the choice of receiving their appointment letter via email. • To reduce printing and postage costs	• Low up-take of email option • Staff training in SOP • Appropriate method of sending leaflets to be decided
	Project: CSIP **Exec lead:** Paul Mapson **Project lead:** Steve Gray	Implementation of a cohesive set of clinically-focused applications and technologies that will transform business processes and provide users with tools and opportunities to improve patient care and achieve efficiencies.	A G G G	• Joint Pathology LIMS System Live (revised go-live date agreed - September) • BigHand project rollout re-commenced • Medway Version 4 Live • Evolve EDM System went live across the BRHC on 4 July. This was supported by Real Time improvements including quick launch into Medway from log-in and creation of E-Forms.	• Development of Wardview Interactive Electronic Whiteboards to support Real Time data recording and reporting. First area to receive • Bluespier live in theatres • EPMA Pilot begins • EDM Project Ready to go-live in BRI (actual go-live date will be agreed with BRI)	Sept Oct Nov Dec	• Improved patient safety and experience through ready access to timely, accurate information • Improved efficiency for all staff involved in handling/viewing/creating patient information • Increased security of patient information (e.g. patient images)	Risk of poor performance of IT infrastructure may impact usability of new systems.
	Project: Sign up to Safety Patient Safety Programme **Exec lead:** Sean O'Kelly **Project lead:** Caroline Beale	To reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.	G G A A G	• Safety culture work stream: in Q1, completion of organisation level safety culture analysis • Deteriorating patient work stream: in Q1 testing revised NEWS escalation protocol and work up of sepsis CQUIN audit plan completed • Peri-operative never events work stream: in Q1, implementation of theatre LocSSIPs and tesing of endoscopy LocSSIP completed • Medicines safety work stream: insulin driver diagram completed and initiation of safety projects • Leadership work stream: in Q1, implementation of new format of executive led patient safety walk rounds	• Safety culture workstream: in Q2, Divisional Board and team level safety culture analysis completed and feedback commenced • Deteriorating patient work stream: next version of adult obs chart produced, new sepsis audit methodologytested and AKI workstream refreshed • Peri-operative never events work stream: continue work on LocSSIP development for other invasive procedures • Medicines safety work stream milestone: in Q2 the 'PharmOutcomes' referral pilot completed and patient self-administration of insulin protocols produced • Leadership work stream: in Q2 pilot ward round checklist developed for testing	Sep Sep Sep Sep Sep	• Reduction in mortality and avoidable harm • Earlier recognition and management of deteriorating patients • Prevention of peri-procedure never events Reduction in insulin medication errors and readmissions due to poor medicines compliance • Increased sustained compliance with patient safety risk assessments and controls	• Risk front line staff cannot release sufficient time to enagage and particpate in quality and safety improvement • Risk that the Patient Safety Improvement Programme objectives are not achieved if funding for patient safety audit and quality improvement nurse is not secured
	Project: Outpatients **Exec lead:** Deb Lee **Project lead:** Candice Tyers	To deliver a high quality service through a friendly, accessible, consistent and timely service.	R G G G	• Working groups for each workstream set up • Standards review workshop with Divisional reps held • Pilot of reworded text reminder reviewed • Referral management operational dashboard developed	• Updated Standards drafted & circulated for feedback • Referral management operational dashboard reviewed and checked for correctness • Outpatient Standards updated version available • Outpatient productivity review carried out in one specialty per Division	Jul Jul Aug Sep	• Improved patient experience due to services working according to the standards, improved training of outpatients staff and one single place to call for appointments • Income generation via 1% DNA reduction/activity increase in 6 specialties who pilot reworded text reminder	• Outpatients Programme being replanned with the current Outpatient Manager leaving.
Improving patient flow	**Project:** Operating Model **Exec lead:** Owen Ainsley **Project leads:** TBC	To establish a fully Integrated Discharge Service which reduces occupied bed days whilst improving patient outcomes and experience	G A	• Project leads identified • Revised project on a page developed	• Integrated Discharge Service Lead appointed • Discharge to assess pathway 1 relaunched • Pilot of Homelessness Support team project • Discharge to assess pathways 2 & 3 relaunched	Jul Aug Sept Q2	• Achievement of A518 (17 beds) closure • Achievement of occupancy at 92% in Medicine Division • Reduction in green to go patients by 17 • Maintain discharges before 12:00 at 30% in Medicine Division • Reduction in last minute cancellations to 0.8%	• No Capacity in the community • No resilience in community • Risk that A518 cannot close if not achieving reduction in green to go bed days • Risk that without appointment of an IDS lead, the IDS project won't deliver
		Roll out an integrated Ward Processes and Real Time programme	G G G	• Operating Model sub-group workstreams, governance, reporting, benefits realisation and project delivery to be agreed • SHN patient flow tracker stakeholder event held • Re-established the SHN transformation steering group	• Integrated ward processes and real time project plan developed - project on a page 2nd Trust wide Ward Processes sharing event held • Recommence electronic ward whiteboard technical development • SHN transformation programme of work approved • Develop electronic ward whiteboard roll out plan • First electronic ward whiteboard (STAU) ready for user acceptance testing • Surgical flow & BHI flow tracker implemented and roll out across SHN and BHI (including escalation SOP)	Jul Jul Jul Jul Aug Sept Q3		• Risk that Operating Model Programme Board will have too large a scope to be able to effectively direct and coordinate the delivery of the programme • Risk that lack of dedicated IM&T resource will delay roll out of electronic whiteboards across the Trust (project commenced March 2015)
		Establish a Virtual Ward	A	• ORLA go live	Evaluation and reporting of performance	Jul		
		Establish a "joint front door" with primary care (CCG led)		Milestones and timings to be confirmed				
	Project: Theatre Transformation Programme **Exec Lead:** Paul Mapson **Project Lead:** Jan Belcher	To provide individualised safe quality patient care with maximum efficiency in responsive operating theatres Trust wide. Which in turn will support the capacity demands for surgical intervention.	G G A	• Planning next steps following quality and culture week • Audit effect of first case process in BEH • Bluespier configuration sign off	• Theatre team leader role established in Children's Hospital • Bluespier phase 1 roll out completed • Bluespier trauma and emergency whiteboard configuration sign off • Bluespier hardware roll out commenced • Bluespier hardware roll out completed	Aug Oct Jul Aug Dec	• Start on time 90% achievement • Turnaround Time 85% achievement • Theatre utilisation 85% achievement	• Theatre Staff recruitment and retention will impact capacity • Further delays to Bluespier implementation
	Project: Real Time Staff Engagement (The Happy App) **Exec Lead:** Sue Donaldson **Project Lead:** Anne Frampton, Andrew Hollowood	To provide a method for staff to leave real-time feedback regarding how they are feeling and the related causes. By doing so we will improve engagement with staff, and in turn we believe this will help us to provide a better quality of care to our patients.	G G G	• Purchase of 1st phase equipment • HSJ application submitted • Roll out of website to 3 areas per Division	• Roll out of website to 3 areas per Division • Roll out of website to 3 areas per Division • Submission of paper to BMJ • Roll out of website to 3 areas per Division • Roll out of website to 3 areas per Division	Jul Aug Sep Sep Oct	• Use of app (number of hits a day per area) • No of areas using website • No of resolved & closed actions per area • Improved staff Friends and Family	• Availability of IT support/resource • Willingness of staff to engage • Administrator resource to respond to comments
Building capability	**Project:** Appraisal improvement project **Exec Lead:** Sue Donaldson **Project Lead:** Sam Chapman	• Staff appraisals are considered valuable and worthwhile • Staff receive an annual appraisal and regular reviews which integrate objectives, development, performance and career discussions • Staff appraisals link to the overall strategic direction of the organisation	G G G G	• Design groups for e appraisal held • Working group set up to formalise electronic appraisal • Work commenced on development of e learning for both appraisers and appaisees • Revised appraisal policy presented at Trust partnership forum	• Final version of appraisal policy released • Amendments made to system based on feedback • Electronic appraisal system implementation trustwide	Jul Aug Sep	• Improved Staff Experience • Reduction in staff turn over • Able to monitor the quality of appraisals • Support a culture of Collective Leadership	• Challenges IT could delay project roll out - mitigated through the HRIS subgroup and weekly AIP meeting
	Project: Admin Teams Transformation Trust Wide **Exec Lead:** Sue Donaldson **Project Lead:** Stephanie Smith-Clarke	To join up the work going on across the Trust in relation to our admin teams and realise the benefits that we could be recognising in our savings programme.	G G A G	• Creation of an Administration Recruitment Plan • Job competency and TNA workshops to commence • TSB Admin SOP to be drafted • Call handler role competencies and training needs workshop held	• Clinic Coordinator role competencies and training needs workshop held • Clinic Clerk (Receptionists and preppers) role competencies and training needs workshop held • Inpatient Booking Coorindator role competencies and training needs workshop held • Ward Clerk role competencies and training needs workshop held • Interview process designed • Assessment centre internal processes planned and agreed • Workspace/connect page created for advertising Bank staff • Approved (and matched) standardised job descroptions held cenrally by HR • Design of training programmes per role	July Sep Sep Oct Sep Sep Sep Oct Nov	• Reduction in bank and agency spend • Reduction in manager time spent recruiting admin roles • Reduction in staff turnover • Improved staff retention • Improved friends and family score/trust survey from A&C staff • Reduction in stress related sick days	• Divisional ability to resource project • Possibility for consultation required for changes to job descriptions

Milestone complete / Activities on track to achieve milestone
Milestone behind plan, with action to remedy
Milestone behind plan, project/programme risk

Updated: 14.07.2016

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
20. Finance Report									
Sponsor and Author(s)									
Sponsor & Author: Paul Mapson, Director of Finance & Information									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
To report to the Board on the Trust's financial position and related financial matters which require the Board's review.

Key issues to note
The summary income and expenditure statement shows a surplus of £3.871m (before technical items) for the first three months of the year. The 2016/17 financial plan, which includes receipt of £13.0m sustainability funding, has been revised to deliver a surplus of £15.9m before technical items. At month three the Trust is £0.013m favourable against the revised plan.

Recommendations
None.
Impact Upon Board Assurance Framework
Strategic Priority 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	25/07/16				

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £3.871m (before technical items) for the first three months of the year. This includes £3.25m of sustainability funding – the position represents a surplus of £0.621m without this new funding The 2016/17 financial plan, which includes receipt of £13.0m sustainability funding, has been updated to reflect acceptance of a revised control surplus of £15.9m (before technical items) following the receipt of the letter (2016/17 Financial Position and Operational Plan) from NHS Improvement of the 9th June 2016. At month three (quarter 1) the Trust is £0.013m favourable against the revised plan.

The run rate overspend in Clinical Divisions and Corporate Services increased significantly in June. The adverse variance was £1.114m compared to £0.602m in May. The year to date overspend is now £2.701m compared to the operating plan trajectory to date of £0.750m.

The subjective analysis is shown below:

(Adverse)/Favourable	June £m	May £m	April £m	2016/17 to date £m	2015/16 outturn £m
Nursing & midwifery pay	(0.251)	(0.555)	(0.348)	(1.154)	(4.276)
Medical & dental staff pay	0.025	(0.321)	(0.123)	(0.419)	(1.805)
Other pay	0.109	0.346	0.175	0.630	1.587
Non-pay	(0.212)	(0.444)	(0.270)	(0.926)	(3.527)
Income	(0.785)	0.372	(0.419)	(0.832)	(1.208)
Totals	**(1.114)**	**(0.602)**	**(0.985)**	**(2.701)**	**(9.229)**

The Divisional positon is disappointing with the concern being that a continuation of the current run rate could compromise delivery of the Control Total only very recently formally agreed with our regulator, NHS Improvement.

There are fortunately offsets which enable the overall Trust position to be reported as being on plan – hence earning the sustainability funding of over £3m. These issues include the following:

- Corporate incomed is estimated to benefit from a £4m gain arising from the actual March 2016 activity charges being substantially higher than estimated due to:

  - Activity increases higher than projected £2.75m.
  - CQUINs delivery of 95% which was an excellent result for patient care plus an increase of £1.25m income compared to plan.

  As this issue has occurred in each of the past few years (but to a much lesser extent) we will revise the basis for charging for March 2017 following discussion with Auditors and Commissioners.

- Some capital charges underspending is expected – say £0.5m

- There will be other savings in the areas of reserves (increments, cost pressures, contingency use etc.) plus the balance sheet will be reviewed comparing UH Bristol to other Trusts. The extent of this potential benefit is still under review but could be between £4m - £5m.

Hence, provided, the Divisional run rate improves the Trust can still forecast delivery of the £15.9m Control Total surplus. However achieving this by using the last non-recurrent measures available to the Trust will inevitably create a deficit position in 2017/18.

There are five key financial drivers which are key to controlling the Trust's financial position to achieve the 2016/17 financial plan:

a) Sustainability funding
b) Nursing and midwifery pay
c) Medical and dental pay
d) Clinical activity
e) Savings programme

These are described in the following sections. It should be noted that the major adverse variance in June was income, due to very low activity levels.

a) <u>Sustainability Funding</u>

The Trust's financial position for quarter 1 includes £3.25million of sustainability funding. Earning sustainability funding in quarter 1 required the agreement of the access standards trajectories only with NHS Improvement / NHS England. However, whilst the eligibility of STF in quarter 1 is not dependent on the actual delivery of the Trust's net surplus Control Total (excluding STF) and the delivery of the access standards trajectories in quarter 1, it is important to understand actual delivery against the trajectories in quarter 1 to provide assurance going forward into quarters 2,3 and 4. This is summarised below.

Trajectory	April	May	June	Total
Control Total delivery	Achieved	Achieved	Achieved	
STF notionally earned			£3.25m	£3.25m
A&E trajectory delivery	Achieved	Achieved	Achieved	
STF notionally earned	£0.135m	£0.135m	£0.135m	£0.405m
Cancer trajectory delivery	Achieved	Failed	Failed*	
STF notionally earned	£0.055m	£0.0m	£0.0m	£0.055m
RTT trajectory delivery	Failed	Achieved	Failed**	
STF notionally earned	£0.0m	£0.135m	£0.405m	£0.405m

* subject to validation.
** failed but within a tolerance of 1%.

Whilst A&E performance has delivered the trajectory and the £0.405m available, it should be noted, however, that the lower activity levels in July did not enable the A&E performance to improve which raises concerns about the increases in the monthly trajectory later in the year. Instead, length of stay appears to have increased.

Cancer performance in quarter 1 earned notionally, £0.055m out of the £0.165m available with delivery of the trajectory in April only. However, performance in May and June dropped back against an increasing trajectory. Whilst it is accepted that June's performance is subject to validation, the trajectory for July is 84.7%. Against June's performance of 73.2%, a significant step change in performance would be required by the Trust in July to meet the trajectory. This raises a significant concern going forward.

RTT reports delivery in May only, however, after the application of the 1% tolerance, a notional sum of £0.405m would have been earned out of £0.405m. Going forward, the trajectory increases from 92.7% at the end of June to 93.1% for the end of November. Whilst actual performance is within the tolerance for quarter 1, it will be important to understand the absolute numbers of patients requiring treatment going forward each month including the recovery of prior month RTT position and the recovery action required by the Trust.

The Diagnostic access standard currently falls outside of the STF and is excluded from this report.

b) Nursing & Midwifery

Nursing and midwifery pay variance for the month is £0.251m adverse. The table below shows the analysis between substantive, bank and agency for each month of the first quarter and year to date. The 2015/16 position is shown for comparison.

	June	May	April	2016/17 year to date	2015/16
	£m	£m	£m	£m	£m
Substantive	0.965	0.483	0.781	2.229	10.099
Bank	(0.617)	(0.476)	(0.345)	(1.440)	(6.684)
Agency	(0.599)	(0.562)	(0.784)	(1.945)	(7.691)
Totals	**(0.251)**	**(0.556)**	**(0.348)**	**(1.154)**	**(4.276)**

Whereas the overall nursing variance improved in June, the level of agency spend has not changed despite the low activity levels experienced. Analysis has shown that whilst there has been a reduction in the hours used, the average cost per shift has increased reflecting the use of agency to cover specialist and hard to recruit posts at a higher premium rate. Substantive staff costs reduced reflecting the additional enhancement costs paid in May resulting from an additional weekend and an additional bank holiday as well as the full month's effect of the 1% pay increase on enhancements.

This shows that planned improvements in nursing spend are not yet being delivered. The impact is then on the overall Divisional overspend run-rate.

The table below shows the Nursing and ODP price and volume variance for June. It shows that Nursing and ODPs were £0.257m overspent in the month with £0.023m as a result of the premium overhead price paid for staff and £0.234m from using above the funded establishment (wte). The table also shows that the wards in the clinical divisions are primarily responsible for the overspend (£0.390m) with £0.075m attributable to the premium price paid for staff and £0.315m for operating above establishment.

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time % (Wards/ED/ Theatres)
Medicine	Ward	50	(158)	(108)	
	Other	(32)	51	18	
	ED	(6)	(10)	(17)	
Medicine Total		**12**	**(117)**	**(106)**	**130%**
Surgery, Head & Neck	Ward	(52)	(96)	(149)	
	Theatres	15	45	59	
	Other	(4)	25	20	
	ED	(3)	0	(3)	
Surgery, Head & Neck Total		**(45)**	**(27)**	**(72)**	**127%**
Specialised Services	Ward	(8)	(56)	(65)	
	Other	(3)	7	4	
Specialised Services Total		**(11)**	**(50)**	**(61)**	**129%**
Women's & Children's Services	Ward	(70)	1	(69)	
	Theatres	(22)	5	(18)	
	Other	101	(17)	84	
	ED	(5)	(2)	(6)	
Women's & Children's Services Total		**4**	**(14)**	**(9)**	**126%**
Clinical Division Total	Ward	(75)	(315)	(390)	
	Theatres	(8)	49	42	
	Other	53	73	126	
	ED	(14)	(11)	(25)	
CLINICAL DIVISIONS TOTAL		**(44)**	**(204)**	**(248)**	**128%**
NON CLINICAL DIVISIONS	Other	21	(29)	(9)	
TRUST TOTAL		**(23)**	**(234)**	**(257)**	**128%**

The HR Nursing Controls dashboard is attached at appendix 3 and shows the registered nursing position for each Division against 8 KPIs. Highlights from the KPIs are as follows,

- Sickness –Surgery, Head and Neck and Women's and Children's Divisions continue to be above trajectory for their sickness levels.
- Vacancies – all but the Women's and Children's Division are above the Trust target of 5% for vacancies with the Division of Medicine being the highest at 8.3%.
- Operating Plan for nursing agency wte – all Divisions except the Division of Women's and Children's are above their Operating Plan position with the Division of Surgery, Head and Neck being the most concerning with an actual position of 25.9wte against a target of 8.6wte. This is also reflected in their percentage of nursing agency against total nursing spend, 10% against a target of 2.6%.
- Nursing assistant, 1:1 and RMN usage – the Medicine Division continues to be above the funded level for NA 1:1's and RMN's. All other Divisions for month 3 are under the funded level.

*c) **Medical and Dental***

Medical and dental pay variance for the month is £0.025m favourable. The table below shows the analysis between substantive, locum and agency for each month of the first quarter and year to date. The 2015/16 position is shown for comparison.

	June 2016/17	May 2016/17	April 2016/17	2016/17 to date	2015/16 Outturn
	£m	£m	£m	£m	£m
Substantive	0.376	0.002	0.267	0.645	2.387
Locum	(0.217)	(0.182)	(0.231)	(0.630)	(1.803)
Agency	(0.134)	(0.141)	(0.159)	(0.434)	(2.389)
Totals	**0.025**	**(0.321)**	**(0.123)**	**(0.419)**	**(1.805)**

Pay costs for medical and dental staff decreased slightly in June. One of the main reasons being the lack of availability of locums plus lower WLI activity due to lower pay rates being introduced for additional work.

NHS Improvement Locum and Agency Ceiling

NHS Improvement has set an expenditure ceiling of £12.793m for all agency and medical locum spend for the Trust. The operational plan submitted by the Trust to NHS Improvement for 2016/17 had a forecast outturn of £11.755m. At the end of June the Trust is currently showing an adverse variance against the NHS Improvement ceiling of £0.469m. Against the Trust's operational plan the variance is £0.760m adverse, due to nursing expenditure being higher than planned.

The table below shows a summary of both the current month and year to date position against the NHS Improvement Operational Plan by staff group.

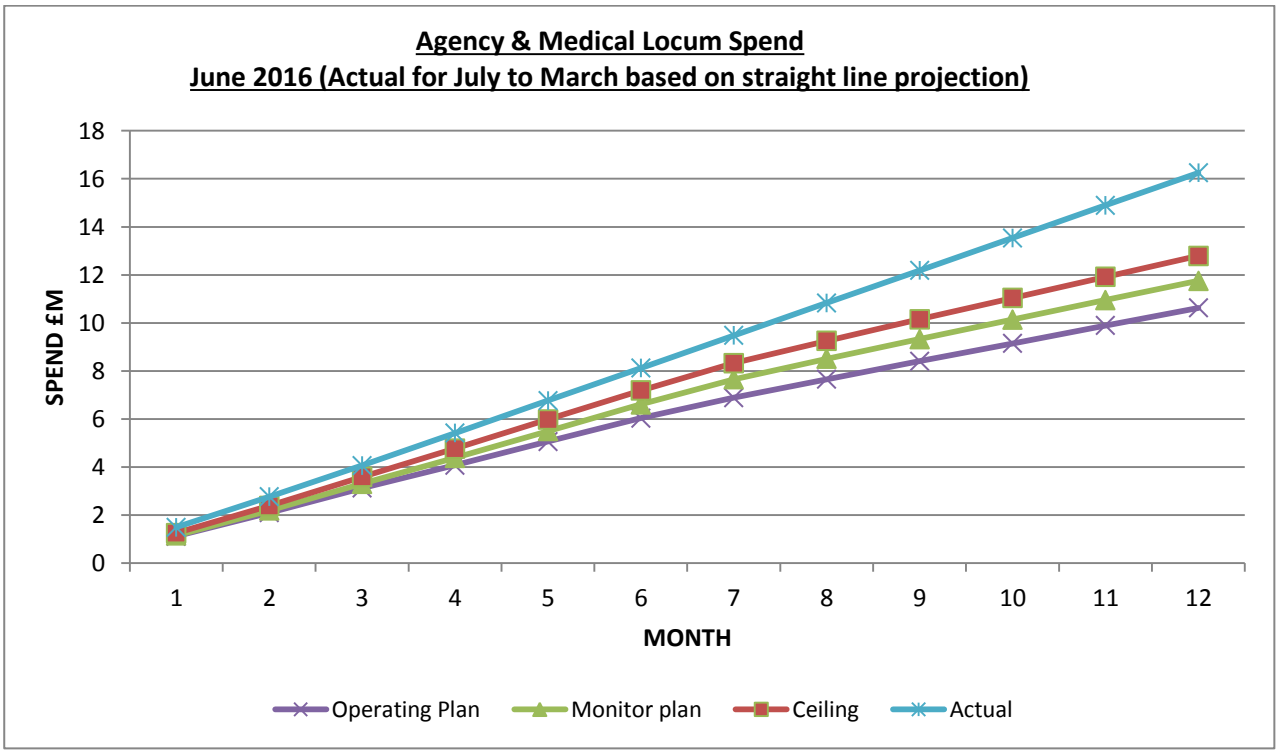
Spending versus NHS Improvement Agency & Locums Ceiling

	Current month position (June)			Year to date position		
Staff category	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m	NHS I Ceiling £m	Actual £m	Variance fav/(adv) £m
Medical	-	0.521		-	1.620	
Nursing (RNs and NAs)	-	0.596		-	1.984	
Other	-	0.177		-	0.458	
Totals	**1.210**	**1.294**	**(0.084)**	**3.594**	**4.062**	**(0.469)**

Spending versus UH Bristol Operational Plan

	Current month position (June)			Year to date position		
Staff category	Operational Plan £m	Actual £m	Variance fav/(adv) £m	Operational Plan £m	Actual £m	Variance fav/(adv) £m
Medical	0.581	0.521	0.060	1.810	1.620	0.190
Nursing (RNs and NAs)	0.365	0.596	(0.231)	0.965	1.984	(1.019)
Other	0.165	0.177	(0.012)	0.527	0.458	0.068
Totals	**1.112**	**1.294**	**(0.183)**	**3.302**	**4.062**	**(0.760)**

The graph below shows the forecast outturn based on a straight-line projection against the ceiling and the NHS Improvement Operational Plan



d) Clinical Activity

Activity based contract performance worsened by £0.811m in June to give a cumulative under performance of £0.095m. The position worsened in June for all divisions with the exception of Diagnostics and Therapies as shown in the table below.

Divisional Variances	June Variance Fav/(Adv)	Year to Date Plan	Year to Date Actual	Year to Date Variance Fav/(Adv)
	£m	£m	£m	£m
Diagnostic & Therapies	0.021	9.926	10.044	0.118
Medicine	(0.309)	13.040	12.723	(0.317)
Specialised Services	(0.048)	14.905	15.200	0.295
Surgery, Head and Neck	(0.271)	20.362	20.283	(0.079)
Women's and Children's	(0.160)	25.927	25.590	(0.337)
Facilities and Estates	(0.011)	0.923	0.917	(0.006)
Corporate	(0.033)	25.731	25.962	0.231
Totals	**0.811**	**110.814**	**110.719**	**(0.095)**

Underperformance to date within Women's and Children's within critical care bed days and elective inpatients continues, although the performance has improved in month. The deterioration in Medicine was due to significantly lower emergency inpatient activity.

e) Savings Programme

The savings requirement for 2016/17 is £17.420m. Savings of £3.008m have been realised to date, a shortfall of £1.209m against divisional plan. The shortfall is a combination of unidentified schemes of £0.794m and a further £0.415m for scheme slippage. The 1/12th phasing adjustment increases the shortfall to date by £0.138m. The adverse variance against plan to date of £1.209m represents a significant deterioration from last month's adverse variance of £0.617m reflecting the revised cost assumptions of delivering dental and ENT contracts within Surgery, Head and Neck.

The year-end forecast outturn has decreased this month to £13.460m, a shortfall of £3.960m, which represents delivery of 77.3% which is diappointing. This decrease is primarily due to the reassessment of schemes relating to outsourced work and income savings schemes within Surgery, Head and Neck and drugs savings within Medicine.

A summary of progress against the Savings Programme for 2016/17 is summarised below. A more detailed report is given under item 5.4 on this month's agenda.

	Savings Programme to 30th June 2016				
	Plan	Actual	Variance fav / (adv)	Phasing adjustment fav/(adv)	Total variance Fav/(adv)
	£m	£m	£m	£m	£m
Diagnostics and Therapies	0.385	0.400	0.015	(0.025)	(0.010)
Medicine	0.352	0.315	(0.037)	(0.069)	(0.106)
Specialised Services	0.355	0.284	(0.071)	(0.023)	(0.094)
Surgery, Head and Neck	1.124	0.570	(0.554)	(0.115)	(0.669)
Women's and Children's	1.216	0.642	(0.574)	0.057	(0.517)
Estates and Facilities	0.166	0.175	0.009	(0.030)	(0.021)
Trust HQ	0.247	0.231	(0.016)	0.067	0.051
Other Services	0.372	0.391	0.019	0.00	0.019
Totals	**4.217**	**3.008**	**(1.209)**	**(0.138)**	**(1.347)**

2. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £1.114m in June to a cumulative position of £2.701m adverse to plan. The table below summarises the financial performance in June for each of the Trust's management divisions against their budget and against their June Operating Plan trajectory. Further analysis of the variances against budget by pay, non-pay and income categories is given at Appendix 2.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)	
	To 31 May £m	June £m	To 30 June £m	Trajectory To June £m	Variance £m
Diagnostic & Therapies	0.081	0.002	0.083	(0.040)	0.123
Medicine	(0.520)	(0.443)	(0.963)	(0.103)	(0.860)
Specialised Services	(0.127)	(0.105)	(0.232)	(0.135)	(0.097)
Surgery, Head & Neck	(0.494)	(0.388)	(0.882)	(0.275)	(0.607)
Women's & Children's	(0.546)	(0.189)	(0.735)	(0.187)	(0.548)
Estates & Facilities	(0.011)	(0.004)	(0.015)	(0.030)	15
Trust Services	0.015	(0.006)	0.009	0.011	(0.002)
Other corporate services	0.015	0.019	0.034	0.009	0.025
Totals	**(1.587)**	**(1.114)**	**(2.701)**	**(0.750)**	**(1.951)**

Variance to Budget:

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

	Budget Variance favourable/(adverse)		
	To 31 May £m	June £m	To 30 June £m
Pay	(0.793)	(0.087)	(0.880)
Non Pay	(0.164)	0.151	(0.013)
Operating Income	(0.102)	0.051	(0.051)
Income from Activities	0.201	(0.611)	(0.410)
Sub Total	(0.858)	(0.496)	(1.354)
Savings programme	(0.729)	(0.618)	(1.347)
Total	**(1.587)**	**(1.114)**	**(2.701)**

Pay budgets have an adverse variance of £0.087m in the month increasing the cumulative adverse variance to £0.880m. The significant adverse movements in the month were within Medicine (£0.141m) and Specialised Services (£0.069m), offset by a favourable variance in Diagnostic and Therapies (£0.191m). Cumulative adverse variances are within Women's and Children's (£0.727m), Surgery, Head and Neck (£0.283m), Medicine (£0.319m) and Specialised Services (£0.142m) offset by favourable variances in Diagnostic & Therapies (£0.396m) and Trust Services (£0.192m).

For the Trust as a whole, agency spend is £3.049m to date. The monthly average spend of £1.016m compares with a monthly average spend in 2015/16 of £1.260m. Agency spend to date is £0.861m in Medicine, £0.548m in Women's and Children's, £0.707m in Surgery, Head and Neck and £0.555m in Specialised Services. Waiting list initiatives costs to date are £0.779m of which £0.336m is within Surgery, Head and Neck, £0.141m in Women's and Children's and £0.131m in Specialised Services.

N**on-pay budgets** have a favourable variance of £0.151m in the month reducing the cumulative adverse variance to £0.013m.

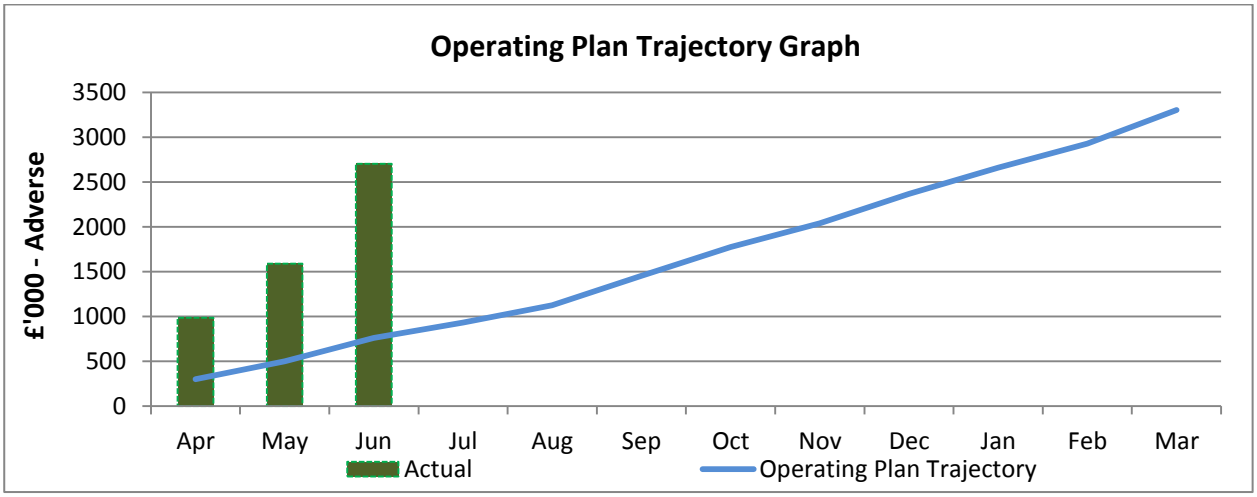
The significant adverse movements in the month were in Diagnostic and Therapies (£0.110m) and Specialised Services (£0.041m). These were offset by favourable variances in Surgery, Head and Neck (£0.123m), Women's and Children's (£0.097m) and Medicine (£0.093m).
Cumulative adverse variances are within Medicine (£0.141m), Diagnostic & Therapies (£0.316m), Surgery, Head and Neck (£0.059m), and Specialised Services (£0.131m) offset by a favourable variance in Women's and Children's of £0.684m.

Operating Income budgets have a favourable variance in the month of £0.051m reducing the cumulative adverse variance to £0.051m.

Income from Activities budgets have an adverse variance in month of £0.611m changing the cumulative variance to £0.410m adverse.
The most significant adverse variances in month were in Medicine (£0.326m) and Surgery, Head and Neck (£0.161m). Other adverse variances in month were in Women's and Children's (£0.068m) and Diagnostic and Therapies (£0.077m).
The principal areas of under achievement to date are within Medicine (£0.415m) and Women's and Children's (£0.174m) offset by over achievement to date in Surgery, Head and Neck (£0.087m) Specialised Services (£0.077m) and Diagnostic and Therapies (£0.030m).

Variance to Operating Plan:

Clinical Divisions and Corporate Services have an adverse variance of £2.701m against a combined operating plan trajectory of £0.750m. The June position is £1.951m above trajectory as shown in the graph below.



Further detail is given under agenda item 5.3 in the Finance Committee papers.

3. Divisional Reports

The following is intended to provide a brief update on the Divisional positions including reasons for variances and actions being taken to address adverse positions. As requested at the previous Finance Committee, the divisional reports at item 5.3 provide further detail on the impact of actions being taken and new actions that have been introduced since the last report.

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

3.1 Division of Medicine

The Division reports an adverse variance to month 03 of £0.963m; the Division is £0.860m adverse to its operating plan trajectory to date. The Division is reporting a savings programme year to date adverse variance of £0.107m and a savings programme forecast outturn favourable variance of £0.390m.

The key reasons for the variance are:

Adverse variances

- An adverse pay variance of £0.319m which represents an in month deterioration of £0.141m. Nursing budgets were adverse by £0.259m; within this total nursing expenditure was £0.050m lower in June than May. Agency expenditure was higher than in April primarily because staffing of the ambulance queue and the requirements of RMN nursing.
- An adverse variance on non-pay of £0.141m which includes, drugs £0.088m and clinical supplies £0.122m.
- An adverse variance on SLA income of £0.415m which represents a deterioration in month of £0.326m, the main reason being lower than expected Emergency inpatient activity this level of activity this month being the lowest experienced since August 2015.

Favourable variances

A favourable variance on income from operations of £0.018m.

Actions being taken and mitigation to restore performance include:

- Reductions in nursing costs – this is being managed via a programme of close controls with respect to the booking of shifts out of hours, the continued close scrutiny of all agency use and the introduction of dementia initiatives aimed at reducing the number of 1:1 shifts required.
- The rolling out of 'Discharge to Assess' for 'Pathway 3' patients expected to improve both length of stay and ultimately occupancy rates.
- Development of Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs) within the Emergency Department (ED) to reduce medical staffing costs.
- Medical Staff Payments includes the review of all WLI and additional payments in accordance with new Trust guidance. A capacity planning exercise, in conjunction with refreshed job plans and the recruitment of acute physicians, is also underway.
- Medical Staff Payments – including the review of all WLI and additional payments in accordance with Trust guidance. A capacity planning exercise, in conjunction with refreshed job plans and the recruitment of acute physicians is also underway.

- Increasing and retaining elective activity volumes and delivering at a margin through the cessation of outsourcing arrangements and better use of existing resources.
- Recognise the planned recovery of non-elective and emergency activity and deliver at marginal rates. It will be important not to react to any increased activity volumes following the closure of ward A518. Managing occupancy and discharge is the key priority, not the seeking of escalation capacity.
- The full management of the ORLA programme – to date, this has included some difficult negotiations but ultimately the insertion of reasonable use clauses (with respect to consumables and medicines) and importantly, the incremental rise in costs is directly linked to a rise in patients being taken through the programme and admitted into the 'virtual ward'.

Furthermore, the Division is proposing:

- A full review of the acute medical model encompassing ability to recruit and contingency plans – it is proposed that will include a full review of recruitment practice across the City and an agreed way forward such that the Division and Trust is not compromised in its vision to deliver the agreed acute model of care.
- That the ownership, accountability and responsibility for community bed placements are passed to commissioners with immediate effect. It is the Division's recommendation that commissioners seek to utilise Care Home Select's existing resources in the absence of an appropriate replacement programme of service. Indeed, the closure of Ward A518 (unfunded post September 2016) is predicated on the re-provision of this service.
- To work with commissioners to ensure that the front door pilot, encompassing the urgent care centre, is progressed and rolled out in tandem with the 'high impact users' initiative – to progress one initiative without the other would be contradictory to the wider aims of managing pressures in the Emergency Department.

The 2016/17 financial plan forecasts a deficit of c. £0.94m but contains a number of risks and assumptions. These include:

- The consultation for and closure of Ward A518, independent of ORLA Healthcare Ltd.
- The mobilisation and careful management of the ORLA Healthcare Ltd initiative.
- Recruitment to the Enhanced Supervision Team.
- Community and social care initiatives including the ownership of a bed placement scheme.

3.2 Division of Surgery, Head and Neck

The Division reports an adverse variance to month 03 of £0.882m; The Division is £0.607m adverse to its Operating Plan trajectory to date. The key reasons for the variance are:

<u>Adverse variances</u>

- An underachievement of savings resulting in an adverse variance to date of £0.669m. The majority relates to unidentified plans £0.375m the rest relates to schemes having been removed with regards to outsourcing savings and other slippage on schemes.
- An adverse variance on pay of £0.283m primarily due to high nursing agency and bank usage.
- An adverse variance on non-pay of £0.059m this has been caused by spend on outsourcing work £0.093m and overspends on clinical supplies offset by underspends relating to support funding.

Favourable variances

- A favourable variance on income from activities of £0.087m after a significant deterioration this month of £0.161m, the most significant deterioration this month being within Oral/Dental services £0.169m.
- A favourable variance on income from operations of £0.043m due to higher than planned research and development income.

The key reasons for the variance against the Operating Plan trajectory are:

- Higher than planned nursing spend £0.266m.
- Higher than planned medical staff spend including waiting list payments £0.093m.
- Higher than planned expenditure on outsourcing £0.084m.
- Higher than planned spend on drugs an clinical supplies £0.223m.
- Slippage on recruitment to vacancies.
- Slippage on CIP delivery.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- Delivery planning is continuing with far greater visibility of detail now with reference to some of the more complex services in the division. Resource planning has been completed and investments discussed with the chief operating officer; costs of delivery have however risen above that in the operating plan in Oral/Dental Services, ENT, and Endoscopy.
- There remains risk around delivery of service level agreement income which has the potential to be substantial; this is driven by increased reliance on outsourcing (due partly to pay rates) and dependence on swift and successful recruitment particularly around oral and dental services.
- The divisional team is aware of the risks around successful delivery of the recruitment plans in terms of medical staff – if this fails then the division could fail to provide increased capacity and hence risk failure of delivery of higher activity levels.
- Lost activity due to bed pressures and theatre sessions being lost to lack of anaesthetic cover are high risks to divisional performance and the team will continue to monitor and report this.
- Failure to deliver the required improvements in both recruitment and retention of staff, in particular in the registered nursing and operating department practitioner workforce will drive additional costs in terms of agency spend into the position. (Particularly an issue for the orthopaedic wards, across all theatres and intensive care).
- The Junior Medical and Dental workforce is vulnerable to changes in trainee levels and difficulty has been found in recruitment particularly in Trauma and Orthopaedics. The need to maintain cover on the wards is driving agency costs and posts remain unfilled.
- Failure to address the appropriate need for 1-1 nursing.
- Failure to work up additional Cost improvement plans to support financial shortfall, failure to take mitigating actions to control rising cost pressures.

Actions being taken and mitigation to restore performance include:

- The Division is holding fortnightly Finance and Performance Meetings where Service Line Managers are held to account for finance and service performance.

- The Division is holding fortnightly CIP meetings where service lines are clear on their individual savings targets and are presenting the development of plans and pipeline ideas to meet those targets.
- Review meetings are being held with Divisional Director, Divisional Finance Manager and General Manager, reviewing actual expenditure and challenging spend.
- A paper on improving financial controls is in progress, and levels of savings against these controls are being assessed. Additional controls on Estates works have already been implemented and have been shown to be effective.
- The Managed Inventory System Project has been approved and there have been further meetings in order to progress the contract terms. This is proving difficult but progress is being made.
- Recruitment plans are under way. The investment in a recruitment/training manager for theatres has been approved and this will drive improvements.
- Reduction of turnover is being approached with additional provision of training and staff development, and career progression opportunities.
- The new Head of Nursing is focussed on the monthly nursing performance and finance meetings. The terms of reference for these meetings will be reviewed to ensure the focus on recovery of the position is a key agenda item.
- The new Head of Nursing is working closely with Matron Colleagues to improve controls and reduce spend on agency and bank staffing.
- The Division continues to work with other divisions in understanding bed modelling and planning going forward.

3.3 The Division of Women's and Children's Services

The Division reports an adverse variance to month 03 of £0.735m. The Division is £0.548m adverse to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances

- An adverse variance on pay of £0.727m including higher than planned nursing agency costs above NHS improvement cap rate, mental health nurse specialling for 3 highly dependent children £0.095m in the first two months has now ceased. and medical staff overspends £0.275m including costs associated with non-compliant junior rotas and significant agency spend for consultants. It should however be noted that the in-month adverse variance is considerably less than month 02.
- An underperformance on the savings programme resulting in an adverse variance to date of £0.528m. The majority of which relates to the level of unidentified savings in the plan £0.453m.
- An adverse performance on SLA income of £0.174m there was a deterioration in this area in month of £0.067m particularly in Paediatric Medicine £0.042m and Paediatric Surgery £0.71m

Favourable variances

A significant favourable variance on non-pay of £0.684m which includes a share of support funding and capacity growth reserves which offset the underachieved of income and slippage on developments.

Actions being taken and mitigation to restore performance:

- Nurse rostering KPI metrics continuing to improve.
- Nursing up to full establishment by autumn.
- Spinal Surgery Investment Plan and re-profiled activity plan developed by Spinal Pathway Transformation Group with first additional lists in June.
- Children's Hospital Flow Programme budget signed off by multi-disciplinary team.
- Outpatient productivity manager started in post.
- Specialty Productivity Reviews beginning with Paediatric T&O.
- Review of theatres productivity metrics and improving data capture to ensure effective utilisation of operating theatres.
- Meeting UK Specialist Children's Alliance colleagues in July to attempt a "mini-Carter Review" process.
- Supplier re-engagement meetings held with cochlear implant suppliers.

The main challenges to the delivery of the Division's Operating Plan moving forward are:

- Identifying mitigations for the significant adverse pay variances caused by mental health nurse 'specialling', and agency cost premiums.
- Identifying a way of ensuring agency usage, where unavoidable, is within NHS Improvement capped rates.
- Ensuring that emergency demand does not disrupt elective throughput.
- Converting savings pipeline ideas into cash releasing savings and identifying new opportunities from the Carter Review and Model Hospital Programme.

3.4 Division of Specialised Services

The Division reports an adverse variance to month 03 of £0.232m. The Division is £0.097m adverse to the Operating Plan trajectory to date.

The key reasons for the variances are:

<u>Adverse variances</u>

- Cardiac Surgery activity - the Division reports an adverse variance to date of £0.055m.The Division has delivered 93% of the contract to date.
- Medical pay budgets show an adverse variance of £0.038m mainly due to agency and waiting list costs.
- Non Pay budgets report an adverse variance of £0.131m spread across a number of areas.
- An adverse variance on Private Patients of £0.07m an improvement of £0.011m from last month.
- Pay budgets are reporting an adverse variance of £0.142m with nursing reporting an adverse variance of £0.140m.
- A year to date shortfall on the savings programme of £0.094m.

<u>Favourable variances</u>

- Operating income reports a favourable variance of £0.058m.
- Cardiology now reports a favourable SLA variance of £0.120m after another good in month performance increasing the favourable variance by £0.088m.

- Bone Marrow Transplant activity has over-performed against contract by £0.132m to the end of June. This variance has been suppressed in this month's position due to potential volatility later in the year.
- Clinical Genetics budgets are reporting a favourable variance of £0.036m; however this is down £0.035m from last month.

Actions being taken and mitigation to restore performance:

- Ambitious plans have been identified for reductions in nursing overspends, the following actions have taken place:

    - Appointment of Nursing recruitment lead
    - Appointment of new training lead
    - Development retention plans
    - Increased focus on tackling sickness levels, with success having been achieved in CICU where levels have halved
    - Reviews one to one practices
    - Reviews of annual leave allocations

- Clinical Genetics has transferred into the division and whilst generating a surplus currently a number of issues have been identified which require immediate attention with regards to capacity planning and addressing patient demand. This presents a risk to the service but also an opportunity financially to develop and run the service more efficiently to a larger scale.

- Agency expenditure

    - Recruiting as quickly as possible once vacancies are known
    - Recruiting permanently into nursing maternity vacancies
    - Replacing long term agency with substantive posts
    - Developing and growing in house staff to fill hard to recruit to areas
    - A plan is close to completion within Cardiac Surgery to replace high cost Jr doctor agency with Nurse Practitioners and Surgical Care Practitioners in addition to amending existing medical rotas. The output of this change will be to provide a more sustainable and stable service as well as to reduce expenditure on high cost agency. Implementation is planned for September.

- National Commissioning changes to pass through items have been identified posing a significant risk to device income through increased bureaucracy. The division has:

    - Held meetings with NHS Supply chain
    - Developing catalogues for products moving to supply chain
    - Advised medical colleagues of changes
    - Developed new processes for prior approval in anticipation of start date
    - Is revising processes and support for purchasing and billing of high cost device

The main challenges to the delivery of the Division's Operating Plan moving forward are:

- Delivery of Cardiac Surgery Activity.

- Meeting contracted levels of activity across other specialties.
- Controlling and reducing Nursing expenditure to deliver a breakeven year end out turn.
- Reducing agency staffing across all staff groups through; improved retention, reduced sickness, improving recruitment to posts that have been covered for longer than a short term period with temporary staff, improved training and development of staff.
- Delivering the savings programmes identified and continuing to develop new schemes.
- Maintaining controls on non-pay expenditure.
- Developing procedures to ensure no adverse impacts will be incurred as a result of national commissioning arrangements e.g. prior approval for devices

3.5 Trust Services

The Division reports a favourable variance to month 03 of £0.009m. The Division is £0.002m adverse to the Operating Plan trajectory to date.

Two Divisions is rated Green for their performance to date

3.6 Diagnostic and Therapies Division

The Division reports a favourable variance to month 03 of £0.083m. The Division is £0.123m favourable compared to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances

- An adverse variance on non-pay of £0.316m which includes double running costs associated with LIMS £0.063m, Radiology outsourcing costs £0.123m, and adverse variances on clinical supplies.
- An adverse variance on operating income of £0.017m.

Favourable variances

- A favourable variance on pay of £0.396m, primarily the result of vacancies in clinical staff. A long standing dispute with NBT regarding their charging for consultant time has been resolved resulting in an in-moth favourable movement of £0.082m.
- The savings programme is £0.010m favourable year to date.
- A favourable variance on SLA income of £0.030m, there is a favourable variance on services hosted by Diagnostics and Therapies of £0.123m offset by adverse variances associated with services hosted by other divisions of £0.093m.
- Adverse variances on non-pay above are offset by a balance of contract transfer funding.

Actions being taken and mitigation to restore performance:

- Developing the savings programme to address the shortfall.
- Review of radiology contract income data underway with support from information analysts.
- Rolling programme of Service Line Reporting meetings to be established with Heads of Service first specialty will be Radiology.
- Specialty review of Radiology taking place for reporting to the Savings Board.

Key risks to delivery of the operating plan and future performance include:

- Other Division's under-performance on contracted activity.
- Non-delivery or under-delivery of savings schemes currently forecast to achieve.
- Employing high cost agency and or locum staff into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as Radiology and Laboratory Medicine.

3.7 Facilities and Estates Division

The Division reports an adverse variance to month 03 of £0.015m. The Division is £0.015m favourable to the Operating Plan trajectory to date.

4. Income

Contract income was in line with plan in June. Activity and pass through payments were below plan while contract penalties and prior year income were above plan. Contract rewards were in line with plan. The table below summarises the overall position which is described in more detail under agenda item 5.2.

Clinical Income by Worktype	In Month Variance Fav/(Adv)	Year to Date Plan	Year to Date Actual	Year to Date Variance Fav/(Adv)
Activity Based	£'m	£'m	£'m	£'m
Accident & Emergency	0.04	3.92	4.02	0.10
Emergency Inpatients	(0.27)	19.28	19.95	0.67
Day Cases	0.05	9.71	9.60	(0.11)
Elective Inpatients	(0.26)	12.66	12.56	(0.10)
Non-Elective Inpatients	(0.23)	6.81	6.07	(0.74)
Excess Bed days	(0.10)	1.73	1.68	(0.05)
Outpatients	(0.20)	20.53	20.33	(0.20)
Bone Marrow Transplants	(0.19)	2.05	2.36	0.31
Critical Care Bed days	0.21	10.97	10.95	(0.02)
Other	0.14	23.15	23.21	0.06
Sub Total	**(0.81)**	**110.81**	**110.73**	**(0.08)**
Contract Penalties	0.05	(0.31)	(0.29)	0.02
Contract Rewards	0.00	2.33	2.33	0.00
Pass through payments	(0.24)	21.69	20.13	(1.56)
2016/17 Total	**(1.00)**	**134.52**	**132.90**	**(1.62)**
Prior year income	1.01	-	1.01	1.01
Overall Total	**0.01**	**134.52**	**133.91**	**(0.61)**

Non Elective inpatients were £0.23m behind plan this month, increasing the cumulative variance to £0.74 adverse. Cardiac surgery and cardiology activity is below plan. There is additional emergency activity in these areas, reflecting volatility in the nature of the work in this area as well as a potential mis-recording which is being reviewed.

Outpatients were £0.20m behind plan this month, moving the cumulative performance to £0.20m behind plan. This includes an allowance for attendances without an outcome which when recorded next month will become chargeable retrospectively. Activity is lower than planned in ophthalmology and dental specialties.

Elective inpatients were £0.26m behind plan this month, changing the cumulative variance to £0.10m adverse. Paediatric spinal surgery activity continued to be behind plan reflecting the challenge in delivering the increased contract for 2016/17. Paediatric cardiac surgery activity was also lower than plan due to PICU capacity constraints.

Emergency inpatients were £0.27m behind plan this month, decreasing the cumulative variance to £0.67 favourable. June activity was lower particularly within Medicine which remained busy but with increased lengths of stay.

A number of CQUINs have been agreed but there is a delay in finalising the specialised ones with Commissioners, particularly Hepatitis C (worth c£2.8m), therefore the CQUIN rewards performance is currently set to plan.

Whilst the national core penalties and local penalties will not be applied in 2016/17 following acceptance of the Sustainability and Transformation Funding (STF), all other national penalties will be applied. £1.3m has been set aside to cover these penalties. Performance against penalties was £0.05m above plan this month, moving the cumulative performance to £0.02m above plan. Within this, cancelled operations are £0.02m below plan.

Pass through payments were £0.24m lower than plan in June, increasing the cumulative position to £1.56m adverse. The year to date adverse variance relates to drugs (£0.90m) and devices (£0.69m).

Due to the timing of the annual accounts, an estimate is made of the final income due for the year. Actual month 12 income for 2015/16 has now been finalised and is higher than anticipated. Higher volumes of activity in month 12 (£2.77m) and higher achievement of CQUINs (£1.25m) have contributed to additional income of £4.022m relating to the prior year. This has been recognised in June resulting in a favourable variance of £1.01m.

Performance at Clinical Divisional level is shown at appendix 4a.

5. Risk Rating

The graphs overleaf show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the period to the end of June, the Trust achieved an overall FSRR of 4 (actual 3.5) against a plan of 4.

The liquidity and income and expenditure margin metrics are each in line with the plan to date with actual metric scores of 4. The capital servicing capacity is also in line with plan with a metric score of 3. The income and expenditure margin variance from plan metric score is 3. A summary of the position is provided in the table overleaf.

		30th June 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		13.33	13.54	11.98	11.98
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		2.11	2.09	2.77	2.77
Metric Rating	25%	3	3	4	4
Income & expenditure margin					
Metric Result		3.55%	3.54%	2.70%	2.70%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	(0.01)%	0.32%	0.00%
Metric Rating	25%	4	3	4	4
Overall FSRR		**3.75**	**3.50**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

6. Capital Programme

A summary of income and expenditure for the three months ending 30 June is provided in the table below. Expenditure for the period is £6.622m against a plan of £6.868m. The plan has been updated to reflect the revised operational capital expenditure plan of £35m and incorporates information from capital leads. Further information is provided under agenda item 6.1.

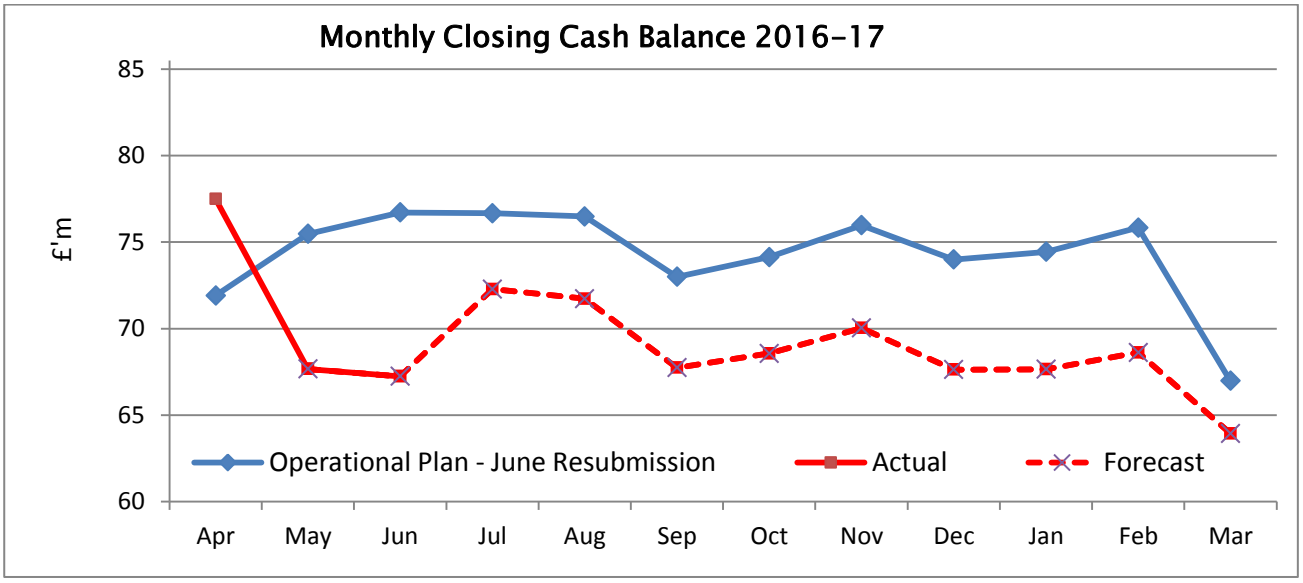
Operational Plan	Current Annual Plan		Month ended 31st May 2016		
			Operational Plan	Actual	Variance
£'m	£'m	**Sources of Funding**	£'m	£'m	£'m
0.273	0.273	PDC	-	-	-
2.732	3.049	Donations	2.223	2.124	(0.099)
		Cash:			
21.634	22.054	Depreciation	5.325	5.321	(0.004)
4.461	9.624	Cash balances	(0.680)	(0.823)	(0.143)
29.100	**35.000**	**Total Funding**	**6.868**	**6.622**	**(0.246)**
		Expenditure			
(14.761)	(14.244)	Strategic Schemes	(4.833)	(4.478)	0.355
(9.741)	(11.142)	Medical Equipment	(0.226)	(0.371)	(0.145)
(3.971)	(4.659)	Information Technology	(0.933)	(0.782)	0.051
(2.545)	(2.815)	Estates Replacement	(0.183)	(0.316)	(0.133)
(11.721)	(13.191)	Operational Capital	(0.693)	(0.675)	0.018
(42.739)	**(46.051)**	**Gross Expenditure**	**(6.868)**	**(6.622)**	**0.246**
1.636	2.706	Planned Slippage	-	-	-
12.003	8.345	I&E Variation from Plan	-	-	-
(29.100)	**(35.000)**	**Net Expenditure**	**(6.868)**	**(6.622)**	**0.246**

7. Statement of Financial Position and Cashflow

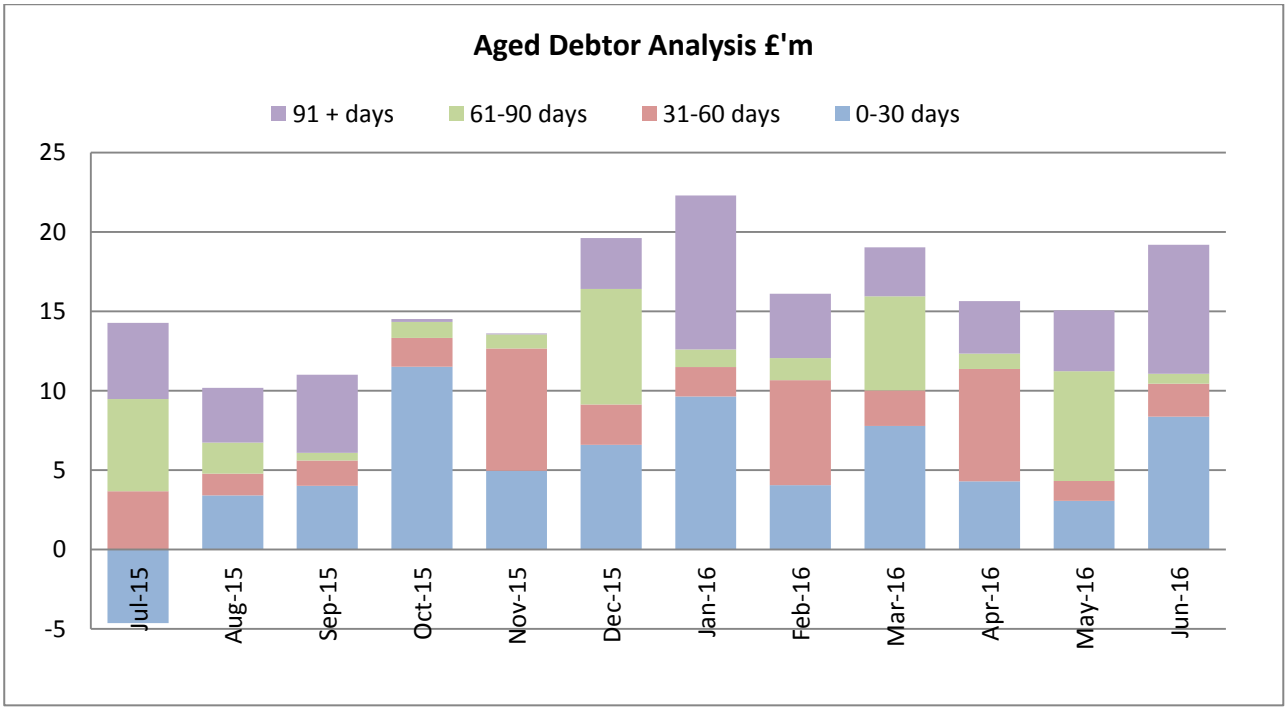
Overall, the Trust had a strong statement of financial position as at 30th June 2016 with net current assets of £32.603m, £0.406m higher than the Operational Plan.

The Trust held cash of £67.356m at the end of June, £9.359m lower than the Operational Plan. This reflects the delay in receipt of prior year activity income and sustainability and transformation funds as well as reduced payments in 2016/17 from Commissioners who are continuing to pay at 2015/16 contract levels pending signing of the 2016/17 contracts.

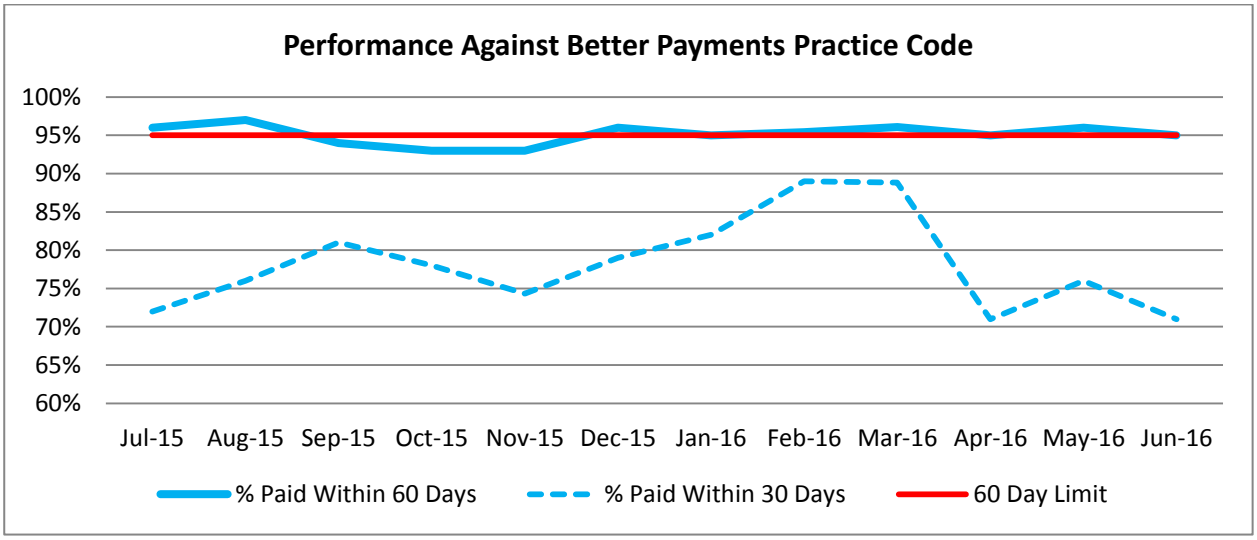
The forecast year end cash balance is £66.979m. The graph below shows the month end cash balance trajectory for the financial year.



The total value of debtors increased by £4.118m in June to £19.186m. SLA debtors increased by £4.034m and non SLA debtors by £0.084m. The total value of debtors over 60 days old decreased by £2.018m to £8.741m. £1.433m of this decrease related to 2015/16 estimated invoices being credited (and replaced by actual invoices which are under 60 days old). The decrease in non SLA debtors of £0.585m is primarily due to payments received by NBT. Further details are provided in agenda item 7.1.



In June, performance for payment of invoices within 60 days was in line with the Prompt Payments Code target of 95%. The number of invoices paid within 30 days decreased to 71% due to resource being prioritised to check agency invoices. A chart plotting performance is provided below.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Financial Sustainability Risk Rating
Appendix 5a – Key Financial Metrics
Appendix 5b – Key Workforce Metrics
Appendix 6 – Financial Risk Matrix
Appendix 7 – Monthly Analysis of Pay Expenditure
Appendix 8 - Release of Reserves

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report June 2016- Summary Income & Expenditure Statement

Approved Budget / Plan 2016/17	Heading	Position as at 30th June			Actual to 31st May
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
541,921	From Activities	133,461	134,176	715	89,377
87,907	Other Operating Income	22,176	22,010	(166)	14,507
629,828	**Sub totals income**	**155,637**	**156,186**	**549**	**103,884**
	Expenditure				
(357,095)	Staffing	(90,462)	(91,404)	(942)	(61,095)
(213,865)	Supplies and Services	(51,768)	(52,696)	(928)	(35,451)
(570,960)	**Sub totals expenditure**	**(142,230)**	**(144,100)**	**(1,870)**	**(96,546)**
(8,816)	Reserves	(1,200)	-	1,200	-
50,052	**EBITDA**	**12,207**	**12,086**	**(121)**	**7,338**
7.95	**EBITDA Margin - %**		**7.74**		**7.06**
	Financing				
(22,472)	Depreciation & Amortisation - Owned	(5,429)	(5,329)	100	(3,550)
244	Interest Receivable	61	75	14	53
(291)	Interest Payable on Leases	(73)	(74)	(1)	(49)
(3,124)	Interest Payable on Loans	(781)	(741)	40	(500)
(8,509)	PDC Dividend	(2,127)	(2,146)	(19)	(1,431)
(34,152)	**Sub totals financing**	**(8,349)**	**(8,215)**	**134**	**(5,477)**
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**3,858**	**3,871**	**13**	**1,861**
	Technical Items				
-	Profit/(Loss) on Sale of Asset	-	-	-	-
2,732	Donations & Grants (PPE/Intangible Assets)	2,170	2,123	(47)	2,060
(6,436)	Impairments	(1,273)	(1,296)	(23)	-
385	Reversal of Impairments	-	-	-	-
(1,610)	Depreciation & Amortisation - Donated	(396)	(389)	7	(265)
10,971	**SURPLUS / (DEFICIT) after Technical Items**	**4,359**	**4,309**	**(50)**	**3,656**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2016- Divisional Income & Expenditure Statement

Approved Budget / Plan 2016/17	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]					Total Variance to date	Total Variance to 31st May	Operating Plan Trajectory Year to Date	Variance from Operating Plan Trajectory Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
540,482	Contract Income	134,518	134,518	-	-	(16)	16	-	-	(1)		
-	Overheads, Fines & Rewards	-	1,381	-	2	-	1,378	-	1,380	359		
35,921	NHSE Income	9,014	9,014	-	-	-	-	-	-	-		
576,403	**Sub Total Corporate Income**	**143,532**	**144,913**	**-**	**2**	**(16)**	**1,394**	**-**	**1,380**	**358**		
	Clinical Divisions											
(51,385)	Diagnostic & Therapies	(12,807)	(12,724)	396	(316)	(17)	30	(10)	83	81	(40)	123
(75,747)	Medicine	(19,133)	(20,096)	(319)	(141)	18	(415)	(106)	(963)	(520)	(103)	(860)
(102,020)	Specialised Services	(25,208)	(25,440)	(142)	(131)	58	77	(94)	(232)	(127)	(135)	(97)
(105,412)	Surgery Head & Neck	(26,365)	(27,247)	(283)	(59)	42	87	(669)	(882)	(494)	(275)	(607)
(119,329)	Women's & Children's	(29,943)	(30,678)	(727)	684	-	(174)	(518)	(735)	(546)	(187)	(548)
(453,893)	**Sub Total - Clinical Divisions**	**(113,456)**	**(116,185)**	**(1,075)**	**37**	**101**	**(395)**	**(1,397)**	**(2,729)**	**(1,606)**	**(740)**	**(1,989)**
	Corporate Services											
(36,096)	Facilities And Estates	(8,928)	(8,943)	8	3	(2)	(3)	(21)	(15)	(11)	(30)	15
(25,036)	Trust Services	(6,493)	(6,484)	192	(152)	(83)	-	52	9	15	11	(2)
(2,510)	Other	(1,248)	(1,215)	(5)	99	(67)	(12)	19	34	15	9	25
(63,642)	**Sub Totals - Corporate Services**	**(16,669)**	**(16,642)**	**195**	**(50)**	**(152)**	**(15)**	**50**	**28**	**19**	**(10)**	**38**
(517,535)	**Sub Total (Clinical Divisions & Corporate Services)**	**(130,125)**	**(132,827)**	**(880)**	**(13)**	**(51)**	**(410)**	**(1,347)**	**(2,701)**	**(1,587)**	**(750)**	**(1,951)**
(8,816)	Reserves	(1,200)	-	-	1,200	-	-	-	1,200	600		
(8,816)	**Sub Total Reserves**	**(1,200)**	**-**	**-**	**1,200**	**-**	**-**	**-**	**1,200**	**600**		
50,052	**Trust Totals Unprofiled**	**12,207**	**12,086**	**(880)**	**1,189**	**(67)**	**984**	**(1,347)**	**(121)**	**(629)**		
	Financing											
(22,472)	Depreciation & Amortisation - Owned	(5,429)	(5,329)	-	100	-	-	-	100	60		
244	Interest Receivable	61	75	-	14	-	-	-	14	12		
(291)	Interest Payable on Leases	(73)	(74)	-	(1)	-	-	-	(1)	(1)		
(3,124)	Interest Payable on Loans	(781)	(741)	-	40	-	-	-	40	21		
(8,509)	PDC Dividend	(2,127)	(2,146)	-	(19)	-	-	-	(19)	(13)		
(34,152)	**Sub Total Financing**	**(8,349)**	**(8,215)**	**-**	**134**	**-**	**-**	**-**	**134**	**79**		
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**3,858**	**3,871**	**(880)**	**1,323**	**(67)**	**984**	**(1,347)**	**13**	**(550)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	-	-	-	-	-	-	-	-		
2,732	Donations & Grants (PPE/Intangible Assets)	2,170	2,123	-	-	(47)	-	-	(47)	60		
(6,436)	Impairments	(1,273)	(1,296)	-	(23)	-	-	-	(23)	-		
385	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,610)	Depreciation & Amortisation - Donated	(396)	(389)	-	7	-	-	-	7	(8)		
(4,929)	**Sub Total Technical Items**	**501**	**438**	**-**	**(16)**	**(47)**	**-**	**-**	**(63)**	**52**		
10,971	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**4,359**	**4,309**	**(880)**	**1,307**	**(114)**	**984**	**(1,347)**	**(50)**	**(498)**		

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.9%*	*3.9%*	*3.9%*	*4.3%*	*4.3%*	*4.3%*	*4.2%*	*4.2%*	*4.2%*	*4.1%*	*4.1%*	*4.1%*
Medicine	Actual	3.1%	1.9%	2.2%									
Specialised Services	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.2%*	*4.2%*	*4.2%*	*4.0%*	*4.0%*	*4.0%*
Specialised Services	Actual	3.2%	3.5%	2.9%									
Surgery, Head & Neck	*Target*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Surgery, Head & Neck	Actual	3.8%	3.8%	5.3%									
Women's & Children's	*Target*	*3.4%*	*3.4%*	*3.4%*	*3.7%*	*3.7%*	*3.7%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*4.5%*
Women's & Children's	Actual	3.9%	4.1%	3.6%									

Source: HR

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	7.5%	8.7%	8.3%									
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	6.5%	7.7%	7.0%									
Surgery, Head & Neck	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery, Head & Neck	Actual	3.9%	5.9%	8.1%									
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	1.5%	2.6%	3.0%									

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*	*15.1%*
Medicine	Actual	16.6%	16.3%	15.8%									
Specialised Services	*Target*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*	*13.3%*
Specialised Services	Actual	15.6%	14.2%	13.3%									
Surgery, Head & Neck	*Target*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*
Surgery, Head & Neck	Actual	14.6%	13.6%	13.3%									
Women's & Children's	*Target*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*	*10.6%*
Women's & Children's	Actual	9.3%	10.1%	10.5%									

Source: HR

Graph 4 **Operating plan for nursing agency £000**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*145.0*	*115.0*	*131.0*	*140.0*	*150.0*	*150.0*	*80.0*	*90.0*	*90.0*	*75.0*	*80.0*	*75.0*
Medicine	Actual	244.6	132.0	169.6									
Specialised Services	*Target*	*54.7*	*54.7*	*54.7*	*36.7*	*36.7*	*32.1*	*32.1*	*27.5*	*18.3*	*18.3*	*18.3*	*18.3*
Specialised Services	Actual	95.0	108.4	107.8									
Surgery, Head & Neck	*Target*	*38.6*	*38.3*	*54.6*	*56.9*	*53.6*	*25.8*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*	*12.5*
Surgery, Head & Neck	Actual	215.0	201.7	183.4									
Women's & Children's	*Target*	*36.9*	*50.8*	*71.8*	*37.7*	*50.7*	*79.5*	*122.1*	*29.1*	*29.1*	*25.3*	*25.3*	*25.3*
Women's & Children's	Actual	158.8	134.0	109.2									

Source: Finance GL (excludes NA 1:1)

Graph 5 **Operating plan for nursing agency wte**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*28.5*	*18.5*	*20.5*	*21.3*	*26.3*	*15.7*	*10.5*	*11.3*	*18.5*	*8.4*	*9.4*	*8.4*
Medicine	Actual	31.3	18.8	24.9									
Specialised Services	*Target*	*8.0*	*8.0*	*8.0*	*8.0*	*8.0*	*7.0*	*7.0*	*6.0*	*4.0*	*4.0*	*4.0*	*4.0*
Specialised Services	Actual	10.6	13.2	13.6									
Surgery, Head & Neck	*Target*	*6.0*	*6.1*	*8.6*	*9.1*	*8.6*	*4.1*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*	*2.0*
Surgery, Head & Neck	Actual	27.5	29.6	25.9									
Women's & Children's	*Target*	*7.8*	*10.8*	*15.3*	*7.8*	*10.6*	*16.8*	*25.8*	*5.8*	*5.8*	*4.8*	*4.8*	*4.8*
Women's & Children's	Actual	15.4	11.3	10.7									

Source: Finance GL (excludes NA 1:1)

Graph 6 **Operating plan for nursing agency as a % of total staffing**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.9%*	*6.4%*	*7.2%*	*7.7%*	*8.3%*	*8.1%*	*4.6%*	*5.1%*	*5.2%*	*4.4%*	*4.6%*	*4.4%*
Medicine	Actual	13.4%	7.1%	9.5%									
Specialised Services	*Target*	*4.3%*	*4.3%*	*4.3%*	*2.9%*	*2.9%*	*2.5%*	*2.5%*	*2.1%*	*1.4%*	*1.4%*	*1.4%*	*1.4%*
Specialised Services	Actual	7.3%	7.7%	7.9%									
Surgery, Head & Neck	*Target*	*1.8%*	*1.8%*	*2.6%*	*2.7%*	*2.5%*	*1.2%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*	*0.6%*
Surgery, Head & Neck	Actual	11.5%	10.5%	10.0%									
Women's & Children's	*Target*	*1.2%*	*1.6%*	*2.3%*	*1.2%*	*1.6%*	*2.5%*	*3.7%*	*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*
Women's & Children's	Actual	4.7%	3.8%	3.2%									

Source: Finance GL (RNs only)

Graph 7 **Funded bed days vs occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*9,270*	*9,579*	*9,270*	*9,579*	*9,579*	*9,270*	*9,579*	*9,270*	*9,579*	*9,579*	*8,652*	*9,579*
Medicine	Actual	9,235	9,359	9,250									
Specialised Services	*Target*	*4,800*	*4,960*	*4,800*	*4,960*	*4,960*	*4,800*	*4,960*	*4,800*	*4,960*	*4,960*	*4,480*	*4,960*
Specialised Services	Actual	4,507	4,639	4,523									
Surgery, Head & Neck	*Target*	*4,740*	*4,898*	*4,740*	*4,898*	*4,898*	*4,740*	*4,898*	*4,740*	*4,898*	*4,898*	*4,424*	*4,898*
Surgery, Head & Neck	Actual	4,657	4,556	4,452									
Women's & Children's	*Target*	*8,790*	*9,083*	*8,790*	*9,083*	*9,083*	*8,790*	*9,083*	*8,790*	*9,083*	*9,083*	*8,204*	*9,083*
Women's & Children's	Actual	7,087	7,399	6,957									

Source: Info web: KPI Bed occupancy

Graph 8 **NA 1:1 and RMN £000 (total temporary spend)**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	64	55	73									
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	17	25	14									
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	24	16	30									
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	86	33	6									

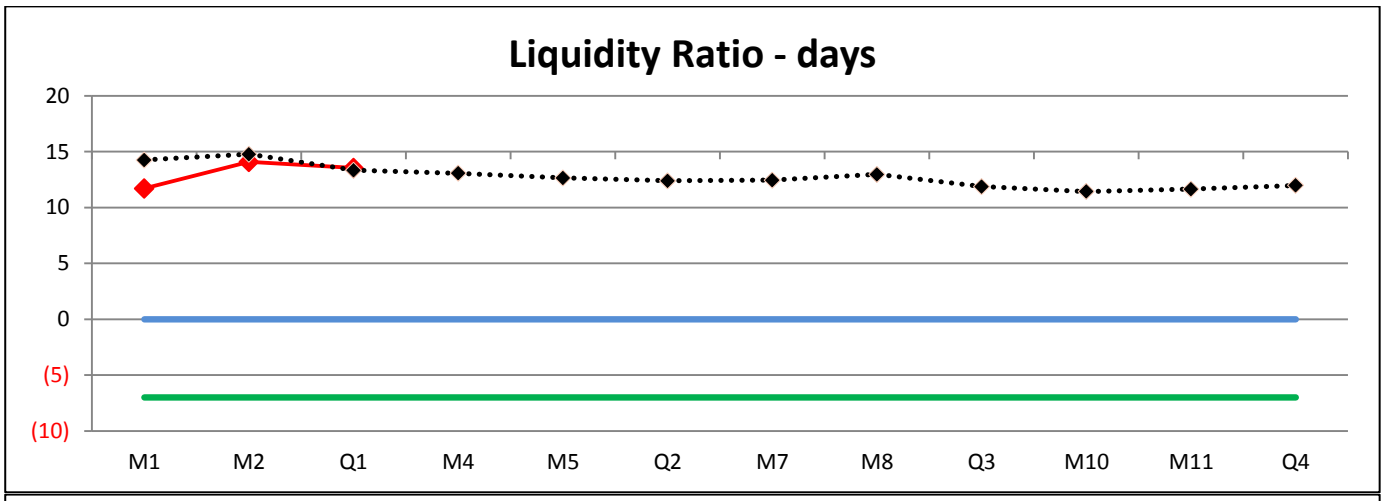
Financial Sustainability Risk Rating – June 2016 Performance

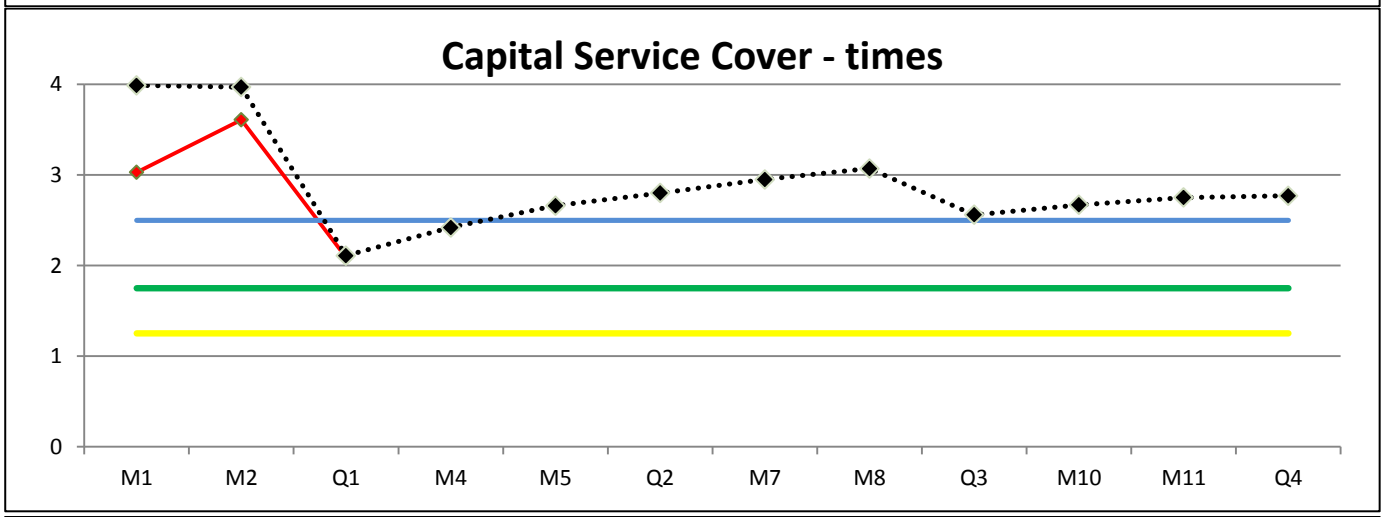
The graphs overleaf show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the period to the end of June, the Trust achieved an overall FSRR of 4 (actual 3.5) against a plan of 4.

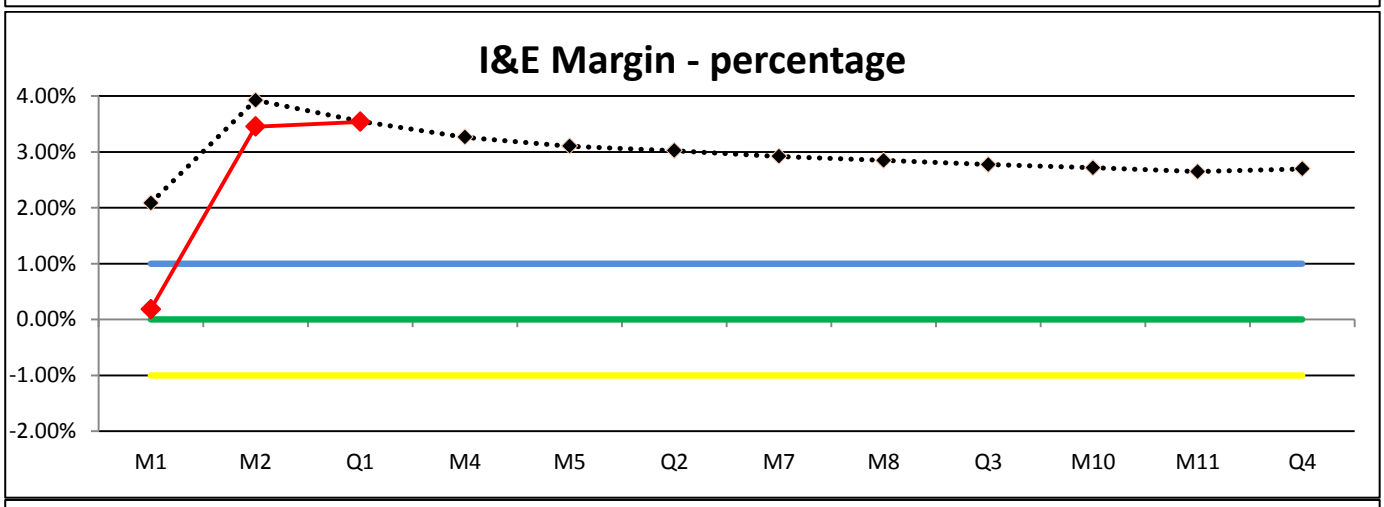
The liquidity and income and expenditure margin metrics are each in line with the plan to date with actual metric scores of 4. The capital servicing capacity is also in line with plan with a metric score of 3. The income and expenditure margin variance from plan metric score is 3. A summary of the position is provided in the table below.

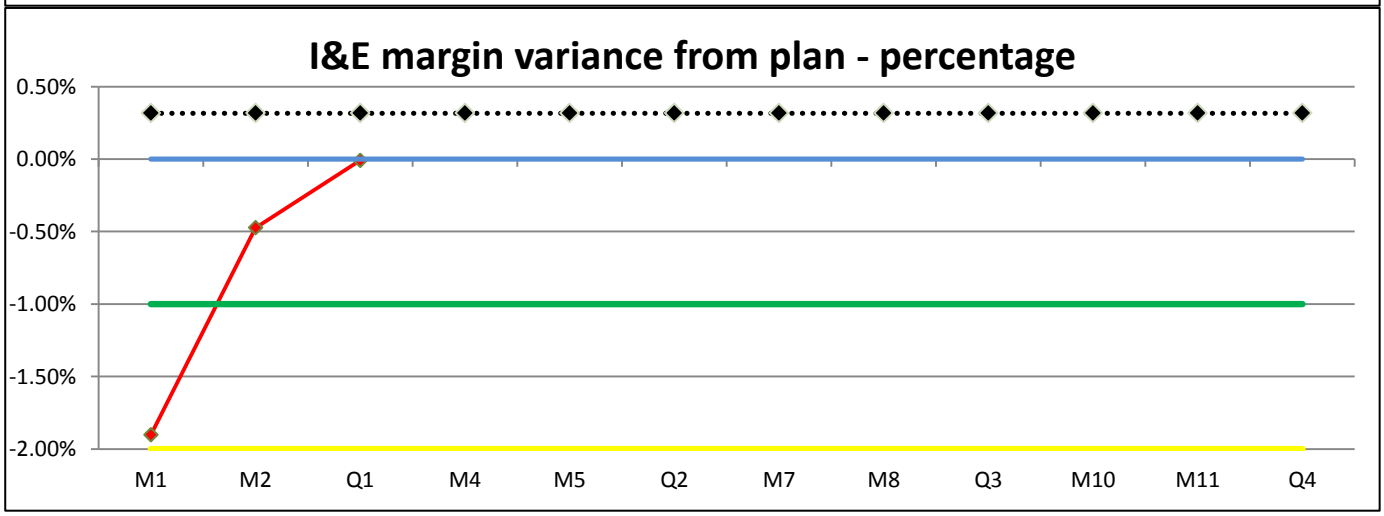
		30th June 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		13.33	13.54	11.98	11.98
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		2.11	2.09	2.77	2.77
Metric Rating	25%	3	3	4	4
Income & expenditure margin					
Metric Result		3.55%	3.54%	2.70%	2.70%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	(0.01)%	0.32%	0.00%
Metric Rating	25%	4	3	4	4
Overall FSRR		**3.75**	**3.50**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The revised 2016/17 Operational Plan submitted to Monitor on 29th June 2016 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.


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


Capital Service Cover - times
4
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
4.00%
3.00%
2.00%
1.00%
0.00%
-1.00%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


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

Key Financial Metrics - May 2016

Appendix 5a

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Activity Based									
Current Month									
Budget	3,380	4,381	5,046	6,952	8,722	313		8,058	36,852
Actual	3,401	4,072	4,997	6,681	8,562	302		8,025	36,040
Variance Fav / (Adv)	21	(309)	(49)	(271)	(160)	(11)	-	(33)	(812)
Year to date									
Budget	9,926	13,040	14,905	20,362	25,927	923		25,731	110,814
Actual	10,044	12,723	15,200	20,283	25,590	917		25,962	110,719
Variance Fav / (Adv)	118	(317)	295	(79)	(337)	(6)	-	231	(95)
Information shows the financial performance against the planned level of activity based service level agreements with Commissioners as per agenda item 5.2									
Contract Income - Penalties									
Current Month									
Plan		(32)	(5)	(13)	(6)			(53)	(109)
Actual		(28)	(2)	(15)	(12)			(4)	(61)
Variance Fav / (Adv)	-	4	3	(2)	(6)	-	-	49	48
Year to date									
Plan		(97)	(14)	(37)	(13)			(152)	(313)
Actual		(98)	(13)	(75)	(92)			(13)	(291)
Variance Fav / (Adv)	-	(1)	1	(38)	(79)	-	-	139	22
Information shows the financial performance against the planned penalties as per agenda item 5.2									
Contract Income - Rewards									
Current Month									
Plan								767	767
Actual								767	767
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-
Year to date									
Plan								2,328	2,328
Actual								2,328	2,328
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-
Information shows the financial performance against the planned rewards as per agenda item 5.2									
Cost Improvement Programme									
Current Month									
Plan	143	122	118	379	402	55	82	124	1,425
Actual	126	67	100	76	198	59	76	130	832
Variance Fav / (Adv)	(17)	(55)	(18)	(303)	(204)	4	(6)	6	(593)
Year to date									
Plan	385	351	355	1,124	1,216	166	247	372	4,216
Actual	400	314	284	570	642	175	231	391	3,007
Variance Fav / (Adv)	15	(37)	(71)	(554)	(574)	9	(16)	19	(1,209)

Key Workforce Metrics

Appendix 5b

Diagnostic & Therapies

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	355	111	36	(11)	18										43	68
Nursing agency expenditure (£'000)	7	1	12	(6)	-										6	(5)
Overall																
Sickness (%)	2.8%		2.4%	2.4%	2.7%										2.4%	
Turnover (%)	12.5%		13.3%	13.5%	12.6%										13.4%	
Establishment (wte)			1,000.69	958.00	966.08											
In post (wte)			961.64	927.00	928.24											
Under/(over) establishment (wte)			39.05	31.00	37.84	-	-	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)			1.7%	0.0%	0.2%										0.8%	
Sickness - unregistered (%)			0.0%	0.0%	10.0%										0.0%	
Turnover - registered (%)	4.1%		19.9%	19.2%	13.2%										19.2%	
Turnover - unregistered (%)	0.0%		0.0%	0.0%	0.0%										0.0%	
Starters (wte)			1.00	1.00	-										2.00	
Leavers (wte)			-	-	-										-	
Net starters (wte)			1.00	1.00	0.00	0	0	0	0	0.00	0.00	0.00	0.00	0.00	2.00	
Establishment (wte)			17.66	17.66	17.66											
In post - Employed (wte)			16.57	18.75	18.24											
In post - Bank (wte)			0.16	1.41	2.35											
In post - Agency (wte)			3.46	0.10	-											
In post - total (wte)			20.19	20.26	20.59	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(2.53)	(2.60)	(2.93)	0.00	0.00	-	-	-	-	-	-	-		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Medicine

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,965	524	334	239	290										863	(339)
Nursing agency expenditure (£'000)	1,395	279	256	140	176										572	(293)
Overall																
Sickness (%)	4.6%		4.4%	3.7%	4.0%										4.1%	
Turnover (%)	13.2%		14.8%	15.1%	14.4%										14.9%	
Establishment (wte)			1,215.16	1,209.00	1,221.06											
In post (wte)			1,253.43	1,230.00	1,246.58											
Under/(over) establishment (wte)			(38.27)	(21.00)	(25.52)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	4.1%		3.1%	1.9%	2.2%										2.5%	
Sickness - unregistered (%)	6.5%		7.8%	7.6%	6.5%										7.7%	
Turnover - registered (%)	15.1%		16.9%	16.5%	15.8%										16.3%	
Turnover - unregistered (%)	25.6%		18.1%	19.5%	19.3%										19.5%	
Starters (wte)			11.19	14.85	5.44										26.04	
Leavers (wte)			12.26	9.16	6.72										21.42	
Net starters (wte)			(1.07)	5.69	(1.28)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.62	
Establishment (wte)			769.87	767.62	768.14											
In post - Employed (wte)			695.64	686.14	686.33											
In post - Bank (wte)			82.62	88.69	97.90											
In post - Agency (wte)			36.20	21.30	27.03											
In post - total (wte)			814.46	796.13	811.26	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(44.59)	(28.51)	(43.12)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Specialised Services

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,332	298	182	196	177										555	(257)
Nursing agency expenditure (£'000)	410	111	100	110	109										319	(208)
Overall																
Sickness (%)	3.6%		3.5%	3.4%	3.3%										3.5%	
Turnover (%)	12.4%		14.2%	13.4%	12.7%										13.4%	
Establishment (wte)			908.17	937.00	932.51											
In post (wte)			901.55	933.00	938.46											
Under/(over) establishment (wte)			6.62	4.00	(5.95)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	4.1%		3.4%	3.8%	2.9%										3.6%	
Sickness - unregistered (%)	7.4%		7.0%	5.4%	6.1%										6.2%	
Turnover - registered (%)	13.3%		15.6%	14.2%	13.3%										14.2%	
Turnover - unregistered (%)	18.0%		12.2%	12.3%	14.4%										12.2%	
Starters (wte)			7.80	4.60	5.80										12.40	
Leavers (wte)			6.37	3.00	5.05										9.37	
Net starters (wte)			1.43	1.60	0.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.03	
Establishment (wte)			480.47	486.02	482.51											
In post - Employed (wte)			441.23	438.90	442.49											
In post - Bank (wte)			27.30	37.55	42.33											
In post - Agency (wte)			12.07	14.14	13.93											
In post - total (wte)			480.60	490.59	498.75	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(0.13)	(4.57)	(16.24)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Surgery, Head and Neck

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	978	183	263	251	193										707	(524)
Nursing agency expenditure (£'000)	343	77	219	207	186										612	(535)
Overall																
Sickness (%)	3.7%		3.9%	3.8%	4.0%										3.8%	
Turnover (%)	12.1%		14.1%	13.7%	13.6%										13.8%	
Establishment (wte)			1,741.45	1,756.00	1,796.48											
In post (wte)			1,785.03	1,772.00	1,773.35											
Under/(over) establishment (wte)			(43.58)	(16.00)	23.13	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	3.8%		4.0%	4.2%	5.3%										4.1%	
Sickness - unregistered (%)	3.7%		7.7%	5.5%	5.2%										6.6%	
Turnover - registered (%)	12.1%		14.6%	13.6%	13.3%										13.6%	
Turnover - unregistered (%)	21.8%		17.1%	18.1%	16.8%										18.0%	
Starters (wte)			4.00	7.37	7.01										10.37	
Leavers (wte)			8.00	4.50	6.77										12.50	
Net starters (wte)			(4.00)	2.87	0.24	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	- 2.13	
Establishment (wte)			695.49	699.86	726.18											
In post - Employed (wte)			662.80	658.55	662.38											
In post - Bank (wte)			49.28	44.54	49.13											
In post - Agency (wte)			28.85	30.80	27.61											
In post - total (wte)			740.93	733.89	739.12	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(45.44)	(34.03)	(12.94)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Women's and Children's

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	775	113	255	162	131										548	(435)
Nursing agency expenditure (£'000)	662	101	217	141	117										475	(374)
Overall																
Sickness (%)	3.8%		3.9%	4.0%	3.6%										4.0%	
Turnover (%)	10.8%		10.9%	11.0%	11.2%										11.0%	
Establishment (wte)			1,899.46	1,878.00	1,884.05											
In post (wte)			1,932.95	1,898.00	1,890.48											
Under/(over) establishment (wte)			(33.49)	(20.00)	(6.43)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	4.0%		4.0%	4.2%	3.6%										4.1%	
Sickness - unregistered (%)	5.0%		8.5%	9.8%	9.6%										9.2%	
Turnover - registered (%)	10.6%		9.3%	10.1%	10.5%										10.1%	
Turnover - unregistered (%)	15.3%		15.3%	12.7%	11.9%										12.7%	
Starters (wte)			4.91	10.22	4.03										15.13	
Leavers (wte)			10.46	11.27	11.91										21.73	
Net starters (wte)			(5.55)	(1.05)	(7.88)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(6.60)	
Establishment (wte)			1,112.90	1,118.77	1,122.66											
In post - Employed (wte)			1,078.77	1,075.80	1,075.11											
In post - Bank (wte)			32.38	42.04	37.18											
In post - Agency (wte)			29.91	19.07	11.44											
In post - total (wte)			1,141.06	1,136.91	1,123.73	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(28.16)	(18.14)	(1.07)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report June 2016 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Inherent Risk (if no action taken)		Action to be taken to mitigate risk	Lead	Current Risk		Target Risk	
		Risk Score & Level	Financial Value			Risk Score & Level	Financial Value	Risk Score & Level	Financial Value
959	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only 82% of the required savings have been identified at 30th April 2016, leaving a savings gap of £3.2m.	16 - Very High	£3.2m	Trust is working to develop savings plans to meet 2016/17 target of £17.4m and close the current savings gap of £3.96m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	OA	12 - High	£3.96m	4 - Low	£0.0m
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	9 - High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	9 - High	-	9 - High	-
951	Risk of national contract mandates financial penalties on under-performance against key indicators.	9 - High	£4.0m	Ongoing negotiations with Commissioners but activity and finance largely agreed. Heads of Terms expected by the end of June 2016. If Sustainability & Transformation funding is agreed the risk reduces to c.£1m.	PM	9 - High	£2.0m	3 - Low	£1.0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3.0m	The Trust has strong controls of the SLA management arrangements.	PM	6 - Moderate	£2.0m	3 - Low	£0.0m
408	Risk to UH Bristol of fraudulent activity.	3 - Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	3 - Low	-	3 - Low	-

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17							2014/15	2014/15
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,357	10,483	10,432	10,413	41,686	3,474		3,580	3,350	3,370	10,299	10,299	3,433		3,373	
	Bank	82	109	93	88	371	31	0.9%	20	21	25	66	66	22	0.7%	26	0.8%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	18	42	42	14	0.4%	87	2.6%
	Waiting List initiative	98	54	95	95	342	29	0.8%	21	42	31	94	94	31	1.0%	22	0.7%
	Overtime	147	94	100	110	450	38	1.1%	47	37	36	120	120	40	1.2%	34	1.0%
	Other pay	9,572	9,648	9,788	9,920	38,927	3,244	94.8%	3,351	3,112	3,071	9,534	9,534	3,178	96.7%	3,198	95.0%
	Total Pay expenditure	10,276	10,146	10,261	10,382	41,063	3,422	100.0%	3,475	3,201	3,181	9,857	9,856	3,285	100.0%	3,367	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	189	443	443	148		5	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	4,258	12,853	12,853	4,284		4,108	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	318	880	880	293	6.6%	297	7.1%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	290	861	861	287	6.5%	291	7.0%
	Waiting List initiative	51	45	56	42	194	16	0.4%	29	29	19	77	77	26	0.6%	16	0.4%
	Overtime	16	21	35	32	105	9	0.2%	8	9	7	23	23	8	0.2%	8	0.2%
	Other pay	11,212	10,941	10,982	11,308	44,443	3,704	85.2%	3,790	3,851	3,794	11,435	11,435	3,812	86.1%	3,568	85.4%
	Total Pay expenditure	13,002	12,817	12,792	13,539	52,151	4,346	100.0%	4,403	4,447	4,428	13,278	13,277	4,426	100.0%	4,180	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(170)	(424)	(424)	(141)		(72)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	3,834	11,459	11,459	3,820		3,266	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	172	425	425	142	3.7%	108	3.2%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	177	555	555	185	4.8%	228	6.7%
	Waiting List initiative	125	144	156	103	528	44	1.2%	41	56	34	131	131	44	1.1%	42	1.3%
	Overtime	29	29	30	25	114	9	0.3%	8	11	13	32	32	11	0.3%	12	0.4%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,330	3,646	3,517	10,492	10,492	3,497	90.2%	2,995	88.5%
	Total Pay expenditure	10,415	10,510	10,516	10,913	42,354	3,529	100.0%	3,654	4,068	3,913	11,635	11,635	3,878	100.0%	3,386	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(79)	(176)	(176)	(59)		(120)	
Surgery Head and Neck	Pay budget	19,366	19,669	19,708	19,855	78,598	6,550		6,588	6,629	6,673	19,890	19,890	6,630		6,030	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	194	542	542	181	2.7%	169	2.7%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	193	707	707	236	3.5%	106	1.7%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	86	135	115	336	336	112	1.7%	139	2.2%
	Overtime	38	47	45	41	171	14	0.2%	11	12	9	33	33	11	0.2%	32	0.5%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,156	6,184	6,174	18,513	18,513	6,171	92.0%	5,859	92.9%
	Total Pay expenditure	19,461	19,885	19,844	19,875	79,062	6,589	100.0%	6,687	6,758	6,685	20,130	20,130	6,710	100.0%	6,305	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(12)	(240)	(240)	(80)		(275)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17							2014/15	2014/15
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	22,562	22,828	23,290	23,780	92,460	7,705		7,944	7,602	7,919	23,465	23,465	7,822		7,178	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	172	498	498	166	2.1%	181	2.5%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	131	548	548	183	2.3%	154	2.1%
	Waiting List initiative	205	169	203	206	783	65	0.8%	32	71	38	141	141	47	0.6%	33	0.5%
	Overtime	23	19	26	35	102	9	0.1%	9	15	17	42	42	14	0.2%	30	0.4%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,750	7,625	7,577	22,952	22,952	7,651	94.9%	6,793	94.5%
	Total Pay expenditure	22,956	23,305	23,991	24,530	94,780	7,898	100.0%	8,188	8,058	7,935	24,181	24,181	8,060	100.0%	7,190	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(16)	(716)	(716)	(239)		(12)	
Facilities & Estates	Pay budget	5,057	5,113	5,142	5,070	20,382	1,699		1,708	1,788	1,744	5,239	5,239	1,746		1,618	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	72	195	195	65	3.7%	89	5.5%
	Agency	145	189	249	154	738	62	3.6%	32	27	37	96	96	32	1.8%	42	2.6%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	225	244	207	200	876	73	4.3%	68	68	65	201	201	67	3.8%	80	5.0%
	Other pay	4,406	4,373	4,371	4,499	17,649	1,471	86.5%	1,572	1,609	1,592	4,773	4,773	1,591	90.7%	1,394	86.9%
	Total Pay expenditure	5,072	5,126	5,106	5,100	20,403	1,700	100.0%	1,717	1,782	1,766	5,265	5,265	1,755	100.0%	1,605	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(22)	(26)	(26)	(9)		13	
(Including R&I and (Incl R&I and Support Services)	Pay budget	6,487	6,496	6,977	7,438	27,398	2,283		2,327	2,532	2,398	7,257	7,257	2,419		2,478	
	Bank	179	211	232	223	846	70	3.2%	60	61	92	213	213	71	3.0%	57	2.4%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	116	239	239	80	3.4%	59	2.5%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0.0%	0	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	3	13	13	4	0.2%	9	0.4%
	Other pay	6,029	5,967	6,201	6,662	24,859	2,072	92.8%	2,190	2,213	2,191	6,594	6,594	2,198	93.4%	2,223	94.7%
	Total Pay expenditure	6,299	6,378	6,843	7,268	26,788	2,232	100.0%	2,280	2,377	2,403	7,059	7,059	2,353	100.0%	2,348	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	(5)	197	197	66		130	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	30,194	90,462	90,462	30,154		28,050	
	Bank	2,949	3,244	2,834	3,254	12,281	1,023	3.4%	774	998	1,046	2,818	2,818	939	3.1%	927	3.3%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	961	3,049	3,049	1,016	3.3%	967	3.4%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	209	333	237	779	779	260	0.9%	252	0.9%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	150	463	463	154	0.5%	204	0.7%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,139	28,240	27,916	84,295	84,295	28,098	92.2%	26,031	91.7%
	Total Pay expenditure	87,480	88,166	89,352	91,607	356,602	29,717	100.0%	30,405	30,690	30,310	91,404	91,405	30,468	100.0%	28,381	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(115)	(942)	(943)	(314)		(331)	

NOTE: Other Pay includes all employer's oncosts.

Release of Reserves 2016/17 **Appendix 8**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	700	11,709	38,455	(690)	2,426	3,194	55,794									
April movements	(120)	(8,993)	(31,315)	-	166	(208)	(40,470)	3,694	9,102	8,756	7,388	9,590	1,238	1,749	(1,047)	40,470
May movements	(28)	(6)	(3,529)	7	(588)	(217)	(4,361)	(119)	(22)	1	1,914	47	26	194	2,320	4,361
June																
SLA Adjustment			87				87								(87)	(87)
Spend to Save						(175)	(175)		140	11	19			5		175
Strategic Schemes Costs						(97)	(97)						91	6		97
CSIP						(39)	(39)							39		39
SIFT					(39)		(39)					39				39
R & I Overheads	129						129								(129)	(129)
EWTD					(121)		(121)	10	25	17	21	44	2	1	1	121
Other	(32)	(9)				(55)	(96)						6	90		96
Month 3 balances	649	2,701	3,698	(683)	1,844	2,403	10,612	3,585	9,245	8,785	9,342	9,720	1,363	2,084	1,058	45,182

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
22. Quarterly Capital Projects Status Report									
Sponsor and Author(s)									
Sponsor: Owen Ainsley, Interim Chief Operating Officer **Author**: Andy Headdon, Strategic Development Programme Director									
Intended Audience									
Committee members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The purpose of this report is to update the Board on the progress, issues and risks' arising from the Trust's remaining major capital developments which are governed through the Estates Capital Project Team and associated programme infrastructure.

Key issues to note

- Decommissioning of Old Building rear courtyard on programme.
- Office accommodation projects all on programme (Site Village completed) with the exception of levels 8&9 of Queen which has been re-phased to accommodate changing needs of Pathology service and delay to vacation by PHE
- Queens facade completed, Signage installed and further planning application for lighting high level sign submitted.
- KEB currently has some programme slippage which requires on-going management to mitigate impact.
- Programme remains within budget, but still some issues to resolve with HMRC regarding VAT recovery on completed major strategic schemes.

Recommendations
The Board is asked to receive this update for **assurance** that the strategic development is on track and being effectively governed.
Impact Upon Board Assurance Framework
Central to delivery of strategic objective 2.1
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
N/A

Resource Implications			
Finance	✓	Information Management & Technology	
Human Resources		Buildings	✓

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

Date report submitted to other sub-committee				
Finance Committee	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

STRATEGIC DEVELOPMENT QUARTERLY STATUS REPORT
Quarter 1
28th July 2016 Trust Board

1. Introduction

This status report provides a summary update for Quarter 1 on the Trust's strategic capital schemes, all of which are managed through their respective project boards, which in turn report to the Senior Leadership Team.

2. Project Updates

The Queens Façade project and the conversion of the site village have both completed in the period.

BRISTOL ROYAL INFIRMARY Phase 4 and Queens Facade		
1	**Decisions required**	None
2	**Progress**	**Old Building** Decommissioning of the Old building is progressing in line with the programme to vacate departments, with Medical Illustration, Medicine and D&T management teams being located to their new locations within the period. Disconnection of all services remains on programme to complete by the required date. A series of department moves is on programme to achieve the required vacant possession date of the 1st August for all the rear courtyard accommodation as requested by Unite, after which demolition work will commence. **Office accommodation** Works to the site village is now complete and fully occupied. Work has commenced in Whitefriars and will be complete by the end of July which will accommodate he HR function and Staff Counselling service. Revised phasing of the works to progress the conversion of levels 8&9 of the Queens building have had to be agreed to accommodate the changing requirement of the pathology service and the vacation of the site by PHE. This is now agreed but there are some operational knock on effects to areas such as the Site Clinical Team accommodation The conversion of 24 Upper Maudlin Street has completed the first phase and is occupied, the second phase has now commenced. **BRI Phase 4** Refurbishment of King Edward Building is now fully under way with works progressing in all areas. The contract programme has experienced some delays mainly with regard to design details and asbestos issues and this will delay occupation of the building into mid-October. Work continues with Unite to mitigate the impact

		of the delay as far as is practical. This requires continued careful management to ensure there is no further slippage to the contract programme. **Queens Façade** The main façade works are now complete and a formal handover was held on 20th June. There is on-going discussion with Council Highways officer regarding the pavement, bus stops and tree pits which are hoped to be resolved shortly, but this has delayed these elements of the scheme. 47 windows on level 6 wards still require internal works to be completed and this is scheduled to commence on 2nd August to meet operational requirements of the ward. The external signage has been installed and a further planning application has been submitted for the sign lighting, which is expected to be determined in the next few weeks.	
3	**Budget**	A total capital allocation for Phase4 and the Façade of £28.454m is in the capital programme which includes funding for façade and assumes charitable funding support of £2m. The final account has been settled on the major strategic schemes and final submissions made to HMRC to agree VAT recovery amounts, however discussions remain on-going with HMRC to finally conclude these issues.	
4	**Programme**	The phase 4 programme has some slippage on the required vacation date of the Old Building however this is being managed in conjunction with Unite to mitigate the impact.	
5	**Risks**	**Risk**	**Mitigation Actions**
		Programme is not delivered to time or cost with resulting operational impacts for both KEB and level 8&9 Queens	Additional external project management support has been retained to oversee largest projects to strengthen project management arrangements. Additionally the Strategic Development Programme Director has temporarily taken over management responsibility for all capital works to support the Director of Facilities and Estates.

3. Conclusion

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

Author: Andy Headdon, Strategic Development Programme Director
Date updated: 1.07.2016

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public
To be held on Thursday 28 July 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
23. Risk Management Policy & Strategy									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author:** Pam Wenger, Trust Secretary & Sarah Wright, Head of Risk Management									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The Risk Management Strategy has been revised in accordance with the required review schedule. The revised Strategy presents a high-level strategic statement on the management of risk, including the Risk Appetite statement to be considered by the Trust Board of Directors.

The associated Risk Management Policy sets out to define the details and process of risk management. The Risk Management Policy and Strategy was approved for submission by the Risk Management Group and Senior Leadership Team in July 2016.

Recommendations

Members are asked to:

- **Note** the report;
- **Approve** the risk appetite statement for the period 2016/17; and
- **Approve** the risk management strategy and policy.

Impact Upon Board Assurance Framework

The Board Assurance Framework (BAF) acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance, that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated. This strategy describes the direction that the Trust will take to manage risk.

Impact Upon Corporate Risk

There is a risk that if the Risk Management Strategy is not adopted, not adequately reviewed or not properly refreshed, the Trust Board may not be fully informed of the key risks and may not have a robust governance process to manage risks; this could lead to decisions being made without sufficient information and inability to deliver the priorities and other statutory duties.

Implications (Regulatory/Legal)							
There may be an adverse effect on the organisation if arrangements are not put in place to manage the risks.							
Equality & Patient Impact							
No impact.							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval	✓	For Information	

Finance Committee	Audit Committee	Quality and Outcomes Committee	Senior Leadership Team	Risk Management Group
			20/07/2016	13/07/2016

RISK MANAGEMENT STRATEGY AND POLICY

SITUATION

The purpose of the report is to present the reviewed and updated Risk Management Strategy and Policy which was previously approved by the Trust Board in 2015.

The updated Strategy and Policy now being presented for approval by the Board has been subject to a robust review and scrutiny process by the Risk Management Group and Senior Leadership Team.

BACKGROUND

The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement Terms of Authorisation, key regulatory requirements such as Care Quality Commission, and its strategic objectives. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

The Trust's strategy is aimed at creating a co-ordinated and focussed framework for the management of risk within the Trust. Implementation of the strategy will be monitored by the Risk Management Group, on behalf of the Board of Directors and Chief Executive who has delegated responsibility from the Board for effective risk management, with significant commitment, support and effort from all members of Trust staff including management teams and senior clinicians.

The Trust's overall strategic aim in respect of risk is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust. These arrangements are set out in more detail in the Trust's Standing Financial Instructions, Scheme of Delegation and Trust wide policies and procedures.

This strategy formalises the Risk Management responsibilities of the Board of Directors and sets out how the public can be assured that our risks are managed effectively. The overall goal of risk management is to have an environment of 'no surprises' where we understand the risks facing the Trust and eliminate or control them to an acceptable level, by creating a culture founded upon assessment, mitigation and prevention of risk.

ASSESSMENT

The Trust's risk management policy sets out its approach to and appetite for risk and its approach to risk management and describes:

- Risk management objectives and risk appetite;
- Structures and responsibilities in place, including roles and responsibilities for risk management at different levels of the organisation;
- Risk management processes and tools in place, including reference to the risk register, risk reporting, frequency of risk activities and available guidelines.

- At each level of the organisation, risk management responsibilities should be clearly defined.

The Risk Management Strategy has been reviewed, by the Risk Management Group and has resulted in the following changes (shown in red in the main document);

- Review of the objectives to deliver the risk management objectives for 2016-17;
- Re-wording of the section in relation to the risk appetite statement; and
- References in relation to Monitor changed to NHS improvement.

Risk Appetite Statement
The Trust Board approved the Risk Appetite Statement in 2015 and is required to review this statement annually. The Board is asked to confirm the agreement of the following statement:.

The Trust operates within a high overall range of risks. The Trust's lowest risk appetite is for safety risks, specifically patient, staff and visitor safety and for breaching our legal obligations. This means that reducing these risks so far as is reasonably practicable will take priority over meeting our other business and strategic objectives.

RECOMMENDATIONS

Members are asked to:

- **Note** the report;
- **Approve** the risk appetite statement for the period 2016/17; and
- **Approve** the risk management strategy and policy.

Pam Wenger
20 July 2016

Risk Management Policy and Guidance

Document Data			
Subject:	Risk Management		
Document Reference	15615		
Document Type:	Policy		
Document Status:	Draft		
Document Owner:	Head of Risk Management		
Executive Lead:	Chief Executive		
Approval Authority:	Risk Management Group		
Review Cycle:	12 Months		
Date Version Effective From:	01/07/2016	**Date Version Effective to:**	01/07/2017

Introduction

University Hospitals Bristol NHS Foundation Trust ('the Trust') is faced with a number of factors that may impact upon its ability to meet its objectives. The effect of uncertainty on those objectives is known as risk.

Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should also be reviewed at appropriate intervals to ensure they continue to be appropriately mitigated.

It is widely recognised that an effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of objectives. A comprehensive management approach to risk reduces adverse outcomes, and can result in benefit from what is often referred to as the 'upside of risk'.

Risk Management is an integral part of good governance and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial.

As well as close links with clinical and corporate governance, risk management is embedded within the Trust's organisational performance, business, planning and investment processes.

This document describes the sources of the Trust's risks and its approach to the identification, assessment, management and escalation of risk within the organisation and is predicated on the belief that risk management is an important activity and should be an inclusive and integrative process covering all risks, set against a common set of principles, and a major corporate responsibility which requires strong leadership and regular review.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
September 2012	1.0	Head of Quality (Patient Safety)	Major	New policy following decision to separate out policy requirements from the previous Risk Management Strategy.
May 2013	1.1	Trust Risk Manager	Major	Comprehensive review following approval of the revised Risk Management Strategy.
August 2013	2.0	Trust Risk Manager	Minor	Policy approved at RMG 07/08/2013.
December 2015	3	Head of Risk Management	Major	Inclusion of Standards and update to the development of the risk management framework.

Table of Contents

1. Purpose

The purpose of the Policy is to define the framework and systems the Trust will use to identify, manage and eliminate or reduce to a reasonable level risks that threaten the Trust's ability to meet its objectives and achievement of its values.

This policy sets out :

- The framework that supports the maintenance and development of a risk-aware culture where the right people do the right thing at the right time;
- Outline the processes to be used for the management of all Trust risks;
- Define risk types and escalation processes to ensure oversight of risks from ward to Trust Board; and
- Define roles of all staff in relation to risk identification, management and review.

2. Scope

The Policy applies to all staff including contractors and agency staff.

3. Definitions

Risk is the threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence.

Risk management is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.

Risk Assessment is a systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk actually happens (impact or magnitude).

Strategic risks are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.

Operational risks are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the Division which is responsible for delivering services.

Risk Registers are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk Registers are available at different organisational levels across the Trust.

Risk appetite is the type and amount of risk that the Trust is prepared to tolerate and explain in the context of its strategy.

Governance is the systems and processes by which the Trust leads, directs and controls its functions in order to achieve its organisational objectives, safety, and quality of services, and in which it relates to the wider community and partner organisations.

Internal controls are Trust policies, procedures, practices, behaviours or organisational structures to manage risks and achieve objectives.

Assurance is the confidence the Trust has, based on sufficient evidence, that controls are in place, operating effectively and its objectives are being achieved.

4. Policy Statements

4.1 *Statement of Commitment*

The Trust is committed to proactive management of the risks posed to our objectives. In order to do so we will adopt best practice in risk management, employ new technologies to help manage risk and ensure our staff are appropriately trained to manage the risk associated with our activities.

We acknowledge that it is not possible or desirable to eliminate all risks and we will encourage positive risk-taking in keeping with our statement of risk appetite risks where risks may result in positive benefits for our patients, staff and visitors (the 'upside' of risk).

4.2 *Policy Statements*

The Trust recognises that an effectively planned, organised and controlled approach to risk management is a cornerstone of sound management practice and is key to ensuring the achievement of strategic aims.

- The Trust seeks to encourage a risk-aware culture in which the assessment and management of risks is an integral part of decision making, both small and large, and where the right people at the right thing at the right time.
- The overriding principle of this policy is that the effort and resources spent on manage risk will be proportionate to the risk. Risks will be evaluated to differentiate those that are unacceptable for those risks which are acceptable (tolerable). This will define the Trust's risk appetite.
- The Trust also accepts that sound risk management can assist in continuous improvement in all its services. Practices will be enacted ensure that the results of risk assessments are used to improve the Trust's processes and procedures.
- It is the intention of the Trust that its management of risk is compliant with all relevant legislation and regulation.
- The Risk Management System will be subject to regular comparison against published best practice.
- The Risk Management System will be regularly monitored and assessed to ensure its effectiveness within the context of the Policy.

5. Risk Management Framework

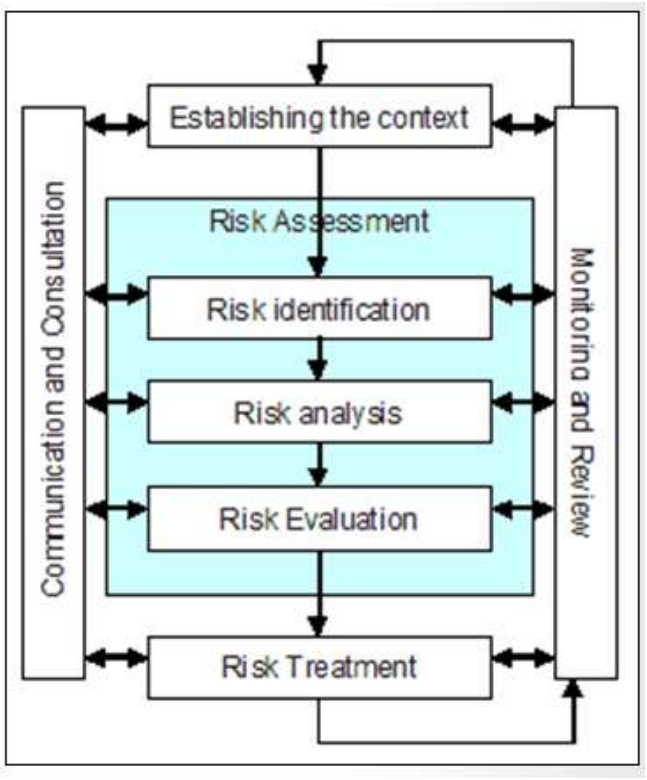
5.1 *Components of the framework*

- Risk Management Strategy;
- Risk Management Policy;
- Definition of the responsibilities and accountabilities at all levels in the organisation;
- Ensuring Risk Management is embedded into all of the Trusts practices an processes;
- Ensuring adequate resources and available;
- Ensuring staff have the appropriate skills, experience and competence;
- Establishing internal reporting processes to encourage accountability for, and ownership of, risk; and
- Establishing external communication and reporting mechanisms for all stakeholders

5.2 *Benefits of Risk Management*

The Trust recognises that there are significant benefits to managing risk. They include:

5.3 *Risk Management Process*



Establishing the context

Risks have no relevance on their own – they only have meaning in relation to the objectives of the organisation and its stakeholders. Understanding the various environments in which the organisation functions is necessary in order to assess what risks there may be, as well as what effect they could have.

- External: those features, relationships and drivers outside the organisation that can influence its success or failure;
- Internal: the organisation's own values, strategy and objectives; its culture, structure and processes; its capabilities and capacity

Risk identification defined as the process of finding, recognising and describing risks, it is the part where the organisation's objectives should be considered in the light of any and all events or situations that could affect their achievement, whether positive or negative.

Risk analysis is defined as the process to comprehend the nature of risk and to determine the level of risk. This is the part where an understanding of the risks is developed. Causes are examined, consequences defined and the likelihood of various scenarios considered, taking into account the effectiveness of any controls that are already in place. This is an important step in providing a basis for risk-informed decision making.

Risk evaluation is defined as the process of comparing the results of risk analysis with risk criteria to determine whether the risk and/or its magnitude are acceptable or tolerable. The risks that have been identified and analysed can now be compared with the risk criteria developed earlier, ideally in the design of the framework. With this as the basis, the organisation can make rational decisions as to the tolerability of the risks and the need for further risk treatment.

Risk Treatment is defined as the options available to management the risk, decision making of action plan to implementation of new controls. It also includes the decision to take no further action and 'accept' the risk.

Communication and consultation
This is important at all stages of the process but is vital as a first step. All those with a stake in the objectives and activities of the organisation, as well as anyone with useful knowledge, should be included from the outset.

Monitor and Review
The process is continuous from re-establishing the context in line with service changes to regular re-assessment as actions plans are completed.

5.4 *Attributes of effective risk management*

Proportionate

The effort spent managing an individual risk should be proportionate to the level of risk faced.

Aligned
The identification and assessment of risk should be in the context of, and aligned to the achievement of the organisations objectives.

Comprehensive

The controls and actions out in place to to manage risk need to be detailed and specific enough that they fully achieve the desired level of mitigation.

Embedded

Risk management should be imbedded into normal working practices, this requires risk to be integrated into business and operational planning cycles.

Dynamic

Risks can change so controls put in place need to be continually monitored to ensure they are up to date.

6. Duties, Roles and Responsibilities

6.1 *Trust Board of Directors*

The Executive and Non-Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. The Executive and Non-Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role.

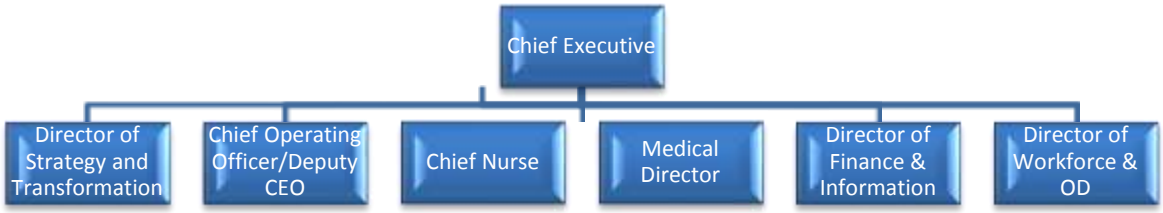
The Board is also responsible for reviewing the effectiveness of its internal control systems and is required to ensure that the Trust's risk management arrangements are sound and protects patients, staff, the public, and other stakeholders against risks of all kinds.

The Annual Governance Statement made by the Trust's Chief Executive in the annual report and accounts must demonstrate that the Trust Board has been informed on all risks and has arrived at its conclusions on the totality of risk based on all the evidence presented to it through the responsibilities delegated to the committees within the organisation.

6.2 *Executive Directors*

Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in the Risk Management Policy and the Terms of Reference of the Risk Management Group. Executive Directors are also responsible for risks allocated to them on the Corporate Risk Register and Trust-wide Risk Register.

The diagram below provides the Risk Management Framework: this shows the principal bodies responsible for the governance and oversight of risk within the Trust and the reporting hierarchy. It details all committees and groups which have some responsibility for risk and report directly to the Trust Board of Directors. This provides assurance to the Board that risk management processes are in place and remain effective.



6.3 *Chief Executive*

The Chief Executive is accountable to the Chairman and the Board and, as the Accountable Officer, has overall responsibility for ensuring that the Trust operates effective risk management processes in order to protect all persons who may be affected by the Trust's business. The Chief Executive is required to sign annually, on behalf of the Board, an Annual Governance Statement, in which the Board acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

6.4 *Medical Director*

Accountable to the Chief Executive and the Board, the Medical Director has joint lead responsibility for healthcare governance with the Chief Nurse. This includes; lead responsibility for clinical performance of the medical workforce: clinical audit: medical innovation: research governance: medical education; the role of SIRO; and will report key clinical risks to the Board on a routine basis.

6.5 *Chief Nurse*

The Chief Nurse has joint lead responsibility for healthcare governance with the Medical Director and is accountable to the Chief Executive and the Board for the delivery of the Trust's patient safety and quality initiatives. The post-holder will also be responsible and accountable for the operational management of the nursing teams and Allied Healthcare Professionals and will lead

the development of clinical nursing practice to achieve excellence in all aspects of nursing. The post-holder will ensure the highest standards of care at ward level and lead on the improvements to patient experience. The Chief Nurse also coordinates the Care Quality Commission Registration and the maintenance of compliance with the regulations and outcomes that apply to the Trust.

6.6 *Deputy Chief Executive/Chief Operating Officer*

The Deputy CEO/Chief Operating Officer is accountable to the Chief Executive and the Board for overall management of Trust corporate services including; Trust Secretariat, risk management; communications; and legal services. The post-holder will ensure that risks in relation to this portfolio are managed in line with the Trust's risk management systems and processes. The post is also responsible for the operational management of divisional teams, supporting the Trust's risk management systems and processes.

6.7 *Director of Strategy and Transformation*

The Director of Strategy and Transformation is accountable to the Chief Executive and the Board leading the development of local health and social care services, strategic development, business planning and service transformation in the Trust. The post-holder will ensure that all risks in relation to this portfolio will be managed in line with the Trust's risk management systems and processes.

6.8 *Director of Finance and Information*

The Director of Finance and Information is accountable to Chief Executive and the Board for the management of financial governance, including advising on financial/business risk, audit and assurance.

6.9 *Director of Workforce and Organisational Development*

The Director of Workforce and OD is accountable to the Chief Executive and the Board for the management of all human resources and associate risks, including those relating to training and organisational development.

6.10 *Senior Information Responsible Officer (SIRO)*

The Medical Director shall also fulfil the role and function of the SIRO and is accountable to the Chief Executive for the management of information risks.

6.11 *The Caldicott Guardian*

The Caldicott Guardian will play a key role in helping to ensure that the Trust satisfies the highest practical standards for managing information governance risks. The Caldicott Guardian will act as the conscience of the organisation in this respect, and will actively support work to manage such risks.

6.12 *Trust Secretary*

The Trust Secretary is responsible for ensuring that the Trust Board of Directors is cognisant of its duties towards risk governance and management and for coordinating the annual cycle of Board business to ensure these duties are incorporated on the Board's agenda. The Trust Secretary is

also responsible for the coordination of the Trust's Board Assurance Framework to ensure proactive management to ensure that the Board remains sighted on the key risks facing the Trust.

6.13 *Head of Risk Management*

The Head of Risk Management develops, implements and monitors compliance with the risk management policy and is responsible for maintaining the overall structure for risk management within the Trust. The post-holder facilitates the development of a risk aware culture within the Trust, compiles risk information and prepares reports for the Senior Leadership Team, Risk Management Group and Trust Board of Directors.

6.14 *Wards and department leads*

Each manager is responsible for ensuring Risk Assessments are completed with implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected.

Line managers must allocate sufficient time for the risk assessor to ensure that they have enough time to complete their assessor responsibilities within normal working hours.

6.15 *Risk Assessor*

Risk Assessors are members of staff who have attended the Trust's risk assessor training and conduct risk assessments on behalf of ward and department managers.

6.16 *All staff (including Honorary Contract holders, locum and agency staff and contractors)*

Notwithstanding the identification of the above key personnel, the Trust recognises that organisational risk management is the responsibility of all members of staff. Every member of staff (including clinicians, temporary staff, contractors and volunteers) are responsible for ensuring that their own actions contribute to the wellbeing of patients, staff, visitors and the Trust.

All staff are required to attend and follow individual essential training requirements and not to use equipment, adopt practices or processes which deviate from mandatory or statutory requirements and procedures for the purposes of health and safety. They are expected to locate, observe and comply with all relevant policies and procedures that have been made available within the Trust.

All staff must contribute to the identification, management, reporting and assessment of risks and to take positive action to manage them appropriately. This is an essential part of managing risks locally and is a statutory requirement.

In addition, staff have a responsibility for taking steps to avoid injuries and risks to patients, staff, and visitors. In fulfilling this role, which may involve raising concerns about standards, staff might consider the need for reporting under the Trust's Speaking Out Policy.

6.17 *Senior Leadership Team*

The lines of accountability in relation to the management of Trust risk are highlighted in the diagram in below.

The Senior Leadership (SLT) is responsible for maintaining the Corporate Risk Register. SLT receives risk exception reports from divisions at each business meeting, informing them of any risks with the division that SLT should have sight of. These may be either risks scoring 15 or above, or those with the potential to significantly impact upon corporate or strategic objectives.

6.18 *Risk Management Group*

As a Management Group established and chaired by the Chief Executive, the Risk Management Group (RMG) is responsible for discharging the responsibility of the Senior Leadership Team for the management of organisational risk. This includes receiving the Corporate Risk Register and divisional risk registers in full on a rotational basis.

6.19 Audit Committee

The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities.

6.20 Quality and Outcomes Committee

The Quality and Outcomes Committee shall receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.

6.21 Finance Committee

The Finance Committee is responsible for monitoring financial risk. The Director of Finance and Information is responsible for reporting this to the Risk Management Group.

6.22 *Divisional Management Boards*

Divisional Management Boards are responsible for having a planned risk assessment programme in place, comprised of quarterly Divisional Management Board meetings and monthly Divisional

Governance meetings, at which, the implementation of recommendations from risk assessments and action plans with realistic timescales for mitigating risks are reviewed.

Divisional Management Boards shall adopt a standardised approach to the management of risk in accordance with the duties defined in the Risk Management Policy and the Terms of Reference of the Risk Management Group. They are also responsible for reviewing the divisional risk register and considering risks escalated to the management board from their departments for adding to the Divisional Risk Register. They are required to present their divisional risk registers in full to the Risk Management Group on a rotational basis.

Divisions are required to report progress of mitigating actions in respect of their key risks in quarterly performance reviews with Executive Directors, ensuring resource is allocated within their division to assess and manage their risks.

Divisional Directors are accountable to the Chief Operating Officer for the implementation of the Risk Management Strategy and Policy locally and for creating associated procedures within their division, ensuring that the divisional risk register is populated with all risks (clinical, non-clinical and financial) and informed by local risk assessments and reviewed on a regular basis. In addition, Divisional Directors have a duty to ensure that their staff are given the necessary information and training to enable them to work safely.

Trust-wide specialist advisers are responsible for advising anyone about a specific risk assessment issue e.g. Head of Health and Safety Services.

Specialist patient care risk assessment support is available from relevant specialists e.g. Blood Transfusion Practitioner, Dementia and Falls Lead, Tissue Viability Nurses.

6.23 *Divisional Governance/Quality/Patient Safety Leads*

Divisional Leads are responsible for:

- Facilitating divisional and departmental risk process' in accordance with this policy and ensure escalation of risks occur in timely manner to the divisional board; and
- Facilitating the preparation of monthly exception reports of any divisional risks of 12 or above, to be received by the central risk team no less than 10 days before the meeting of the SLT.

6.24 *Trust-wide specialist advisers*

Responsible for advising anyone about a specific risk assessment issue e.g:

- Health and Safety Advisors;
- Manual Handling and Ergonomic Advisor;
- Radiation Protection Advisor; or
- Specialist patient care risk assessment support is available from relevant specialists e.g:
    - Blood Transfusion Practitioner
    - Dementia and Patient Falls Leads
    - Tissue Viability Nurses.

6.25 *Risk Owners*

Each risk owner is responsible for ensuring:

- That risk registers relating to their area of responsibility are managed in accordance with this policy and related procedures;
- That risks are reviewed, updated and progress added prior to quarterly review by Risk Management Group or Divisional Boards (annually to governance groups for departmental risks) or when there are any changes which impact on the risk;
- Generic Health and Safety Risk Assessments for their area of responsibility are completed and uploaded to the Generic Health and Safety workspace in accordance with the Standard Operating Procedure.
- The implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected;
- Line managers must allocate sufficient time for the risk assessor to ensure that they have enough time to complete their assessor responsibilities within normal working hours; and
- Risk handlers should successfully complete the Trusts Risk Management e-learning once implemented.

6.26 *Health & Safety Generic Risk Assessors*

Generic Risk assessor's (GRA's) are responsible for conducting risk assessment on behalf of ward and department managers. They should:

- Have attended the Trust's generic risk assessor training, followed by 3 yearly updates;
- Also attend specific training, e.g. Control of Substances Hazardous to Health (COSHH) and manual handing risk assessment;
- Enter details of all assessments onto the Generic Health and Safety workspace and upload a copy of any related documentation;
- Ensure essential assessments for their area are completed and re-assessed as necessary; and
- If the GRA is also a risk handler (responsible for entering details of identified risks onto Datix), they should also successfully complete the Trusts Risk Management e-Learning.

6.27 *Risk Handler*

A member of staff with delegated responsibility from the risk owner for ensuring:

- Risks and all associated information is entered onto Datix and maintained in accordance with this policy; and
- Risk handlers should successfully complete the Trusts Risk Management e-learning.

6.28 *All Staff*

Notwithstanding the identification of the above key personnel, the Trust recognises that organisational risk management is the responsibility of all members of staff. Every member of staff (including clinicians, temporary staff, contractors and volunteers) are responsible for ensuring that their own actions contribute to the wellbeing of patients, staff, visitors and the Trust.

All staff are required to attend and follow individual essential training requirements and not to use equipment, adopt practices or processes which deviate from mandatory or statutory requirements and procedures for the purposes of health and safety. They are expected to locate, observe and comply with all relevant policies and procedures that have been made available within the Trust.

All staff must contribute to the identification, management, reporting and assessment of risks and to take positive action to manage them appropriately. This is an essential part of managing risks locally and is a statutory requirement.

In addition, staff have a responsibility for taking steps to avoid injuries and risks to patients, staff, and visitors. In fulfilling this role, which may involve raising concerns about standards, staff might consider the need for reporting under the Trust's Speaking Out Policy.

6.29 *Monitoring Groups*

Monitoring groups are to provide oversight and scrutiny of risks related to their area of work. Monitoring groups are not accountable for risk.
For example:

- Trust Health & Safety and Fire Safety Committee will review fire, environmental and health and safety risks
- The Clinical Quality Group will review clinical risks and risks to Care Quality Commission compliance
- The Human Resources Board will review workforce risks
- Information Risk Management Group will review information governance risks
- The Infection Control Group will review infection control risks.

7. Reporting to External Bodies

There are various national external agencies that monitor the Trust on its risks management processes and arrangements and the implementation of these, included but restricted to:

7.1 *NHS Improvement*

The Trust is required to, on a quarterly basis, submit to NHS Improvement self-declared Financial Risk Rating (based on various financial indicators: EBITDA, I&E) and Governance Risk Rating (based on the achievement of operational targets and the Trust's CQC Compliance status).

7.2 *Care Quality Commission (CQC)*

The CQC will undertake announced and unannounced inspections of the Trust's sites throughout the year. The Trust is required to provide the CQC with information on the steps that have/will have been taken in addressing any risks/compliance concerns arising from these inspections.

7.3 *Health and Safety Executive (HSE)*

The Trust will respond to any visit, either planned or unplanned, by the enforcing authorities e.g., HSE and provide to them, on request, any information they require. In addition, under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) the Trust has an obligation to report categorised incidents types (death and specified injuries that are work related, injuries where an employee is away from work or unable to perform their normal work duties for more than seven consecutive days as the result of an occupational accident or injury, diagnosis of any Occupational Disease made by a GP or Consultant and the member of staff has been carrying out work activities that led to the condition and finally any Dangerous Occurrences that are certain listed near misses.

7.4 *National Reporting and Learning System (NRLS)*

The Trust reports all patient safety incidents through the NRLS via the online reporting system. Serious incidents are uploaded as soon as classified as such.

7.5 *NHS Central Alerting System (CAS)*

The Trust is obliged to respond to all CAS alerts (i.e., safety alerts, drug alerts, medical device alerts) within timescales dictated by CAS according to the nature and seriousness of each individual alert.

7.6 *NHS Protect*

The Trust is expected to provide NHS Protect with information relating to the provision of the Local Security Management Specialist workplan annual report. Physical assault statistics and security incidents.

7.7 *Police*

The Trust liaises with Avon and Somerset Constabulary in relation to any suspected criminal activity either taking or having taken place.

7.8 *Public Health England (PHE)*

The Trust is required on a weekly, monthly and quarterly basis to report on data relating to Clostridium Difficile, E. Coli, Glycopeptide-Resistant Enterococci (GRE), MRSA and MSSA Bloodstream Infections.

7.9 *Safeguarding*

The Trust will actively work within an inter-agency framework to ensure that the welfare and safety of patients at risk is paramount. This joint working will be under the auspices of the Bristol Safeguarding Adults Board and the Bristol Safeguarding Children Board.

8. Incident Investigations and Root Cause Analysis

Investigations into the circumstances of incidents, accidents, claims and complaints provide an essential source of risk identification. Where a risk is identified through such an investigation, that cannot be immediately addressed, it should be entered onto the appropriate risk register. Further detailed guidance relating to undertaking investigations can be found in the Complaints and Concerns Policy and the Serious Incident Policy.

The Trust adopts a Root Cause Analysis (RCA) methodology when undertaking investigations relating to potentially serious incidents and never events. RCA is a problem solving methodology based on the premise that, once removed from the problem fault sequence, addressing the root cause prevents the final undesirable event from recurring. It is a systems-based approach to analysis rather than focussing on individual actions and has been shown to provide a means to identify effective learning and long term solutions to a range of issues.

9. Board Assurance Framework (BAF)

The BAF is the key document enabling the Board to understand the strategic risks facing the organisation. The BAF provides the Trust with a single but comprehensive method for the effective and focused management of the principle risks to meeting the Trust's overall strategic objectives. The risks identified from the BAF cover the full range of strategic objectives and

includes consideration of present risks, future risks, risks arising from within the organisation and risks occurring as a result of external pressures and changes.

The BAF is a live document updated by the Executive leads for each of the strategic objectives on a quarterly basis and provides the basis for both the assurances and gaps in control reported in the Annual Governance Statement.

The BAF is the primary mechanism for ensuring that the Trust Board received assurance that the risks to the Trust's strategic objectives are being appropriately treated.

10. Risk Registers

10.1 *Types & Frequency of Review*

The minimum requirement for the review of risk registers whether 'action required' or 'accepted':

- Corporate Risk Register - At least quarterly and prior to review at SLT/Board
- Divisional Risk Register - At least quarterly and prior to review at Divisional Board
- Departmental Risk Registers – Prior to review at appropriate governance group

All risks regardless of level or status should be review and updated in line with any service changes.

10.2 *Corporate Risk Register*

The Corporate Risk Register is comprised of risks that have the potential to impact on the Trusts ability to meet its strategic objectives, as outlined in the BAF. The risks identified on the Corporate Risk Register are referenced against the principal risks to the Organisation on the BAF.

Corporate Risks:

- Are assessed as having a current rating of 12 or above
- Pose a significant risk to the corporate objectives of the Organisation
- Includes risks scored 12 or above and escalated by divisions.

The Corporate Risk Register is maintained on Datix, by the Head of Risk Management. Risks are approved for entry onto the Corporate Risk Register by the Senior Leadership Team or the Trust Risk Management Group on their behalf.

10.3 *Divisional Risk Register*

Each division has its own risk register which captures in one place how divisional risks are being managed. The Divisional Boards are accountable for the assessment, communication and management of risks within their area of responsibility.

Divisional Risks are:

- Assessed as having a current rating of 12 or above, or;

- Affecting more than one department or speciality
- Includes risks that score 12 or above escalated from the departmental risk registers

The Divisional Risk Registers are maintained on Datix, by the divisional governance leads. Risks are approved for entry into the Divisional Risk Register by the Divisional Board.

10.4 *Departmental Risk Registers*

In this context, the term 'departments' is defined as wards, departments, services and clinics listed in the 'Department' field on Datix.

Each department will maintain a register of risks to departmental objectives The Departmental Risk Registers are maintained on Datix, by the department manager or specialty lead. Risks are approved for entry onto the Risk Register by the department manager or specialty lead.

Health & Safety Risk assessment should in the first instance be completed on the template available and uploaded to the health & safety generic risk assessment workspace to determine if an unacceptable element of risk exists.

All risk assessments completed that identify an element of risk outside of acceptable parameters or uncontrolled by standard operating procedures should, following consultation from the ward manager and Divisional Health & Safety Advisor be entered onto the departmental risk register Where a paper risk assessment has been completed, a copy of the document should be attached to the Datix record for information.

10.5 *Cross-divisional and Trust-wide risks*

To ensure appropriate oversight and scrutiny, all risks must reside on one of the six divisional risk registers. Divisional ownership of a risk will usually be dictated by the division to which the individual risk owner belongs. Where a risk is identified in a division that may also be a risk to another division, it is attendant on the owner of the risk to notify the other division. There is functionality in Datix to communicate and give staff access to a new risk.

A decision will then be made as to whether:

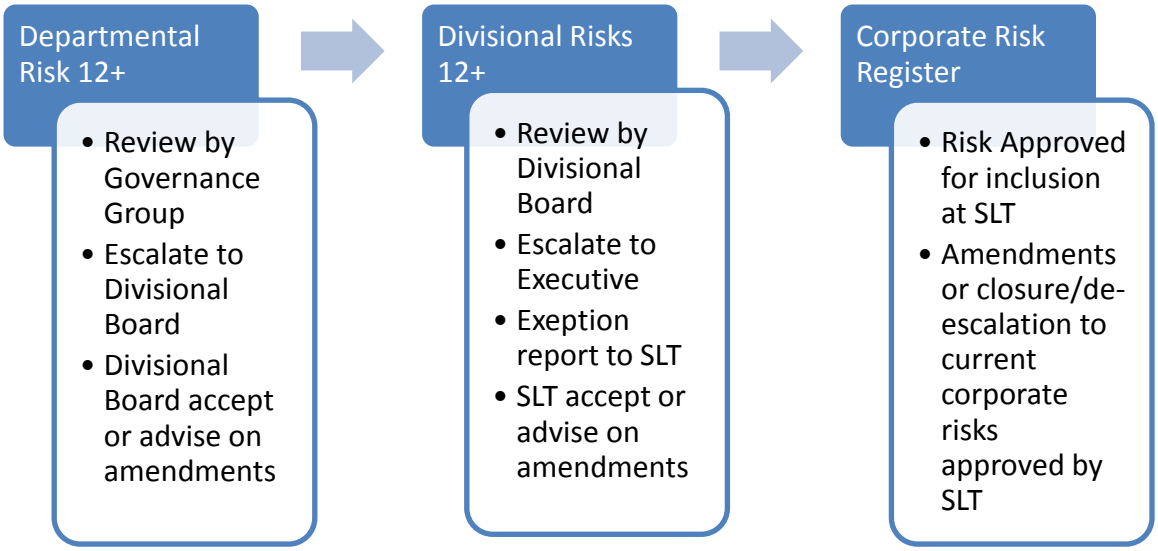
- One division takes a lead on managing the risk, involving the other division as appropriate; or
- Both divisions record the risk (e.g. patient falls) in their risk register and each manage their own risk in accordance with the risk management policy; or
- Where the risk is under the control of a speciality that crosses divisions, e.g. pharmacy, the risk may reside in the division in which the speciality is housed, e.g. Diagnostics and Therapies; or
- Where the risk is Trust-wide, e.g. compliance with the National Patient Safety Agency Right Patient, Right Blood alert, agreement can be sought from the relevant Executive Director for the risk to be added to the Trust Services Risk Register.
- Risks may be 'owned' by one division, but have actions added against staff in a number of other divisions.

10.6 *Escalation of Risk*

Where a significant departmental risk scoring 12 or above is identified, following appropriate scrutiny from the divisional risk lead or manager, it will be reported into the divisional governance or risk management group. If the risk score is approved the group will then make a recommendation to the divisional board for the risk to be escalated to the divisional risk register. Upon receipt of the recommendation the board will re-assess the risk in the context of the division and either agree to accept the risk onto the divisional risk register or provide advice to the risk owner on the effective management. If the risk remains 12 or above at a divisional level continue to follow the step below:

Where a divisional level risk is assessed as scoring 12 or above the divisional board will first approve the new assessment and request the risk owner to contact the relevant Executive for their assessment from a corporate perspective in the context of the Organisation. This is done by way of an exception report which is produced from the template section of Datix. Upon completion of the Executive Director assessment the exception report will either be submitted via the risk management team to SLT or advice will be provided by the Executive on either the assessment or effective management. See escalation report template guidance at Appendix E

Escalation process



11. Appendix A – Monitoring Table for this Policy

Objective	Evidence	Method	Frequency	Responsible	Committee
Ensure that risks are appropriately escalated to the corporate risk register and managed in accordance with the requirements of this policy.	To include agendas, risk register reports and minutes of: Trust Board. Senior Leadership Team. Risk Management Group.	Audit of Trust's risk management arrangements	Every 2 years	Head of Risk Management	Risk Management Group
That key individuals – Executive Directors, Divisional Directors the Trust Risk Manager are performing their responsibilities under this policy.	Risks presented to Divisional Boards and Governance Groups. Risk Management Group agendas, reports and minutes evidencing Executive Director risk portfolio reports.	Audit of Trust's risk management arrangements	Every 2 years	Head of Risk Management	Risk Management Group
That risk is managed at a divisional level through review of divisional and departmental risk registers at Governance Group and Divisional Boards.	Agendas, risk register reports and minutes of Divisional Boards and Governance Groups. Risk registers reviewed by Divisional Boards.	Audit of Divisions risk management arrangements	Every 2 years	Head of Risk Management	Risk Management Group
Ensure that risk descriptions and assessments of risks are completed in line with Trust guidance.	Quality of risk registers.	Review of divisional risk registers	Annual	Head of Risk Management	Risk Management Group
Ensure that Risks are kept up to date on Datix and that action plans are included where appropriate	Quality of risk registers.	Review of divisional risk registers	Annual	Head of Risk Management	Risk Management Group

12. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Risk Management
This document replaces existing documentation:	Version 2.0
This document is to be disseminated to:	Executive Directors, Divisional Board members, Risk Management Group members, Patient Safety Group members, Divisional Health and Safety Leads
Training is required:	Risk Management ELearning
The Training Lead is:	Head of Risk Management

Additional Comments
The Risk Management Policy & Strategy is made available to staff via the intranet. Generic risk assessor training is available to all divisions through the Health & Safety Department and where request is made to the Risk Management Team to provide such training. General awareness-raising for staff is also undertaken through staff briefings, induction programmes and various newsletters. A new e-Learning package on risk and incident management will be available from October 2016. For all other enquiries or for Datix Training contact the Risk Management Team, DatixSupport@UHBristol.nhs.uk Ext 23691 or visit the Risk management Pages on Connect Connect_about us_Corporate Governance Risk Management.

13. Appendix C – Document Checklist

The checklist set out in the following table confirms the status of 'diligence actions' required of the 'Document Owner' to meet the standards required of University Hospitals Bristol NHS Foundation Trust Procedural Documents. The 'Approval Authority' will refer to this checklist, and the Equality Impact Assessment, when considering the draft Procedural Document for approval. All criteria must be met.

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct:	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation:	No
	All terms used are explained in the 'Definitions' section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Not Applicable
	The following were consulted:	RMG
	Suitable 'expert advice' has been sought :	Yes
Evidence Base	References are cited:	Not Applicable
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	[DCL - Trust Objectives]
Equality	'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	[DCL - Equality Impact Assessment completed]
Monitoring	Monitoring provisions are defined:	Yes
	There is an audit plan to assess compliance:	Yes
	The frequency of reviews, and the next review date are appropriate for this procedural document:	Yes
Approval	The correct 'Approval Authority' has been selected :	Yes

14. Appendix D - Equality Impact Assessment

Query	Response	
What is the aim of the document?	To provide guidance for the management of procedural documents within the organisation.	
Who is the target audience of the document (which staff groups)?	Authors of procedural documents and members of approval authorities. Add ☑ or ☒	
Who is it likely to impact on **and how**?	**Staff**	☑ guidance
	Patients	☒
	Visitors	☒
	Carers	☒
	Other	☒
Does the **document** affect one group more or less favourably than another based on the 'protected characteristics' in the Equality Act 2010**:**	**Age** (younger and older people)	☒
	Disability (includes physical and sensory impairments, learning disabilities, mental health)	☒
	Gender (men or women)	☒
	Pregnancy and maternity	☒
	Race (includes ethnicity as well as gypsy travelers)	☒
	Religion and belief (includes non-belief)	☒
	Sexual Orientation (lesbian, gay and bisexual people)	☒
	Transgender people	☒
	Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)	☒
	Human Rights (particularly rights to privacy, dignity, liberty and non degrading treatment)	☒

15. Appendix E – Risk Register Review Procedure

Standard Operating Procedure

RISK REGISTER REVIEW PROCEDURE

SETTING Trustwide

FOR STAFF Staff with responsibilities for maintaining risk registers

ISSUE To ensure a consistent standardised approach to the maintenance of risk registers

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Standards to follow when reviewing a risk register

Risk Details

1. Current approval status – Departmental risks should be moved to 'action required' or 'accepted' within 1 month of the record being opened, this allows for a consultation period with the risk owner. To flag your risk up as needing divisional review, change the status to 'Pending Divisional Approval' at the bottom of the page.
2. Risk level – This can only be amended by your divisional PS lead following acceptance of the risk onto the divisional risk register or onto the corporate risk register following review by Senior Leadership Team.
3. Domain of risk – this must be the domain you are assessing, please refer to the matrix in the simple guide for examples.

Risk Description

4. Risk Title – should read 'Risk of…' or 'Risk that…', this helps to focus on the event of concern.
5. Description – Keep it brief, avoid the use of abbreviations or complex terminology, these documents are publically available. Describe the **situation**, **event** and possible **outcome.**
6. Controls – These are thing currently in place to mitigate the risk (preventative, detective and corrective).
7. Adequacy of controls – How effective are your controls at mitigating the risk, use the information under the  button for help.

Risk Ownership

8. Handler/ Risk Assessor – The member of staff with delegated responsibility for maintaining the risk record.

9. Risk Owner – The member of staff with overall responsibility for the management of the risk. Divisional risks should have a senior divisional manager/owner.
10. Grading – use the  boxes for definitions and always refer to the matrix in the simple guide.
11. Rationale – explain what example you are following from the guidance, both likelihood and consequence.
12. Date by which target is to be achieved – this is the date you expect to reach your target score.

Review Details

13. Frequency of Review – Divisional risks should be reviewed quarterly.
14. Next review due – Divisional risks should be set for review a couple of weeks before the quarterly review of the board.

The risk owner should add the progress achieved towards mitigation into the 'Progress notes'.

Progress notes

15. This is where you can summarise the progress achieved towards risk mitigation and add any notes relevant to the risk.

Approval Status

16. Move risk record to: By using this drop down box you can move the risk through the workflow. A high departmental risk scoring (12+) should be set to 'Pending Divisional Approval', the governance group will then recommend to the board whether is should be escalated or remain as departmental, the board will then approve the recommendation.

RELATED DOCUMENTS	Risk Management Policy Risk Management Strategy Simple Guide to Risk Management Risk Matrix Guide
AUTHORISING BODY	Datix Governance Group
SAFETY	N/A
QUERIES	Contact Risk Management Team on Ext 23691

Download a copy of this document from the DMS: HERE

16. Appendix F – Exception Report Template

Guidance to completion of this exception report template

1	2	3	4	5	6	7	8
ID.*	**Risk Domain***	**Risk Title and Description***	**Divisional Risk Owner***	**Current Risk Assessment***	**Supporting Information**	**Revised assessment and recommendations from Executive review**	**Exec Title and date of review**
Datix Risk ID	The domain as recorded on Datix	The title of the risk directly from Datix 'Risk of…' Risk description directly from Datix. Careful consideration should be given to ensure you are describing the potential risk and not the causes. For Corporate risks this information will be in the public domain.	The Owner as recorded on Datix	The current divisionally approved assessment as recorded on Datix.	1. Please provide the Criteria that fits into (see list of Criteria Below). 2. Additional information you feel it is important SLT are aware of in relation to this risk.	Divisional risks assessed as having a current score of 12 or above should be reviewed and commented on by the appropriate Executive prior to submission to SLT	E.g.; Medical Director 29/03/16

*Columns 1-5 are automatically populated from the exception report template on Datix.

Exception Criteria

Criteria A – New Divisional Risk assessed and approved by the Divisional Board to score 12 or above

Criteria B – Current Divisional Risk re-assessed and approved by the Divisional Board to score 12 or above

Criteria C – Amendments to existing corporate risks requested by the Divisional Board.

Please note **no changes to Corporate risks** title, description or scoring to be made on Datix until agreed by SLT. Details of the requested amendment should be included in the table above and the reason for the amendment add to column 6

17. Appendix G – Exception Report Process Flowchart

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Risk Management Strategy 2016-17

Document Data	
Subject:	Risk Management
Document Type:	Strategy
Document Status:	Published
Executive Lead:	Chief Executive
Document Owner:	Deputy Chief Executive
Approval Authority:	Trust Board of Directors
Document Reference:	0004
Review Cycle:	12 Months
Next Review Date:	29/04/2016
Estimated Reading Time:	30 minutes

Document Abstract

Risk Management is an integral part of good governance. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical, organisational or financial. As well as close links with clinical and corporate governance, risk management is embedded within the Trust's organisational performance, business, planning and investment processes.

This strategy is the high level document within the Trust and does not set out to cover in detail the management of specific risks. This more detailed information is set out in relevant strategies and policies, in particular the Risk Management Policy.

Document Change Control				
Date of Version	***Version Number***	***Lead for Revisions***	***Type of Revision***	***Description of Revision***
Unspecified 1999	Unspecified	Director of Nursing	Minor	Planned review and update.
Unspecified 2000	Unspecified	Director of Nursing	Minor	Planned review and update.
Unspecified 2002	Unspecified	Director of Nursing	Minor	Planned review and update.
Unspecified 2004	Unspecified	Director of Nursing	Minor	Planned review and update.
Unspecified 2007	Unspecified	Director of Nursing	Minor	Planned review and update.
20 August 2009	1.0	Assistant Director of Governance	Major	Supersedes United Bristol Healthcare Trust Risk Management Strategy. Planned review and update.
12 August 2010	2.0	Assistant Director of Governance	Major	Updated following NHLSA Level 1 assessment September 2009, Internal Audit of Risk Management 2009, review of Trust risk management arrangements March 2010, and updated linked polices and guidance.
09 February 2012	2.1	Chief Executive	Major	Rewrite to reflect NHS NHSLA Level 2 assessment and revised Procedural Document Framework. Approved by Risk Management Group & noted by Trust Management Executive.
27 March 2012	3.0	Chief Executive	Major	Approved by Trust Board of Directors
27 March 2013	3.1	Trust Risk Manager	Major	Insertion of Sections 5-7 and 9, section 8 extended.
9 April 2013	3.2	Trust Risk Manager	Minor	Amendments made following discussion at the Risk Management Group on 9 April 2013.Added table of risk domain definitions to section 8.2.
29 April 2013	4.0	Trust Risk Manager	Major	Approved by Trust Board of Directors

21 May 2013	4.1	Trust Risk Manager	Minor	Minor typos corrected.
22 April 2015	5.0	Trust Secretary	Major	Complete restructuring
30 June 2016	6.0	Trust Secretary	Minor	Additions to include Risk Management Objectives and greater clarity in terms of the risk appetite

1. *Introduction*

University Hospitals Bristol NHS Foundation Trust (UHB or 'the Trust') is committed to a comprehensive, integrated approach to the management of risk to ensure that associated risks in the delivery of services and care to patients are minimised, the health and well-being of patients, staff and visitors is optimised and that the assets of the Trust, business systems and income is protected.

In fulfilling this aim, UHB will establish a robust and effective framework for the management of risk. One that is proactive in understanding risk, builds upon existing good practice and is integral to all decision making, planning, performance reporting and delivery processes. The Board however, acknowledges that some risks will always exist and never be eliminated and accepts responsibility for risk where this occurs.

This strategy is predicated on the belief that risk management is an important activity and should be an inclusive and integrative process covering all risks, set against a common set of principles, and a major corporate responsibility which requires strong leadership and regular review.

To fulfil this requirement, the Board of Directors will ensure that the organisation:

- Minimises the potential for harm to patients, all staff and visitors to a level as low as reasonably practicable;

- Protects everything of value such as high standards of patient care, staff safety, reputation and assets or income streams through effective risk systems, practices and processes

- Operates an effective system of risk management through the deployment of sound policies, procedures and practices including the operation of a Risk and Incident Reporting System;

- Anticipates and respond to changing circumstances, i.e., social, environmental, legal and financial;

- Maximises opportunity by adapting and remaining resilient to changing risk factors;

- Secures the commitment of management at all levels to promote risk management and provide the necessary leadership and direction to ensure risk management is integrated and managed holistically;

- Adopts common standards throughout the Trust to provide and maintain robust systems to ensure compliance with relevant statutory requirements;

- Monitors and reviews risk management performance at all levels against agreed standards to ensure that standards are met and corrective action is taken where necessary;

- Informs policy and operational decisions by identifying risks and their mitigations alongside likely impact;

- Recognises the contribution of all key stakeholders, including patients, staff and the public, to ensure their involvement and participation in the overall risk management process;

- Has in place effective systems of Trust wide communication to ensure the dissemination of information on risk management;

- Secures the provision of resources, facilities, information, training, instruction and supervision to meet these objectives

This strategy is the high level document within the Trust and does not set out to cover in detail the management of specific risks. This more detailed information is set out in relevant strategies and policies, in particular the Risk Management Policy.

Accountability arrangements in relation to risk are covered in this strategy and it is recognised that robust governance is supported by an effective risk management system designed to deliver continual improvements in safety and quality.

2. *Purpose*

The purpose of the Risk Management Strategy is to detail the Trust's framework within which the Trust leads, directs and controls the risks to its key functions in order to comply with Health and Safety legislation, NHS Improvement Terms of Authorisation, key regulatory requirements such as Care Quality Commission, and its strategic objectives. The risk management strategy underpins the Trust's performance and reputation, and is fully endorsed by the Trust Board.

The Trust's strategy is aimed at creating a co-ordinated and focussed framework for the management of risk within the Trust. Implementation of the strategy will be monitored by the Risk Management Group, on behalf of the Board of Directors and Chief Executive who has delegated responsibility from the Board for effective risk management, with significant commitment, support and effort from all members of Trust staff including management teams and senior clinicians.

The Trust's overall strategic aim in respect of risk is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust. These arrangements are set out in more detail in the Trust's Standing Financial Instructions, Scheme of Delegation and Trust wide policies and procedures.

This strategy formalises the Risk Management responsibilities of the Board of Directors and sets out how the public can be assured that our risks are managed effectively. The overall goal of risk management is to have an environment of 'no surprises' where we understand the risks facing the Trust and eliminate or control them to an acceptable level, by creating a culture founded upon assessment, mitigation and prevention of risk. To realise this goal, this strategy seeks to achieve the effective management of risk within a common set of principles which will:

- Be integral to all decision making, planning (including resource allocation), performance, reporting and delivery processes;

- Manage risk closest to where the risk can be most effectively managed and mitigated;

- Improve the quality of patient care by preventing or reducing harm or potential harm to patients and staff;
- Minimise liabilities in the event of harm to a patient, visitor or member of staff;
- Improve the safety and quality of the working environment for the benefit of all staff; and
- Ensure stakeholders are kept informed of the developing risk management process

3. *Process for Risk Management*

Risk Management can be defined as the identification, assessment, and prioritisation of risks followed by a coordinated and economical application of resources to minimise, monitor and control the probability and/or impact of unfortunate events. Risks should also be reviewed at appropriate intervals to ensure they continue to be appropriately mitigated.

The Board Assurance Framework (BAF) acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance, that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated. UHB is faced with a number of factors that may impact upon its ability to meet its objectives. This strategy describes the direction that the Trust will take to manage risk.

The Board Assurance Framework and Risk Register reflect the organisation's risk profile. They contain the strategic risks identified by the Trust, describe the controls in place and give the strength and quality of assurance available on how well the risks are being managed. These documents support the Board in making a declaration on the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

The Trust is exposed to a wide range of potential risks, including:

- Clinical risks e.g. unavoidable and avoidable risks in treatment or provision of care
- Operational risks e.g., unavoidable and avoidable risks in the delivery of services to staff and patients;
- Health and safety risks e.g. accidents involving patients, staff or visitors
- Workforce and recruitment risks e.g. insufficient staff, or skill shortages
- Financial and business risks e.g. not achieving the corporate objectives
- Estate and environmental risks e.g. poor maintenance or faulty equipment
- Information Governance risks e.g. breaches of confidentiality

Risk assessment is implicit in every activity in the Trust, and the Trust Board must manage its risks in such a way that people are not harmed and losses are minimised to the lowest acceptable levels and clinical and organisational quality are maintained at all times.

4. *Strategic Risk Management Objectives 2016/17*

The strategic objectives in relation to risk management will be achieved by:

- Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management;
- Ensuring that all staff are adequately trained and competent to execute their duties in respect of risk management;
- Including risk management issues when writing reports and considering decisions;
- Continuing to demonstrate the application of risk management principles in line with the Risk Management Policy;
- Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust;
- Maintaining a comprehensive register of risks (clinical and non-clinical) and reviewing these on a periodic basis;
- Ensuring controls are in place to effectively mitigate the risk and are understood by those expected to apply them;
- Ensuring gaps in control are rectified and assurances are reviewed and acted on in a timely manner;
- Maintaining documented procedures of the control of risk and provision of suitable information, training and supervision; and
- Monitoring arrangements and continually seeking improvement

The Trust is using the principles of the National Patient Safety Agency model risk matrix used to inform grading of severity. The overriding principle is that the Trust will have in place an effective risk management system. This can be defined as the effective and systematic application of management policies, procedures, and practices to provide the context of identifying, evaluating, treating, monitoring and communicating risk.

5. *Framework*

This section describes the broad framework for the management of risk. Operational instructions for risk management, investigation of incidents, and learning from incidents are detailed in separate policies and procedures.

5.1. *The Approach*

The Trust has a structured approach to risk management. This process is described in detail in the Risk Management Policy and involves:

- A pro-active approach to the identification and mitigation of principal risks that may threaten the achievement of strategic, operational and divisional objectives;

- A reactive approach to the identification and management of risks that may threaten the achievement of the Trust's risk management systems and processes; and

- Progress reports to the Board via the submission of the Corporate Risk Register on a quarterly basis; and

- Delegated authority of the oversight of risk management to the Risk Management Group

The detail of the process is set out in the Trust Risk management Policy

5.2. *The Board Assurance Framework*

The Board Assurance Framework (BAF) is the key document enabling the Board to understand the strategic risks facing the organisation. The BAF provides the Trust with a single but comprehensive method for the effective and focused management of the principle risks to meeting the Trust's overall strategic objectives. The risks identified from the BAF cover the full range of strategic objectives and includes consideration of present risks, future risks, risks arising from within the organisation and risks occurring as a result of external pressures and changes.

The BAF is a live document updated by the Executive leads for each of the strategic objectives on a quarterly basis and provides the basis for both the assurances and gaps in control reported in the Annual Governance Statement.

5.3. *Corporate Risk Register*

The Corporate Risk Register is comprised of risks that have the potential to impact on the Trusts ability to meet its strategic objectives, as outlined in the BAF. The risks identified on the Corporate Risk Register are fed directly back to the BAF.

5.4. *Divisional Risk Register*

Each division has its own risk register which captures in one place how divisional risks are being managed. The Divisional Boards are accountable for the assessment, communication and management of risks within their area of responsibility.

5.5. *Risk Assessment*

Risk assessment is fundamental to risk management as without it effective controls cannot be introduced. In managing risks, decisions will need to be taken on where resources should be targeted. Risks are reported and monitored through Datix patient safety software for incidents, complaints, claims and risk management. The system is supports the Trust to demonstrate regulatory compliance and drive continual improvements in quality care.

5.6. *Risk Evaluation*

The evaluation aspect of the risk assessment will involve the analysis of the individual risk to identify the impact, consequences, severity and likelihood of the risk being realised. The consequence and likelihood of the risk is given a numeric score based on the following matrix as recommended by the National Patient Safety Agency (NPSA):

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Red	Very high risks
Amber	High risks
Yellow	Moderate risks
Green	Low risks

The higher the risk, the greater the urgency for action and the more frequent its review. Urgent action is required for very high risks in order to mitigate their likelihood and consequence, and such risks and actions should be reviewed regularly to ensure mitigation is effective. Low rated risks are likely to require less urgent action and less frequent review.

Descriptors of the consequence of risk are outlined in Risk Management Policy to guide staff as to what would amount to each level of severity/consequence/impact and likelihood respectively.

Risk thresholds are intended as a guide to decision-making and the reporting of risk. They do not describe the risk in absolute terms and instead provide a means by which risks may be prioritised, as relative to each other.

Further direction on the handling of risks dependent on risk thresholds will be set out in the Risk Management Policy and supporting documents.

5.7. *Process for Board level review of Risk Management Framework*

As noted in Section 4, the Board Assurance Framework is the primary mechanism for ensuring that the Trust Board received assurance that the risks to the Trust's strategic objectives are being appropriately treated.

6. *Board Statement of Risk Appetite*

The Trust acknowledges that a certain degree of risk is unavoidable and therefore it needs to take action in a way that it can justify, to manage risk to a tolerable level. Risk appetite is the degree of risk exposure, or potential adverse impact from an event, that the Trust is willing to accept in pursuit of its objectives.

If no such statement exists, there is insufficient guidance for managers on the levels of risk that they are permitted to take, or opportunities are not seized upon due to the perception that taking on additional risk is discouraged – risk appetite involves taking considered risks where the long term benefits outweigh any short term losses.

The Trust has adopted the following principles/definitions, to be applied to the key business drivers in Table 1 below, in determining risk appetite:

Assessment	Description of potential effect
Very High Risk Appetite 5	The Trust Board **accepts risks that are likely** to result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
	Upper threshold
High Risk Appetite 4	The Trust Board **is willing to accept risks that may result** in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Moderate Risk Appetite 3	The Trust Board **is willing to accept some risks in certain circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Low Risk Appetite 2	The Trust Board **aspires to avoid (except in very exceptional circumstances) risks that may** result in reputation damage, financial loss or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and / or legislative compliance, potential risk of injury to staff / service users.
Zero Risk Appetite	The Trust Board **aspires to avoid risks under any circumstances that may** result in reputation damage, financial loss or exposure, major breakdown in services, information

6.1. *Overarching statement*

The Trust operates within a high overall range of risks. The Trust's lowest risk appetite is for safety risks, specifically patient, staff and visitor safety and for breaching our legal obligations. This means that reducing these risks so far as is reasonably practicable will take priority over meeting our other business and strategic objectives.

Where business and strategic risks can be effectively controlled, and within clearly defined limits of authority, positive risk taking will be encouraged where it may deliver innovation, service improvement or greater efficiency in our operations.

6.2. *Relative willingness to accept risk*

To support decision-making, the Trust sets out its relative willingness to accept risk across domains as follows:

	Relative willingness to accept risk[1]				
	Low		Medium		High
	1	2	3	4	5
Safety	■				
Quality		■			
Workforce			■		
Statutory	■				
Reputation				■	
Business			■		
Finance		■			
Environmental			■		

Definitions relating to the domains above:

Domain	Definition
Safety	Impact on the safety of patients, staff or public
Quality	Impact on the quality of our services. Includes complaints and audits.
Workforce	Impact upon our human resources (not safety), organisational development, staffing levels and competence and training.
Statutory	Impact upon on our statutory obligations, regulatory compliance, assessments and inspections.
Reputation	Impact upon our reputation through adverse publicity.
Business	Impact upon our business and project objectives. Service and business interruption.
Finance	Impact upon our finances.
Environmental	Impact upon our environment, including chemical spills, building on green field sites, our carbon footprint.

The relative willingness to take risks is intended as an aid to decision making where two or more areas of risk come into conflict, and balances our willingness to accept risks relative to each other. It does not attempt to describe the Trusts absolute willingness to accept risk in any area.

7. *Duties, Roles and Responsibilities*

7.1. *Trust Board of Directors*

The Executive and Non Executive Directors have a collective responsibility as a Trust Board to ensure that the Risk Management processes are providing them with adequate and appropriate information and assurances relating to risks against the Trust's objectives. The Executive and Non Executive Directors are responsible for ensuring that they are adequately equipped with the knowledge and skills to fulfil this role.

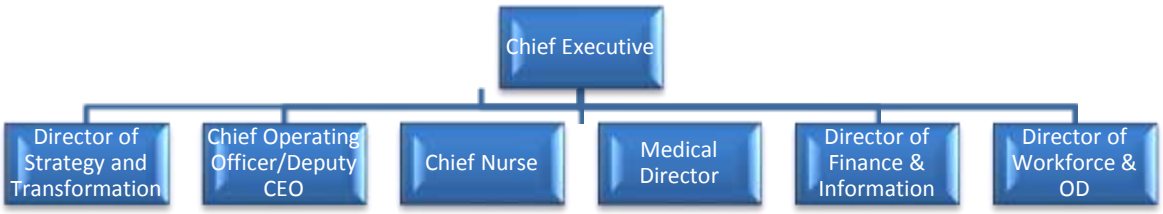
[1] Adapted from *Understanding and articulating risk appetite*, KPMG 2008

The Board is also responsible for reviewing the effectiveness of its internal control systems and is required to ensure that the Trust's risk management arrangements are sound and protects patients, staff, the public, and other stakeholders against risks of all kinds.

The Annual Governance Statement made by the Trust's Chief Executive in the annual report and accounts must demonstrate that the Trust Board has been informed on all risks and has arrived at its conclusions on the totality of risk based on all the evidence presented to it through the responsibilities delegated to the committees within the organisation.

7.2. *Executive Directors*

Executive Directors are responsible for managing risk as delegated by the Chief Executive and set out in the Risk Management Policy and the Terms of Reference of the Risk Management Group. Executive Directors are also responsible for risks allocated to them on the Corporate Risk Register and Trust-wide Risk Register.
The diagram below provides the Risk Management Framework: this shows the principal bodies responsible for the governance and oversight of risk within the Trust and the reporting hierarchy. It details all committees and groups which have some responsibility for risk and report directly to the Trust Board of Directors. This provides assurance to the Board that risk management processes are in place and remain effective.



7.3. *Chief Executive*

The Chief Executive is accountable to the Chairman and the Board and, as the Accountable Officer, has overall responsibility for ensuring that the Trust operates effective risk management processes in order to protect all persons who may be affected by the Trust's business. The Chief Executive is required to sign annually, on behalf of the Board, an Annual Governance Statement, in which the Board acknowledges and accepts its responsibility for maintaining and reviewing the effectiveness of a sound system of internal control, including risk management.

7.4. *Medical Director*

Accountable to the Chief Executive and the Board, the Medical Director has joint lead responsibility for healthcare governance with the Chief Nurse. This includes; lead responsibility for clinical performance of the medical workforce: clinical audit: medical innovation: research governance: medical education; the role of SIRO; and will report key clinical risks to the Board on a routine basis.

7.5. *Chief Nurse*

The Chief Nurse has joint lead responsibility for healthcare governance with the Medical Director and is accountable to the Chief Executive and the Board for the delivery of the Trust's patient safety and quality initiatives. The post-holder will also be responsible and accountable for the operational management of the nursing teams and Allied Healthcare

Professionals and will lead the development of clinical nursing practice to achieve excellence in all aspects of nursing. The post-holder will ensure the highest standards of care at ward level and lead on the improvements to patient experience. The Chief Nurse also coordinates the Care Quality Commission Registration and the maintenance of compliance with the regulations and outcomes that apply to the Trust.

7.6. *Deputy Chief Executive/Chief Operating Officer*

The Deputy CEO/Chief Operating Officer is accountable to the Chief Executive and the Board for overall management of Trust corporate services including; Trust Secretariat, risk management; communications; and legal services. The post-holder will ensure that risks in relation to this portfolio are managed in line with the Trust's risk management systems and processes. The post is also responsible for the operational management of divisional teams, supporting the Trust's risk management systems and processes.

7.7. *Director of Strategy and Transformation*

The Director of Strategy and Transformation is accountable to the Chief Executive and the Board leading the development of local health and social care services, strategic development, business planning and service transformation in the Trust. The post-holder will ensure that all risks in relation to this portfolio will be managed in line with the Trust's risk management systems and processes.

7.8. *Director of Finance and Information*

The Director of Finance and Information is accountable to Chief Executive and the Board for the management of financial governance, including advising on financial/business risk, audit and assurance.

7.9. *Director of Workforce and Organisational Development*

The Director of Workforce and OD is accountable to the Chief Executive and the Board for the management of all human resources and associate risks, including those relating to training and organisational development.

7.10. *Senior Information Responsible Officer (SIRO)*

The Medical Director shall also fulfil the role and function of the SIRO and is accountable to the Chief Executive for the management of information risks.

7.11. *The Caldicott Guardian*

The Caldicott Guardian will play a key role in helping to ensure that the Trust satisfies the highest practical standards for managing information governance risks. The Caldicott Guardian will act as the conscience of the organisation in this respect, and will actively support work to manage such risks.

7.12. *Trust Secretary*

The Trust Secretary is responsible for ensuring that the Trust Board of Directors is cognisant of its duties towards risk governance and management and for coordinating the annual cycle of Board business to ensure these duties are incorporated on the Board's agenda. The Trust Secretary is also responsible for the coordination of the Trust's Board Assurance

Framework to ensure proactive management to ensure that the Board remains sighted on the key risks facing the Trust.

7.13. *Head of Risk Management*

The Head of Risk Management develops, implements and monitors compliance with the risk management policy and is responsible for maintaining the overall structure for risk management within the Trust. The post-holder facilitates the development of a risk aware culture within the Trust, compiles risk information and prepares reports for the Senior Leadership Team, Risk Management Group and Trust Board of Directors.

7.14. *Wards and department leads*

Each manager is responsible for ensuring Risk Assessments are completed with implementation of suitable and sufficient control measures and for communicating the risk assessment to those affected.

Line managers must allocate sufficient time for the risk assessor to ensure that they have enough time to complete their assessor responsibilities within normal working hours.

7.15. *Risk Assessor*

Risk Assessors are members of staff who have attended the Trust's risk assessor training and conduct risk assessments on behalf of ward and department managers.

7.16. *All staff (including Honorary Contract holders, locum and agency staff and contractors)*

Notwithstanding the identification of the above key personnel, the Trust recognises that organisational risk management is the responsibility of all members of staff. Every member of staff (including clinicians, temporary staff, contractors and volunteers) are responsible for ensuring that their own actions contribute to the wellbeing of patients, staff, visitors and the Trust.

All staff are required to attend and follow individual essential training requirements and not to use equipment, adopt practices or processes which deviate from mandatory or statutory requirements and procedures for the purposes of health and safety. They are expected to locate, observe and comply with all relevant policies and procedures that have been made available within the Trust.

All staff must contribute to the identification, management, reporting and assessment of risks and to take positive action to manage them appropriately. This is an essential part of managing risks locally and is a statutory requirement.

In addition, staff have a responsibility for taking steps to avoid injuries and risks to patients, staff, and visitors. In fulfilling this role, which may involve raising concerns about standards, staff might consider the need for reporting under the Trust's Speaking Out Policy.

7.17. *Senior Leadership Team*

The lines of accountability in relation to the management of Trust risk are highlighted in the diagram in below.

The Senior Leadership (SLT) is responsible for maintaining the Corporate Risk Register. SLT receives risk exception reports from divisions at each business meeting, informing them of any risks with the division that SLT should have sight of. These may be either risks scoring 15 or above, or those with the potential to significantly impact upon corporate or strategic objectives.

7.18. *Risk Management Group*

As a Management Group established and chaired by the Chief Executive, the Risk Management Group (RMG) is responsible for discharging the responsibility of the Senior Leadership Team for the management of organisational risk. This includes receiving the Corporate Risk Register and divisional risk registers in full on a rotational basis.

7.19. *Audit Committee*

The Audit Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities.

7.20. *Quality and Outcomes Committee*

The Quality and Outcomes Committee shall receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.

7.21. *Finance Committee*

The Finance Committee is responsible for monitoring financial risk. The Director of Finance and Information is responsible for reporting this to the Risk Management Group.

7.22. *Divisional Management Boards*

Divisional Management Boards are responsible for having a planned risk assessment programme in place, comprised of quarterly Divisional Management Board meetings and monthly Divisional Governance meetings, at which, the implementation of recommendations

from risk assessments and action plans with realistic timescales for mitigating risks are reviewed.

Divisional Management Boards shall adopt a standardised approach to the management of risk in accordance with the duties defined in the Risk Management Policy and the Terms of Reference of the Risk Management Group. They are also responsible for reviewing the divisional risk register and considering risks escalated to the management board from their departments for adding to the Divisional Risk Register. They are required to present their divisional risk registers in full to the Risk Management Group on a rotational basis.

Divisions are required to report progress of mitigating actions in respect of their key risks in quarterly performance reviews with Executive Directors, ensuring resource is allocated within their division to assess and manage their risks.

Divisional Directors are accountable to the Chief Operating Officer for the implementation of the Risk Management Strategy and Policy locally and for creating associated procedures within their division, ensuring that the divisional risk register is populated with all risks (clinical, non-clinical and financial) and informed by local risk assessments and reviewed on a regular basis. In addition, Divisional Directors have a duty to ensure that their staff are given the necessary information and training to enable them to work safely.

Trust-wide specialist advisers are responsible for advising anyone about a specific risk assessment issue e.g. Head of Health and Safety Services.

Specialist patient care risk assessment support is available from relevant specialists e.g. Blood Transfusion Practitioner, Dementia and Falls Lead, Tissue Viability Nurses.

8. *Reporting to External Bodies*

There are various national external agencies that monitor the Trust on its risks management processes and arrangements and the implementation of these, included but restricted to:

8.1. *NHS Improvement*

The Trust is required to, on a quarterly basis, submit to NHS Improvement self-declared Financial Risk Rating (based on various financial indicators: EBITDA, I&E) and Governance Risk Rating (based on the achievement of operational targets and the Trust's CQC Compliance status).

8.2. *Care Quality Commission (CQC)*

The CQC will undertake announced and unannounced inspections of the Trust's sites throughout the year. The Trust is required to provide the CQC with information on the steps that have/will have been taken in addressing any risks/compliance concerns arising from these inspections.

8.3. *Health and Safety Executive (HSE)*

The Trust will respond to any visit, either planned or unplanned, by the enforcing authorities e.g., HSE and provide to them, on request, any information they require. In addition, under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) the Trust has an obligation to report categorised incidents types (death and specified injuries that are work related, injuries where an employee is away from work or unable to perform their normal work duties for more than seven consecutive days as the result of an

occupational accident or injury, diagnosis of any Occupational Disease made by a GP or Consultant and the member of staff has been carrying out work activities that led to the condition and finally any Dangerous Occurrences that are certain listed near misses.

8.4. *National Reporting and Learning System (NRLS)*

The Trust reports all patient safety incidents through the NRLS via the online reporting system. Serious incidents are uploaded as soon as classified as such.

8.5. *NHS Central Alerting System (CAS)*

The Trust is obliged to respond to all CAS alerts (i.e., safety alerts, drug alerts, medical device alerts) within timescales dictated by CAS according to the nature and seriousness of each individual alert.

8.6. *NHS Protect*

The Trust is expected to provide NHS Protect with information relating to the provision of the Local Security Management Specialist workplan annual report. Physical assault statistics and security incidents.

8.7. *Police*

The Trust liaises with Avon and Somerset Constabulary in relation to any suspected criminal activity either taking or having taken place.

8.8. *Public Health England (PHE)*

The Trust is required on a weekly, monthly and quarterly basis to report on data relating to Clostridium Difficile, E. Coli, Glycopeptide-Resistant Enterococci (GRE), MRSA and MSSA Bloodstream Infections.

8.9. *Safeguarding*

The Trust will actively work within an inter-agency framework to ensure that the welfare and safety of patients at risk is paramount. This joint working will be under the auspices of the Bristol Safeguarding Adults Board and the Bristol Safeguarding Children Board.

9. *Investigations and Root Cause Analysis*

Investigations into the circumstances of incidents, accidents, claims and complaints provide an essential source of risk identification. Where a risk that cannot be immediately addressed is highlighted through such an investigation, this should be registered on the appropriate register. Further detailed guidance relating to undertaking investigations can be found in the Complaints and Concerns Policy and the Serious Incident Policy.

The Trust adopts a Root Cause Analysis (RCA) methodology when undertaking investigations relating to potentially serious incidents and never events. RCA is a problem solving methodology based on the premise that, once removed from the problem fault sequence, the root cause prevents the final undesirable event from recurring. It is a systems-based approach to analysis rather than focussing on individual actions and has been shown to provide a means to identify effective learning and long term solutions to a range of issues.

10. *Risk Management Training and Information*

Training and information are key elements in the development of a positive risk management culture. They provide staff with the necessary awareness, knowledge and skills to work safely and to minimise risks at all levels.

The Trust has a framework that enables all staff to access education, training and development so that they achieve the level of competence required to deliver service needs and provide safe and high quality patient care.

The Risk Management Strategy is made available to staff via the intranet, and risk management training is available to all divisions through the training department and where request is made to the Associate Director Healthcare Governance to provide such training. General awareness-raising for staff is also undertaken through staff briefings, induction programmes and various newsletters.

11. *Associated Documentation*

This strategy should be read in conjunction with all other Trust key documents, policies and procedures, having relevance to the management of risk, that have been set in place to support the Trust in the management and control of risk.

Risk Management Policy

Risk Assessment Standard Operating Procedure

Policy for the Management of Incidents

Serious Incident Policy

Information Governance Policy

12. *References*

Building the Assurance Framework: A Practical Guide for NHS Boards (DOH March 2003)

Assurance – The Board Agenda (DOH July 2002)

A Practical Guide for NHS Boards (DOH March 2003)

NPSA Guide: A Risk Matrix for Risk Managers

NPSA Guide: Healthcare Risk Assessment Made Easy

13. *Definitions*

The following terms are used in this document:

Objective	The objectives set by the Trust Board of Directors in the annual planning process specify the standards, outcomes, achievements and targets for various areas of the Trust's operations.
Consequence	The outcome or potential outcome of an event. Sometimes referred to as 'impact' or 'severity'.
Control	A measure in place to mitigate a risk.
Current score	What the risk score is when assessed.
Inherent risk	An assessment of the risk prior to any mitigation and controls being applied. This is the "raw" risk.
Likelihood	The probability that the consequence will actually happen.
Risk	The effect of uncertainty on objectives. An 'effect' may be positive, negative or a deviation from the expected position.
Risk appetite	The amount of risk exposure an organisation is willing to accept in connection with delivering a set of objectives.
Risk assessment	The process of identifying and analyzing risk. Risk is measured as a combination of the likelihood and the consequence of an event occurring
Risk assessor	The person who conducts the risk assessment.
Risk framework	The stages of the life-cycle of an individual risk, from identification to closure.
Risk owner	The person responsible for ensuring the risk is adequately managed.
Target risk	An assessment of the current or anticipated risk after the planned actions have been applied.

Appendix A – Monitoring Table for this Strategy

Strategy Requirement	Evidence
Trust Board of Directors The Trust Board of Directors requires the reporting of risk exceptions of high and extreme risks to the Board by quarterly presentation of the Corporate Risk Register and the Board Assurance Framework.	Trust Board of Directors quarterly reports and Minutes demonstrating receipt of the Corporate Risk Register and the Board Assurance Framework.
Audit Committee As set out in the Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.	Audit Committee reports and Minutes demonstrating receipt of the Board Assurance Framework.
Senior Leadership Team As set out in the Terms of Reference, SLT shall maintain and review Corporate Risk Register and receive risk exception reports from divisions at each business meeting. These may be either risks scoring 15 or above, or those with the potential to significantly impact upon corporate or strategic objectives	SLT minutes and reports demonstrating receipt of appropriate information and decisions to escalate/de-escalate issues/risks as appropriate.
Quality and Outcomes Committee As set out in the Terms of Reference, the Committee shall receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.	Quality and Outcomes Committee reports and Minutes demonstrating receipt of the Corporate Risk Register.
Finance Committee As set out in the Terms of Reference, the Committee shall review and monitor financial risk. The Director of Finance and Information shall report the financial risk register to the Risk Management Group	Minutes and reports to both the Finance Committee and Risk Management Group and decisions to escalate/de-escalate issues/risks as appropriate
Risk Management Group As set out in the Terms of Reference, the Group is responsible for the delegated responsibility of SLT for the management of organisational risk, including monitoring and reviewing the Corporate Risk Register and divisional risk registers in full on a rotational basis	Minutes and reports to the Risk Management Group.
Divisional Boards Management Boards will have in place a planned risk assessment programme to address issues arising from risk assessments and will maintain an action plan with realistic timescales for mitigating risks.	Risk register reports to RMG on rotation

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public
To be held on Thursday 28 July 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
24. Board Assurance Framework Report – Quarter 1 Update									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author:** Pam Wenger, Trust Secretary									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To provide assurance that the organisation is on track to achieve its strategic and annual objectives for the current year. Importantly, the Board Assurance Framework describes any risks to delivery that have been identified to date and describes the actions being taken to control such risks so as to ensure delivery is not compromised.

The Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. This report provides the Board with an update on the development of the BAF and the associated monitoring mechanisms and invites further discussion about the Trust's principle risks identified.

Key issues to note:

At the Board Seminar in March 2016, the Trust Board agreed to the structure and format of the BAF that provides less of a focus on the detail of activity taking place to achieve the Trust's annual objectives and represents a move to focus the Board on the risks to achieving the longer term strategic objectives of the Trust.

The revised format allows members of the Board to discharge its responsibility for internal control by providing the key sources of evidence that links strategic objectives to risks and assurances in place. It was also agreed that as all Board business is underpinned by the content of the Board Assurance Framework, it is has been recognised that the positioning of the Board Assurance Framework at the bottom of the agenda should be reviewed.

The BAF also details the residual risk to achieving annual priorities. This is a RAG rating is based on the risk assessment process which indicates whether the annual priority is likely to be achieved at the year-end.

Recommendations
Members are asked to: • **Note** the report and the Board Assurance Report as at 30 June 2016; and • **Approve** the principle risks outlined in the Board Assurance Framework.
Impact Upon Board Assurance Framework
N/A
Impact Upon Corporate Risk
Corporate Risks contained within the Corporate Risk Register are included in the Board Assurance Framework, where applicable, to provide further assurance as to the actions taken to mitigate risks.
Implications (Regulatory/Legal)
N/A
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Finance Committee	**Audit Committee**	**Quality and Outcomes Committee**	**Senior Leadership Team**	**Risk Management Group**
		26 July 2016	20 July 2016	

BOARD ASSURANCE FRAMEWORK QUARTER 1

SITUATION

The Board Assurance Framework (BAF) forms part of the Trust's risk management strategy and is the framework for identification and management of strategic risks. This report provides the Board with an update on the development of the BAF and the associated monitoring mechanisms and invites further discussion about the Trust's principle risks identified.

BACKGROUND

The Board Assurance Framework and Risk Register reflect the organisation's risk profile. They contain the strategic (principle) risks identified by the Trust, describe the controls in place and give the strength and quality of assurance available on how well the risks are being managed. These documents support the Board in making a declaration on the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

The use and presentation of, the Board Assurance Framework was highlighted as an area for development by Deloitte in the Trust's Well Led Governance Review undertaken in 2015. The recommendation was that the Board improve its overall oversight of strategic and corporate risk, to enable Board members to use the BAF as a tool for strategic risk management.

At the Board Seminar in March 2016, the Trust Board agreed to the structure and format of the BAF that provides less of a focus on the detail of activity taking place to achieve the Trust's annual objectives and represents a move to focus the Board on the risks to achieving the longer term strategic objectives of the Trust.

The revised format allows members of the Board to discharge its responsibility for internal control by providing the key sources of evidence that links strategic objectives to risks and assurances in place. It was also agreed that as all Board business is underpinned by the content of the Board Assurance Framework, it is has been recognised that the positioning of the Board Assurance Framework at the bottom of the agenda should be reviewed. It is proposed therefore, that the BAF is discussed as the first item at the top of the Board agenda (following patient story), to provide context for all other reporting into the Board. It is anticipated that this will be actioned from September 2016.

ASSESSMENT

The Board Assurance Framework sets out the key threats to achieving the Trust's strategic priorities for 2016/17. Risks may be escalated from the Trust Wide Corporate Risk Register following the process established in the Risk Management Policy and associated procedures, ensuring that the Board is aware of strategic risks emerging from directorates.

The potential risks to achieving the Trusts objectives outlined on the proposed BAF should be identified in two ways: the 'top-down' proactive identification of risks that directly affect the achievement of objectives; and the 'bottom-up' assessment through the Trust's Corporate Risk Register.

Currently, high level risks in the Corporate Risk Register (scoring 12 or above), are reported to the Board alongside the BAF for consideration and oversight. The attached BAF framework ensures that some of these risks would continue to be transferred to the BAF, following approval and review from the Senior Leadership Team.

As the BAF would be used to identify and review these corporate level risks, it would also allow the Board to review the Corporate Risk Register in further detail in the Board of Directors private session. This would allow all risks scoring 12 and above to be reviewed in private session via the Corporate Risk Register supporting the Board to have sightedness and exposure to high level organisational risks (as opposed to only corporate level risks). This provides an integrated approach to the management of risk and internal and control.

Principle Risks

- **Principle Risk 1:** Failure to maintain the quality of patient services.
- **Principle Risk 2**: Failure to develop and maintain the Trust estate.
- **Principle Risk 3:** Failure to act on feedback from patients, staff and our public.
- **Principal Risk 4:** Failure to recruit, train and sustain an engaged and effective workforce
- **Principle Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Principle Risk 6:** Failure 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, transformation and partnership working.
- **Principal Risk 7:** Failure to maintain financial sustainability
- **Principle Risk 8:** Failure to comply with targets, statutory duties and functions

Position at as at end of June 2016

The Board Assurance Framework (Appendix one) sets out the key threats to achieving the Trust's strategic priorities for 2016/17. Risks may be escalated from the Trust Wide Risk Register following the process established in the Risk Management Policy and associated procedures, ensuring that the Board is aware of strategic risks emerging from directorates. The risks appearing in both the Assurance Framework and Trust Wide Risk Register are cross-referenced.

In this reporting period the BAF analysis shows that there are no extreme risks (scoring 15 and above).

RECOMMENDATIONS

Members are asked to:

- **Note** the report and the Board Assurance Report as at 30 June 2016; and
- **Approve** the principle risks outlined in the Board Assurance Framework.

University Hospitals Bristol NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

2016-17

1. Board Assurance Framework for the delivery of Objectives.

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, primarily through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.

2. The Trust 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.

2.1 Trust 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:

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

3. 2016/17 Priorities

The following priorities are outlined in our 2016/17 annual NHS Improvement Operational Plan.

	1. Care and Quality
1.1	Delivery of 12 Quality Objectives 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.
1.2	Achievement of our 'Sign up to Safety' priorities as follows; • 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.
1.3	Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients" as follows;* "*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".*
1.4	Participate in the annual publication of avoidable deaths.
1.5	Demonstrate affordable progress towards delivery of the four key seven day services standards by 2020.

1.6	Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care.
1.7	Delivery of agreed specialised and local CQUIN targets.
	2. Non-Financial Performance
2.1	Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard.
2.2	Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge.
2.3	Successful implementation of the Orla Healthcare community based 'virtual ward'.
	3. IM&T and Estates
3.1	Continue with the necessary upgrading of the Estate along with medical equipment replacement.
3.2	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.
3.3	Development of our innovation and technology strategy
	4. Financial Performance
4.1	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.
4.2	Delivery of 16/17 income plans and Cost Improvement Programme.
4.3	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.

5. Organisational and System Strategy and Transformation	
5.1	Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review.
5.2	Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17.
5.3	Development of the system Sustainability and Transformation Plan - 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, transformation and partnership working.
6. Workforce and Engagement	
6.1	Further development and implementation of strategic workforce plans, linked to the evolving STP.
6.2	Achieve NHS Improvement's locum and agency expenditure requirements.
6.3	Successful implementation of workforce recruitment and retention plan.
6.4	Delivery of agreed workforce KPIs.
6.5	Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.

4. Principal Risks

- **Principal Risk 1:** Failure to maintain the quality of patient services.
- **Principal Risk 2**: Failure to develop and maintain the Trust estate.
- **Principal Risk 3:** Failure to act on feedback from patients, staff and our public.
- **Principal Risk 4:** Failure to recruit, train and sustain an engaged and effective workforce.
- **Principal Risk 5:** Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.
- **Principal Risk 6:** Failure 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, transformation and partnership working.
- **Principal Risk 7:** Failure to maintain financial sustainability.
- **Principal Risk 8:** Failure to comply with targets, statutory duties and functions.

Risk scoring = consequence x likelihood

	Likelihood				
score	**1**	**2**	**3**	**4**	**5**
Consequence	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 – 6	Moderate risk
8 – 12	High risk
15 – 25	Very High risk

The current scores for principal risks are summarised in the following heat map.

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic					
4 Major			3, 6		
3 Moderate			1, 4, 7		
2 Minor			5	2	
1 Negligible					

University Hospitals Bristol Control Framework

Vision, organisational priorities and outcomes, aims, values and behaviours, policies and procedures, budget and budget control, performance measures and trajectories and management of associated risks

Leadership → Staff → Systems and Processes → Finances → Technology

Controls and Assurance Mechanisms

High Quality Care

***Controls*: evidenced within**

- Operational Plan 2016/17 – Strategic and annual objectives
- Commissioning
- Annual Quality Objectives
- intentions and plans
- Capital and Estates Strategy
- Quality Impact Assessment protocol
- Equality Impact Assessment

***Assurance*: gained via**

- Quality and Outcome Committee
- Divisional Quality Groups
- Senior Leadership Team
- Annual Quality Statement
- Annual Report and Annual Governance Statement
- Chairs Reports
- Visits and Inspections

Performance Management

***Controls*:**

- Objectives and Appraisals
- Performance targets
- Performance Dashboards and monthly reporting
- Regular Performance and Quality reports
- Concerns and Patient Experience Reports
- Serious Incident Reporting

***Assurance*: gained via**

- Divisional Boards, Service/Ward levels
- Escalation arrangements
- Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees
- Internal/External Audits

Risk Management

***Controls*:**

- Risk management strategy and Policy
- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register

Reports to the Board, Senior Leadership Team and sub committees
Policies and Procedures
Scheme of Delegation

***Assurance*: gained via**

- Divisional Boards, Service/Ward levels
- Escalation arrangements
- Internal/External Audits, visits
- Executive Director and Senior Leadership Team meetings
- Quality and Outcomes, Finance and Audit Committees
- Risk Management Group

Levels of Assurance

VISION AND CORPORATE PRIORITIES

First Line
Operational

- Organisational structures – delegation of responsibility through line Management arrangements
- Appraisal process
- Policies and Procedures
- Incident reporting and thematic reviews
- Risk Management processes and systems
- Performance Reports, Complaints and Patient Experience Reports, Workforce Reports, Staff Nursing Report, Finance Reports

Second Line
Risk and Compliance

Assurance and Oversight Committees

- Audit Committee
- Finance Committee
- Quality and Outcomes Committee
- Remuneration Committee
- Risk Management Group, Clinical Quality Group, Health and Safety Groups etc

Findings and/or reports from inspections, Friends and Family Test, Annual Reporting through to Committees, Self-Certification NHS Improvement

Third Line
Independent

- Internal Audit Plan 2016-17
- External Audits (eg. Annual Accounts and Annual Report)
- CQC Inspections/NHS Improvement
- Visits by Royal Colleges
- Independent Reviews – Verita Investigations
- Independent Review Paediatric Cardiac Surgery
- Well Led Governance Review

REGULATORS

EXTERNAL AUDIT

Key

The Assurance Framework has the following headings:

Principal Risk	What could prevent the objective from being achieved? Which area within organisation does this risk primarily impact on – clinical, organisational or financial?
Ref	This should include the reference to the Strategic Priorities and also align with the top corporate risk register
Key Controls	What controls / systems do we have in place to assist secure delivery of the objective?
Gaps in Controls	Gaps in control: Are there any gaps in the effectiveness of controls/ systems in place?
Gaps in assurance	Where can we improve evidence about the effectiveness of one or more of the key controls / systems which we are relying on?
Assurances on the Effectiveness of controls:	What does the evidence tell us in relation to the effectiveness of the controls / systems which are being relied on
Action Plans	Plans to address the gaps in control and / or assurance
Current Risk Rating	Assessment of the quality of the controls to manage the risk (not assessment of the risk itself)
Direction of travel	Are the controls and assurances improving? ↑ ↓ ↔

STRATEGIC PRIORITY 1 : We will consistently deliver high quality individual care, delivered with compassion

OPERATIONAL PLAN 2016/17 PRIORITIES	**Quality and Care** • Delivery of 12 Quality Objectives • Achievement of our 'Sign up to Safety' priorities • Delivery of the two objectives identified in the Medical Royal Colleges 2014 "*Guidance for taking responsibility: Accountable clinicians and informed patients* • Participate in the annual publication of avoidable deaths. • Demonstrate affordable progress towards delivery of the four key seven day services standards by 2020. • Further embed hosted Operational Delivery Networks (ODN), including paediatric neurosciences, Congenital Heart Disease and Critical Care. • Delivery of agreed specialised and local CQUIN targets.	**Non Financial Performance** • Deliver the agreed performance trajectories for Referral To Treatment (RTT), 6 week diagnostic, Cancer and the Accident and Emergency (A&E) four hour waiting standard. • Effective cross sector and patient flow remains a challenge due to external system wide factors. Work actively with our partners and through the STP, Better Care Programme and Urgent Care Network to develop and implement plans to improve flow and materially reduce the number of patients with a delayed discharge. • Successful implementation of the Orla Healthcare community based 'virtual ward'.

Principal Risk description	Key Controls	Assurance on the effectiveness of assurance	Assurance on the effectiveness of controls	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Failure to maintain the quality of patient services.	Serious Incident Reporting process Risk Management Strategy and Policy Professional Standards and Code of Practice/Clinical Supervision Trust Values Quality Objectives Sign up Safely Campaign Business Continuity and Emergency planning arrangements NICE guidelines self-assessments/ Clinical Audit Programme	Reports to Quality and Outcomes Committee. Performance reporting through the Risk Management Group and to the Board. Annual Report. Quality Account. Clinical Quality Group/Clinical Audit Group.	Quality metrics demonstrate that despite operational pressures, our patients are receiving good quality care despite delays in their discharge.	No significant gaps in controls.	Emergency Preparedness, Resilience and Response (EPRR) externally assessment as red rating.	Quality Strategy in development and to be considered by the Board in September 2016. Action Plan in place to address the issues and to be re-submitted in October 2016.	Chief Operating Officer **Quality and Outcomes Committee**	9	↑

Principal Risk description	Key Controls	Assurance on the effectiveness of assurance	Assurance on the effectiveness of controls	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Failure to act on feedback from patients, staff and our public.	**Stakeholder feedback:** - Participation in the national patient surveys - Comments cards available on wards and in clinics - The Friends and Family Test administered at discharge in day case, inpatient and Emergency Department settings - A team of volunteers who visit wards to interview patients whilst at UH Bristol - A monthly post-discharge inpatient, outpatient, parent and maternity survey - A team of volunteers who undertake the 15 Step Challenge in wards. **Staff feedback:** - National Staff Survey - Regular staff workshops are held to gather feedback and views from staff members in an informal setting. - The Staff Friends and Family Test . - Other, local or more specific surveys/focus groups also take place sickness and turnover).	Quality meetings with commissioners and information shared as part of the annual quality schedule; including serious incident investigation outcomes. Regular attendance of Trust staff at local authority overview and scrutiny committee meetings. Patient Stories are a monthly item on the Trust Board agenda. Appointed governors on the Council of Governors from partner organisations including the local authority and universities. The outcomes are analysed by the Senior Leadership Team.	Council of Governor meetings Governor focus groups Non-Executive Director Counsel meetings Governors log of queries and concerns	None identified.	Although some of the patient feedback collected corporately is made available directly to inpatient wards (e.g. via posters and circulation of spreadsheets), there is an opportunity to make this more rapidly available and more accessible to ward staff.	The Patient Experience & Involvement Team is continuing to explore a solution to this, with a focus on responsiveness to patients' needs. Funding has been identified to procure a new patient feedback system during 2016/17.	Chief Nurse **Quality and Outcomes Committee**	9	↑

STRATEGIC PRIORITY 2 : We will ensure a safe, friendly and modern environment for our patients and our staff

OPERATIONAL PLAN 2016/17 PRIORITIES	**IM&T and Estates** • Continue with the necessary upgrading of the Estate along with medical equipment replacement • 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: o Rolling out digital case notes across our other hospital sites together with the implementation of e-forms and workflow automation; o Commencing delivery of a new nursing e-observations and replacement e-rostering systems; o Going live across the Trust with electronic prescribing and medicines administration; o Providing more convenient access to our systems and services through the wider use of mobile technology and telehealth techniques; and o 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.

Principal Risk description	Key Controls	Sources of Assurances	Assurance on the effectiveness of controls	Gaps in controls	Gaps in assurance	Actions Agreed for any gaps in controls or assurance	Executive Lead and Assuring Committee	Current Risk Rating	Direction of travel
Failure to develop and maintain the Trust estate	Health and Safety Policies Risk Management Group Health and Safety Groups Divisional Boards Risk assessments at Departmental level.	Audit Committee oversight. Internal Audit work programme. External audit of the Trust's Annual Accounts and Annual Report. Findings and/or reports from inspections. Incident reporting and thematic reviews of incidents.	Audit Committee review. Unqualified external audit opinion for the Trust's 2014/15 annual accounts. 2015/16 annual accounts subject to audit. Recent PLACE inspection reports did not surface any key risks. Incident reporting in relation to aspects of estate, reveal limited assurance in respect of drain blockages and roofs – action in hand to remedy (see below).	No significant gaps in controls.	No apparent gaps in assurance. Insufficient assurance in respect of drains and roofs.	None. Operational and capital works programme for 16/17 provides resources to address risks in relation to drains (both to improve controls and address risks) and roofs (both to controls and risks.	Director of Finance **Finance Committee** **Audit Committee** Chief Operating Officer **Service Delivery Group**	8	↔

STRATEGIC PRIORITY 3 : We will strive to employ the best staff and help all our staff fulfil their individual potential									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Workforce and Engagement** • Further development and implementation of strategic workforce plans, linked to the evolving STP. • Achieve NHS Improvement's locum and agency expenditure requirements. • Successful implementation of workforce recruitment and retention plan. • Delivery of agreed workforce KPIs. • Development and delivery of staff engagement plan, linked to the learning from the results of the 2015 staff survey.								
Principal Risk description	**Key Controls**	**Sources of Assurances**	**Assurance on the effectiveness of controls**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Failure to recruit, train and sustain an engaged and effective workforce.	HR Policies and Procedures Clear accountability at Divisions Trust wide learning opportunities Essential Training Appraisal Process/Personal Development Plan Corporate and Local Induction Quality objective on staff engagement Agency Controls Group.	Metrics reviewed by Senior Leadership Team, QOC and Trust Board. Staff survey results/ Exit Interviews. Review of ET compliance. Annual learning and development report. Health and Safety Reports. Staff Recognition Awards. Friends and Family Test. Weekly returns agency staffing.	Metrics indicate we have a risk around staff retention, although improving. Limited – primarily around essential training. Monthly compliance reports to Divisions and trajectories to achieve compliance. Divisional Reviews including performance against workforce plans.	Metrics reviewed by Senior Leadership Team, QOC and Trust Board. Comprehensive development plans at Divisional and trust wide level.	Metrics indicate we have a risk around staff retention, although improving.	Refresh of the Workforce and Retention Strategy.	Director of Workforce and OD **Trust Board**	12	↑

STRATEGIC PRIORITY 4 : We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Development of our innovation and technology strategy								
Principal Risk description	**Key Controls**	**Sources of Assurances**	**Assurance on the effectiveness of controls**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	Memorandum of agreement with University of Bristol. Joint Posts. Clinical Networks. Research Standing Operating Procedures. Process in place for corrective and preventative actions where breaches of GCP/protocol are identified to support learning by PI/CI and research team. Regular review of research recruitment on a trust-wide level. Staff engagement embedded in planning service improvement and transformation work via direct involvement and variety of communication mechanisms. Transformation and other service improvement leads networked across the divisions – role includes identifying and supporting local innovation. Partnership with the Academic Health Science Network to train a cohort of improvement coaches to add capacity to this support network. Programmes such as Bright Ideas. During 16/17 review of approach to supporting innovation across the Trust planned (take stock of current work, identify gaps in support, develop solutions).	Trust Research Group. Divisional research committees/groups. Regular reports to the Board KPI reviews (trust wide & divisional) Board metrics. Audit/inspections. Education and Training Annual Report Project steering groups /reporting to Transformation Board & Senior Leadership Team. Regular reports to the Trust Board.	Research grants, Research Capability Funding, commercial and delivery income maintained. SPAs recognised in consultant job plans. Evidence of wide range of innovation and improvement programmes completed/underway. Good response to Bright Ideas/Trust Recognising Success awards.	Medicine, Surgery, Head and Neck divisional research committees/groups in setup/upgrade. Gap expected to be closed by end of q2 16/17. Key Performance Indicators at divisional level (bedholding only) to be finalised and form part of regular divisional review. Gap expected to be closed by end q3 16/17. Need to better connect scope of activity underway across all aspects of improvement and innovation and clarify routes to support for proposals. Consider provision of access to basic improvement toolkit via e-learning. Better communicate and promote improvement priorities and provide mechanisms for increased staff input (e.g. Happy App).	Clear mechanism for protecting time for non-medical PIs recruiting to National Institute of Health Research portfolio trials not in place. Additional measures to be identified in review of innovation.	Work in progress to address the gaps in controls. Review of Trust approach to supporting innovation and improvement to identify and address specific gaps. (Sept 2016) Workshops held in May and June to establish degree of connectedness of wide range of innovation/improvement work underway, identify gaps/duplication and develop proposals for further testing. Plan/strategy to be developed for consideration at Transformation Board with final approval by end of September 2016.	Medical Director **Quality and Outcomes Committee** Director of Strategy and Transformation **Senior Leadership Team/** **Trust Board**	9	↑

STRATEGIC PRIORITY 5 : We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Organisational and System Strategy and Transformation** • Complete a full refresh of our Trust strategy in Autumn 2016, along with the development of a new governance structure for strategic planning and implementation, to ensure that we are aligned to the system wide Sustainability and Transformation Plan (STP) and maintain the recommendations of the Well Led Governance Review. • Further evaluate opportunities to continue to develop our specialised services portfolio throughout 2016/17. • Development of the system Sustainability and Transformation Plan - 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, transformation and partnership working.								
Principal Risk description	**Key Controls**	**Sources of Assurances**	**Assurance on the effectiveness of controls**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Failure 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, transformation and partnership working.	Executive to Executive meetings with NBT. Partnership Programme Board. CEO leading the process for BNSSG Sustainability and Transformation Plan.	Board Partnership Reports. Reports to Trust Board. Staff survey feedback. Appraisal process KPI. Board Partnership Reports. "Critical Friend" approach being considered within STP process. Tender Framework in place from April 2016 explicitly addressing partnership opportunities. National feedback on Sustainability and Transformation Plan processes and leadership.	Staff involved in wide range of external activities e.g. Bristol Health Partners, Better Care Bristol, CLAHRC West, BNSSG System Leadership Group. Chief Executive agreed as local system leader for STP for BNSSG. No indication in current self-assessment within STP of adverse perceptions. Evidence in recent tenders that Trust a sought after partner - Children's Community Services; Sexual Health.	Complete visibility of scope of staff engagement in external activities challenging and not necessarily required.	No significant gaps. Ability to harness soft information.	None.	Director of Strategy and Transformation **Trust Board**	6	↑

STRATEGIC PRIORITY 6 : We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal									
OPERATIONAL PLAN 2016/17 PRIORITIES	**Financial Performance** • 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. • Delivery of 16/17 income plans and Cost Improvement Programme • Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital.								
Principal Risk description	**Key Controls**	**Sources of Assurance**	**Assurance on the effectiveness of controls**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Failure to sustain financial sustainability	Budgetary control systems in place. Scheme of delegation and agreed budget holders. Financial Control Procedures. Standing Financial Instructions. Monthly Divisional CIP reviews. Monthly Divisional Performance reviews. Monthly review by CIP Programme Steering Group. Divisional control of vacancies and procurement monitored at monthly performance meetings. Expenditure performance, capital expenditure and the statement of financial position at the Finance Committee.	Delivery of 16/17 capital programme, including the prioritisation and allocation of strategic capital. Regular Reporting to the Finance Committee and Trust Board. Monthly management scrutiny of capital expenditure at the Capital Programme Steering Group. Rolling 5 year Medium Term Capital Programme (source and applications of funds) approved annually by the Finance Committee and Board.	Limited assurance that all controls are effective in light of continued spend above plan in some areas e.g. agency spend. Weak assurance in some specialities.	Evidence that staffing controls are weak in some areas.	Lack of assurance that expenditure controls are fully effective.	None.	Chief Operating Officer **Savings Board** **Monthly & Quarterly Divisional Reviews**	12	↔

STRATEGIC PRIORITY 7 : We will ensure we are soundly governed and are compliant with the requirements of our regulators									
OPERATIONAL PLAN 2016/17 PRIORITIES	• Implementation of the recommendations from the Well Led Governance Review								
Principal Risk description	**Key Controls**	**Sources of Assurances**	**Assurance on the effectiveness of controls**	**Gaps in controls**	**Gaps in assurance**	**Actions Agreed for any gaps in controls or assurance**	**Executive Lead and Assuring Committee**	**Current Risk Rating**	**Direction of travel**
Failure to comply with targets, statutory duties and functions	Trust Board and all committees have an annual forward plan aligned to their terms of reference, Trust's Standing Orders and Standing Financial Instructions to ensure appropriate annual reporting against plans is in place. Regular reporting to NHS Improvement following Board approval. Monitoring of CQC inspection action plans via Clinical Quality Group, Senior Leadership Team, QOC.	Terms of Reference. Constitution in place. Annual Report, Annual Governance Statement, Annual Quality Report, Annual Account. NHS Improvement returns signed off by the Trust Board. Internal Audit Reports : Governance, risk management, financial accounts. CQC Inspection Visits/ CQC Fundamental Standards Self-assessment. Monthly Board Reports. Performance and Finance Reports at each Board Meeting. Committee Reports at each Board Meeting.	Partial assurance of effectiveness of actions and controls, in light of on-going failure of some standards. CQC Inspection Report provides assurance into areas inspected.	No significant gaps in control. No significant gaps in control.	No significant gaps. No significant gaps.	None. None.	Chief Executive **Trust Board**	9	↔

Appendix 2: Links to the Corporate Risk Register

STRATEGIC OBJECTIVE	PRINCIPAL RISK	CORPORATE RISK REGISTER	CURRENT RISK RATING
STRATEGIC PRIORITY 1: We will consistently deliver high quality individual care, delivered with compassion.	**Principal Risk 1:** Failure to maintain the quality of patient services.	**423 -** Risk that length of stay does not reduce in line with planning assumptions resulting in an increase in bed occupancy. **674 -** Risks of excessive agency and bank costs, low staff morale and service impact arising from higher than sector turnover of staff. **856 -** Risk that the emotional & Mental Health needs of children and young people are not being fully met. **919 -** Risk that the Trust does not meet the national standard for cancelled operations. **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards. **949 -** Risk that perinatal mental health services are not adequate to the needs of those requiring to access the service. **961 -** Risk of harm to patients awaiting discharge, once medically fit **1497 -** Risk of Delays in transfer of North Somerset patients due to temporary closure of Clevedon Hospital. **1595 -** Risk that patients detained under s136 may be brought to ED due to lack of capacity in community provision **1598 -** Risk of Patients Falls Resulting in Harm. **1640 -** Risk of poorer quality service for patients due to delays with reporting of histology samples following service transfer.	9
STRATEGIC PRIORITY 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	**Principal Risk 2:** Failure to develop and maintain the Trust estate.	None.	8
STRATEGIC PRIORITY 3: We will strive to employ the best staff and help all our staff fulfil their individual potential**.**	**Principal Risk 6:** Failure to recruit, sustain an engaged and effective workforce.	**793 -** Risk of work related stress affecting staff across the organisation. **921 -** Risk of not achieving 90% compliance for Essential Training for all Trust staff.	12
STRATEGIC PRIORITY 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation.	**Principal Risk 7:** Failure to achieve the potential benefits and return on investment from innovation and research activity.	None.	9
STRATEGIC PRIORITY 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	**Principal Risk 9:** Failure 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, transformation and partnership working.	None.	6
STRATEGIC PRIORITY 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	**Principal Risk 10:** Failure to sustain financial sustainability.	**959 -**Risk that Trust does not Deliver 2016/17 financial plan due to Divisions not achieving their current year savings target.	12
STRATEGIC PRIORITY 7: We will ensure we are soundly governed and are compliant with the requirements of our regulators.	**Principal Risk 11:** Failure to comply with targets, statutory duties and functions.	**801 -** Risk that the Trust does not maintain a GREEN Monitor Governance Rating **869 -** Risk of Reputational Damage Arising From Adverse Media Coverage of Trust Activities **919 -** Risk that the Trust does not meet the national standard for cancelled operations **932 -** Risk of failure to deliver care that meets National Cancer Waiting Time Standards **970 -** Potential risk of non-compliance with some of Monitor's core 4-hour Wait Clinical Indicator **1413 -** Risk of non-compliance with IG Toolkit at Level 2 2016/17 **1530 -** Risk of adverse operational impact arising from unplanned closure of Weston Emergency Department due to staffing shortages	9

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in public
To be held on Thursday 28 July 2016 at 11:00am in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
25. Risk Assessment Framework Declaration Report – Quarter 1 Update

Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive **Authors:** Owen Ainsley, Interim Chief Operating Officer; Paul Mapson, Director of Finance and Information; Xanthe Whittaker, Associate Director of Performance

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary
Purpose All NHS Foundation Trusts require a licence from Monitor stipulating specific conditions that they must meet to operate including financial sustainability and governance requirements. The 'Risk Assessment Framework' constitutes Monitor's approach and their use of the framework to assess individual FT compliance with two specific aspects of their work: the Continuity of Services and Governance conditions in their provider licences. The purpose of a Monitor assessment under the framework is to highlight when there is a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or poor governance. It is important to note that concerns do not automatically indicate a breach of the licence or trigger regulatory action. Rather, they will prompt Monitor to consider where a more detailed investigation may be necessary to establish the scale and scope of any risk. Key issues to note This report provides an analysis of governance risk (Appendix A) in addition to the Finance Director which addresses the finance risk. Following making the necessary enquiries, the Senior Leadership Team confirmed that it is not aware of any matters arising during the quarter requiring an exception report to Monitor which have not previously been reported. The recommendation from the Senior Leadership Team (SLT) is to declare the standards failed in quarter 1 to be the A&E 4-hour standard, the 31-day first definitive, the 31-day subsequent surgery, the 62-day GP and 62-day Screening cancer standards. It is also recommended that the ongoing risks to achievement of the 62-day screening and 62-day GP cancer standards, and the A&E 4-hour standard, are flagged as part of the narrative that accompanies the declaration, along with the elevated risk to RTT Incomplete pathways standard failure.

Recommendations
The Board is asked to endorse the following Quarter 1 declaration for submission to NHS

Improvement on 29th July 2016:

- A submission against the 'Governance Rating' reflecting the standards failed in quarter 1 to be the A&E 4-hour standard, the 31-day first definitive, the 31day subsequent surgery, the 62-day GP and 62-day Screening cancer standards;
- The recommendation that the planned ongoing failure of the listed standards continues to be flagged to Monitor, as part of the narrative that accompanies the declaration (see Appendix A);
- Confirmation that the Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months; and
- Confirmation that the Board anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the forecast in the financial return

Impact Upon Board Assurance Framework
This report does not result in any changes to the Board Assurance Framework.
Impact Upon Corporate Risk
This report does not result in any changes to the Corporate Risk Register.
Implications (Regulatory/Legal)
None
Equality & Patient Impact
Not applicable

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Finance Committee	**Audit Committee**	**Quality and Outcomes Committee**	**Senior Leadership Team**	**Risk Management Group**
		26 July 2016		

NHS Improvement Quarter 1 declaration against the 2016/17 Risk Assessment Framework for Governance

1. Context

The Trust is required to make its quarter 1 declaration of compliance with the 2016/17 NHS Improvement Risk Assessment Framework by the 31st July 2016.

The Trust's scores against the Risk Assessment Framework are used to derive a Governance Rating for quarter 1, by counting the number of 'Governance Concerns' that have been triggered in the period. These Governance Triggers at present include the following:

- Service Performance Score of 4 or greater (i.e. four or more standards failed in the period)
- A single target being failed for three consecutive quarters
- The A&E 4-hour standard being failed for two quarters in any four-quarter period *and* in any additional quarter over the subsequent three-quarter period
- Breaching the annual *Clostridium difficile* objective by failing three consecutive year-to-date quarters *or* failing the full-year objective at any point in the year
- CQC warning notices

NHS Improvement also uses other information to signal potential Governance Concerns, using patient and staff metrics such as satisfaction rates, turn-over rates, levels of temporary staffing and other information from third party organisations.

The resultant Governance Rating that NHS Improvement publishes will depend on further investigations it conducts following Governance Concerns being triggered. The following shows the rationale for the application or either a GREEN or a RED rating:

Table 1 NHS Improvement's process for determining the Governance 'status' of a Foundation Trust

Governance 'status' of the Foundation Trust		Governance rating: What Monitor will publish
No evident concerns	→	Green
Issue identification **Prioritisation** **Consideration of breach**	Emerging concerns (e.g. persistently failing access targets; major third party concerns, financial issues) Further information requested Concerns serious enough to trigger formal investigation Breach or likely breach identified; formal/informal action pending	**Current status and a description of:** • Factors driving concerns • Actions Monitor is taking/considering • Next steps
Action Formal regulatory action under sections 105 (Enforcement undertakings), 106 (Discretionary requirements), and/or 111 (Licence condition and Powers of removal, suspension and disqualification of directors and governors)	→	Red

Each quarterly declaration to NHS Improvement must take account of performance in the quarter, and also note expected performance risks in the coming quarter. The forecast risks will be declared to NHS Improvement as part of the narrative that accompanies the submission.

NHS Improvement compares the quarterly declarations a trust makes with its Annual Plan risk assessment. If a trust declares a standard as not met as part of its quarterly declaration, which it

did not declare at risk in the annual plan risk assessment, the trust may be required to commission an independent review of its self-certification and associated processes. In the Trust's Annual Plans the standards declared to be at risk of failure in quarter 1 and quarter 2 2016/17 were as shown below:

	Quarter 1 2016/17	Quarter 2 2016/17
Standards not forecast to be met	A&E 4-hours 62-day GP cancer 62-day Screening cancer 31-day first definitive 31-day subsequent surgery	A&E 4-hours 62-day GP cancer 62-day Screening cancer
Score	**4.0**	**2.0**

2. Performance in the period

Table 2 shows the performance in quarter 1 against each of the standards in NHS Improvement's Risk Assessment Framework. The following standards were not achieved in the quarter:

- A&E 4-hour standard (score 1)
- 62-day GP and 62-day Screening cancer standards (combined score of 1)
- 31-day first definitive treatment cancer standard (score 1)
- 31-day subsequent surgery cancer standard (score 1)

Overall the Trust scores 4 against the Risk Assessment Framework, although under the rules set-out within the Risk Assessment Framework, the failure of the 62-day GP and screening standards, and the A&E 4-hour standard, in quarter 1 would trigger Governance Concerns for repeated failures of the same standard. However, NHS Improvement has restored the Trust to a GREEN rating but will continue to NHS Improvement progress with achievement of recovery trajectories.

Please note that performance against the cancer standards is still subject to final national reporting at the beginning of August and therefore the position shown in Table 2 remains draft. The 31-day subsequent drug therapy standard is now forecast to be achieved, although the breach volumes are higher than in previous quarters due to high levels of patient choice, medical deferral and work-up for entry into clinical trials. Achievement is dependent upon an assumed additional number of oral chemotherapy treatments being recorded as expected. A validation of this quarterly data source is underway and will be completed before national reporting.

Quarter 2 2016/17 risk assessment

The risk assessment detailed in Table 2 sets-out the performance against each standard in NHS Improvement's 2016/17 Risk Assessment Framework in quarter 1, along with the key risks to target achievement for quarter 2. The mitigating actions that are being taken are also provided, along with the residual risk.

The national standard of at least 92% of patients waiting less than 18 weeks at month-end from Referral to Treatment (RTT) was achieved in each month in quarter 1. The 7% increase in demand for outpatient appointments seen in April and May this year relative to the same period last year, has resulted in an increase in the RTT Non-admitted pathways backlog in quarter 1. The elective waiting list has also risen, although the impact on RTT is still to be felt. These factors in conjunction with a poor uptake of waiting list initiatives following a change to payment rates, poses a risk to the achievement of the 92% standard in quarter 2 2016/17.

The A&E 4-hour 95% standard failed to be achieved in the period. However, performance during each month of quarter 1 was significantly above the performance trajectory submitted to NHS England as part of the Sustainability & Transformation Plan (STP), and for the quarter as a whole was 5.8% above the performance in quarter 4 2015/16. Continuing the trend seen in quarter 4

2015/16, emergency demand remained higher than expected in quarter 1, with a 5% increase in both emergency attendances and admissions relative to the same period last year. Levels of delayed discharges also remained above plan, which in combination with ongoing high levels of demand led to bed occupancy remaining above target levels, although lower than in quarter 4.

There continues to be the potential for failure of the 62-day Screening standard, following the transfer out of the Avon Breast Screening service. This is because the bowel screening pathway is now the highest volume reported pathway, but is a difficult one to complete within 62-days due to a high proportion of breaches resulting from patient choice and other causes outside of the Trust's control. National performance for bowel screening pathways was 70.1% and 66.2% for April and May 2016 respectively, against the 90% standard. A total of eleven patients (9.5 breaches in accountability terms out of 18 patients treated) were not treated within 62 days of referral in quarter 1. The reasons for the breaches were: patient choice (6 patients), surgical diagnostic procedure delay (3 patients) clinical complexity (1 patient) and delayed outpatient appointment (1 patient), with the majority being outside of the control of the Trust. As noted in previous quarters, although it is expected the 90% standard will be achieved in some quarters, it is unlikely to be achieved every quarter. It is therefore recommended that the high risk of failure of this standard continues to be flagged to NHS Improvement for quarter 2, and future quarters.

The 62-day GP cancer standard continued to be failed in quarter 1, with the STP recovery being met in April but not in May or June. Late referrals continued to be the major cause of breaches, and for April and May accounted for 35% of breaches. These risks continue into quarter 2, along with the anticipated increase in breaches of the 62-day GP standard associated with delayed histopathology reporting arising following the centralisation of the service at North Bristol Trust. It is recommended that the potential risk to failure of the 62-day GP cancer standard that our case-mix, delayed histopathology reporting and late tertiary referrals brings, continues to be flagged to NHS Improvement as part of the narrative that accompanies the declaration, along with the likely failure of the A&E 4-hour standard due to ongoing emergency/system pressures.

Unusually, the Trust will be reporting failure of the 31-day first definitive and 31-day subsequent surgery cancer waiting times standards in quarter 1 2016/17. This was due to exceptional levels of demand on the adult Intensive Therapy Unit (ITU) / High Dependency Unit (HDU), in terms of both numbers and increasing patient acuity, which resulted in the cancellation of a high volume of cancer surgery cases during March and early April. These patients were subsequently treated in April and the first half of May. The Trust reported failure of these two cancer standard in April, but recovered performance ahead of schedule, with the national standards being met again in both May and June. No further issues are anticipated for these standards in quarter 2.

The residual risk for the failure of the RTT Incomplete pathways standard has been elevated to high for the reasons set-out above. The 31-day subsequent drug therapy cancer standard has had its risk rating elevated to moderate due to the increasing numbers of patients seen entering clinical trials, the work-up for which can result in treatment starting after day 31 on the pathway. These standards along with all those at risk remain under close scrutiny through the Service Delivery Group (SDG) and the Senior Leadership Team (SLT).

3. Recommendation

The recommendation from the Senior Leadership Team (SLT) is to declare the standards failed in quarter 1 to be the A&E 4-hour standard, the 31-day first definitive, the 31-day subsequent surgery, the 62-day GP and 62-day Screening cancer standards. It is also recommended that the ongoing risks to achievement of the 62-day screening and 62-day GP cancer standards, and the A&E 4-hour standard, are flagged as part of the narrative that accompanies the declaration, along with the elevated risk to RTT Incomplete pathways standard failure.

Table 2 Summary of performance in quarter 3 2015/16, and the risks to quarter 4 compliance

Indicator	Score	Achieved in Q1 2016/17?	New risks to Q2 2016/17?	Risks/Issues	Steps being taken to mitigate risks	Original risk rating	Residual risk rating[1]
18-weeks Referral to Treatment for incomplete pathways	1.0	Yes – 92% standard met in each month	Yes – increase in outpatient referrals and potential reduction in activity associated with changes to waiting list initiative payment rates	- Non admitted RTT treatments difficult to plan because an RTT clock may or may not stop at each outpatient attendance; - Increased growth in outpatient demand above planning assumptions, which has now translated into a rise in the elective waiting list; - Changes to waiting list initiative payment rates, which may reduce the Trust's ability to respond quickly to rising demand	- IMAS (Interim Management & Support) Capacity and Demand models used to plan activity required in 2016/17 for continued achievement of the 92% standard, and further reduction of backlogs in non-achieving specialties; - Validation of long waiters to improve data quality and waiting list management; - Robust monitoring and escalation to optimise the number of long waiters booked each month; - Plans to try to address rising demand in quarter 2 under development, including consideration of changes to waiting list initiative payment rates to improve up take of extra sessions.	High	High
A&E Maximum waiting time 4 hours	1.0	No	No – Ongoing risks from Q1	- Levels of emergency attendances and admissions via the Bristol Royal Infirmary and Bristol Children's Hospital	- Wide-ranging internal improvement plan including ORLA community-based patient management (latter half of 16/17), improved ward-based	High	High

[1] The 'Residual' Risk Rating represents the most likely risk level that will remain once the impact of mitigating actions have been applied to the 'Original' risk. The 'Original' risk is the risk rating before any mitigating actions have been taken. For this reason the terms are different from the 'Current' and Target' risk categories used on the Trust's Risk Register for the management of risk.

				Emergency Departments 5% higher in quarter 1 than the same period last year and materially above plan; - Delayed Discharges have risen and remain well above plan; - Other local providers continuing to report a high proportion of over 4-hour waits, increasing the potential for ambulance diverts and high levels of variation in demand; - Performance trajectory based upon impact of system-wide actions not forecasting achievement of 95% standard in Q2.	discharge processes, and changes in the management of particular patient pathways, which should reduce length of stays for a large cohort of medical patients; - Escalation of risks relating to delayed discharges to partner organisation Execs; - Continued implementation of system-wide Resilience Plan.		
Cancer: 62-day wait for first treatment – GP Referred	1.0	No	Yes – lengthened pathways resulting from histopathology delays	- Very high levels of late tertiary referrals continuing to be main cause of breaches (circa 35% of breaches) - High levels of medical deferral, patient choice, and clinical complexity (none of which can be accounted for in waiting times and are difficult to mitigate) - Increasing/high volumes of patients for tumour sites that nationally perform well below the 85% standard - Delays in histopathology	- Cancer Performance Improvement Group overseeing action plan, which has included the implementation of 'ideal timescale' pathways (complete) and offering patients a first appointment within 7 days, wherever possible; - Monthly and quarterly breach reviews, along with benchmarking against an equivalent peer group, being used to inform further improvement work; - Patients on the cancer patient tracking list continue to be	High	High

				reporting following the transfer of the service to North Bristol Trust - Awareness raising campaigns likely to continue to increase demand	actively managed, with oversight of the waiting list through divisional and Trust-wide weekly meetings, and any delays escalated to Divisional Directors and Chief Operating Officer; - Further capacity and demand modelling for ITU/HDU being undertaken to inform future operational model and limit future cancellations once in place; - Histopathology recovery plan developed by NBT with oversight of recovery being also tracked by commissioners and NHS Improvement.		
Cancer: 62-day wait for first treatment – Screening Referred		No – performance below 90% (58% of breaches outside of the control of the Trust)	No	- Following the transfer of the Avon Breast Screening Service in quarter 2 2014/15, the majority of the Breast Screening pathways will no longer be reported under this standard; breast pathways normally completed in under 62 days, unlike bowel which nationally performs well below the 90% standard; - All bowel screening pathways originate at the Trust, and capacity constraints at other providers will have a knock-	- Specialist practitioner and colonoscopy waiting times remain short and continue to be closely monitored; - Any patients on shared pathways continue to be actively tracked via our Cancer Register until treated at other providers; - Need for additional elective capacity for colorectal surgery continuously reviewed; - All CT colon scanning and reporting delays escalated, and further capacity and demand modelling has been undertaken to reduce waits;	High	High

				on impact on performance for shared pathways; - Patient choice in bowel screening pathway; - Patient choice and medical deferral related breaches cannot be fully mitigated, and for this reason the residual risk remains high; - Numbers of cases reported under this standard are now low, due to the loss of the breast pathways, so small numbers of breaches may have a large impact.	- Capacity and demand review undertaken for colorectal service; additional consultant appointed and started in April 2016.		
Cancer: 31-day wait for subsequent treatment - subsequent surgery	1.0	No – not achieved in April due to ITU/HDU bed pressures	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds), although not forecast to impact in quarter 2; - Having enough surgical capacity to meet peaks in demand, especially for the colorectal and hepatobiliary services - Unpredictably high volume of delays due to medical deferrals in some quarters.	- See actions under 62-day GP regarding ITU/HDU bed capacity - Ongoing proactive management of cancer patient tracking list, to identify bulges in demand as early as possible;	Moderate	Low
Cancer: 31-day wait for subsequent treatment - subsequent drug therapy		Yes	Yes – see next box	- Increasing numbers of patients entering clinical trials, which can delay treatment beyond day 31 due to the clinical work-up required for the trial; it is not possible to fully mitigate	- Continue to pro-actively manage patients on the Cancer patient tracking list	Moderate	Moderate

				this risk, and for this reason the residual risk rating is Amber.			
Cancer: 31-day wait for subsequent treatment - subsequent radiotherapy		Yes	No	- No significant risks	- Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Cancer: 31-day wait for first definitive treatment	1.0	No – not achieved in April due to ITU/HDU bed pressures	No	- Cancellations of surgery due to emergency pressures (mainly ITU/HDU beds), although not forecast to impact in quarter 2.	- See actions under 62-day GP, including those related to ITU/HDU bed capacity	Moderate	Low
Cancer: Two-week wait - urgent GP referral seen within 2 weeks	1.0	Yes	No	- The Trust's skin cancer clinic capacity is limited at Weston, but patient demand relatively high, with patients choosing to wait over 14 days; - Very high levels of demand now being experienced in some months, for reasons not well understood.	- Patients referred with a query skin cancer being offered an earlier appointment at the BRI first, before being offered an appointment at Weston; - Continue to pro-actively manage patients on the Cancer patient tracking list	Low	Low
Clostridium difficile	1.0	Yes, although still awaiting confirmation of the number of cases deemed by the commissioners to be potentially avoidable.	No	- Flat profiling of annual target continues to be imposed by NHS Improvement; - Bristol community is an outlier for antibiotic prescribing	- Procalcitonin testing of high risk patients in the Elderly Assessment Unit (EAU) and Medical Assessment Unit (MAU) continues, to reduce the use of un-necessary antibiotics - An antibiotic prescribing phone application has been implemented - Use of Fidaxomicin to treat	Low	Low

					patients at high risk of C. diff recurrence or relapse - Awareness sessions for GPs and Nursing Home Managers - Rigorous Root Cause Analysis of cases to continue to enable any C. diff cases not resulting from a lapse in quality of care to be demonstrated to the commissioners.		
Certification against compliance with requirements regarding access to healthcare for patients with a learning disability	1.0	Yes	No	- No significant risks	See the standard set-out in Appendix 1, which the Trust is declaring compliance with.	Low	Low

Appendix 1 – Learning Disability Access Criteria

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

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

Appendix 2 – Draft declaration

Click to go to index

Declaration of risks against healthcare targets and indicators for 201617 by University Hospitals Bristol NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:

must complete
may need to complete

Target or Indicator (per Risk Assessment Framework)	Annual Plan				Quarter 1			
	Threshold or target YTD	Scoring Per Risk Assessment Framework	Risk declared	Scoring Per Risk Assessment Framework	Performance	Declaration	Comments / explanations	Scoring Per Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	1.0	No	0	92.3%	Achieved	92% standard achieved each	0
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	1.0	Yes	1	89.3%	Not met		1
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	Yes	1	73.9%	Not met	Subject to final reporting	1
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	90%	1.0	Yes		47.2%	Not met	Subject to final reporting	
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation					73.9%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation					47.2%			
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	Yes	1	90.1%	Not met	Subject to final reporting	1
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	1.0	No		98.3%	Achieved	Subject to final reporting	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	94%	1.0	No		97.9%	Achieved	Subject to final reporting	
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	Yes	1	94.7%	Not met	Subject to final reporting	1
Cancer 2 week (all cancers)	93%	1.0	No	0	94.2%	Achieved	Subject to final reporting	0
C.Diff due to lapses in care (YTD)	11.25	1.0	No	0	0	Achieved	All cases still subject to revie	0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)					8			
C.Diff cases under review					8			
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0	No	0	N/A	Achieved		0
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	Report by Exception	No			No		
Date of last CQC inspection	N/A		N/A			08/09/2014		
CQC compliance action outstanding (as at time of submission)	N/A		No			No		
CQC enforcement action within last 12 months (as at time of submission)	N/A		No			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)	N/A		No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	N/A		No			No		
Overall rating from CQC inspection (as at time of submission)	N/A		N/A			Requires improvement		
CQC recommendation to place trust into Special Measures (as at time of submission)	N/A		N/A			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A		No			No		
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)	N/A		N/A			N/A		
Service Performance Score				4				4

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

A There are five targets in Monitor's Risk Assessment Framework for which the Board is unable to declare compliance with in quarter 1. These are: the A&E 4-hour standard, the 31 day first definitive cancer standard, the 31-day subseuqent surgery standard, and the combined 62-day GP and 62-day screening cancer standards.

The Trust performed at 89.3% against the A&E 4-hour standard in the period, meeting the STP recovery trajectory in each month. During the quarter the Trust continued to experience high levels of growth in emergency admissions through both the adult and the paediatric Emergency Departments, above the levels assumed in the plan. In addition, delayed discharges continued at circa 60 patients un-necessarily occupying hospital beds at any point in time, which is double the jointly agreed agreed plan with partners of 30. In quarter 1 the Trust commenced work on establishing a service delivered in partnership with ORLA Healthcare, with patients that would otherwise be admitted to an acute bed being cared for within their own homes. The first patients were discharged to ORLA's care in July. The Trust is also continuing to mitigate system risks through an action plan with partner organisations, with additional actions being taken to address delayed discharges and improve the ability of partner organisations to respond to demand.

Continued below

B The 62-day GP cancer standard has been failed since quarter 4 2013/14, primarily due to high levels of unavoidable breaches (late referrals, medical deferrals/clinical complexity and patient choice) and tumour site case-mix. A significant programme of cancer pathway improvement work was implemented in 2015/16 including reductions in waits for the 2-week wait step, and implementation of ideal timescale pathways. In addition to this work to minimise internal causes of breaches, the Trust has also been working with other providers to reduce late referrals. The case mix of patients treated (typically having a -3.5% impact on performance) and late referrals into the Trust continues to make achievement of the 62-day GP standard challenging. The Trust met its STF trajectory in April and May in aggregate, but in June has incurred a very high volume of late referrals and histopathology reporting related delays following the transfer of the service to North Birstol Trust.
During quarter 2 of 2014/15 the Avon Breast Screening service transferred to North Bristol Trust. As a result performance against the screening standard is largely based on a relatively small number of bowel screening treatments, which nationally performs well below 90%. In quarter 1, 11 screening referred patients (9.5 breaches in accountability terms) were not treated within 62 days of referral. Breach analysis demonstrates 5.5 of the 9.5 screening breaches were for reasons outside of the control of the Trust (i.e. patient choice and medical deferral/clinical complexity).

C As noted in the quarter 4 submission, the Trust will unusually be reporting a failure of the 31-day first definitive and 31-day subsequent surgery cancer waiting times standards in quarter 1 2016/17. This is due to exceptional levels of demand on the adult Intensive Therapy Unit (ITU) / High Dependency Unit (HDU), in terms of both numbers and patient acuity. This heightened demand arose from emergency patients. The result was the cancellation of most ITU/HDU elective surgical cases, the majority of which were cancer patients, over a three week period in March and early April. These patients were treated in April and the first half of May. The 31-day standards were achieved in both May and June, but this was not sufficient to enable achievement for quarter 1 as a whole.
The Trust continues to report achievement of the 92% Incomplete pathways national standard. The stretch trajectory was met in May, but not in April or June. As part of the 2016/17 business planning round, the Trust again undertook detailed capacity and demand modelling using the Interim Management and Support (IMAS) models. Delivery plans to meet the required level of both recurrent and non-recurrent capacity have been established and the activity required to deliver these agreed with commissioners. Levels of demand for outpatient services for April and May were 7% above the same period last year. As a result the Non-admitted backlog has increased over the period. The additional outpatient demand has converted into a rise in the elective waiting list. These patients will become over 18 week waiters if this heightened level of demand cannot be met. Plans are being enacted to try to mitigate the risk this rising waiting list poses to cotinued RTT standard achievement. But the residual risk is consisdred as high and the Trust is therefore flagging this risk to NHS Improvement.

Cover report to the Board of Directors meeting held in Public
To be held on Thursday 28 July 2016 at 11:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
26. Governors' Log of Communications									
Sponsor and Author(s)									
Sponsor: John Savage, Chairman **Author:** Kate Hanlon, Head of Membership & Governance									
Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓
Executive Summary									
Purpose: The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-executive Directors when new items are received and when new responses have been provided.									
Recommendations									
None.									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		
Date the paper was presented to previous Committees									
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**				

ID **Governor Name**

156 **Angelo Micciche and Mo Schille** ***Theme:*** Impact of service changes ***Source:*** From Constituency/ Members

Query **20/07/2016**

At a recent Health Matters event, a Foundation Trust member raised the question of how the Trust effectively manages the impact of changes to services, from the point of view of the patients and staff involved. The member had raised this question at the last annual members meeting and was awaiting a more detailed response, and has also since completed a freedom of information request in relation to this matter.

Please can we be assured that this question will be dealt with urgently, and that processes are in place to capture members' questions from public meetings that require follow up.

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response

Status: *Pending Assignment*

ID	Governor Name		
155	Mo Schiller	***Theme:*** Contacting patients	***Source:*** From Constituency/ Members

Query **11/07/2016**

Elderly people cannot always get to the phone in time to pick up a call, the problem being most phones have a limited ring before going to an answerphone system. Also the existing hospital phone system says caller number withheld, so some people avoid picking up calls if they don't know who is on the other end – if the call is from the hospital is to cancel an appointment this could be a problem. If the call is following up from a message left with the OPD line/co-ordinator and no message is left then the patient thinks they have not been called back.

When you call the outpatient appointment co-ordinators you frequently get, "I am not at my desk/am on another call, leave your name, hospital number and telephone number and we will call you back." Should there be a message saying who called, why they called /a number to call back? Why is the caller number withheld? We need to consider a lot of our patients are now old.

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 11/07/2016

Response **21/07/2016**

The outpatient standards outline that answerphone messages with minimal information can be left when contacting patients on either a landline or mobile phone. An example of a standard message that can be left on a machine to protect patient confidentiality is: 'This is a call for Joe Smith about your admission date, please ring us on 0117 342 ….' . In terms of the caller ID, organisations such as hospitals and the police used to be encouraged to withhold their numbers, however with the public now able to request a block on undeclared numbers this stance has changed. When the Trust moves to a new external line provider (which we anticipate will be in the next 12 months) we will then have the capability to declare a Trust ID on outbound calls. How the Trust then deals with the returned calls to that declared ID has still to be decided, as has the timeframe for implementation.

Status: *Assigned to Executive Lead*

ID	Governor Name			
154	Mo Schiller and Angelo Miccich	***Theme:*** Volunteers		***Source:*** Other

Query **30/06/2016**

Governors were concerned to receive a letter (27 June 2016) from the volunteers at the Cancer information and support centre, Bristol Haematology and Oncology Centre, about the lack of consultation around the decision to enforce a uniform policy without any regard for the volunteers views or their special unique role.

The volunteers are obviously extremely upset that there had been no discussion or consultation prior to the Trust's decision.

They have also highlighted that the volunteer committee that represents volunteers in the trust does not actually have any volunteers as part of that committee, which appears to be an unusual approach. Our volunteers do invaluable work supporting our patients through difficult periods of their lives.

Can you explain firstly why this change was made and why implemented without consulting with the volunteer group (i.e. why weren't their specific concerns taken into account?), secondly whether there is an opportunity to re-evaluate the change in policy for this group and lastly whether the structure and membership of the volunteer committee can be changed so that it includes Trust volunteers?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **08/07/2016**

The decision to introduce a uniform for volunteers was part of the Trust's response to one of the recommendations from the Saville Inquiry. This recommendation was for all healthcare providers using volunteers to ensure that volunteers are visible to the patients, staff and members of the public accessing health care services. There was no consultation on whether to introduce a polo shirt for volunteers as it was felt by the Chief Nurse who holds the executive lead for volunteer services within the Trust that this was a must do action to ensure that the Trust complied with the above recommendation.

The voluntary services steering group (VSSG) was informed of the proposal and why the Trust was taking this action. The Trusts volunteer manager has also met with the General Manager of the Bristol Haematology and Oncology Centre (BHOC) and the Manager of the Cancer Information and Support Centre to discuss the reasons for the introduction of a uniform for all volunteers. An evaluation of the impact of volunteers being more visible will be undertaken with volunteers and staff in approximately 6 months.

The Trust has many volunteers in different roles, a further benefit of introducing a uniform was to make volunteers more visible to staff so that the best use of volunteer support can be made. We wanted to raise the profile of volunteers across the Trust for staff, patients and visitors to appreciate the wide variety of roles volunteers have and the contribution volunteers make within our hospitals.

If a volunteer representative elected by their peers to represent them wanted to join the VSSG that would be welcomed.

ID	Governor Name		
Status:	*Awaiting Governor Response*		
153	**Mo Schiller**	***Theme:*** BRI redevelopment	***Source:*** Chairman's Counsel

Query **29/06/2016**

Governors are concerned about the poor quality of the paving area, which runs alongside the newly completed BRI façade. The paving runs parallel to the drop off area and main entrance to the hospital. It is uneven and needs immediate attention as it is a hazard not only to our patients but visitors alike. We would welcome assurance that this will be reviewed as a priority.

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **06/07/2016**

Following completion of the work on the façade, we are aware that the paving outside the BRI has not been finished to the standard we were expecting. We submitted details of the works to the pavement to Bristol City Council in February to seek their approval as required under the S278 agreement for works on the highway.

Despite numerous attempts to engage the Council during the work on the façade, including advising the Council we would start work on the paving to maintain the contract programme, we received no response until council officers visited the site in early June. At this time we were ordered to stop works on the paving as the Council did not support the design or the specification. We have made the pavement safe as far as we can for the current time, awaiting further discussion with the Council, which we are continuing to pursue.

Status: *Awaiting Governor Response*