PUBLIC TRUST BOARD
Meeting to be held on 29 November 2016, 11:00 - 1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1	Apologies for absence	Information	*Chairman*	Verbal
2	Declarations of Interest	Information	*Chairman*	Verbal
3	Patient Experience Story	Information	*Chief Nurse*	Verbal /3
4	Minutes of the last meeting	Approval	*Chairman*	5
5	Matters arising and Action Log	Approval	*Chairman*	19
6	Chief Executive Report	Information	*Chief Executive*	20
Care and Quality				
7	Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital.	Assurance	Medical Director	24
8	Independent Review of Children's Cardiac Services in Bristol	Assurance	Chief Nurse	41
9	Interim Annual Report for Children's Services	Assurance	Chief Nurse *Ian Barrington attend to present*	68
10	Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Assurance	Chief Operating Officer	82
11	Quality and Outcomes Committee Chair's report	Assurance	Quality & Outcomes Committee Chair	To be tabled
Organisational and System Strategy and Transformation				
12	Bristol, North Somerset & South Gloucestershire Sustainability and Transformation Plan	Assurance	Chief Executive	141

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Financial Performance				
13	Finance Report	Assurance	Director of Finance & Information	271
14	Finance Committee Chair's Report	Assurance	Finance Committee Chair	To be tabled
Workforce				
15	Taking further action to reduce agency spend	Assurance	Acting Director of Workforce and Organisational Development	311
Governance				
16	Changes to the Trust Constitution	Information	Trust Secretary	319
Items for Information				
17	Governors' Log of Communications	Information	Chairman	416
Concluding Business				
18	Any Other Urgent Business	Information	*Chairman*	Verbal
19	Date and time of next meeting **Thursday 22 December 2016, 9:00 – 10:00 am, Conference Room, Trust HQ, Marlborough St Bristol BS1 3NU**		*Chairman*	Verbal

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	29 November 2016
Report Title	Patient Story		
Author	Tony Watkin		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

Purpose

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

The 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.

Key issues to note

Bristol Black Carers supports carers and those whom they care for to access healthcare. In this story, Andeloris Chacon, the Manager at Bristol Black Carers, will reflect on the experiences of carers who have supported patients at UH Bristol, the perceptions the local community have of our hospitals and how her organisation is developing a voice in the Trust through our Involvement Network.

Recommendations

Members are asked to:

- **Note** the patient story

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☒	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)

Minutes of the Public Trust Board Meeting

Held on 31 October 11:00-1:00pm, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Present
Board Members

Member Name	Job Title/Position
Emma Woollett	Non-Executive / Vice- Chair **(Chaired meeting in absence of Chairman)**
Robert Woolley	Chief Executive
Julian Dennis	Non-Executive
Alison Ryan	Non-Executive
Jill Youds	Non-Executive
Paul Mapson	Director of Finance and Information
Sean O'Kelly	Medical Director
Carolyn Mills	Chief Nurse
Owen Ainsley	Interim Chief Operating Officer
Alex Nestor	Acting Director of Workforce and Organisational Development
Paula Clarke	Director of Strategy and Transformation
Lisa Gardner	Non-Executive
Guy Orpen	Non-Executive
David Armstrong	Non-Executive

In Attendance

Name	Job Title/Position
Pam Wenger	Trust Secretary
Fiona Reid	Head of Communications
Tony Watkins	Patient and Public Involvement lead
Judy Caesley	Patient (Item 1.2)
David Wynick	Director of Research (Item 2.1)
Annabel Paler	Member of Public
Nick Sedgemore	Member of Public
Tim Clevel	Member of Public
Ray Phipps	Governor
Sue Milestone	Governor
Garry Williams	Governor
Mily Yogananth	Governor
Rashid Joomun	Governor
Mo Schiller	Governor
Clive Hamilton	Governor
Sue Silvey	Governor
Carole Dacombe	Governor
Pauline Beddoes	Governor

Kathy Baxter	Governor
Hussein Amiri	Governor
Flo Jordan	Governor
Graham Briscoe	Governor
Malcom Watson	Governor

Minutes:

Zainab Gill	Corporate Governance Administrator

The Chair opened the Meeting at 11:00am

Minute Ref	Item Number	Action
101/10/16	**Welcome and Introductions (Item 1.1)**	
	Apologies were noted from John Savage (Chairman) and John Moore (Non-Executive).	
102/10/16	**Patient Experience Story (Item 1.2)**	
	The meeting began with a patient story, from a long-standing patient (and member of staff) Judy Caesley of the Trust's Rheumatology service. Judy Caesley described her journey and the treatment she had received since 1996. She highlighted her experiences and how she felt that the quality of care she had received at the Trust had improved over 20 years. Judy Caesley stated that she felt that the developments in research had impacted on the care she had received. Members noted the high quality care she had received and her views on the implications of living with a long term condition and the importance of continuity of care for patients. The story ended with a reflection on the role patients can play in working alongside clinicians to improve services and the aspirations for the service as it moves into new premises later this year. **Members RESOLVED to:** • **Receive** the patient story.	
103/10/16	**Minutes of the last meeting (Item 1.3)**	
	The minutes of meeting held on 29 September 2016 were agreed as a true and accurate record subject to minor amendments as detailed below: • *Minute ref 83/09/16 page 5*, note apologies from David Armstrong. • *Minute ref 89/09/16 page 8*, amend word "Member" to Members" and in the third paragraph amend word "recommendations" to "recommendation".	

Minute Ref	Item Number	Action
	• *Minute ref* 89/09/16 *page 9,* amend last paragraph word "Ombudsman" to Ombudsmen" and change word "public" to "parliamentary". • Minute ref *96/09/16* page 12, amend Governor in last paragraph to Malcom Watson and not Clive Hamilton, re-write titles to read "North Bristol Trust and South Gloucestershire and North Somerset Clinical Commissioning Groups" and amend sentence to read "may have an indirect impact on the Trust". **Members RESOLVED to:** • **Approve** the minutes from the meeting held on 29 September 2016 as a true and accurate record subject to the minor amendments recorded above.	
104/10/16	**Matters arising and Action Log (Item 1.4)**	
	Members received and reviewed the action log. The progress against the outstanding actions was noted. - *Minute ref 79/07/16* – an update on patient appointment letters would be presented to Governors at the Quality Focus Group in January 2016. - *Minute ref 85/07/16* – It was agreed that as this was a routine item on the agenda, this action could be closed. - *Minute ref 92/09/16* – It was agreed that the updated position would be provided at the Quality and Outcomes Committee. This action was closed. - *Minute ref 87/09/16* – It was noted that an update on the high risk complaint would be provided in November 2016.	
105/10/16	**Chief Executive's Report (Item 1.5)**	
	Robert Woolley discussed the highlights from the Chief Executive's report which were as follows: <u>Single Oversight Framework</u> Robert Woolley provided an update on the Single Oversight Framework and confirmed that NHS Improvement had published the shadow segmentation. Members noted that under the new Single Oversight Framework, which replaced the old risk assessment framework with effect from 1 October 2016, there were now four segments providers would be placed in, depending on the extent of support needs identified through the oversight process. Robert Woolley confirmed the Trust was in segment two which meant there were minor concerns and potential support was needed.	

Minute Ref	Item Number	Action
	NHS Improvement Robert Woolley provided an update to the Board on the recent communication from NHS Improvement describing additional measures to strengthen financial accountability this year and particularly looking at growth and agency staffing. He advised there would be a requirement for more formal Board oversight on agency and locum usage in the future. It was noted that the arrangements for any additional oversight in relation to agency spend had not yet been confirmed, and the Board would be notified if there was any further action required. Sustainability and Transformation Plan Members received an update in relation to the Sustainability and Transformation Plan for Bristol, South Gloucestershire and North Somerset. Robert Woolley confirmed that there would be a report on this at the next Public Board Meeting in November 2016, which would include the outline programme for wider public engagement on the Sustainability and Transformation Plan. He went on to explain that there had been system-wide discussions, and that the general consensus between commissioners and providers was that there was a need to operate in a way that was closer to an accountable care system model. He confirmed there had been a statement from NHS Improvement requesting the Trust and North Bristol Trust to consider options for shared leadership. It was noted that this was being progressed and that the Board would have final sign off and approval. Graham Briscoe sought clarification in relation to the submission of the Sustainability and Transformation Plan. Robert Woolley confirmed that whilst a draft plan had been submitted at this stage the Trust had not received any feedback. Malcom Watson acknowledged that a briefing had been provided on this to the Bristol Health and Wellbeing Board but sought assurance South Gloucestershire and North Somerset Health and Wellbeing Boards had also been briefed. Robert Woolley advised that South Gloucestershire Health and Wellbeing Board had received a briefing via South Gloucestershire Clinical Commissioning Group and he agreed to confirm the position in relation to North Somerset. Never Event Robert Woolley informed the Board that there had been a 'Never Event' this month despite all efforts and monitoring in place to avoid these. He reaffirmed that there would be a full investigation and that the Root Cause Analysis for this 'Never Event' would be considered at the Quality and Outcomes Committee.	

Minute Ref	Item Number	Action
	Parliamentary and Health Service Ombudsman Report Robert Woolley reported back to the Board that there had been media coverage on a Parliamentary and Health Service Ombudsman Report, relating to the Independent Review of Children's Cardiac Services in Bristol. He reaffirmed that, as the Board was aware, the Parliamentary and Health Service Ombudsman Report was received a month later than the outcome of the wider Independent Children's Cardiac Review. Therefore the issues highlighted as part of this PHSO Report did not form part of the wider review of Paediatric Cardiac Surgery, although they had been conducted within the same timescale and covered some similar issues. Robert Woolley further confirmed that governors had received a briefing on the recommendations following the Review by Carolyn Mills on 11 October 2016 and an extra-ordinary briefing session on 24 October 2016 to respond to the issues in relation to the Parliamentary and Health Service Ombudsman Report on the open letter to Governors. Clive Hamilton thanked Robert Woolley for the briefing to governors which was very helpful and confirmed the position in relation to both these issues. Robert Woolley reaffirmed that apology letters had been sent to all families involved. He also said an offer had been made to the families to meet with the Trust and to be involved in the completion of actions recommended by the Independent Children's Cardiac Review, CQC case review and PHSO Reports. Robert Woolley informed the Board that work had already started to address the recommendations in all these reports. It was noted that, in relation to the Parliamentary and Health Service Ombudsman Report, progress would be made significantly earlier then the Ombudsman's deadline of February 2017. Robert Woolley concluded by assuring the Board that the Trust was committed to working with the families involved, assuring the families of actions in place and of the continued work and monitoring to ensure lessons have been learned and that these issues do not occur again. Guy Orpen asked for assurance on the support available to the staff in this service in light of the latest media coverage around this report. Robert Woolley thanked Guy Orpen for raising this issue and confirmed that there were mechanisms in place to support the staff. In response to Sue Silvey, Robert Woolley confirmed that the Trust had received an expression of interest from one of the families involved in the Independent Children's Cardiac Review to engage in the work to address the recommendations.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the Chief Executive report for information; and • **Confirm** the position of the North Somerset Health and Wellbeing Boards briefing on the Sustainability and Transformation Plan.	*Chief Executive*
107/10/16	**Board Assurance Framework Report Q2 2016-17 (Item 1.6)**	
	The Board received the Board Assurance Framework for quarter 2 and noted that the report had been received by Sub Committees before consideration by the Board. The Board warmly welcome the new format for the report and the clarity of the assessment of risks to delivery of the Board's strategic priorities. There was a discussion regarding the controls outlined in the Board Assurance Framework as it was considered that there were some gaps in this report and that this should be strengthened for future reports. Robert Woolley assured the Board that each individual risk had clear executive ownership. Alison Ryan commented on Principal Risk 1 – *Failure to maintain the quality of patient services* and asked whether this reflected the current position in relation to Referral to Treatment (RTT) and Accident and Emergency pressures given the position reported in the Performance Report. Robert Woolley responded by confirming that he felt this was covered in principal risk one, however agreed to look at how the controls around the access targets are described and review as required. Jill Youds asked for assurance in relation to Principal Risk 8 – *Failure to comply with targets, statutory duties and functions*. Robert Woolley confirmed that he considered the risk rating to be appropriate but he would review the controls and actions. **Members RESOLVED to:** • **Receive** the Board Assurance Framework for assurance; and • **Receive** further assurance on the controls in place around access targets.	*Chief Executive*
108/10/16	**Research and Innovation Quarterly Update Report (Item 2.1)**	
	Members received the quarterly report and presentation on the progress since the last report to the Board. David Wynick provided an overview of the key successes since the last report. It was noted that UHBristol and the University of Bristol were was successful in the recent bid for a Biomedical Research Centre to the value of £20.8m and that work was being progressed to prepare an updated business plan. He went on to confirm that the performance in	

Minute Ref	Item Number	Action
	initiating and delivering research continued to be maintained at a good level for five successive quarters. The Board were pleased to note the progress made within the last five years and in particular welcomed the significant added value and impact on Trust activity, including significant increases in research funding. The Board had a discussion on how changes would be implemented and the challenges around this. The Board noted an incremental approach would be applied and the Transformation Team would work closely with the University of Bristol on this. **Members RESOLVED to:** • **Receive** the Research and Innovation quarterly update report for assurance.	
109/10/16	**Independent Review of Children's Cardiac Services in Bristol (Item 3.1)**	
	Members received a report from Carolyn Mills in relation to the progress against the implementation of the recommendations. Members noted the progress report and the actions taken in the last month including: • Implementation of the programme plan to address the recommendations set out in the Independent Review of Children's Services; • Final completion of the programme plan that fully describes and updates the detailed actions, timescales and responsibilities; and • Embedding processes to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the action plans. Members noted that the three Key Delivery Groups are meeting on a monthly basis to monitor progress against the action plans. Members also noted that an assurance framework for the closure of each recommendation has been developed. Members discussed the issue of involvement with parents and families and it was confirmed that a plan is in place for involving families with improvement work alongside the Parents and Young Persons reference group. David Armstrong asked if the report encompassed the action plans relating to the two cases reported by the Parliamentary and Health Service Ombudsman. Robert Woolley advised there were separate action plans for the two cases and Board would have sight of them once they were finalised. Members discussed the format of the reporting and it was agreed that	

Minute Ref	Item Number	Action
	the monthly exception reports would also include the updated action plan for assurance. Members welcomed the report and assurance was provided in relation to the comprehensive and robust governance structure in place. **Members RESOLVED to**: • **Receive** the report for assurance; and • **Note** the actions taken since the publication of the Independent Review of Children's Cardiac Services; and • **Receive** a monthly highlight report which includes the progress against the action plans. • **Receive** draft action plans relating to the two cases reported by the Parliamentary and Health Service Ombudsman.	*Chief Nurse* *Chief Executive*
110/10/16	**Quality Strategy (Item 3.2)**	
	Members received and approved the Quality Strategy for 2016-2020. It was noted that the new strategy took a broader view of quality than previous versions, embracing staff experience and timeliness of access to services. Members noted the Strategy had been through a number of Committees/Groups for sign off including the Quality Outcomes Committee. **Members RESOLVED to:** • **Receive** and **approve** Quality Strategy; and • **Agree** to review the Quality Strategy annually.	
111/10/16	**Quality Performance Report (Item 3.3)**	
	Owen Ainsley provided an overview of the performance for September 2016 and it was noted that whilst challenges remain there have been some encouraging improvements in performance against several of the access standards this month. Members noted that there had been a reduction in the number of patients waiting over six weeks for a diagnostic test, in line with the recovery trajectory; an increase in the percentage of patients being treated within 62 days following GP referral for a suspected cancer; and the last-minute cancelled operations standard being met for a second consecutive month. Whilst the percentage of patients waiting under 18 weeks from Referral to Treatment has not improved and remains well below the 92% national standard, there has been a decrease in the number of over 18 weeks waiters and positive signs that waiting list sizes are starting to reduce. Members noted that disappointingly, performance against A&E 4-hour was below the in-month trajectory, although the Trust is currently performing above the year-to-date trajectory. **Members RESOLVED to**: • **Receive** the Quality Performance Report for assurance.	

Minute Ref	Item Number	Action
112/10/16	**Quality and Outcomes Committee Chair's Report**	
	Members received the report following the meeting of the Quality and Outcomes Committee held on 27 October 2016. Alison Ryan, Chair of the Quality and Outcomes Committee, provided a brief update on the issues discussed at the last meeting. Members noted the key highlights from the report including the continued focus on patient flow and the challenging performance position. Members received assurance that the reporting of histopathology results following the transfer of the service to North Bristol Trust had shown a significant improvement in performance since August. Further assurance was provided in relation to the appointment of the consultant for the service. Members noted that the Committee had received an update on the outcome of the Royal College of Paediatrics and Child Health Review of Neonatal Intensive Care Unit Progress Report. It was noted that a follow-up report would be presented to the Committee in six months. The Board reaffirmed the importance of ensuring the most robust matrix is being used in the Quality and Outcomes Committee. The Board agreed to explore further in the next scheduled matrix review **Members RESOLVED to:** • **Receive** the Quality and Outcomes Committee Chairs Report for assurance.	

Minute Ref	Item Number	Action
113/10/16	**Winter Planning (Item 3.5)**	
	Members received a briefing which highlighted the plans in relation to winter planning. Owen Ainsley explained that all the divisions had a nominated lead and local winter planning templates were being populated on the internal patient flow management workspace. He assured the Board that fortnightly winter planning meetings had started to support the planning process, which is overseen by the Service Delivery Group. It was noted that the capacity planning and escalation, including bed usage and availability, were all discussed in detail in the report. Jill Youds asked whether this would the virtual ward project would have an impact internally and sought clarification on the work being progressed with partners to address winter pressures. Owen Ainsley said they were optimistic that the project would help to address some of the patient flow and pathway pressures in the organisation. **Members RESOLVED to:** • **Receive** the Winter Planning report for assurance.	
114/10/16	**Transforming Care Programme Board (Item 3.6)**	
	Members received a report providing an update on progress over the last quarter on the Trust-wide programmes of work within the Transforming Care programme. Robert Woolley asked the Board to note progress made in key areas both operational but also long standing, including Outpatients, Communication and Administration. Members discussed the 'Happy App'. Jill Youds asked for assurance around point 8 on the report, relating to communication. Robert Woolley agreed to provide an update on this in due course. The Board agreed to evaluate the benefits of use of the Happy App. **Members resolved to:** • **Receive** the Transforming Care Programme Board for assurance. • **Receive** an evaluation on the benefits of use of the Happy App.	*Chief Executive*
115/10/16	**Audit Committee Chair's Report (Item 4.1)**	

Minute Ref	Item Number	Action
	The Board received the report from the meeting of the Audit Committee held on 18 October 2016. Members noted the update on the progress against the Internal Audit Plan. Members noted that the Audit Committee had received an update in relation to the audit work completed/currently being undertaken. It was noted that seven reports have been issued –three of those were graded as amber and four were graded as green. Members noted that the process for the appointment of external auditors had been considered by the Audit Committee for onward consideration by the Council of Governors. **Members RESOLVED to:** • **Receive** the Audit Committee Chairs Report for assurance.	
116/10/16	**Audit Committee Terms of Reference (Item 4.1b)**	
	Members received and approved the terms of reference for the Audit Committee and noted that they have been reviewed in the Audit Committee. **Members RESOLVED to:** • **Approve** the Audit Committee's Terms of Reference	
117/10/16	**Quarterly Risk Assessment Framework (Item 4.2)**	
	Robert Woolley advised the purpose of this report was to brief the Board on the Trust's performance against the standards outlined in the NHS Improvement Risk Assessment Framework at quarter 2. Members noted that no declaration was required for performance against access or governance standards, due to the new NHS Improvement Single Oversight Framework coming into effect from the start of quarter 3. Members noted that the standards failed in quarter 2 were the A&E 4-hour standard, the RTT incomplete pathways standard, the 62-day GP and 62-day screening cancer standards, which would have formed part of the quarterly declaration to NHS Improvement. Members also noted the risks to achievement of the new standards in quarter 3, which form part of the Single Oversight Framework. **Members RESOLVED to:** • **Receive** the Quarterly Risk Assessment Framework for assurance.	
118/10/16	**Register of Seals (Item 4.3)**	
	Members received the report setting out the use of the Trust Seal since June 2016. **Members RESOLVED to:** • **Receive** the Register of Seals for assurance.	

Minute Ref	Item Number	Action
119/10/16	**Trust Strategic Planning and Implementation Framework – Refreshed Approach from 2016-17 (Item 5.1)**	
	Members received the report and noted the update on the development and delivery of a programme of work to revise the Trust's approach to the planning and implementation of strategic change. Members noted the key activities that had been completed through 2016/17 to deliver a step change in how strategic planning and implementation is managed within the Trust and to progress specific strategic decisions identified by divisions. Alison Ryan asked for assurance in relation to the involvement with the divisions to deliver the savings required. Assurance was provided that the divisions are fully engaged and committed to progressing strategic decisions that place the Trust in a more sustainable position. **Members RESOLVED to:** • **Receive** the Trust Strategic Planning and Implementation Framework – Refreshed Approach from 2016-17 (Item 5.1) for assurance.	
120/10/16	**Finance Report (Item 6.1)**	
	Paul Mapson provided an update to the Board on the Trust's financial position and confirmed this was the Month 6 Report. Members received the Finance Report at month 6 and noted that the summary income and expenditure statement showed a surplus of £8.170m (before technical items) for the first six months of the year. This includes £6.337m of sustainability funding – the position represents a surplus of £1.833m without this funding. Members noted that at month 6 the Trust is £1.488m adverse against plan and that the deterioration from last month reflects the continued adverse run rate in clinical divisions. Members noted that the agreed NHS Improvement plan required a surplus of £8.135m at month 6, the Trust had just achieved this and therefore was able to receive the sustainability and transformation funding subject to activity performance. The position, however, relied on a planned lower run rate in the second half of the year. The Board agreed to take any questions after receiving the Finance Committee Chair's report. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	

Minute Ref	Item Number	Action
121/10/16	**Finance Committee Chair's Report (Item 6.2)**	
	The Board received the report from the meeting of the Finance Committee held in October 2016. Lisa Gardner reaffirmed that a considerable amount of the meeting was spent discussing the Trust's financial position for this year and that the position was only being achieved by utilising non-recurring items. Concerns were raised that this is not sustainable in future years. Members noted the discussions at the Finance Committee in relation to the progress against the Procurement Transformation Plan, including the key activities that the Trust needs to undertake to achieve the targeted performance improvement. **Members RESOLVED to:** • **Receive** the Finance Committee Chairs report for assurance.	
122/10/16	**Finance Committee Terms of Reference (Item 6.2b)**	
	Members received and approved the terms of reference for the Finance Committee and noted that they have been reviewed by the Finance Committee. **Members RESOLVED to:** • **Approve** the Finance Committee Terms of Reference	
123/10/16	**Quarterly Capital Project Status Report (Item 6.3)**	
	The Board received this report from Owen Ainsley and noted the progress in relation to the delivery of the Capital Programme which is governed through the Estates Capital Project Team and associated programme infrastructure. Members noted that the programme to vacate the Old Building has changed as Unite failed to secure planning permission for its development causing them a 12 month delay. A variation to the sale agreement has been agreed, removing the need for the Trust to vacate the building by 31 October 2016 and removing any financial penalties. Members noted that this change had taken the pressure off the King Edward Building project; however the Old Building was still due to be completely vacated by early December. Members noted the discussions with Bristol City Council regarding final details were preventing the remedial works to the pavement outside the new façade being completed; however this was expected to be resolved before the end of December 2016. Members noted that Public Health England had confirmed they will vacate the site on 21 November 2016 thus allowing the Level 8&9	

Minute Ref	Item Number	Action
	works to proceed to their revised programme. The Board had no comments on the report. **Members RESOLVED to:** • **Note** the for Quarterly Capital Project Status Report assurance	
124/10/16	**Governors' Log of Communications (Item 7.1)**	
	The report provided the Board with an update on governors' questions and responses from Executive Directors. **Members RESOLVED to:** • **Note** the Governors' Log of Communications.	
125/10/16	**Any Other Business (Item 8.2)**	
	The Board had no other urgent business.	
126/10/16	**Date of Next Meeting (Item 8.3)**	
	Tuesday 29 November 2016, 11-1pm, Conference Room, Trust HQ, Marlborough St, Bristol,BS1 3NU	

Chair's Signature: ..... Date: .....

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 31st October 2016
Action tracker

Outstanding actions following meeting held 31st October 2016					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1	**105/10/16**	**Chief Executives Report** Confirm the position of the North Somerset Health and Wellbeing Boards briefing on the Sustainability and Transformation Plan.	Chief Executive	November 2016	**Work in progress.**
2	**107/10/16**	**Board Assurance Framework Report Q2 2016-17 (Item 1.6)** Receive further assurance on the controls in place around access targets	Chief Executive	January 2017	**Work in progress.** Updates to be included in Quarter 3 report.
3	**109/10/16**	**Independent Review of Children's Cardiac Services in Bristol** Receive a monthly highlight report which includes the progress against the action plans.	Chief Nurse	Ongoing	**Work in progress.** Agenda Item 8.
4	**114/10/16**	**Transforming Care Programme Board** Receive an evaluation on the benefits experienced from use of the Happy App.	Chief Executive	January 2017	**Work in progress.** Update to provided at the January Board Meeting.
Completed actions following meeting held 31st October 2016					
5	**109/10/16**	**Independent Review of Children's Cardiac Services in Bristol** Receive draft action plans relating to the two cases reported by the Parliamentary and Health Service Ombudsman.	Chief Executive	November 2016	**Completed** Circulated to Board Members.
6	**87/09/16**	**High Risk Complaint** Receive update on Verita Report in relation to minute ref 20/07/16	Medical Director	November 2016	**Completed** Agenda Item 7.

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Public Trust Board	**Meeting Date**	29 November 2016
Report Title	Chief Executive Report		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff. c.	☒	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.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

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 November 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. Members are asked to: • **Note** the report.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees

Audit Committee	Finance Committee	Quality and Outcomes Committee	Remuneration & Nomination Committee	Other (specify)

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – NOVEMBER2016

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

The group **considered** a draft submission for the 2017/2018 Operating Plan of a performance trajectory for the Accident and Emergency 4-hour standard and agreed that the Chief Executive should sign off final submission on 24 November.

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

3. STRATEGY AND BUSINESS PLANNING

The group **noted** an update on the Operating Plan 2016/2017 and forward look for 2017/2018.

The group **noted** an update on the 2017/2018 Commissioning for Quality and Innovation (CQUIN) position.

The group **approved** proposals to the Recognising Success process for 2017, including a wider review of the approach to reward and recognition and exploring options for holding a staff open day.

The group **supported** the development of a new process for assessing adult mortality and unexpected death in hospital, subject to funding approval as part of the formal planning process.

4. RISK, FINANCE AND GOVERNANCE

The group **reviewed** the financial position of the Trust at month 7.

The group **approved** action cards for the Incident Response Plan.

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

The group **received** two low impact Internal Audit Reports in relation to Equality in Recruitment and WIFI Review and one medium impact in relation to Policy Management.

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 **noted** the Intellectual Property Policy for information.

The group **noted** staff guidance on attending Board Sub-Committees for information.

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

5. RECOMMENDATIONS

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

Robert Woolley
Chief Executive
November 2016

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Meeting Title	Public Trust Board	**Meeting Date**	**29 November 2016**
Report Title	Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital		
Author	Sean O'Kelly, Medical Director		
Executive Lead	Sean O'Kelly, Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

This paper is to update the Board on progress with the implementation of the Verita recommendations.

Key issues to note

Seven of the nine recommendations in the Verita report have now been completed. One action has been completed to the extent possible (R3) and one further action (R9) remains in progress while responses are compiled to questions formulated through a number of meetings with the family.

Recommendations
Members are asked to: • **Note** the report for information

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public ☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Update report to Trust Board, 29th November 2016

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 sets out a report on progress with the implementation of the recommendations contained within the Verita report, commissioned by the University Hospitals Bristol NHS Foundation Trust following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

2. BACKGROUND

Ben, who was born at 29 weeks' gestation on 17 February 2015, sadly died on the paediatric intensive care unit (PICU) at the Bristol Royal Hospital for Children on 17 April 2015, after a week on the unit.

His death was described as 'unexpected' and his cause of death was documented as:

"1a. Acute Respiratory Distress Syndrome
1b. Human Metapneumovirus Respiratory Infection
1c. Sepsis
2. Prematurity"

In a meeting with consultants, his parents found out on 4 June 2015 (seven weeks after his death) that he had had an infection (pseudomonas) that was not mentioned at the time. During the meeting, clinicians gave Ben's parents inaccurate information about the timing of blood tests in the days before he died.

3. PROGRESS SUMMARY

Seven of the nine recommendations in the Verita report have now been completed. One action has been completed to the extent possible (R3) and one further action (R9) remains in progress while responses are compiled to questions formulated through a number of meetings with the family.

A number of Trust Standard Operating Procedures produced through the work to complete the report's recommendations are included as appendices.

4. PROGRESS IN IMPLEMENTING THE VERITA RECOMMENDATIONS

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 followed up with the trainee doctor concerned. Action was not required or taken 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	**COMPLETE.** 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, **Appendix 1).** • use of the Patient Administration System 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. (Complete)
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	Director of Workforce	**ACTIONED.** The Trust's duty of confidentiality to its staff means the report itself cannot be released. As much as can be appropriately extracted for release was given to the family by

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.		the Medical Director in the 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.
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 **(Appendix 2).**
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	**COMPLETE.** New standard operating procedure (SOP) has been developed to clarify existing practice regarding the reporting and communication of laboratory results **(Appendix 3).** This includes the appropriate process for dissemination of information within departments when results are received. The final SOP was agreed at the Trust's Service Delivery Group on 3rd October 2016 and is being disseminated via Divisional Boards. 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	**IN PROGRESS.** 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. Four meetings with the family have taken place to date, totalling about ten hours altogether. These meetings have identified and refined a number of questions, which were presented to the Trust on the 9th November. The Women's & Children's Division have now begun work to provide responses to these questions. The Trust's Medical Director has communicated with family regarding the current position.

5. RECOMMENDATIONS

Members are asked to:

- Note the progress achieved with the implementations of the recommendations contained within the Verita report.

Dr Sean O'Kelly
Medical Director

Appendix 1.

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Standard Operating Procedure (SOP)
Child Death Review process

SETTING	Division of Women's & Children's Services
FOR STAFF	All Staff in the division of Women's & Children's Services
PATIENTS	All

1. Overview

The Child Death review process is the overarching prcoess by which child deaths are investigated at the Bristol Royal Hospital for children. It's broad principles are underpinned by statutory guidance (Chapter 5, Working Together, DE (2015)). Detailed guidance on all aspects of management of a child death may be found on the Child Death Procedures guidance page within the Community/General paediatrics section of Divisional clinical guidelines website Child Death Procedures. Detailed guidance relating to how the management of a child death interfaces with the Trust serious incident policy can be found within the Trust serious incident policy Trust Serious incident Policy.

2. General principles

- This guidance should be read in conjunction with the SOPs for 'Rapid Response', 'Root Cause Analysis', 'Action Plans', and the 'Management of the Interface between Complaints, Root Cause Analysis Investigations, Child Death Reviews and Inquests', and the Guidance for Bereavement Support (under development at time of approval).
- For the purposes of national data collection, an unexpected death is defined as one '*which was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death*'.
- In the ED setting an unexpected death should trigger a full multi-agency investigation as per the Child Death Procedures guidance. There will also be 'unexpected' deaths on the intensive care units which will require a full multi-agency investigation. This will be at the discretion of the PIC and NIC Consultant team.
- The Child Death Review Administrative Team are a part of the wider Divisonal Clinical Quality and Patient Safety Team, and work directly with the Lead Clinicians for Child Death at BRHC and St Michaels Hospital.
- A CDR is held for all children who die within BRHC.
- Key perfomance metrics for the review of child deaths are summarised in the annual report of the West of England Child Death Overiew panel, but include the holding of a child death review meeting within 3 months of the child's death.
- In the context of providing support to bereaved families, information regarding the CDR process will be given to families in the immediate period following the death of their child. The bereavement support service and the appropriate clinician/clinical team will ensure that this is coordinated on behalf of the family.
- If any concerns about the care provided to the child by the hospital are raised by the family, these will be immediately fed into hospital management processes and responded to as appropriate.
- The CDR process will include formal communication with the families as follows:
    - All parents are written to by the BRHC Bereavement service and invited to submit

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questions or concerns to the CDR meeting.
    - All parents are contacted after the CDR meeting and invited to attend a follow-up meeting where feed-back from the CDR process is provided.
- In advance of the CDR meeting, attendees should confirm any conflicts of interest that might impact upon objective review of the facts. At the start of the meeting, the Chair should reconfirm that the meeting is able to proceed with full objectivity. An example of a possible conflict of interest might be if the Chair of the meeting was also the child's named Consultant.
- The Chair of the meeting will be the Lead Clinician for Child Death. This will be the default arrangement unless it is anticipated that loss of trust in the service arising from identified service care issues is likely to lead to problematic eventual resolution of the case to the satisfaction of all parties. In such circumstances, an external chair might be considered. The preferred party for this role would be a lay representative identified through the RCPCH.
- It should also be noted that the Lead Clinician for Child Death will not chair the meeting if he/she has been involved in providing care to the child whose case is being reviewed. In this situation, an appropriate colleague will chair the meeting.
- At BRHC, a CDR meeting occurs in the follow manner:
    - A single child will be presented at each meeting.
    - The timing of the meeting will be arranged around the availability of the key professionals involved in the child's care.
    - The 'life course' of the child is reviewed to ensure that all contributory factors to the child's death are captured.
    - Input intelligence: Form B data from relvant professional groups, Post mortem data, SUI/RCA reports
    - Output: Notes of meeting, Form C summary report
- At St. Michaels, the review of neonatal deaths essentially follows the same principles except for:
    - Stillbirths and live born deaths are reviewed at a monthly neonatal mortality meeting, attended by members of the obstetric and midwifery department
- The draft notes of the meeting will be circulated for comment to those attending the meeting for a maximum period of 2 weeks before sign-off. Sign-off is the responsibility of the Lead Clinicians for child death at BRHC and St Michaels hospitals. These notes will form part of the patient record. The finalised set of notes will then be circulated to all relevant parties including the Coroner's office if relevant. The completed Form C dataset will be sent to the West of England Child Death Overview panel office.
- Responsibility for the enacting of agreed actions defaults to the relevant speciality governance team as described in the SOP for Action Plan management.
- All details relating to a child's death sit within the Medway database. This is kept up to date by the CDR administrator with support from the lead clinician for child Deaths at BRHC. The Medway IT team will provide support to the CDR administrative office to ensure continued automation of current data tracking systems. The Medway platform triangulates parallel processes (complaints, incident review, inquests) relating to a child death and tracks all progress relating to completion of actions in an evidential fashion.
- All actions associated with CDR reports are monitored by the Divisional Quality Assurance Committee.
- The BRHC CDR administrative office will undertake to provide bi-annual data to the Trust Clinical Quality Group and to write an annual report.

3. Monitoring

Monitoring of this SOP will be via an annual audit whereby the following parameters will be checked against all child deaths in a 12 month period:

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Child death	CDR held	CDR held within 3 months	Family meeting offered before	Family meeting offered after	Actions completed	Evidence of dissemination of learning

RELATED DOCUMENTS

SOP for Rapid Response Meetings
SOP for Formal Complaint Management
SOP for Root cause Analysis
SOP for Management of the Interface between Complaints, Root Cause Analysis Investigations, Child Death Reviews and Inquests
SOP for Action Plan Management

Appendix 2.

Procedure

LINK BETWEEN SERIOUS INCIDENTS AND OTHER INVESTIGATORY PROCEDURES (E.G. COMPLAINTS AND CHILD DEATH REVIEW)

SETTING	All settings where patients are cared for
FOR STAFF	All staff involved in the serious incidents for which another investigatory process (e.g. a complaint investigation or child death review) is running concurrently
PATIENTS	Any patient involved in an incident investigation and a further investigatory process.

1. Background

- When a patient is involved in a patient safety incident it is possible that additional investigatory processes will be triggered, alongside the Root Cause Analysis Investigation (as detailed in the SI Policy).
- This may occur as a result of the patient or their family making a complaint, or as a result of another statutory process requiring a form of investigation, such as the Child Death Review Process (see the SOP for the Child Death Review Process).
- The independent statutory reporting requirements associated with these three processes can be seen in figure 1.

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- This complex reporting structure can be difficult for families (and staff) to make sense of, especially when they are seeking answers to questions about the care they or their relative received.

- This SOP clarifies the interface between the different investigatory processes and outlines the process for ensuring that multiple investigations are consistent and accessible to both families and staff.

2. Support for families

- When something goes wrong in the provision of healthcare it can be extremely distressing for both the patient and their family. UH Bristol recognises this and wants to support patients and their families as effectively as possible.

- The role of the case manager, described below, is fundamental to the coordination and communication associated with any situation where more than investigatory process is underway.

- This person has responsibility for ensuring that those involved have an understanding of the statutory requirements the Trust is working to, how the Trust will bring in objectivity (this is usually via the Patient Safety Advisor but might be through an external review or expert opinion), the timescales that each investigation will be working to, what information they will consider, how the patient/family can input into the process and how they would like to receive feedback.

- In most cases the patient's clinical team will continue to be a source of support for the family and early meetings with the consultant/matron/Clinical Nurse Specialist are vital for maintaining relationships and ensuring that the patient/family has the support they need.

- Services may also be able to provide psychological support and referral to this discipline should be considered.

- LIAISE or the Patient Support and Complaints Team can also provide support and help families to articulate any questions that they may have about their care. Referral to a patient advocacy company may also be considered.

- Legal support is established independently to the hospital but LIAISE and the Patient Support and Complaints Team will have experience in this and be able to sign post patients/families where this is desired. This is also true for other agencies and charitable support groups that may be supportive to the situation.

3. Staff Support

- Being involved in an incident or clinical error can be one of the most challenging times in a healthcare professional's career; this can be made more difficult when multiple investigations are required to meet different statutory requirements.

- As above, the role of the case manager, described below, is fundamental to the coordination and communication associated with any situation where more than one investigatory process is underway. This person is also likely to be a point of support for staff who might be worried about any aspect of the investigatory processes.

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- The case manager has responsibility for ensuring that those staff involved have an understanding of the statutory requirements the Trust is working to, how the Trust will bring in objectivity (this is usually via the Patient Safety Advisor but might be through an external review or expert opinion), the timescales that each investigation will be working to, what information they will consider, how staff will be expected to input into the investigations, how the patient/family will be involved in the process, and how they, and the patient/family, will receive feedback.

- Support for staff will come predominantly from their line manager and their immediate colleagues. The line manager has a responsibility to ensure that they, and the staff member, are familiar with the related Trust policies and, using support from the case manager, know what is expected of their staff member.

- A debrief meeting might be appropriate, depending on the nature of the incident. This should be facilitated by an appropriate person. Members of the clinical psychology department may also be available to support individual or group staff debriefs.

- Appropriate time should be provided to the staff member to respond to, and participate in, the investigations.

- Consideration of the member of staff's ability to continue in work should be considered and referral to occupational health made as required.

- If there is a risk that the incident may result in a HR process being activated for a staff member, the line manager (who is most likely being advised by the case manager) should be upfront about this and enable the staff member to seek appropriate support, for example via their Union or medico legal representation.

4. Serious incidents and the formal complaints process

- Formal complaints will always be investigated in line with the Trust Complaints Policy.

- When an incident is identified as a result of a complaint the SOP for the identification of incidents and serious incidents from complaints and concerns should be followed to ensure appropriate incident reporting and investigation, in line with the Trust SI policy and the Trust Risk Management Strategy.

- If a formal complaint is raised immediately following an already-identified patient safety incident a **case manager** should be identified to ensure oversight of the two separate investigatory procedures. This is usually an experienced General Manager, who will work closely with the clinicians involved in the complainants care and the Patient Safety Advisor/Lead Clinician responsible for delivering the incident investigation.

- The case manager provides an administrative function, tracking progress and monitoring deadlines, in order to ensure that clinicians, and others involved in the complaint and/or incident investigation are providing information in line with the commitments made to the patient/family and/or Trust deadlines.

- This SOP does not apply if the incident investigation has already been completed when the complaint is received. In this circumstance, the formal complaints policy can be followed in

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isolation, using information provided in the completed incident investigation to respond to the complaint. This is important to ensure consistency.

- If it is clear the investigations will run concurrently, it is good practice for the case manager to contact the complainant and introduce themselves and their role in overseeing the two investigatory procedures. The incident investigation will be the "lead" investigation; this should be explained to the patient/family and their expectations should be managed with regard to the likely timeframes for completion.

- The case manager will review the complaint and ensure an investigation is commenced into any issues not included in the incident investigation. Information from the complaint will be shared with the Patient Safety Advisor/Clinician leading the incident investigation to ensure that the incident investigation has accurately captured all the patient/family's concerns associated with the incident. A further meeting of the incident investigation team with the patient/family at this point may be advisable. It should be noted that issues raised within the complaint that are not associated within the investigation of the incident should be responded to within the normal Trust deadline for a complaint response.

- The case manager should confirm to the family which issues will be included in the complaint response and which issues will be investigated as part of the incident investigation.

- If the family would like all the issues responded to together, the complaint response should draw on information from the incident investigation. In this situation, the patient/family should be advised of the longer timescale anticipated to allow for completion, and Divisional sign off, of the incident investigation.

- The case manager will lead on all aspects of communication between the family and the clinical team. This does not preclude clinicians from contacting the family but all communication associated with the investigatory processes must be notified to the case manager in order for this person to manage deadlines for responses and to ensure that information submissions are not duplicated or contradictory to each other.

- When the family wish to meet to have feedback from their complaint investigation, the Trust "Guidance for meetings with families to discuss concerns" should be referred to, to support the leading staff members (case manager, Patient Safety Advisor/Lead Clinician, others as appropriate) to hold an effective and supportive meeting with the patient/family.

5. Serious incidents and the Child Death Review (CDR) Process

For further information on the child death review process, please refer to the SOP for the Child Death Review process.

- Not all unexpected child deaths will be a result of an incident.

- Notification of all child deaths is made to the Quality and Patient Safety Team and LIAISE teams to allow for cross-referencing of existing incidents associated with that child and/or any informal concerns/complaints raised.

- Where it is clear an incident has occurred this will be reported and investigated in line with

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the Trust Serious Incident Policy

- Incident investigations which are the subject of a child death review will be signed off at the level of the Division before being released for inclusion in the child death review process. The timescales associated with gaining full sign off by the Clinical Quality Group and commissioners are likely to be prohibitive to the timely organisation of the CDR meeting.

- Where there is initial uncertainty as to whether there has been an incident which may have caused or contributed to the unexpected death, a rapid response meeting review, described in Appendix A of the Serious Incident Policy, will take place. Such meetings should be noted in the patient record.

- The rapid response meeting will be supported by a member of the Patient Safety Team, who has responsibility for writing up the report and taking forward the incident investigation with a Lead Clinician when an incident is identified or questions remain unanswered about a child's death.

- Should an incident (or serious incident) be identified as a result of the rapid response meeting, this will be reported and investigated in line with the Serious Incident Policy.

- In this situation, and in the absence of a formal complaint, the Patient Safety Advisor will become the **case manager**, undertaking the same role as described for item 4, above. This person assumes a lead role in communication with the family, working alongside the bereavement key worker (please also refer to the SOP "Supporting families following the death of a child" and "Supporting families … adults") to ensure that the family is aware of the incident investigation process, the child death review process and the interface between the two.

- When a formal complaint is also received by the Trust, case management reverts to the General Manager, as detailed under item 4, who will support the Patient Safety Advisor with the incident investigation, provide a full complaint response and work alongside the bereavement key worker to ensure that all communication with the family is coordinated and Trust deadlines are met.

- When a child has died, the outcome of an incident investigation will form part of the dataset presented at the CDR meeting. The Patient Safety Advisor/Lead Clinician overseeing the incident investigation will attend the CDR meeting to present the salient points arising from the incident investigation.

- The minutes, and resulting Form C report, from the CDR will form the overarching view of the circumstances pertaining to the death of the child.

- All documentation from the CDR process is uploaded on the Medway system under the patient's record. This allows for accessibility and sharing of information.

- Feedback to the family from the CDR is likely to follow the usual CDR process but be additionally supported by the Patient Safety Advisor/Lead Clinician. Where appropriate, feedback from the incident investigation and CDR reports may be combined. The Trust "Guidance for meetings with families to discuss concerns" should be referred to, to support the leading staff members to hold an effective and supportive meeting with the patient/family.

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6. Serious incidents and other investigatory processes

- Where other investigatory processes, such as regulatory or public health investigations, are commissioned the concept of a **case manager** should also be adopted.
- This is most likely to be an experienced General Manager who has a good understanding of the different investigatory processes.
- When the family wish to meet to have feedback from the investigation(s), the Trust "Guidance for meetings with families to discuss concerns" should be referred to, to support the leading staff members (case manager, Patient Safety Advisor/Lead Clinician, others as appropriate) to hold an effective and supportive meeting with the patient/family.

7. Executive Support

- All Serious Incidents have an executive lead identified. The Executive Lead should be kept appraised of the progress of the different investigatory processes, and any issues that are arising, by the case manager.
- In all instances, the Executive Lead will have a role in supporting the case manager to answer all the questions raised by the family, the Trust or the regulator, and ensure compliance with all relevant Trust policies. They will also act as a conduit between the Trust Board and any external agencies that may be involved, such as regulators or commissioners.

RELATED DOCUMENTS	Serious Incident Policy, SOP for the Child Death Review, Complaints Policy, Policy for the Management of Incidents, Guidance for meetings with families to discuss concerns, Support to families following the death of a child/adult, The Risk Management Strategy.
AUTHORISING BODY	Clinical Quality Group
SAFETY	No special considerations
QUERIES	Head of Quality (Patient Safety)

Appendix 3.

University Hospitals Bristol NHS
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Clinical Standard Operating Procedure (SOP)

REPORTING ABNORMAL PATHOLOGY RESULTS TO CLINICIANS

SETTING	Trust wide (24/7)
FOR STAFF	All staff who receive pathology results
PATIENTS	All patients who require pathology investigations

STANDARD OPERATING PROCEDURE

This SOP provides guidance on the reporting of markedly abnormal pathology results that should be telephoned direct to the requesting clinician by an appropriately trained and competent Healthcare Scientist or Consultant Pathologist. A markedly abnormal laboratory test result is a result that may signify a pathophysiological state, that may be life threatening or of immediate clinical significance and that requires urgent action.

Action required may include:

i) Immediate medical intervention or change in the patient's treatment

ii) Urgent referral for assessment

The responsibility of the laboratory staff is to telephone the markedly abnormal test result to the Nurse/Midwife in charge, or Consultant in charge. For high levels of rhesus antibodies, the transfusion lab will phone CDS and the on call neonatologist. For other specific results, the laboratory staff will give clear guidance on what steps need to be taken for the patient. In all other cases, it is the responsibility of the member of staff taking the details to communicate the details to all relevant members of the clinical team.

It is the responsibility of the clinical team to act upon that abnormal result in the interests of the patient.

Telephoning Results

When reporting a markedly abnormal result, laboratory staff will telephone the ward/department and ask to speak to the nurse in charge or the consultant in charge. The laboratory staff are then required to give the following information:

- The name and date of birth of the patient, together with any unique patient identifier
- The abnormal test result (and reference range if requested)
- The date and time of the request
- The name of the requesting clinician
- As much clinical history as is available from the request on ICE if recorded

Within the laboratory information system (LIMS) the following are recorded

1. Who the result was phoned to.
2. When the result was phoned (date and time) and by whom

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RELATED DOCUMENTS	Ward protocol required for how the result is acted on (if not directed by pathology)
AUTHORISING BODY	Service Delivery Group (SDG)- August/October 2016
SAFETY	No unusual or unexpected safety concerns (to staff or patient)
QUERIES	Contact Liz Worsam: ext 22575

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on 29 November 2016 11:00 -1:00 pm at in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NX

		Agenda Item	8
Meeting Title	Public Trust Board	Meeting Date	**29 November 2016**
Report Title	Independent Review of Children's Cardiac Services progress report		
Author	Cat McElvaney Cardiac Review Project Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary
This paper provides an update to Board members on development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. <u>Key issues to note</u> Progress on work to involve families and young people in the co-creation of actions and the governance of the programme

Recommendations
Members are asked to: • **Receive** report for Assurance; and • **To approve** the revised assurance framework.

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public ☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
Nil

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children (BRCH)

1.0 Introduction

This paper provides an update to Board members on development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan.

2.0 Programme management

The tables below details a high level progress update for the whole programme and for the three of the delivery groups. The plan shows that all actions will be complete by 30th June 2017. Reporting is a month in arrears this is to allow for validation and sign off of the action plans by the Steering Group each month before submission to the Trust Board.

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	CLOSED
Sept '16	0	0	16	1	11	4	
Oct '16	0	0	26	5	1	0	

Table 2: Status Women's & Children's Delivery Group (total= 18)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	CLOSED
Sept '16	0	0	13	1	4	0	0
Oct '16	0	0	15	3	0	0	0

1

Table 3: Status Consent Delivery Group (total= 5)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	CLOSED
Sept '16	0	0	1	0	1	3	
Oct '16	0	0	5	0	0	0	

Table 4: Status Incident and Complaints Delivery Group (total= 5)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	CLOSED
Sept '16	0	0	1		4	0	0
Oct '16	0	0	5	0	0	0	0

Table 5: Status Other Actions governed by Steering Group (total=4)

MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	CLOSED
Sept '16	0	0	1	0	2	1	
Oct '16		0	1	2	1	0	

3.0 Risks to Delivery

No risks to report to the Board.

4.0 Assurance Framework

The assurance framework, for closing recommendations approved by the Board at the last meeting has been refined to include an approval step by the Parents Reference Group. Please see appendix 1 for the revised assurance framework.

The request to close template has also been reviewed and amended by the Steering Group to reflect changes to the assurance framework, please see appendix 2. The section on evaluation and improvement has been strengthened to ensure there is a plan to further evaluate/audit or improve, where required, before a recommendation is closed.

5.0 Parent and young person's reference group and family involvement activities

- A draft Parent Representative Role and Responsibilities have been developed for parents who would like to act as a representative on the Steering Group. These

are due for review/approval by the W&C delivery group on 22/11/16. Parents have been involved in the development of these.

- A draft Virtual Parents Reference Group Terms of Reference have been developed with parental input, and are due for review/approval by the W&C delivery group 22/11/16.
- There are 15 projects in the action plan that have had, or will have, family involvement in the associated service developments.
- The virtual parent reference group are reviewing the content of our existing action
- A young person's involvement consultation has commenced to explore how they would like to get involved and feedback on where and how the Trust could further develop/ improve service provision.

6.0 Wider Communications

To help fulfil our commitment to openness and transparency the Independent Review page on the trust website has been updated with links to the monthly Trust Board paper which includes the detailed action plan. We are currently developing the webpage further to include more details on what activities to date to support delivery of the plan and further information on how patients and families can get involved.

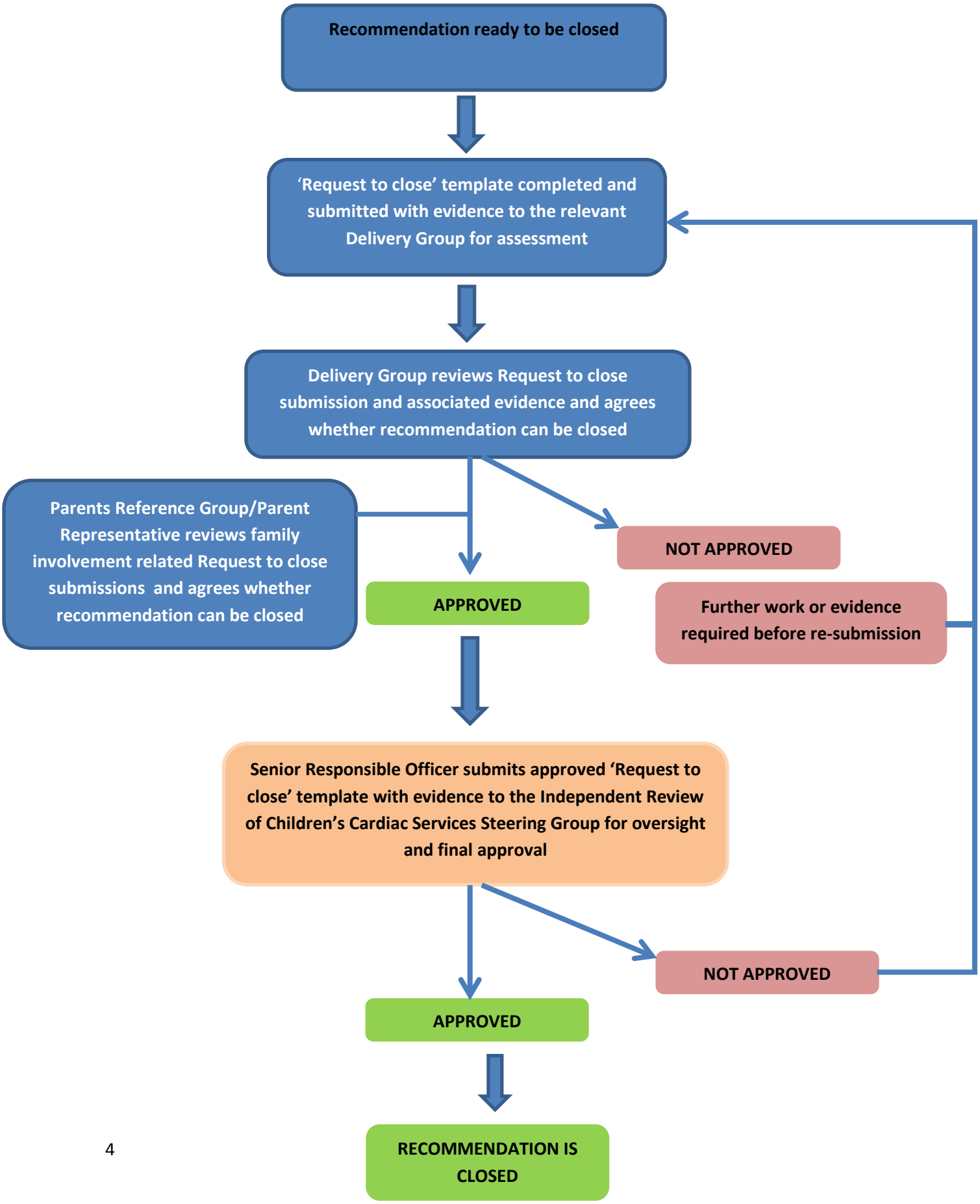
7.0 Recommendations closed

No recommendations were closed during this reporting period.

The Trust Board is recommended to:

- Receive the progress report
- Approve the revised assurance framework

Figure 1. Assurance framework for the implementation of the recommendations from the Independent Review of Children's Cardiac Services and CQC report



INDEPENDENT REVIEW OF CHILDRENS CARDIAC SERVICES STEERING GROUP

REQUEST TO CLOSE RECOMMENDATION FORM

PURPOSE This document is a request to the Independent Review of Children's Cardiac Services Steering Group to close a recommendation from the Independent Review action plan. The request to close will have already been presented to, and approved by the relevant delivery group. The Steering Group is responsible for assuring the Trust Board that recommendations have been completed fully with robust evidence to support closing.

REQUESTED BY

RECOMMENDATION

DATE REQUESTED

1.	**Recommendation no. and detail .**
2.	**Summary of why recommendation should be closed?**
	Please provide a summary of why the recommendation should be closed/how it has been fulfilled.
3.	**Evidence to enable closure.**
	Please detail the evidence to support the recommendation being closed and attach to the email along with this request form.
4.	**Actions completed.**
	Please give the high level actions undertaken to fulfil the recommendation- these should mirror what is on the delivery group action plan for this recommendation.
5.	**Please give details of family representatatives and staff who have been involved in the actions.**
	Please indicate whether staff and family representatives have been involved in the actions to deliver this recommendation and how they have been involved.
6	**Benefits of implementing this recommendation**
	Please detail any benfits from implementing this recommendation including any patient, family, staff, organisation benefits.
7	**Please indicate ongoing evaluation/ audit /improvement work planned and what group/committee will monitor/govern this work**
	Please ensure there is a plan to evaluate the impact of implementing the recommendation and also any further work that is planned around this area that will deliver over and above what has been recommended Please indicate what committee or group will monitor/govern delivery of this work.

APPROVAL STATUS

For completion by the Delivery Group

Name of delivery group:

Date reviewed	Approved/not approved	Rationale

For completion by the Parent Representive Group/Parent Representative

Name of Parent Representatives:

Date reviewed	Approved/not approved	Rationale

For completion by Independent Review of Childrens Cardiac Services Steering Group

Date reviewed	Approved/not approved	Rationale

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – October 2016

1. Women's and Children's Delivery Group Action Plan, Senior Responsible Office: Ian Barrington, Divisional Director

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
2	That the Trust should review the adequacy of staffing to support National Congenital Heart Disease Audit (NCHDA) audit and collection of data.	General Manager for Cardiac Services	Apr '17	**Blue- on target**	None	n/a	Review of staffing	Assistant General Manager for Cardiac Services	Sept '17	**Green- complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Cardiac Services	Sept '17	**Green- complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Cardiac Services	Apr' 17	**Blue- on target**	Expression of interest form and Women's and Children's Operating Plan
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	Specialist Clinical Psycholog ist	Apr '17	**Blue- on target**	Risk that we are unable to complete a visual diagram of pathway due to technical constraints and permission to change website and	n/a	Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green- complete**	Revised patient information leaflets
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Blue- on target**	Revised Catheter and Discharge leaflet
							Enhance existing information with a visual diagram displaying pathways of care.	Specialist Clinical Psychologist	Apr' 17	**Blue- on target**	Pathway of Care accessible visual

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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.				funding to do it		Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. This will be additional and not essential for delivery of the recommendation	Specialist Clinical Psychologist and LIASE Team leader	tbc		
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	Congenital Heart Disease (CHD) Network Clinical Director	Apr '17	**Blue- on target**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies	n/a	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: a. Commissioner oversight of network b. Commissioner support for IR actions (4,5 &11) c. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Blue- on target**	Agreed pathway of care in line with new CHD standards and in line with patient feedback
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Blue- on target**	
							Working groups to define changes / new pathways, taking account of patient feedback	Working groups	Jan '17	**Not started**	
							Undertake patient survey and focus groups (FI)	CHD Network Manager	Jan '17	**Not started**	
							New pathways in place (Jan – Apr)	CHD Network Clinical Director and Network Manager	Apr '17	**Not started**	Summary paper showing previous and new ways of working, detailing an assessment of the benefits

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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.	CHD Network Clinical Director	April '17	**Blue- on target**	As above	n/a	Linked to recommendation no. 4. Actions detailed under recommendation no. 4 will also achieve recommendation no. 5				
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.	General Manager Cardiac Services	Jan '17	**Blue- on target**	None	n/a	Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan (completed Aug '16)	Patient Safety Manager	Aug '16	**Green- complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Blue- on target**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Not started**	Audit presentation and Cardiac Clinical Governance Agenda and minutes January meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting (completed Aug '16)	Assistant General Manager for Cardiac Services	Aug '16	**Green- complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
8	The Trust should monitor the experience of children and families to ensure that improvements in the organisation of outpatient clinics have been effective.	Chief Nurse and Project Lead for Children's Services	Oct '16	**Green-complete**		n/a	Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green-complete**	Outpatient Experience Review paper September 2016, Women's and Children's Delivery Group meeting agenda and minutes 20.09.16
							Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green-complete**	
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Blue- on target**	Women's and Children's Outpatients and Clinical Investigations Unit standard agenda
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	Women and Children's Divisional Director	Jan'17	**Blue-on target**	Risk that other sites are unable to share data required to complete a comprehensive	n/a	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 (Jan)	CHD Network Manager	Jan '17	**Blue- on target**	
							Identification of actions required to address the gaps (end Jan)	CHD Network Manager	Jan '17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.				benchmarking exercise Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.		Progress to implementing any changes in practice that are deemed necessary	Women and Children's Divisional Director and CHD Network Manager	Jan '17	**Blue- on target**	
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	Network Clinical Director	Jan'17	**Blue- on target**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9						

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)										
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.	Clinical Lead for Cardiac Services and Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**			Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Paediatric Cardiac Surgeon and Specialist Clinical Psychologist	Dec '16	**Blue- on target**	
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.	General Manager for Cardiac Services	Nov '16	**Blue- on target**			Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure (completed Aug '16)	Cardiac Review Programme Manager	Aug '16	**Green- complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented (Nov '16)	Paediatric Cardiac Surgeon and Cardiac Review Programme Manager	Nov '16	**Blue- on target**	
20	That the Trust should set out a timetable for the establishment of	General Manager for Cardiac	Nov '16	**Blue- on**	None		End-of-life care and bereavement support pathway developed (FI)	General Manager for Cardiac Services	Sept '16	**Green- complete**	End-of-life and bereavement support pathway

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	appropriate services for end-of-life care and bereavement support.	Services		**target**			Implementation and roll out of new pathway	General Manager for Cardiac Services	Dec '16	**Blue- on target**	
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support	Commissioners					Previous submission to commissioners for psychological support updated (Sept '16)	Consultant Clinical Psychologist	Sept '16	**Green- complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Consultant Clinical Psychologist and General Manager for Cardiac Services	Apr '17	**Blue- on target**	Expression of interest and W&C Business plan
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.	General Manager Cardiac Services	Dec '17	**Blue- on target**	None		Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management	General Manager for Cardiac Services	Sept '16	**Green- complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff (on going)	Patient Safety Team Manager	Dec '16	**Blue- on target**	
CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Cardiology Clinical Lead	Nov '17	**Blue- on target**			ECHO form for reporting in theatres implemented	Consultant Cardiologist	Aug '16	**Green- complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	Nov '16	**Blue- on target**	
CQ C. 3	Recording pain and comfort scores in	Ward 32 Manager	Aug '16	**Green- complete**			Documentation developed to record pain scores more easily	Ward Manager	tbc	**Green- complete**	Nursing documentation

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	line with planned care and when pain relief is changed to evaluate practice						Complete an audit on existing practise and report findings	Ward Manager	Aug '16	**Green- complete**	Audit of nursing documentation
CQ C. 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)	Head of Nursing, Women's and Children's	Dec '16	**Blue- on target**			Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	Dec '16	**Blue- on target**	
CQ C. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Cardiology Clinical Lead	Apr '17	**Blue- on target**			*Links to cardiac review recommendation no.3*				
CQ C.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professional	Jan '17	**Blue- on target**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services (Oct '16). Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professional	Oct '16	**Blue- on target**	Assessment documentation
							Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professional and Cardiology Clinical Lead	Nov'16	**Not started**	Agreed mechanism for including AHP advice into discharge planning for children within

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
						Services					Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professional and Cardiology Clinical Lead	Jan 17	**Not started**	Implementation plan delivery report

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

2. Trust wide Incidents and Complaints Delivery Group Action Plan – Senior Responsible Officer; Helen Morgan, Deputy Chief Nurse

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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.	Chief Nurse	Jan '17	**Blue- on target**			**26.1** Develop an appendix to the Serious Incident (SI) policy defining "link" between Child Death Review (CDR), complaints and SI investigations / reporting.	General Manager for Paediatric Cardiac Services	July '16	**Green- Complete**	
							26.2 Develop and implement guidance for staff on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of a bereavement.	General Manager for Paediatric Cardiac Services	Dec '16	**Blue- on target**	
							26.3 Develop 'guidance' / information for **families** how the x3 processes of Child Death Review (CDR) / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate ***(FI)***	Patient Safety Team Manager	April '17	**Blue- on target**	
							26.4 Develop 'guidance' / information for **staff** on how the x3 processes of CDR / SI / RCA investigation inquests and complaints are initiated / managed and integrate	General Manager for Paediatric Cardiac Services	Dec '16	**Blue- on target**	
							26.5 Develop the above **staff** guidance for adult patients and families (minus CDR).	Head of Quality (Patient Safety)	tbc	**Not started**	
							26.6 Develop the above **family** guidance for adult patients and families (minus CDR).	Head of Quality (Patient Safety)	tbc	**Not started**	
							26.7 Develop a process of identification of a 'case manager' / 'key worker' and 'medical lead' for families / patients undergoing / involved in a number	Head of Quality (Patient	Apr '17	**Not started**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							of complex process to be a defined point of contact co-ordinating a communication with the family / patient- **Adult** services	Safety) and Head of Quality (Patient Experience and Clinical Effectiveness)			
							26.8 As above- **Children's** services	General Manager for Paediatric Cardiac Services	Dec '16	**Blue- on target**	
							26.9 Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options ***(FI)*****.**	Head of Quality (Patient Safety)	June '17	**Not started**	
							26.10 Implement a process for gaining regular feedback from patients / families involved in a SI RCAs process to understand what it felt like for them and how we can improve the process for them	Head of Quality (Patient Safety)	Jan '17	**Not started**	
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.	Chief Nurse	June '17	**Blue- on target**			**27.1** Guidance developed to medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed	Medical Director	Aug '16	**Green- completed**	
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				
							Develop a framework for training staff to support them to effectively and sensitively manage processes relating to CDR/SI's and complaints	Tbc	June '17	**Not started**	
28	That guidance be drawn up which identifies when, and if so, how, an	Chief Nurse	Dec '16	**Blue- on target**			To review UHBristol's previous use of independent review / benchmarking from other trusts to inform above. - Complaints	Patient Support and Complaints		**Green- complete**	Report of the

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	'independent element' can be introduced into the handling of those complaints or investigations which require it.						- RCA's	Manager and Patient Safety Manager	Nov '16 Nov '16		review undertaken
							Develop guidance for when to access 'independent advise / review' for - Complaints - SI RCAs	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Oct '16 Dec '16	**Blue- on target**	Complaints policy SI policy
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.	Chief Nurse	Apr '17	**Blue- on target**			Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green- complete**	Complaints policy
30	That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in	Chief Nurse	Dec '16	**Blue- on target**			Develop a clear process with timescales trust-wide for feedback to families / patients outcomes involved in SI panels / review and actions ongoing from this and staff ***(FI)***	Head of Quality (Patient Safety)	Apr '17	**Not started**	
							Inclusion in complaints to get responses as to how complainants can get (where appropriate) involved in developing local solutions to issues raised ***(FI)***	Head of Quality (Patient	Oct '16	**Green- complete**	

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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.							Experience and Clinical Effectiveness)			

Key	
R	Red - Milestone behind plan, impact on recommendation delivery date and/or benefits delivery
A	Amber - Milestone behind plan, no impact on recommendation delivery date and benefits delivery
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)

3. Trust wide Consent Delivery Group Action Plan – Senior Responsible Officer: Jane Luker, Deputy Medical Director

	Progress overview	Detailed actions

No.	Recommendation	Lead Officer	Completion date of recommendation	Status	Delivery Risks	Revised timescale & reason	Actions to deliver recommendations	By	When	Status	Evidence
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.	Medical Director	Dec '16	**Blue on target**			**12.1** Guidance developed to medical staff to ensure patients and families are given the option to record conversations when a diagnosis, course of treatment, or prognosis is being discussed	Medical Director	Aug '16	**Green-completed**	Medical Staff Guidance
							12.2 Review of new existing guidance to reflect the recommendation	Deputy Medical Director	Nov '16	**Blue- on target**	
							12.3 Incorporate new guidance into existing Children's Consent pathway (existing letter that goes to families before their surgical appointment) (FI)	Consultant Paediatric Cardiac Surgeon	Dec '16	**Blue- on target**	
13	That the Trust review 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	Deputy Medical Director	Jan '17	**Blue-on target**	E-learning lead is currently on learn term sick which has led to a delay in updating e-learning material		**13.1** Trust wide Consent delivery group set up	Deputy Medical Director	Sept '17	**Green-Completed**	Terms of reference for Trust Wide Consent Group
							13.2 Review the consent policy and agree a re-write policy or amend existing policy to ensure patients and clinicians are supported to make decisions together	Consent Group	Oct '16	**Blue-on target**	Revised consent policy ratified by COC
							13.3 Develop training and communication plan	Deputy Medical Director	Dec '16	**Blue on Target**	Training and communications plan
							13.4 Advice from legal team and safeguarding on revised consent policy and e-learning	Deputy Medical Director	Dec '16	**Blue on track**	Legal and safeguarding assurance confirmation
							13.5 Update e-learning for any changes to consent policy and process	Deputy Medical Director	Jan '17	**Blue on track**	Updated E-learning package for consent

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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	Deputy Medical Director	**Linked to recommendation no. 13, actions, timescales and status as detailed under this recommendation – Blue on target, date completion scheduled Jan '17**								
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	Deputy Medical Director	May'17	**Blue- on target**			**17.1** Anaesthetic group to be set up to review current practise in pre-op assessment in relation to consent for anaesthesia and how they can implement a consent for anaesthesia process trust wide (FI)	Consultant Paediatric Cardiac Anaesthetist	Dec '16	**Blue on target**	
							17.2 Liaise with Royal College of Anaesthesia and other appropriate professional bodies with regarding national policy	Paediatric Anaesthesia consent group	Jan' 17	**Not started**	
							17.3 Implementation plan for trust wide consent process	Paediatric Anaesthesia consent group	May '17	**Not started**	
CQC. 1	Recording the percentage risk of mortality or other major complications discussed with	Deputy Medical Director	Jan' 17	**Blue- on target**			**1.1** Review trust wide consent form in use to agree whether they should be amended to improve recording of risk	Consent Group	Dec '17	**Blue- on target**	

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	parents or carers on consent forms										
							1.2 Paediatric Cardiac Services to agree whether service would benefit from a bespoke cardiac consent form that includes percentage risk	Consultant Paediatric Cardiac Surgeon	Nov '16	**Blue- on target**	
							1.3 Cardiac Services- agree and implement process for discussing percentage risk with families (FI)	Consultant Paediatric Cardiac Surgeon	Nov '16	**Blue- on target**	

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4. Other Actions Plan – governed by the Independent Review of Childrens Cardiac Services Steering Group

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
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.	Trust Secretary	Sept '16	**Green-complete**			Review of current arrangements and processes (Sept '16)	Trust Secretary	Sept '16	**Green-complete**	Executive Lead Role description
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.	Commissioners and Trust	Tbc	Tbc			Discussion with commissioners on how best to achieve this	Commissioners and Trust	Oct '16	**Tbc**	
31	That the Trust should review the history of recent events and the	Chief Nurse	Oct '16	**Green-complete**			Trust board paper presented in July acknowledging the role which parents have played in bring about significant	Chief Executive	July '16	**Green-complete**	Trust Board Paper and Trust Board Agenda,

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	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.						changes in practice and in improving the provision of care				July '16
							Presentation to Health and Overview Scrutiny Committee	Chief Executive, Medical Director, Chief Nurse and Women's and Children's Divisional Director	Aug '16	**Green- complete**	
							Presentation to the Bristol Safeguarding Children's Board	Chief Nurse	Oct '16	**Green- complete**	
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.	Medical Director	Dec '16	**Blue- on target**			Adoption of the term "Safety of Patients" in place of "Patient Safety" going forward and communication of preferred term Trust wide (Dec '16)	Medical Director	Dec '16	**Blue- on target**	

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Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11:00 am -1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Meeting Title	Public Trust Board	**Meeting Date**	29 November 2016
Report Title	Interim Annual Report for Children's Services		
Author	Ian Barrington, Divisional Director; Rebecca Dunn, Deputy Divisional Director and Jonathan Lund, Divisional Finance and Business Development Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	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.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

An Annual Report requested by the Trust Board to raise awareness of major successes, challenges & opportunities facing Children's Services. A supporting presentation will be given at the meeting by Ian Barrington, Divisional Director, Women's and Children's Services.

Key issues to note

The breadth of successes across Children's Services over the last 12 months and the key conclusion that Children's Services are meeting our strategic objectives and improving the quality of care each year.

Reflections on the Independent Review into Paediatric Cardiac Services.

The over-riding challenges of managing with ever constrained resources, the rising expectations of patients and their carers, and the Bristol Royal Hospital for Children consistently operating at near full capacity.

The need to incorporate Children's Services into Sustainability & Transformation Plans for BNSSG and other regional STPs. Alongside the opportunities presented by national reviews of Paediatric Critical Care and Paediatric Surgery, and national commissioning policies for Congenital Cardiac Services and Paediatric Neurosurgery.

Recommendations

Members are asked to:

- **Note** the contents of this report and support its publication to wider stakeholders of Children's Services

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

University Hospitals Bristol NHS
NHS Foundation Trust

Children's Services at the University Hospitals Bristol NHS Foundation Trust

Interim Report - October 2015 to September 2016

Bristol Royal Hospital For Children

University Hospitals Bristol NHS
NHS Foundation Trust

Contents:

Bristol Royal Hospital For Children

1. Welcome and Introduction

We are pleased to present the Interim Annual Report for Children's Services October 2015 to September 2016. This report covers the achievements, pressures and opportunities arising over the last twelve months. This is second Annual Report that has been presented to the Trust Board. The intention is to publish a full report in Summer 2017 to cover the preceding 18 months and then move to an annual cycle of financial years in line with business planning and Trust Annual Report timetables. The report again focusses on Children's Services provided at Bristol Royal Hospital for Children, the Department of Paediatric Audiology and Regional Neonatal Intensive Care Unit based at St Michael's Hospital. In the Summer report we also intend to introduce a focus on those Children's services delivered with great passion and skill at Bristol Dental Hospital, Bristol Eye Hospital and the purpose-built Teenage & Young Adults Cancer Centre.

Over the last 12 months we have identified 8 key commitments, and positive progress is being made in all of these domains, we hope the Interim Annual Report gives a flavour of the successes and challenges we face; and the dedication & hard work that all our teams deliver every day:

1. Patient safety – we will improve our approach to risk management and governance, building our patient safety infrastructure to support clinical teams.
2. Patient experience – we will deliver a 7 point plan designed to ensure that what our patients' say is at the heart of what we do.
3. Quality of care – our overriding ambition is to provide all patients and families who use our services with the highest quality individual care each time they are in contact with us.
4. Staff engagement – our operating plan will only be delivered if our staff feel valued and engaged. Starting with the "conversations" we are committed to embedding our staff experience programme.
5. Research and education – we have refreshed our strategies in both of these key areas and in 2016/17 intend to develop our capacity and capability.
6. Performance – we are committed to delivering all access standards as laid out in the NHS constitution.
7. Financial sustainability – we recognise the current financial position is not acceptable; and the need to go further in our thinking to identify further savings and efficiencies.
8. Strategic delivery – our focus will be on our three strategic and transformational priorities:
    a. Local system partnership,
    b. Regional system partnership and
    c. Developing our tertiary specialities

The introduction would not be complete without reference to the prolonged period of close scrutiny on our paediatric cardiac services. The report of the independent review, led by Professor Sir Ian Kennedy, was published earlier this year and will have a far reaching impact on not just the cardiac service itself but also on the Children's Hospital, the Trust and the NHS as a whole. Our task has been to learn from the report's recommendations, implement further change where required, provide reassurance to patients and their families and support our staff. We view the report as a positive opportunity to move our services forward.

Bryony Strachan, Clinical Chair, Division of Women's and Children's Services
Ian Barrington, Divisional Director, Division of Women's and Children's Services

Bristol Royal Hospital For Children

2. Success and Challenges

2.1 Successes

The major changes to the Children's Hospital funding and infrastructure created by the Centralisation of Specialist Paediatrics transfer have enabled many services to flourish, notably in a number of cross-hospital services such as palliative care & bereavement support; the last 12 months contained many individual successes set out below:

- A very proactive recruitment campaign, and then emphasis on supporting and settling in new employees are improved the nurse staffing levels over the year. Over 100 new nurses joined the team during this period, an increase of registered and unregistered nurses from 795 whole time equivalents to 822 whole time equivalents over the period. The programme has included hosting Open days, personal follow up with nurses moving from other Universities and Trusts, nurse preceptorship and mentoring programmes, & development of Clinical Skills Facilitators role. In addition, this year we have introduced rotational posts through our dedicated HDUs and are working with our partners – Children's Hospice and Jessie May Trust – with the introduction of the Palliative Care rotational posts.

SPOTLIGHT ON… Palliative Care and Bereavement Support

Drawing on direct service user experience, and with engagement from across Children's and Neonatal Services, information available to families and clinicians has been enhanced and a "core offer" of bereavement support has been described that will be available to *all* families, regardless of the circumstances in which their child dies. The Paediatric Palliative Care team, established in 2015, has been further enhanced to provide bereavement support to all families that suffer the death of a child whilst under the care of the Children's Hospital. Our Palliative Care and Bereavement Support Team are already gaining a national profile for the excellent work that they are doing.

- Professor Ramanan's work into Severe Uveitis has been quickly translated from a successful NIHR research project into NHS England clinical policy in record time; showcasing the value of translational research in the NHS.
- The success of last year's inaugural Children's Services Annual Report has added momentum and enthusiasm to many individual teams developing their own Annual Reports, which are a great way of engaging staff, reflecting on successes and challenges over the period, setting strategy for the future and working in a multi-disciplinary way. Many of these have allowed teams to showcase their work at the Children's Hospital Governing Executive Committee including Neurosciences Advanced Nurse Practitioners, Clinical Site Team, Paediatric Medical Specialties, Paediatric Major Trauma Service and Paediatric Critical Care Services. The Children's Hospital Governance Committee has also received a rolling programme of Specialty Governance Reviews.
- Consultant recruitment has once again been successful with many high calibre appointments, including attracting staff from other Hospitals; and most satisfactorily appointing, after competitive processes, a number of consultants from that were trained in the Hospital.
- We continue to deliver more activity year on year in Children's Services and, for this reason, operational management of the Children's Hospital has taken a front seat for a second year running. Everyone is working to ensure the effective and responsive management of our patients on a daily basis. Steps taken in the last 12 months include: the establishment a senior nurse into a Clinical Operational Lead role with responsibility for oversight of the site and delivery of smooth operational pathways; the development of an electronic Situation Report (SitRep), which includes predictions on emergency activity not previously achieved; a refreshed Flow Programme with strong engagement from clinicians from all corners of the hospital;

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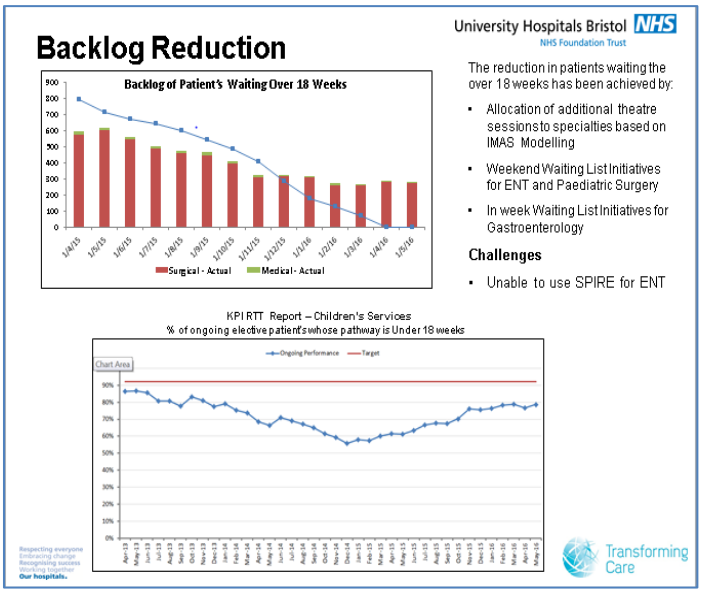
and all the extreme escalation policies have been updated and improved. Supported by a daily briefing involving all the Ward Sisters, communication hospital wide is strong regarding operational matters and the competency and consistency of our Clinical Site Team has notably improved.

- Staff Survey Results demonstrated improvement in 85% of the questions between 2014 and 2015. Particular improvements were reported as management's interest in staff health and wellbeing, staff incidents of feeling unwell due to stress and anxiety and reports of discrimination. More staff reported they felt enthusiastic about their work, which was also supported in the Staff Friends and Family test, where again an improvement between 2014 and 2015 was noted in staff recommending their place of work.

- The South Wales and South West Congenital Heart Services Operational Delivery Network has been established. A very successful welcome event was hosted with very positive engagement across the whole region, and is now providing a platform for monitoring compliance with new national standards, ensuring standard pathways and sharing clinical information. It is hoped that this is a model that can be developed for the other tertiary children's services that provide care across the wider region.

- In 2015/16, we successfully reduced many of the waiting lists for children's surgery to sustainable levels, a major achievement. In 2016/17 maintaining this momentum has been challenging as we have sought to expand a number of our complex surgical specialties, such as Cardiac, Neuroscience and Spinal. As well as recognising the pressures that working at this pace has placed on the reliance and sustainability of our hard working Theatre nurses and operating department practitioners.



- Mark Goninon was successful in securing our Head of Nursing position for Children's Services and he started in September 2016.

- We formally opened the Children's Changing Place bathroom which enables children with complex disabilities who attend our hospital as outpatients or as siblings, to have a dedicated space where their families can appropriately care for them.

- The Trust signed a partnership agreement with other local NHS providers to bid to Child and Adolescent Mental Health and Children's Community Health Services across Bristol & South Gloucestershire. The partnership was announced as preferred bidder and is hoping to sign a contract to run services from April 2017 under a prime contractor model led by Sirona Health.

- The digitalisation of medical records using the Evolve system was successfully rolled out to the Children's Services and new electronic information systems were successfully implemented within NICU and PICU.

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- Staff & Family Engagement has been central to the agenda this past year and we have stepped up our programme of activities as a Division; listening events are being run in a number of Children's Services, a parent reference group for Paediatric Intensive Care has been established, Conversations week (see Spotlight On) took place, a Patient Involvement and Experience group was set up, and the Children's Hospital launched its own Facebook page. The LIAISE team was also strengthened with a further position specifically to support activities around social media.

- New Advanced Nurse Practitioners jobs have been created in Critical Care Transport and Oncology/Haematology. These add a new skill set, have replaced medical roles, provide more career pathways for experienced nurses and offer a solution to the problems of junior doctor recruitment and rota sustainability.

SPOTLIGHT ON… The Independent Review of Children's Cardiac Services

This report on Children's Cardiac Services looks at the care delivered to Cardiac patients at the Children's Hospital between 2011 and 2014. It was received at the end of June 2016. The report has provided opportunity for reflection on the work that has been done to improve our services over this time and where we need to continue to make positive changes within the Division, the Trust and the wider NHS that will improve patient care and experience. A plan to deliver the recommendations made by the review by June 2017 has been established within the Trust. This plan is being closely monitored by a steering group, chaired by the Chief Nurse, and delivered by 3 distinct delivery groups focused on women's and children's services, incidents and complaints management, and consent, respectively. A new parent and young person's reference group will enable parents and patients to help shape the future of Cardiac Services across the South West and South Wales Network.

2.2 Remaining Key Challenges

- Growth in emergency demand and the associated capacity constraints continue to present big challenges. There were 40,368 Children's A&E attendances in the period, up from 36,842 (9.6% increase, understood to mainly by change in referral patterns from GPs and facilities in the old Frenchay Hospital catchment area. Whilst 2,307 more patients were seen, treated or admitted in less than 4 hours than ever before unfortunately performance against the Government's flagship performance standard dropped from 92.8% to 90.4%
- A growing trend of the last few years has been the management of highly complex complaints and associated adverse media coverage. Whilst the service always strives to meet the needs of patients and families, and has at time fallen short of these standards, the burdens of personal and professional scrutiny, and amount of resources and capacity pressures placed on clinical and managers has been at time overwhelming.
- Despite attempts to secure an interested candidate into the Clinical Director Role for Paediatric Surgery, this role remains vacant.
- Whilst most training jobs are filled for major specialties in the Children's Hospital the recruitment and delivery of sustainable rotas for Junior Doctors remains very challenging. A number of surgical rotas are declaring non-compliance with European Working Time Directive standards; and the Hospital at Night resident rota is often operating one member of staff down. An increasingly part time workforce is a major driver of this challenge.

- The highly successful and national recognised programme for Selective Dorsal Rhizotomy neurosurgery for Cerebral Palsy was sadly not routinely commissioned by NHS England after a 2 year "Commissioning through Evaluation" programme. Whilst there is early evidence of positive outcomes of this work, the commissioners have insisted on a two year moratorium whilst they evaluate the programme. This left many families disappointed, and whilst the service has been offered as a private service many families cannot afford this and it is increasingly challenging to maintain the clinical skills during the period of uncertainty.

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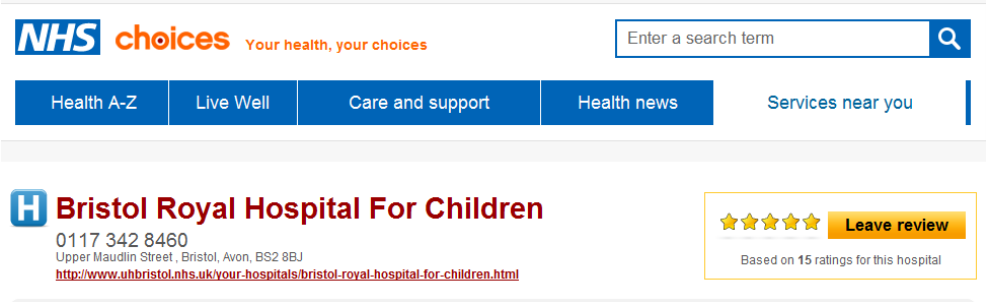
- Lack of Parent Accommodation options since the expansion of the inpatient bed base is consistently flagged by families as a cause of concern. Whilst our charitable partners are very committed to supporting this agenda in the immediate term, this is a cause of distress and inconvenience to our patients.
- Children's Theatres has been through a significant period of change and growth (volume and complexity) over the last two years. This has led to a big challenge in nurse recruitment and retention. At the end of October 2016 there are 16wte substantive nurse vacancies (18% of required workforce) and a consistent reliance of agency staffing to support capacity. There is also a need to cancel elective surgical lists.
- Meeting and sustaining 90% compliance in Level 3 (core and specialist) Children's Safeguarding Training has not been achieved. Individuals and teams are working hard to ensure staff are appropriately trained but this remains an ongoing concern which is on the risk register.
- During the period of this report, we were unable to open Ward 38b neuro-rehabilitation owing to staffing numbers – however plans to open in November 2016 are well underway to see this ward area established.

3. Business Review

3.1 Quality & Clinical Governance

Quality and excellent governance remain at the heart of all we do and further strides have been taken in this arena over the past 12 months.

- Overall patient feedback has been excellent within Children's Services and this is very publically seen on the NHS Choices website, where we achieve a 5 star rating. An improvement from 3.5 stars seen in previous years.

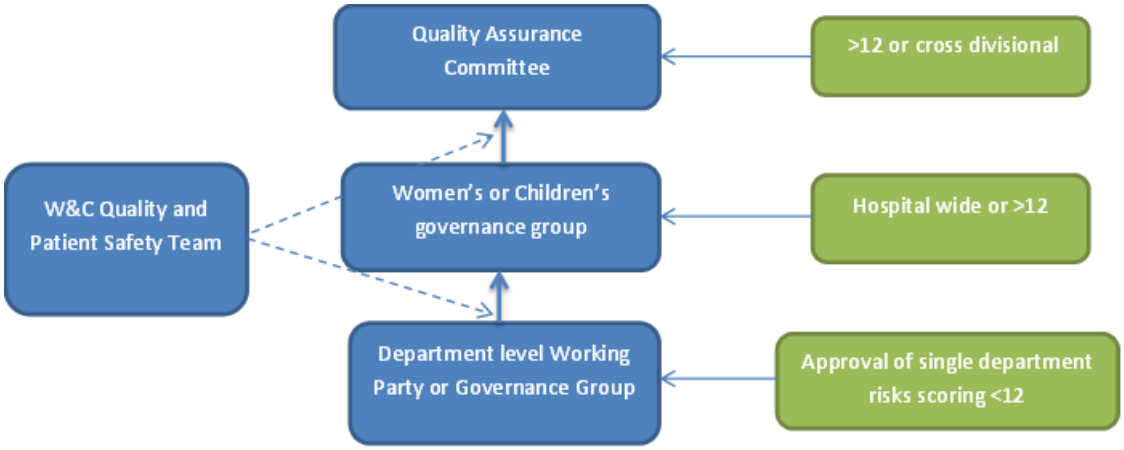


- There have been no avoidable CDiff positive patients within the timeframe of this report.
- There have been no hospital acquired Grade 3 pressure ulcers in The Children's Hospital within the timeframe of this report; there have however, been 3 hospital acquired grade 2 pressure ulcers reported which were equipment related – the leaning form these has been used to change practice.
- 100% of SI investigations completed were completed within timescale and positive feedback has been received about the quality of the RCA reports being produced for Children's Services.
- The development of standard operating procedures for complaints management, the child death review process and the "Link between SI investigations and other investigatory processes SOP" (an appendix to the Trust SI Policy) is supporting staff to improve the way in which information is made available to families and multiple investigations are handled by the organisation, something that is frequently found in paediatric services.
- There was one Never Event which involved a medicine being administered via the wrong route; an RCA investigation highlighted the need for independent checking of medicines and this learning has been used Trust-wide.

SPOTLIGHT ON… Sign up to Safety

The Paediatric Emergency Department has successfully implemented a screening tool for sepsis, which has been embedded into Medway and is used at the point of triage to identify patients at risk. A draft tool has also been developed for inpatients. This is the first of its kind across the country and, if successfully implemented, will support clinical staff in the identification of patients at risk of rapid deterioration as a result of sepsis.

- Risk management has improved across the Division and a new SOP has been implemented to help guide staff through the process. Risk escalation pathway:



Opportunities for further improvement remain in a number of key areas; these will be a focus of the next 6-12 months.

- There are an increasing number of risks pertaining to Children's Services that are outside of the Divisions' ability to resolve. Paediatric mental health and community care issues feature highly and collaborative work will be required across the health system to mitigate the risks identified.
- Meeting the 30% inpatient target response rate for the Patient Friends and Family Test has remained challenging since being introduced into Children's Services in April 2015. Our latest actual response rate is 26.7%. Of those families who responded, 97.2% said they are very likely or likely to "recommend us to a friend or family if they needed similar treatment". Improving response rates will be a focus of the new Head of Nursing for Children's Services.
- The number of unmanaged incidents in Children's Services is high and needs attention; this is being addressed, an 8% reduction has been seen in the first month.

3.2 Changes to the Hospital Environment

The previous period saw the biggest changes to the Children's Hospital environment since it's opening in 2001. This year has seen the final pieces of that jigsaw complete:

- There is now a dedicated Children's MRI scanner on Level 3, sparing children and their carers a long journey across into the Bristol Royal Infirmary.
- A the beginning of November 2016 the upgraded Paediatric Medical High Dependency Unit was opened on Ward 30b, providing state of the art facilities and the final part of the creation of dedicated high dependency nursing, junior and consultant medical workforce and facilities within Cardiac (Ward 32); Neurosurgery, Spinal & Burns (Ward 33) and Medical HDU (Ward 30).
- There has also been an increase in use of technology - Radiology PACS systems are now available in Neonatal Intensive Care Unit; a new digital image viewing platform and tele-conferencing facilities are being purchased for the Cardiac team and Evolve digital medical records have been introduced throughout Children's Services.

Bristol Royal Hospital For Children

- A major project for next year will be the Signage and Wayfinding roll out to Children's Hospital, with the opportunity to rename wards and departments; and continue to make the environment more child and family friendly.
- The activity demand pressures set out have now led to a major strategic planning process to consider the size of the Children's Hospital. Outpatient clinics; inpatient, intensive care and ambulatory beds; and operating theatres are all funded and operating at full capacity so further building works may well be required over the coming years.

3.3 Workforce overview

- Staff engagement and health and wellbeing have been at the forefront of many workplace activities in the period covered by the report. Building on our 2015 staff engagement plan, particularly in the area of communication, we designed "Conversations", our hospital wide patient and staff engagement event, held in September. This was also an opportunity to launch our staff awards, which attracted over 200 nominations, saw 26 winners and the Project Team being shortlisted for a Trust wide Recognising Success Award, under the category of Quality Champions. The event was kindly sponsored by our charitable partners.

SPOTLIGHT ON…
#CONVERSATIONS

10 days full to the brim of activities to promote conversations between staff and staff, staff and the management team, patients and staff and patients and the management team. The highlights were the Choir singing the "Talk to Us" song, the hospital video, which has had 37.5K hits online, the model hospital and the activities such as the Big Question, Ward Roadshows, Job Swap and the Future Hospital, which will all serve to build the next steps towards charters for patients and families as well as

- We used this event to market our Employee Assistance Programme, Care First, and held the first mental wellbeing sessions for staff and managers, which were well received.
- Our Divisional newsletter has just had its first anniversary and will be evaluated in the coming months, returning in 2017 with a refreshed look.

- Our challenges for 2017 are varied – designing different workforce models to mitigate the risks of junior doctor shortages, further improving our staff engagement scores through the staff survey, improving attendance and upskilling our front line managers to improve staff experience.

3.4 Access Performance and activity

Children's Services are monitored against a range of key national targets. Some of the headlines are set out below:

- Emergency activity and performance: Whilst 2,307 more patients were seen, treated or admitted in less than 4 hours than ever before unfortunately performance against the Government's flagship performance standard dropped from 92.8% to 90.4%
- Referral to Treatment: At the end of November 2015 88.6% of patients were waiting more than 18wks for their planned treatment; this deteriorated to 85% at the end of October 2016. The Government's standard is 92%.

Bristol Royal Hospital For Children

3.5 Finance and Resources

Managing within constrained financial resources and meeting stretching efficiency targets of 2% per annum remains an ongoing challenge.

The direct management budgets for Children's Services increased during the period from £86m to £93m reflecting growth in activity & inflationary pressures. The Division of Women's and Children's Services finished the financial year 2015/16 £1.55m overspent against its budgets; although noting that this was the closest of all bed holding Division's to its Operating Plan control position. This overspend largely reflects inability to deliver sufficient efficiency savings. 2016/17 is proving even more challenging and there is currently a forecast overspend of £2,500k.

Reassuringly, the long term sustainability of services is supported by its Service Line Reporting profitability position of £4.7m surplus (in context of Trust wide normalised surplus of £3.6m) and Reference Cost Index of 101, which whilst marginally higher than national average is below its peer group average. The recovered after deterioration in 2014/15 caused by the implementation phase of the Centralisation of Specialist Paediatrics transfer.

4. Closing remarks and forward look

The whole NHS in undergoing a period of sustained pressure; and reflecting on the changes needed to ensure services are sustainable and fit for the future; most clearly reflected in the Sustainability and Transformation Plans being developed across health economies. Within this context there are some clear opportunities and risks emerging for Children's Services.

The Sustainability & Transformation Plans are at an early stage in their development. One of the challenges to engagement in this process has been the regional and supra-regional provision of many of the Children's Hospital services, 75% of all revenue comes from NHS England Specialised commissioning and most services patient flows go far beyond the 'footprint' of the BNSSG STP, including with South Wales; not many children's services overlap with other providers in our local patch. There are also nationally-led commissioning initiatives such as new standards for Congenital Heart Services, reviews of Paediatric Critical Care and Paediatric Surgery, and review of Children's Epilepsy Surgery Services that are running in parallel.

The notable exception for Children's Services is Neonatal Critical Care where the case for change has been developed to centralise Level 3 care in Bristol at St Michael's Hospital which presents an opportunity for new investment, changes in patient activity flows and new ways of working with Southmead Hospital Neonatal Intensive Care Unit.

Many of our regional services have rightly been recognised for their networked and outreach models of

Bristol Royal Hospital For Children

care, these now require even more emphasis as partnership working (as well as prime contracting); sharing skills and resources, providing integrated pathways of care become key priorities. For example, we are currently developing a pilot project to take governance and ownership of outreach clinics at Derriford Hospital in Plymouth; and are procuring an e-prescribing system for all shared care Paediatric Oncology centres across the South West.

We also have a real opportunity to participate in the biggest change to children's services in Bristol for many years. Our involvement in the formal partnership that has been awarded the contract to operate children's mental health and community services is a fantastic chance to integrate and improve hospital and community based children's care.

Trust wide strategy development and options appraisals for major capital investment have continued over the Summer and has identifying a clear need to expand the overall capacity of the Children's Hospital, which is running at near full capacity for much of the year, in particularly peak winter pressures, which creates patient safety risks; as well as limiting the opportunity to grow and develop.

As the Children's Hospital celebrates its 150th Anniversary there are many things to be proud of; and many opportunities to build on existing successes and harness the immense power of our staff to meet our 8 key commitments.

Bristol Royal Hospital For Children

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10
Meeting Title	Public Trust Board	**Meeting Date**	29 November 2016
Report Title	Quality and Performance Report		
Author	• Xanthe Whittaker, Associate Director of Performance • Anne Reader, Head of Quality (Patient Safety) • Heather Toyne, Head of Workforce Strategy & Planning		
Executive Lead	Owen Ainsley, Interim Chief Operating Officer		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards. Key issues to note Please refer to the Executive Summary in the report.

Recommendations
Members are asked to: • **Note** the quality and performance report.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☒	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☒
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
No change required to the following risks (recently reviewed): Risk 810 – Failure to maintain a Green Risk Rating – score 16 Risk 888 – Failure to meet recovery trajectories – score 16 Risk 932 – Failure to meet national cancer waits – score 20

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		25th November 2016		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

November 2016

Executive Summary

Further progress has been made in recovering performance against the national access standards this month, in line with the Trust's recovery forecasts. This includes a reduction in both the number of patients waiting over 18 weeks from Referral to Treatment (RTT), and the number of patients waiting over 6 weeks for a diagnostic test. Final reported performance against the 62-day referral to treatment GP cancer standard for quarter 2 showed a marked improvement over quarter 1, although challenges remain in improving performance in quarter 3 due to the high level of late referrals still being received from other providers. Disappointingly, performance against the A&E 4-hour standard continues to be below the in-month trajectory, although we remain above the year-to-date trajectory. The Overview page of this report provides further details of the priorities, risks and threats for the coming months, along with noteworthy successes in the period.

Levels of emergency admissions into the Bristol Children's Hospital in October were 5.8% on the same period last year, and also significantly higher than in September. There was a resulting deterioration in A&E 4-hour performance. Although the overall level of emergency admissions into the BRI remained similar to October last year, the number of patients requiring admission via the ED increased by 6.0%. This discrepancy likely reflects the numbers of patients being managed and discharged directly from the Emergency Department, following a decision to admit being made. The number of Green to Go (i.e. delayed discharge) patients remains at circa 60 patients, and twice the level agreed in the community-wide plan. Fewer long-stay patients (i.e. staying 14 days or more) were discharged in October than in any month since August 2015, with the number of in-hospital long stay patients and occupied beds rising as a result. The percentage of beds occupied within the BRI is now at the highest level this year, with a consequent worsening of bed availability, A&E 4-hour waiting times, and the number of patients outlying from their optimal specialty ward. The reduced level of ward bed availability has also resulted in an increase in the number of patients whose elective operations have been cancelled.

There has been a small seasonal rise in the number of patients seen for their first outpatient appointment. In combination with a reduction in the level of referrals relative to earlier in the year, this has led to a further and more significant decrease in the outpatient waiting list. The number of patients on the elective waiting list has also decreased, despite more outpatients being seen and a small decrease in the number of elective admissions due to an increase in cancellations of elective operations due to emergency pressures. Consistent with the decrease in both the outpatient and elective waiting lists, the percentage of patients waiting over 18 weeks from Referral to Treatment has reduced for the first time since July, with performance for October at 91.2% against the recovery target of 90.8%. The number of patients waiting over 6 weeks for a diagnostic test has reduced by 170, with the highest percentage performance against this standard being reported since March 2016.

Despite the emergency pressures, the Trust continues to perform well against the majority of the core quality indicators including the rate of inpatient falls and pressure ulcers, and the NHS Safety Thermometer composite measure of Harm Free care. The management of patients who have sustained a fractured neck of femur continues to be the focus of significant attention, and there have been encouraging improvements across several of the pathway Key Performance Indicators in the last month. The improved performance against the National Early Warning Scores (NEWS) measure of our management of deteriorating patients continues to be sustained, as does the low rate of missed doses of critical medication. Also noteworthy is the achievement of the antibiotic compliance target for the first time in 2016. System pressures continue to provide context to the ongoing workforce challenges, especially bank and agency spend and considerable focus is being placed on the reasons and necessity for each band and

agency shift. The recent improvement in turn-over and vacancy rates reflects the continued strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand. We 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 stars	OK	OK	OK	OK	✓ 98.5%
STM	4 stars	OK	OK	OK	OK	✓ 98.4%
BRI	3.5 stars	OK	OK	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	OK	OK	Not avail
BEH	4.5 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 Single Oversight Framework

In October the Trust failed to achieve the trajectory for each of the four access standards in the Single Oversight Framework. However, the recovery trajectories (not shown, but please see the relevant sections later in this report) were met for 6-week diagnostics and RTT.

The Trust has been off trajectory, for each of these standards, for greater than two consecutive months. Under the rules of the Single Oversight Framework this means that NHS Improvement may consider providing additional support to the Trust to recover performance.

Access Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3		
		April 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16		
A&E 4-hours	Actual	87.2%	91.7%	89.0%	89.3%	90.0%	87.3%	82.9%		
	STF trajectory	81.9%	84.4%	85.9%	87.6%	88.4%	92.2%	93.3%	90.0%	89.3%
62-day GP cancer standard	Actual	77.2%	70.5%	70.8%	72.9%	84.5%	80.5%			
	STF trajectory*	72.7%	73.2%	81.8%	84.7%	81.7%	85.0%	85.0%	85.1%	86.9%
Referral to Treatment Time	Actual	92.3%	92.6%	92.1%	92.0%	90.5%	90.4%	91.2%		
	STF trajectory*	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%
6-week wait diagnostic	Actual	98.3%	98.6%	96.3%	96.1%	95.5%	96.9%	98.9%		
	STF trajectory*	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%	99.2%

*minimum requirement is achievement of the national standard

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:

AMBER to RED
- Cancer Waiting Times

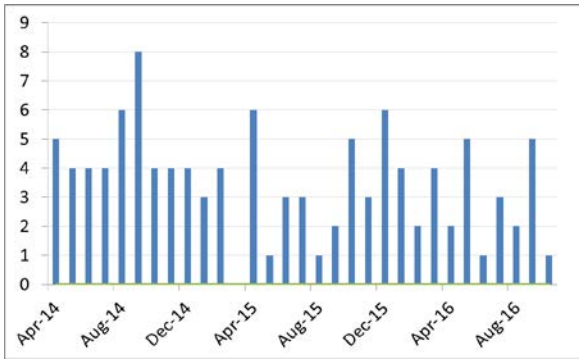
RED to AMBER:
- Referral to Treatment Times (RTT)

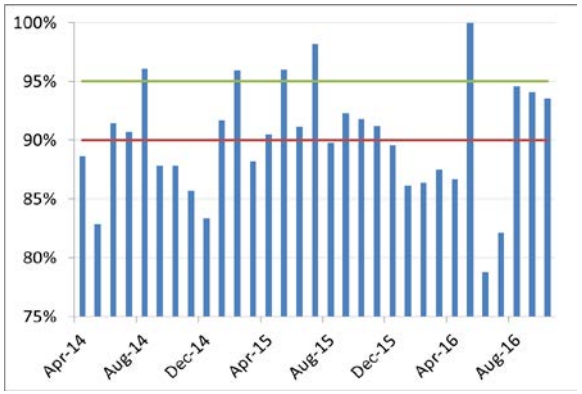
GREEN to RED:
- Cancelled operations
- Outliers
- Sickness absence

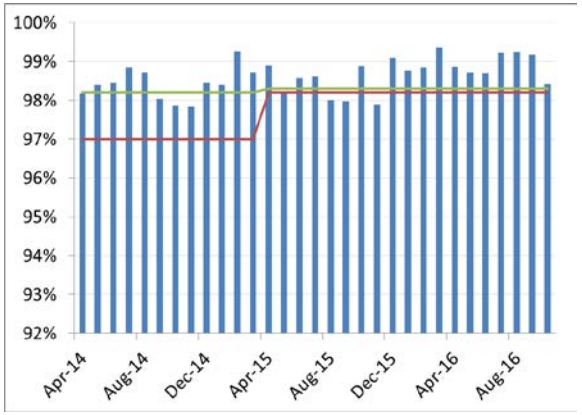
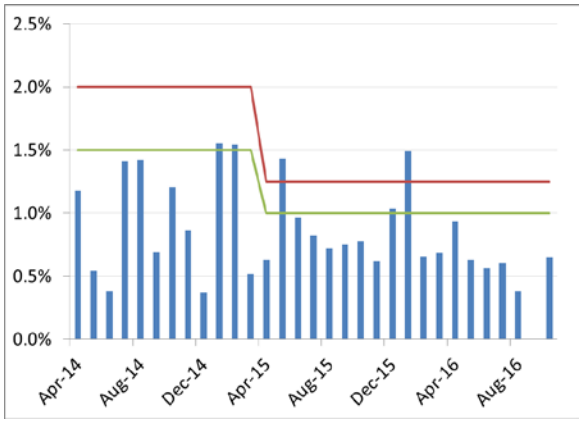
Overview

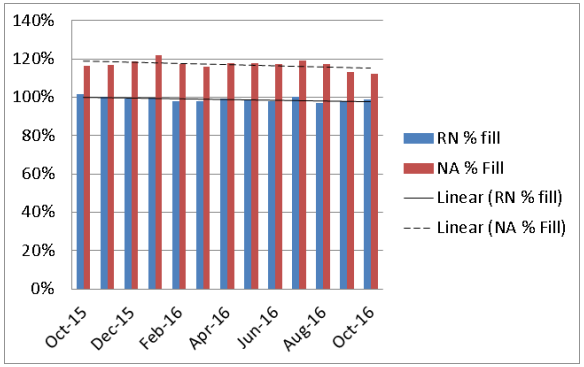
The following summarises the key successes in October 2016, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 3 2016/17.

Successes	Priorities
• In October 2016 there was only one reported case of *Clostridium Difficile* compared with five in September 2016; • In October 2016 Antibiotic compliance was reported to be 90.9%. This is the first time in 2016 that the 90% target has been achieved; • Registered nurse turnover, at 12.1%, is at the lowest since July 2014, and registered nursing vacancies have reduced to the lowest level since April 2014 to 84.3 FTE (3.4%); • Reduction in the number of patients waiting over 6 weeks for a diagnostic test (now just 0.1% off the national standard); • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), although remaining below the 92% standard.	• Improvement in care of patients with fractured neck of femur, including timeliness to theatre; • A never event incident relating to a retained foreign object was reported in October 2016. This is being investigated and the results will be reported to the Quality and Outcomes Committee in due course; • Continued focus on the reduction of staff turnover and sickness with the development of action plans to support the achievement of workforce KPIs; • Reduction in the number of patients waiting over 18 weeks Referral to Treatment (RTT), by delivering additional activity in each month in quarter 3; • Continued improvement in performance against the 62-day GP cancer waiting times standard during quarter 3; • Implementation of a recovery plan for restoring performance against the 6-week wait diagnostic standard by the end of November.
Opportunities	**Risks & Threats**
• The flu campaign is being reinvigorated to increase the opportunity to achieve the CQUIN target from the current level of 55% to the target of 75% by 31st December.	• In October 2016 there was an increase of 368 outlier bed-days over September's figure of 461. Due to operational pressures on the hospital the number of medical patients who outlie into other wards has significantly increased; • Sickness absence has increased from 3.7% to 4.6% due largely to unusual levels of cold and flu related absence; achieving forecast KPI out turn of 3.8% depends on achieving levels below the current position during the winter months; • Although the waiting list sizes are decreasing, there is a risk that a further increase in outpatient referrals could make recovery of the 92% RTT national waiting times standard more challenging; • Delays in histopathology reporting, following centralisation of the service at North Bristol Trust, continues to impact on performance against the cancer waiting times standards, although to a lesser extent.

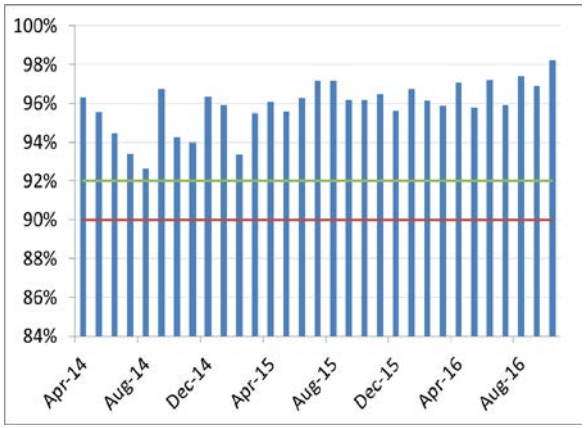
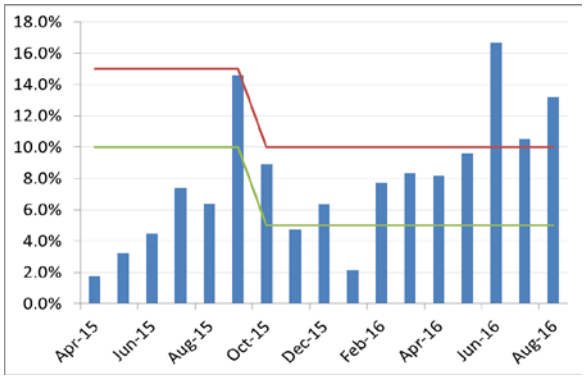
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).</td>
<td>There was one case of Clostridium difficile (C. diff) attributed to the Trust in October. This was attributed to division as shown in the table below.
<table>
<tr><th></th><th>C. difficile</th></tr>
<tr><td>Specialised Services</td><td>1</td></tr>
</table>
</td>
<td>Total number of C. diff cases
 

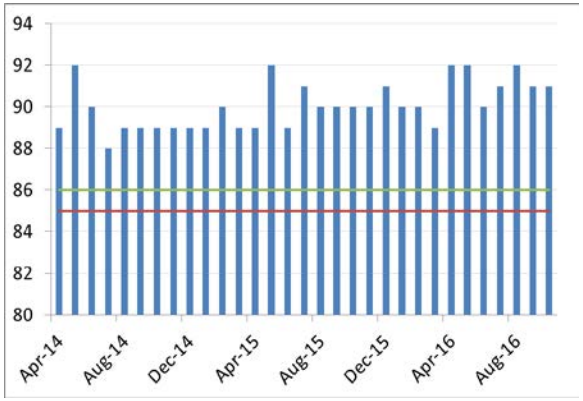
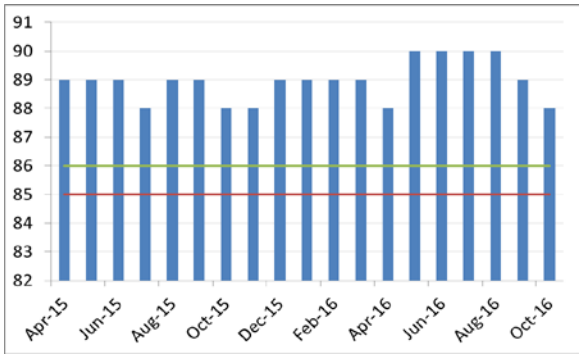
A total of 19 cases (unavoidable + avoidable) have been reported in the year to date against a limit of 45 for April 2016 to March 2017.</td>
<td>The annual limit for the Trust for 2016/17 is 45 avoidable cases. The monthly assessment of cases continues with the Clinical Commissioning Group. The total number of cases to date attributed to the Trust is nineteen. Nine cases have been assessed as unavoidable, and five cases assessed as avoidable. Five cases for October are still to be assessed.</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 in October was 93.5% (two breaches) against a three year improvement goal of 95%. This slight deterioration from September's position of 94.1% (one breach).
The two breaches occurred in the Division of Medicine. Both breaches were due to the patients not being reviewed within the required timeframe. In both cases the deterioration was recognised and escalated as per Trust protocol. Neither patient came to harm as a result of the breaches.</td>
<td>Deteriorating patient: percentage of early warning scores acted upon
 
</td>
<td>Work continues in the deteriorating patient work stream of our patient Safety Improvement Programme and is reported in detail to the Programme Board.
Details of the actions being taken are described in the actions section (Actions 1A to 1E).</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 October 2016, the percentage of patients with no new harms was 98.4%, against an upper quartile target of 98.26% (GREEN threshold) of the NHS Improvement patient safety peer group of trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The October 2016 Safety Thermometer point prevalence audit showed five new catheter associated urinary tract infections, three falls with harm, four new pressure ulcers and there were no incidences of a new venous thrombo-emboli.
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 October 2016, 0.65% of patients reviewed (5 out of 1050) had one or more omitted critical medications in the past three days. The target for omitted doses is no more than 1%, the average for the year to date is 0.56%. The 0.65% for October is a slight deterioration from the September 2016 figure when there were no patients with one or more omitted critical medications.	**Percentage of omitted doses of listed critical medicines** 	Month-on-month this figure has been evidencing a downward trend during 2016-17 with nine months in a row below 1%. Actions being taken are described in the actions section (Actions 2A and 2B)

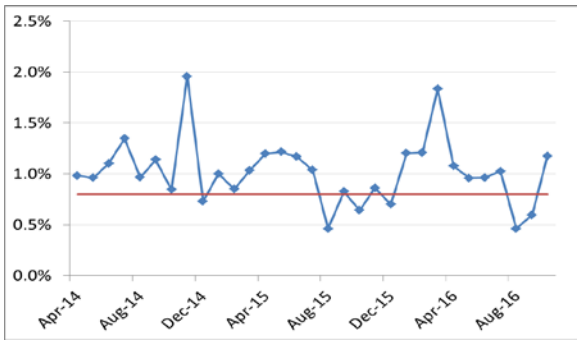
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Achievement of the Green threshold for this indicator depends on all five categories of Essential Training achieving 90%. Overall compliance is 87% (excluding Child Protection Level 3), up from 86% last month. Compliance with each of the new reporting categories is provided below.
<table>
<tr><th>October 2016</th><th>UH Bristol</th></tr>
<tr><td>Total</td><td>87%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>88%</td></tr>
<tr><td>Annual (Fire & IG)</td><td>75%</td></tr>
<tr><td>Induction</td><td>96%</td></tr>
<tr><td>Resuscitation</td><td>81%</td></tr>
<tr><td>Safeguarding</td><td>89%</td></tr>
</table>
</td>
<td>There are four graphs which are included in the appendix which show the performance for Fire and Information Governance, which are the most challenged topics, against the new trajectories for Fire and Information Governance (IG). It should be noted that the reporting for Fire has now been refined due to the changes in the training requirements, and is no longer comparable with previous months.</td>
<td>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 October the Trust had rostered 221,312 expected nursing hours, with the number of actual hours worked of 226,956. This gave a fill rate of 102.6%
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>62,774</td><td>58,053</td><td>+4,721</td></tr>
<tr><td>Specialised Services</td><td>41,522</td><td>39,836</td><td>+1,686</td></tr>
<tr><td>Surgery Head & Neck</td><td>43,666</td><td>42,424</td><td>+1,242</td></tr>
<tr><td>Women’s & Children’s</td><td>78,994</td><td>80,998</td><td>-2004</td></tr>
<tr><td>Trust - overall</td><td>226,956</td><td>221,311*</td><td>+5,645</td></tr>
</table>
*The difference between this figure and the narrative above is explained by rounding of part-hours at divisional level.</td>
<td>The percentage overall staffing fill rate by month


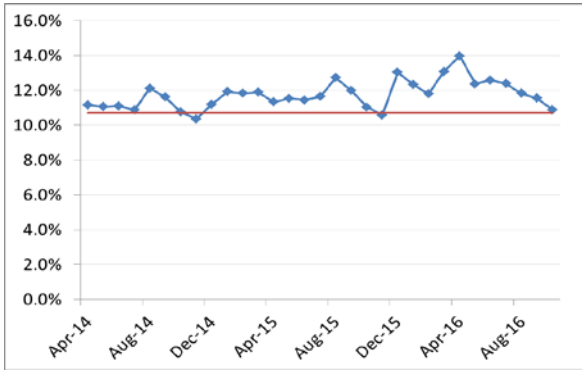
</td>
<td>Overall for the month of October 2016, the Trust had 100% cover for registered nurses on days and 98% registered nurse cover for nights. The unregistered nursing level of 108% for days and 118% for nights reflects the activity seen in September. This was due primarily to nursing assistant specialist assignments.
See also Action 4.</td>
</tr>
</table>

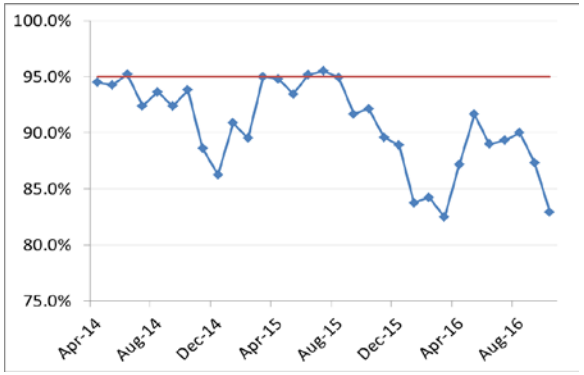
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for October 2016 was 98.2%. This metric combines Friends & 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 in the quarterly Patient Experience and Involvement report.	**Inpatient Friends & Family scores each month** 	The scores for the Trust 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 two months in arrears. This means that the latest data in the board dashboard is for the month of August 2016. Performance for August was 13.2% against a green target of 5%. As of 14th October, seven of the fifty three complaints responses sent out in August had resulted in dissatisfied replies. One case was for the Division of Medicine, three for the Division of Women's & Children's, two for the Division of Specialised Services and one for the Division of Surgery, Head & Neck.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our performance for 2015/6 was 6.15% compared with 11.19% 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 (Actions 5A to 5C).

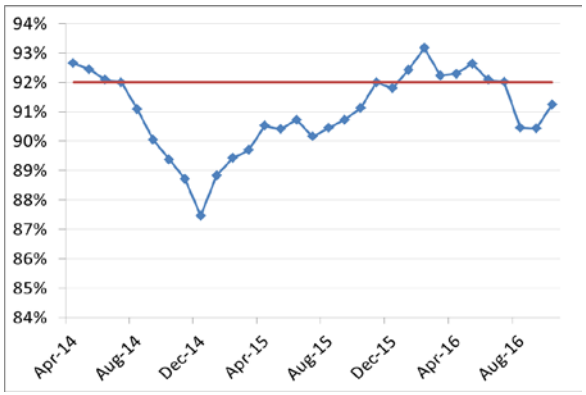
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as “key drivers” of patient satisfaction via analysis and focus groups.</td>
<td>For the month of October, the score was 91 out of a possible score of 100. Divisional level scores are provided on a quarterly basis to ensure sample sizes are sufficiently reliable.
<table>
<tr><th></th><th>Q1 2016/2017</th><th>Q2 2016/2017</th></tr>
<tr><td>Trust</td><td>91</td><td>91</td></tr>
<tr><td>Medicine</td><td>87</td><td>88</td></tr>
<tr><td>Surgery, Head & Neck</td><td>92</td><td>92</td></tr>
<tr><td>Specialised Services</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>92</td><td>92</td></tr>
<tr><td>Women's & Children's Division (Postnatal wards)</td><td>90</td><td>92</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 score for the Trust as whole was 88 in October 2016 (out of score of 100). Divisional scores for quarter 2 are provided as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful.
<table>
<tr><th></th><th>Q1 2016/2017</th><th>Q2 2016/2017</th></tr>
<tr><td>Trust</td><td>89</td><td>90</td></tr>
<tr><td>Medicine</td><td>93</td><td>89</td></tr>
<tr><td>Specialised Services</td><td>85</td><td>87</td></tr>
<tr><td>Surgery, Head & Neck</td><td>87</td><td>92</td></tr>
<tr><td>Women's & Children's (Bristol Royal Hospital for Children)</td><td>80</td><td>89</td></tr>
<tr><td>Diagnostics & Therapies</td><td>94</td><td>94</td></tr>
</table></td>
<td>Outpatient Experience Scores (maximum score 100) each month
 
</td>
<td>The Trust’s performance is in line with national norms in terms of patient-reported experience.

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>

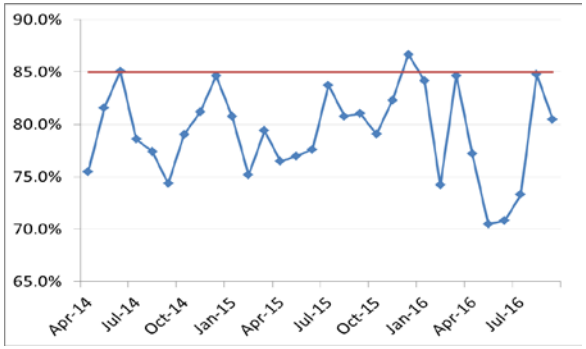
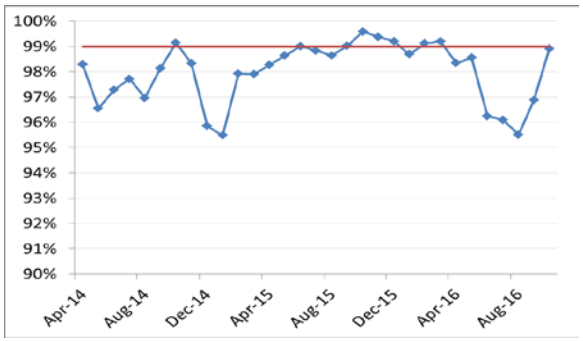
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In October the Trust cancelled 73 (1.18% 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>No HDU/ITU bed available</td><td>21 (29%)</td></tr>
<tr><td>Emergency patient prioritised</td><td>16 (23%)</td></tr>
<tr><td>No ward bed available</td><td>8 (11%)</td></tr>
<tr><td>No theatre staff</td><td>7 (10%)</td></tr>
<tr><td>Surgeon ill/unavailable</td><td>7 (10%)</td></tr>
<tr><td>Other causes (7 different breach reasons - no themes)</td><td>14 (19%)</td></tr>
</table>
Three patients cancelled in September were readmitted outside of 28 days. This equates to 92.3% of cancellations being readmitted within 28 days, which is below the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

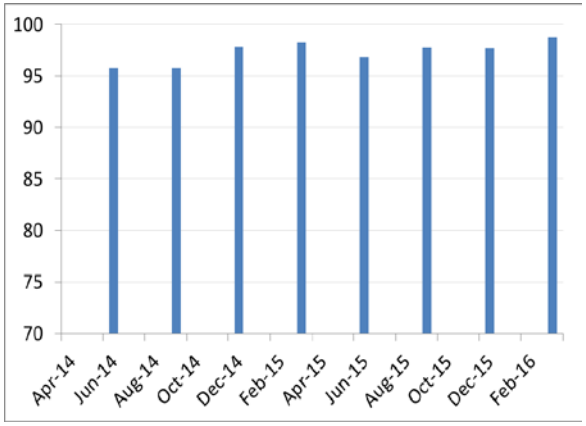
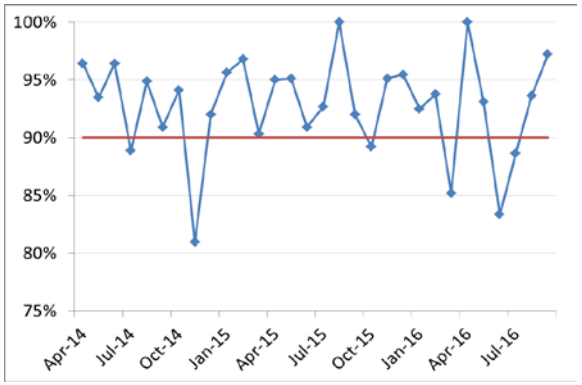
The national 0.8% standard is currently not forecast to be met in November due to emergency pressures.</td>
<td>Emergency pressures continues to be the predominant cause of cancellations this month, with emergency patients needing to be prioritised, a lack of High Dependency / Intensive Therapy Unit beds (due to these being occupied by emergency patients), and ward bed availability making-up 62% of all cancellations. 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 C) and outlier bed-days (13A).</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 October 10.9% of outpatient appointments were cancelled by the hospital, which is just 0.2% above the Red threshold of 10.7%. This is the fourth consecutive month of improvement.</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 was recently refreshed, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 7A to C).</td>
</tr>
</table>

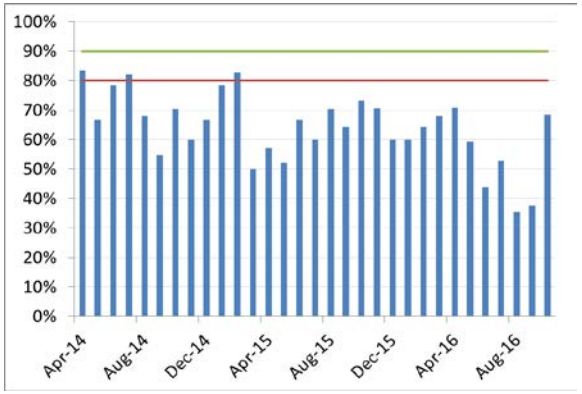
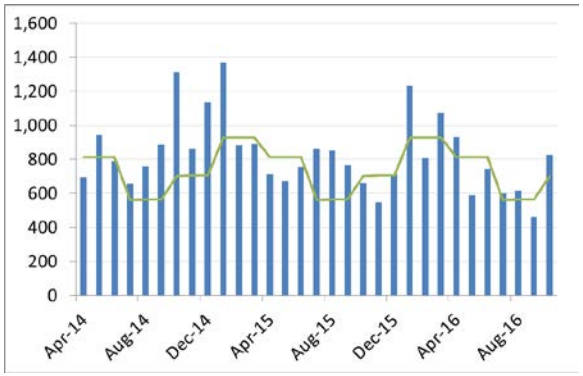
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in October. Trust-level performance at 82.9% was also below the in-month trajectory (93.3%). Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>Oct 2015</th><th>Sep 2016</th><th>Oct 2016</th></tr>
<tr><td>Attendances</td><td>5752</td><td>5525</td><td>5859</td></tr>
<tr><td>Emergency Admissions</td><td>1686</td><td>1808</td><td>1980</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5139
89.3%</td><td>4463
80.8%</td><td>4300
73.4%</td></tr>
<tr><th>BCH</th><th>Oct 2015</th><th>Sep 2016</th><th>Oct 2016</th></tr>
<tr><td>Attendances</td><td>3432</td><td>3228</td><td>3519</td></tr>
<tr><td>Emergency Admissions</td><td>838</td><td>823</td><td>887</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3196
93.1%</td><td>2956
91.6%</td><td>3190
90.7%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

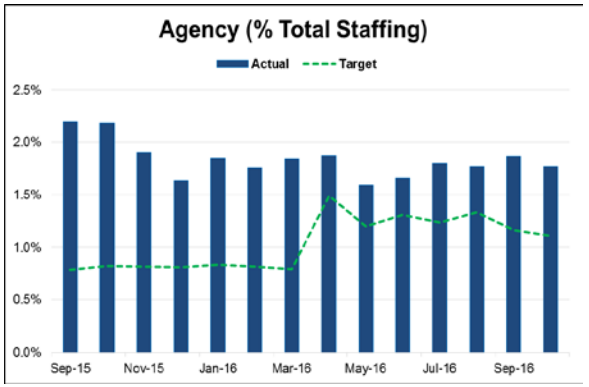
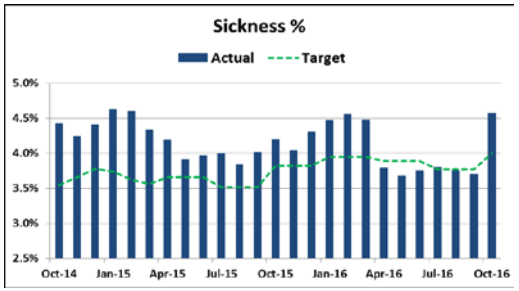
Trajectory of 90.0% not forecast to be met in November, due to a rise in emeregency admissions.</td>
<td>Levels of emergency admissions via the ED were 5.8% and 6.0% up on the same period last year in the BCH and BRI respectively. The number of patients on the Green to Go (delayed discharge) list increased slightly, from 60 at the end of September to 62 at the end of October. The number of 14 days stays also remains high. The BRI bed occupancy has increased to the highest level for the year to date. Actions continue to be taken to manage demand and reduce delayed discharges / length of stay (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 not met at the end of October. But the recovery forecast of 90.8% was achieved, with 91.2% of patients waiting less than 18 weeks at month-end (see Appendix 3).
The number of patients waiting over 40 weeks RTT at month-end increased in October, mainly due to specific capacity pressures in the Division of Women's & Children's.
<table>
<tr><th></th><th>Aug</th><th>Sep</th><th>Oct</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>33</td><td>27</td><td>53</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0</td><td>1</td><td>0</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 

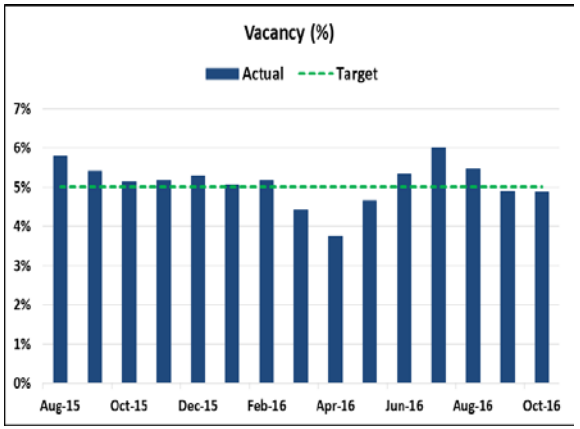
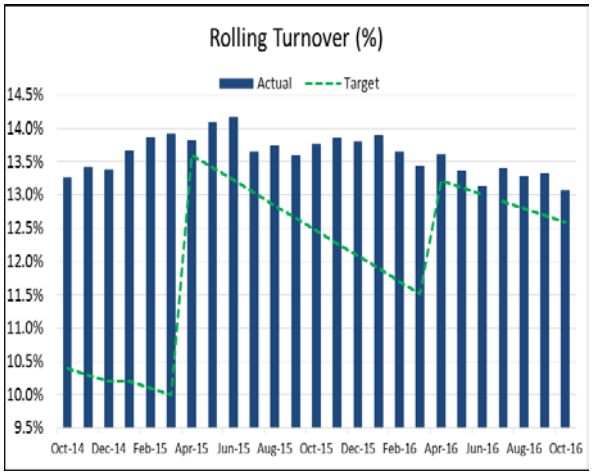
Recovery forecast for Nov and Dec = 91.4% and 91.6% respectively, with achievement of 92% for each month in Q4.</td>
<td>In addition to the number of over 18 week waiters having decreased, the size of the elective and outpatient waiting lists have also continued to decrease. This suggests that capacity is currently exceeding demand. The recovery plan continues to be implemented and monitored through weekly escalation meetings with Divisions. The weekly RTT Operational Group retains oversight of the management of the longest waiting patients (Action 9A and 9B).</td>
</tr>
</table>

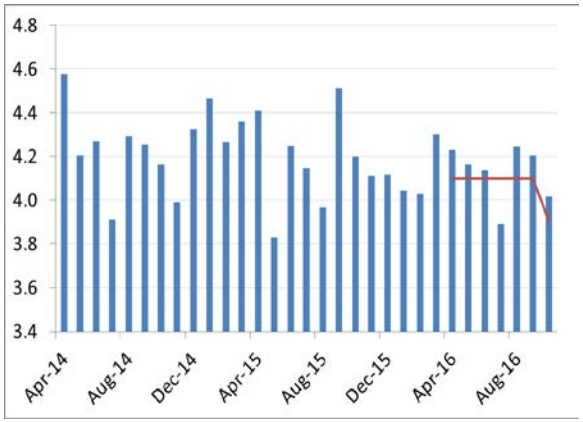
Description	Current Performance	Trend	Comments
Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.	September's performance was 80.5% against the 85% 62-day GP standard, and a trajectory of 85.0%. The 85% standard was met for internal pathways with performance at 87.3%. The main reasons for failure to achieve the 85% 62-day GP standard are shown below. **Breach reason** / **Sep 16** Late referral by/delays at other provider: 7.5 Patient choice: 5.5 Medical deferral/clinical complexity: 3.5 Histopathology delay: 1.0 Outpatient appointment delay: 2.0 Other reasons (two different causes): 1.0 **TOTAL: 20.5**	**Percentage of patients treated within 62 days of GP referral**  Performance against the 90% 62-day screening standard was 44.4%, with 2.5 breaches for the following reasons: patient choice (1.5), and insufficient surgical capacity (1.0).	Performance continues to be impacted by factors outside of the control of the Trust, including high levels of late referrals, patient choice and medical deferrals. Histopathology reporting delays are still occurring, but in much smaller numbers. A local CQUIN came into effect on the 1st October, along with a national policy for 'automatic' breach reallocation of late referral and treatments not carried-out within specified times. An improvement plan continues to be implemented to minimise avoidable delays (Action 10A to 10B).
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.	Performance against the 99% national standard, and recovery trajectory of 98.5%, was 98.9%. The number and percentage of over 6-week waiters at month-end, is shown below: **Diagnostic test** / **Aug** / **Sep** / **Oct** MRI: 7 / 14 / 1 Ultrasound: 23 / 10 / 0 Sleep: 86 / 109 / 20 Endoscopies: 208 / 97 / 40 CT: 4 / 0 / 25 Echo: 16 / 24 / 0 Other: 12 / 3 / 1 **TOTAL: 356 / 257 / 87** Percentage: **95.5% / 96.9% / 98.9%** Recovery trajectory: 95.2% / 96.7% / 98.5%	**Percentage of patients waiting under 6 weeks at month-end**  Performance is forecast to recover to above 99% at the end of November, although there are risks as noted to the right.	There was a significant decrease in the number of patients waiting over 6 weeks for a diagnostic test between September and October as predicted, with performance remaining above trajectory. The 99% standard was achieved for all except three types of tests (endoscopy, sleep studies and CT). Achievement of the 99% standard was forecast for the end of November, due to the actions being taken (Action 11A to 11C). However, staff sickness within ultrasound suggests the number of long waiters may not decrease.

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 March 2016 was 98.7. 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 overall 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. Coronary atherosclerosis alerts remain under investigation. 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 September (latest data), 35 out of 36 patients (97.2%) were treated within 90 minutes of arrival in the hospital. Performance for the year as a whole remains above the 90% standard at 92.8%.	**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 October 2016 we achieved 68.4% (13/19 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 73.7% (14/19 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Priority given to other patients with fractured neck of femurs</td><td>Two patients. Other patients with fractured neck of femurs were considered a higher priority for theatre.</td></tr>
<tr><td>Priority given to other surgical trauma cases.</td><td>Three patients. Other trauma patients were considered to be more clinically urgent.</td></tr>
</table></td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>Two patients did not receive any ortho-geriatrician review due to sickness and planned annual leave.
Actions are being taken to establish a future service model across Trauma &Orthopaedics, and 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 October 2016 there were 829 outlier bed-days against a target of 705 outlier bed days. Performance showed a significant deterioration in October with an increase of 368 bed-days over September’s figure of 461.
<table>
<tr><th>Outlier bed-days</th><th>September 2016</th><th>October 2016</th></tr>
<tr><td>Medicine</td><td>225</td><td>528</td></tr>
<tr><td>Surgery, Head & Neck</td><td>118</td><td>205</td></tr>
<tr><td>Specialised Services</td><td>97</td><td>87</td></tr>
<tr><td>Women's & Children's</td><td>16</td><td>7</td></tr>
<tr><td>Diagnostics and Therapies</td><td>5</td><td>2</td></tr>
<tr><td>Total</td><td>461</td><td>829</td></tr>
</table></td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>Due to an increase in emergency pressures the number of medical patients outlying into other wards significantly increased from the previous month, with a small increase also in surgical outlying patients.
Ongoing actions are shown in the action plan section of this report. (Actions 13B).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage reduced by 8.3 FTE, reducing from 1.9% to 1.8% of total staffing. Levels dropped across all Divisions except Medicine and Facilities & Estates. Nursing agency usage reduced by 3.9 FTE. **October 2016** / **FTE** / **Actual %** / **KPI** **UH Bristol** / **149.1** / **1.8%** / **1.1%** Diagnostics & Therapies / 7.2 / 0.8% / 0.6% Medicine / 43.8 / 3.4% / 1.1% Specialised Services / 20.5 / 2.1% / 1.5% Surgery, Head & Neck / 28.6 / 1.6% / 0.4% Women's & Children's / 20.1 / 1.0% / 1.5% Trust Services / 18.0 / 2.5% / 2.2% Facilities & Estates / 10.8 / 1.3% / 1.2%	**Agency usage as a percentage of total staffing by month** 	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.
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2015/16. The red threshold is 0.5% over the monthly target.	Sickness absence was at its highest since last February, up from 3.7% to 4.6%. There were increases in cold and flu related absence (up 140%), gastro-intestinal (up 42%), psychological (up 22.1%) and musculo-skeletal (up 22.5%). There were increases in all Divisions and across all staff groups except healthcare scientists. **October 2016** / **Actual** / **KPI** **UH Bristol** / **4.6%** / **3.8%** Diagnostics & Therapies / 3.1% / 2.7% Medicine / 5.5% / 4.6% Specialised Services / 4.2% / 3.7% Surgery, Head & Neck / 4.2% / 3.7% Women's & Children's / 4.5% / 3.5% Trust Services / 2.8% / 3.2% Facilities & Estates / 8.1% / 5.2%	**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*	Average monthly sickness absence for the year to date stands at 3.8%, compared with 4% for the same period last year. Action 15 describes the ongoing programme of work to address sickness absence.

Description	Current Performance	Trend	Comments
Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.	Overall vacancies remained static at 4.9%. Registered nursing vacancies reduced to the lowest level since April 2014 to 84.3 FTE (3.4%) but there were small increases in medical (up 7.7 FTE to 0.7%) ancillary (up by 6.3 FTE to 5.5%), and administrative clerical (up by 6.4 FTE to 8.3%) vacancies. **October 2016** / **Rate** **UH Bristol** 4.9% Diagnostics & Therapies 6.6% Medicine 5.7% Specialised Services 5.6% Surgery, Head & Neck 6.1% Women's & Children's 1.1% Trust Services 6.9% Facilities & Estates 5.1%	**Vacancies rate by month** 	The recruitment action plan is summarised in Action 16. Appendix 2 details progress in reducing specialist nursing vacancies. Planned and some in-month starters are not reflected in these graphs. In Coronary Intensive Care, 13.8 FTE started in the last two months, leaving a gap of 6 FTE as the budget increased by 4.25 FTE. Heygroves Theatres is expecting 10 to start between September and December, but these are yet to be reflected in the finance ledger figures.
Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory**.**	Turnover has reduced from 13.3% to 13.1%, with reductions in all Divisions except Facilities & Estates and Trust Services. Registered nurse turnover reduced to the lowest level since July 2014 at 12.1%. **October 2016** / **Actual** / **Target** **UH Bristol** **13.1%** **12.6%** Diagnostics & Therap. 11.8% 12.7% Medicine 14.4% 13.7% Specialised Services 11.5% 13.1% Surgery, Head & Neck 13.6% 12.9% Women's & Children's 11.8% 10.8% Trust Services 15.4% 13.1% Facilities & Estates 14.4% 13.7%	**Staff turnover rate by month** 	Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 17).

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 October the average length of stay for inpatients was 4.02 days, which is above the quarter 3 RED threshold of 3.90 days. This is a 0.19 day decrease on the previous month. The percentage of patients discharged in October who were long-stay stay patients, was the lowest it has been since August 2015. This suggests the decrease in length of stay is only due to fewer long stay patients being discharged and not an underlying improvement in LOS performance. The number of long stay patients in hospital hence remains high. This suggests that length of stay will continue to be above plan, especially in the month(s) when this cohort of long stay patients are discharged.	**Average length of stay (days)**  Length of stay is forecast to remain above the RED threshold in November.	At the end of October the number of Green to Go delayed discharges at 62 was similar to that of the same period last year, and also the number at the end of last month. The jointly agreed planning assumption of 30 patients continues to not be met. 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 8A to 8C and 13A to 13B).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Deteriorating patient Early warning scores for acted upon.	1A	Further targeted teaching for areas where NEWS incidents have occurred.	Commenced February 2016 and on-going	Monthly progress reviewed in the deteriorating patient work stream and quarterly by the Patient Safety Improvement Programme Board, Clinical Quality Group and Quality and Outcomes Committee	Sustained improvement to 95% by 2018.
	1B	Accessing doctor education opportunities to assist with resetting triggers safely	Commenced April 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1C	Convening of a focus group to further understand the reasons why nurses and doctors are unable to escalate or respond to escalation and address these accordingly. Also please see 1E below.	November 2016	As above	Sustained improvement to 95% by 2018.
	1D	Spreading point of care simulation training in adult general ward areas to address human factors elements of escalating deteriorating patients and use of structured communication.	September 2016 and on-going	As above	Sustained improvement to 95% by 2018.
	1E	Additional time allocated for patient safety in doctors' induction to train new appointees	From September 2016 and ongoing	As above	Sustained improvement to 95% by 2018.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		on resetting triggers safely and human factors awareness of escalation conversations.			
Non-purposeful omitted doses of critical medication	2A	Datix dashboard being developed to capture omitted doses, to allow detailed thematic analysis.	October 2016	Improvement under development	Maintain current improvement and sustain performance below 1%
	2B	Trust-wide bulletin on medicines for Parkinson's disease. Information to be sent to Matrons for dissemination to ward staff.	October 2016	Highlight this issue and the drug availability.	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	Divisional Trajectories show compliance by the end of March 2017.
		Detailed plans focus on improving the compliance of Safeguarding Resuscitation, Information Governance and Fire Safety.	Ongoing	Oversight of safeguarding training compliance by Safeguarding Board /Workforce and Organisational Development Group.	
		Newly developed trajectories for Fire and IG are monitored at a divisional level at monthly and quarterly Performance and Operations meetings	September 2016 to March 2017.	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.	
	5C	Dissatisfied responses are now routinely checked by the Head of Quality (Patient Experience & Clinical Effectiveness) to identify learning where appropriate. All cases where a complaint is dissatisfied for a second time are escalated to and reviewed by the Chief Nurse.	Implemented September 2015 and ongoing		
Last minute cancelled operations	6A	Continued focus on recruitment and retention of staff to enable all	Ongoing	Monthly Divisional Review Meetings;	Improvement to be evidenced by a continued reduction in

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited and in post. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	To be confirmed – expected to be by quarter 4, when virtual ward up to full impact, relieving ward bed pressures	Relevant Steering Group to be confirmed, but likely to be Cancer Steering Group, due to the recent impact on cancer	cancellations in Q3. Achievement of quality objective on a quarterly basis.
	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	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 November	Report provided for Outpatient Steering Group;	Outpatient Steering Group to identify any new actions arising from this analysis, which may alter performance trajectory.
	7B	Select six highest hospital cancellation specialities and investigate reasons for cancellations with frontline staff and Performance & Operations	End of November	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
		Managers. Share learning with all over specialities via the Outpatient Steering Group.			
	7C	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 November	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 (and re-formed in July), to understand drivers of increase in paediatric emergency demand and to identify possible demand management solutions.	Ongoing	Urgent Care Board	Achievement of recovery trajectory each month.
	8B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of recovery trajectory each month.
	8C	Working with partners to continue to mitigate shortfalls in social services provision and other causes of higher levels of delayed discharges. See also actions 12A to 12E relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of recovery trajectory each month.
Referral to Treatment Time (RTT)	9A	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.	Reduction in over 18 week RTT pathways through to the end of December, in line with recovery forecast (met for October).
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.		Improvement Group, with escalation to Cancer Steering Group.	quarter 3 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 (currently on track).
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 October (significant reduction in October, now expected to meet 99% standard in November).
	11B	Additional Sleep Studies waiting list sessions being undertaken to help address the bulge in demand;	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard by end of October - achieved for October.
	11C	Establish additional sessions for Echo, Ultrasound and MRI.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	Recovery of 99% standard for total Radiology (including Ultrasound and MRI) by end July (now achieved) and Echo by the end of November (now achieved).

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 October 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	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.	September 2016	Successful funding bid and subsequent recruitment to post.	Agreement to fund has been provided by the Division of Surgery and recruitment for this post has commenced.
	12C	Build and submit case for specialist acute fracture nurse support (Band 6 permanent).	April 2017	Successful funding bid and subsequent recruitment to post.	Expected to form part of investment proposal for the 2017/18 operating plan.
	12D	Review the ward structure to see whether separate wards with protected beds and capacity for fractured neck of femurs will allow	April 2017	Focussed care consolidated in each ward, suitable to meet the patients' needs. Improved recruitment and	Proposals have been submitted to split the wards into one elderly trauma and fractured neck of femur ward (A604),

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		additional focus to meet patient's needs		retention of ward staff.	and one young trauma and elective ward (A602). Awaiting full feedback, but the initial reaction was positive.
	12E	Review and make the case to increase physiotherapy services to support fractured neck of femurs patients on the trauma and orthopaedic wards across seven days	April 2017	Earlier physiotherapy and nutritional support, earlier mobilisation and better chest management.	Proposals being worked up with Division of D&T, and have been submitted as an Internal Cost Pressure for 2017/18 contract.
Outlier bed-days	13A	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

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	14	Corporate actions to directly target agency expenditure (in addition to sickness absence, recruitment and turnover actions – see section 14,15 and 16) are detailed below:		Nursing agency: oversight by Savings Board through its sub group (Nursing Controls Cost Improvement Group). Medical agency: oversight through the Medical Efficiencies Group.	The mid-year review which took place in September 2016 forecast an out turn in March 2017 of 1.5% compared with the 2016/17 KPI of 1.1% as a percentage of total staffing. Divisional Performance against plan is monitored at monthly and quarterly Divisional Performance reviews.
		Effective rostering: Ensuring annual/study leave and sickness absence are planned and monitored appropriately. Actions include:			

		• "Allocate" implementation will provide:
		  • Acuity and dependency to match staffing with demand;
		  • Improved rostering and booking functionality for both ward managers and staff;
		  • Robust management information.
			Pilot November 2016, go live April 2017		

		• Pending the new rostering system, a staffing dashboard is in place.	June 2016 to April 2017		
		Controls: • Robust Escalation policy with clear sign off process	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		• Operating plan agency trajectories monitored through divisional reviews	Monthly and quarterly reviews		
		Enhancing bank provision: • External marketing drive • Internal communications (messages in payslips/contacting inactive bank workers) • Bank incentive payment under review	November 2016		
Sickness Absence	15	**A dedicated lead**: To develop a sickness absence management plan: • Reviewing current strategies and develop impact assessment measures • Making further recommendations, supported by an action plan. Current actions include:	Recommendations approved by Senior Leadership Team September 2016, action plan to follow.	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. Based on the mid-year review which took place in September, it was anticipated that this would be achieved. However, sickness is unusually high for the time of year, and achievement of the KPI will depend on reductions compared with October 2016 in the ensuring winter period.
		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.	To be spot audited in Q2 16/17		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Supporting Attendance Policy: • Audit Action plan to be implemented • Full review of policy including simplifying content/ structure, sign posting and tools to assess attendance	September 2016 to March 2017 January 2017		
		Training for managers: Training review complete to ensure training meets the needs of managers and achieves improved competence/confidence	To commence January 2017		
		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	Ongoing		
		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	January 2016 to January 2018		
		Flu Vaccination: The flu campaign and communications plan is being re-vitalised with the support of the Trust vaccinators. **Flu Vaccination:** 3567 frontline staff have been vaccinated to date. This represents 55% of reportable staff compared with the 75% CQUIN target.	Campaign October 2016 to February 2017		
		Staff Health and Well Being CQUIN: Implementation plan has been developed, which is focussed on improving health and wellbeing. Three posts to assist in delivery of CQUIN recruited - a physiotherapist, Associate Counsellor and Administrative and Clerical support.	October 2017 (Peer review Bristol Clinical Commissioning Group) Funded until March 2017	CQUIN short term working group	
Vacancies	16	Recruitment action plan includes the following activities.	Review quarterly	Workforce and OD Group /Recruitment Sub Group.	Detailed trajectories are in place for key recruitment

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Marketing and advertising: • Divisional Performance and Operations Meetings monitor performance against operating plan requirements and ongoing vacancies.			hotspots, including theatres; critical care, haematology and ancillary staff
		• A new nursing recruitment website as part of the Nurse Marketing Strategy has been developed. This includes videos of staff promoting working at UH Bristol. Similar approaches are being developed with radiography and sonography. • An overview of the impact of the Marketing Plan on vacancies will be provided to Finance Committee	November 2016 November 2016	Divisional Performance and Operational Reviews	
		Service level agreements and KPIs for recruitment have been developed to measure performance against the agreed KPI of 45 days, tracked through divisional reviews. Performance can now also be measured at specialty level.	Reviewed quarterly		
		Support for recruitment and retention initiatives in specialist areas - Heygroves Theatres, Ward D703 and CICU. Trajectories are	Reviewed monthly		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		shown in appendix 3.			
Turnover	17	Key corporate and divisional actions include the following: **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; • Engaging staff through feedback sessions. Future actions include: • Communication plan • Further pilots for improved E appraisal system	March 2017 Launch Jan 2017 Dec 2016	Transformation Board	The KPI for 2016/17 has been set at 12.1%. The forecast out turn for March 2017, based on the mid-year review, was 12.4%.
		Targeted leadership and management development programme: The first programme will be completed and evaluated by the end of February. Leadership and Management Development programmes continue with over 200 managers accessing one of the modules in	End February 2017		

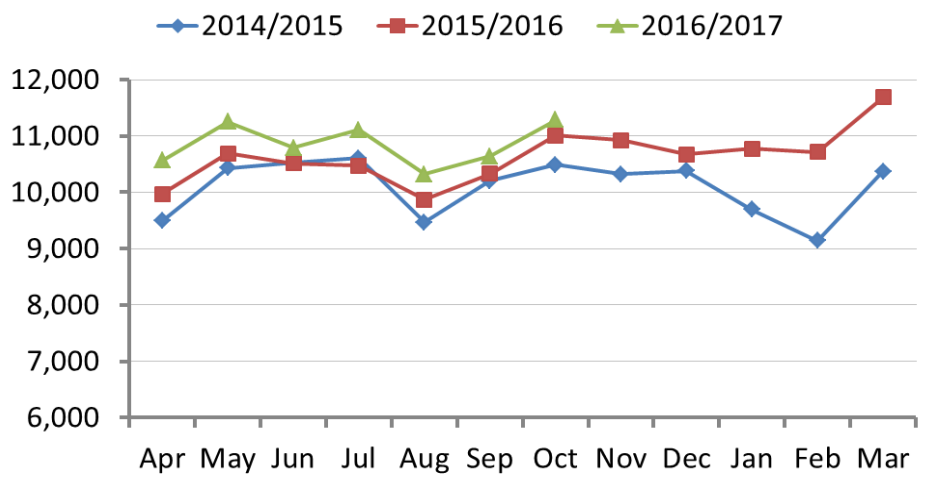
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		the last quarter.			
		Team building and local decision making: Work with Aston Organisational Development to develop team coaches, taking teams through a programme of work-based activities. Findings from the pilot will be evaluated to inform future roll-out. Options appraisal to be considered by Senior Leadership team in January 2017.	Evaluation in February 2017 December 2016/January 2017	Workforce and OD Group	
		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.	
		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 autumn across the trust to identify and develop expected behaviours of our leaders. Paper was presented and approved to Senior Leadership Team in October Leadership Behaviours to be developed and implemented through training in	Workshops planned for December 2016 to January 2017.	Senior Leadership Team/Board	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		the first quarter 2017/18.			
		Staff Survey: Staff survey distributed in September. Results will be available in March/April.	March/April 2017	Workforce and OD Group	

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.

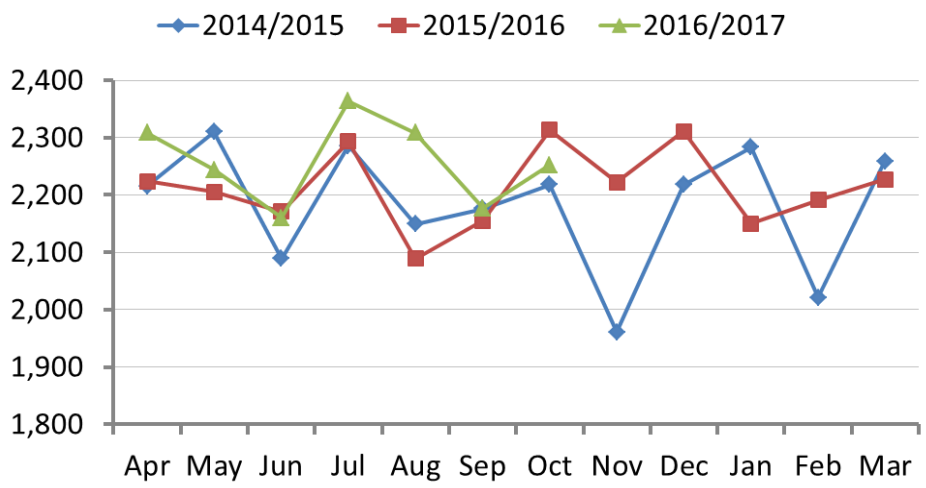
Emergency Department (ED) attendances



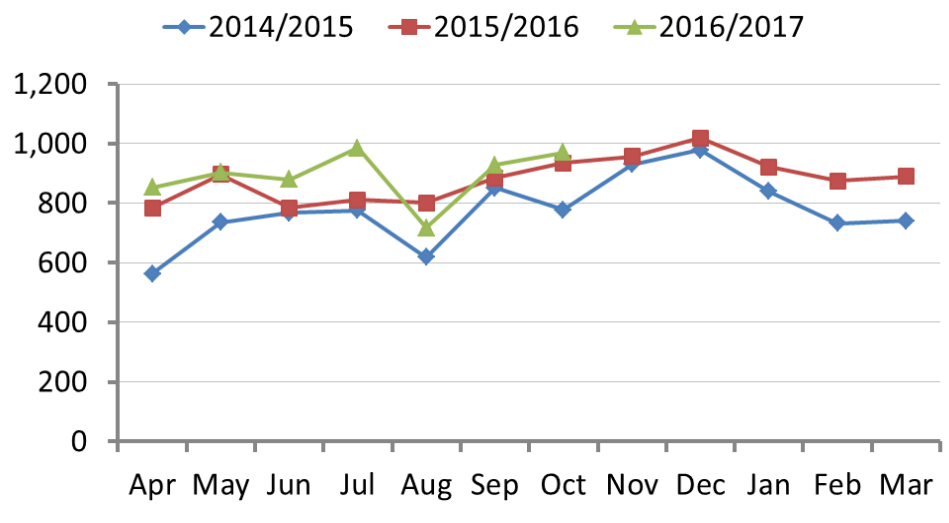
Summary points:

- Emergency attendances remain slightly above the same period last year; total emergency admissions into the BRI have returned to the seasonal norms, with BCH levels being slightly above (although see also the A&E 4-hour report, showing emergency admission levels via the EDs);
- The number of new outpatient attendances increased up to the level of the seasonal norm, with the outpatient waiting list now decreasing in size;
- The number of elective admissions is slightly down on the last two months, reflecting the increase in cancelled operations; however, as will be seen from the Assurance section, the number of patients on the elective waiting list has continued to decrease, despite elective activity decreasing slightly and the number of outpatients being seen for their new outpatient appointment having increased.

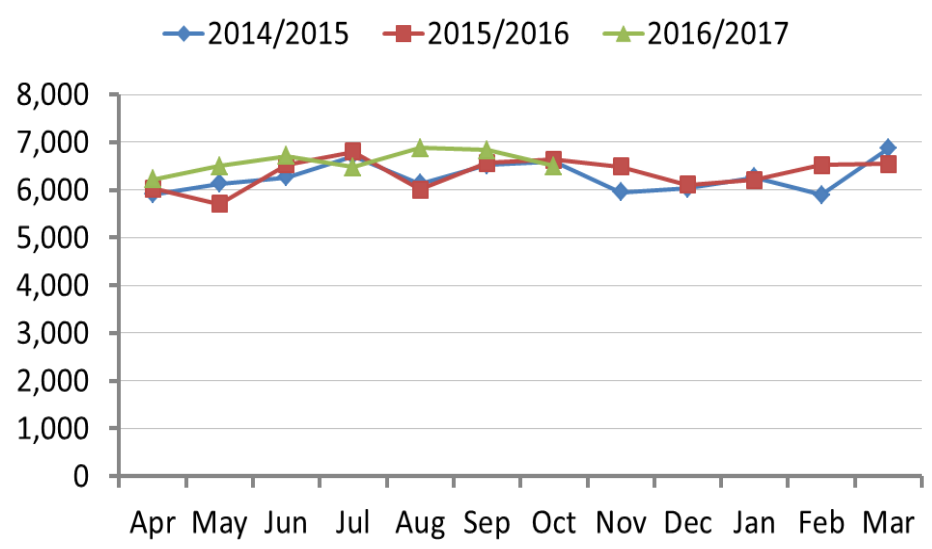
Emergency admissions (BRI)



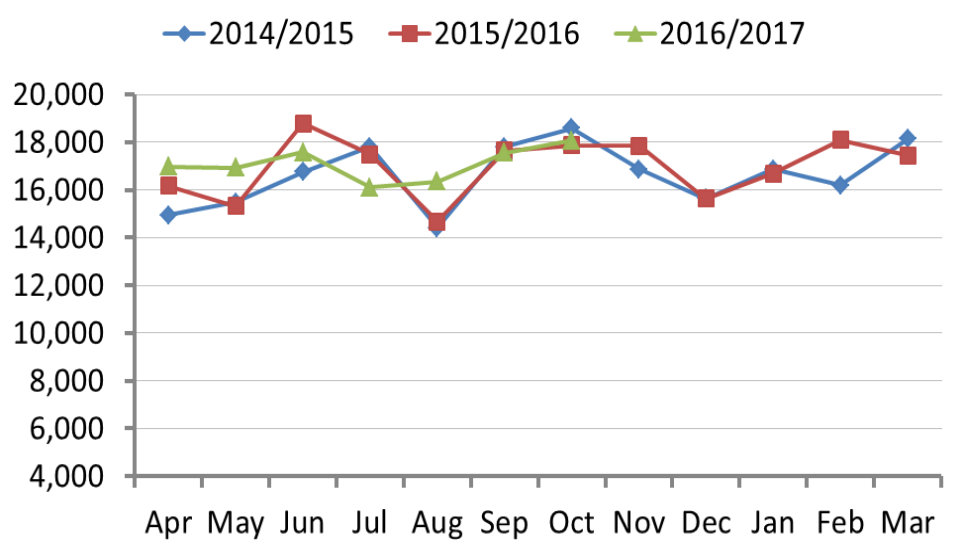
Emergency admissions (BCH)



Elective admissions



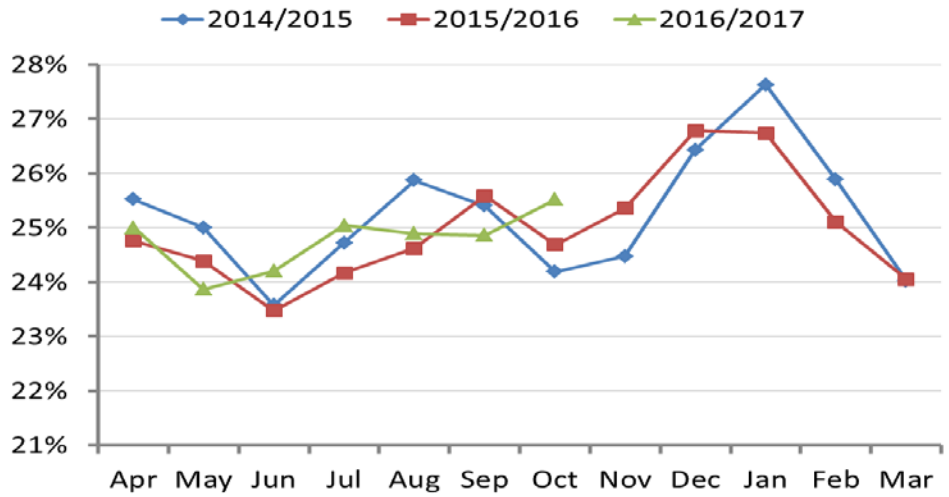
New outpatient attendances



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.

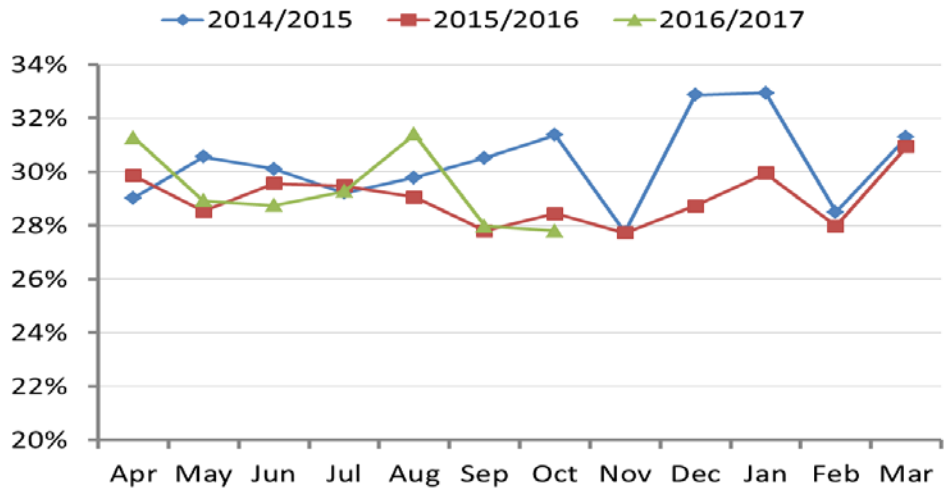
Percentage ED attendances resulting in admission



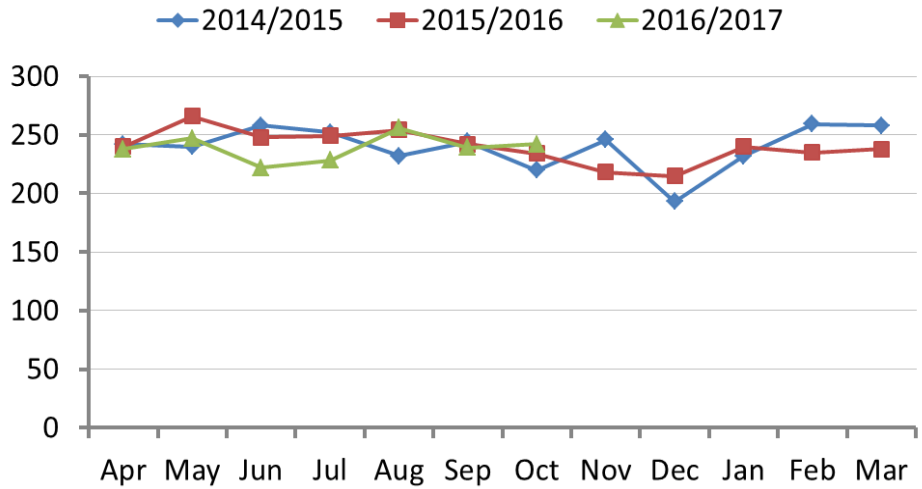
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission is above the same period last year; however, the percentage of patients admitted aged 75 years and over is now slightly below the seasonal norm;
- The number of delayed discharges was similar to last year's level, but BRI bed occupancy has increased sharply, to the highest level all year;
- The number of patients on the outpatient waiting list has decreased again, as has the number on patients on the elective waiting list; consistent with this, the number of patients waiting over 18 weeks RTT has decreased (see Appendix 3);
- The number of patients referred by their GP with a suspected cancer (2-week waits) is significantly above the same period last year; the number of 62-day GP cancer treatments also remains high for this reason.

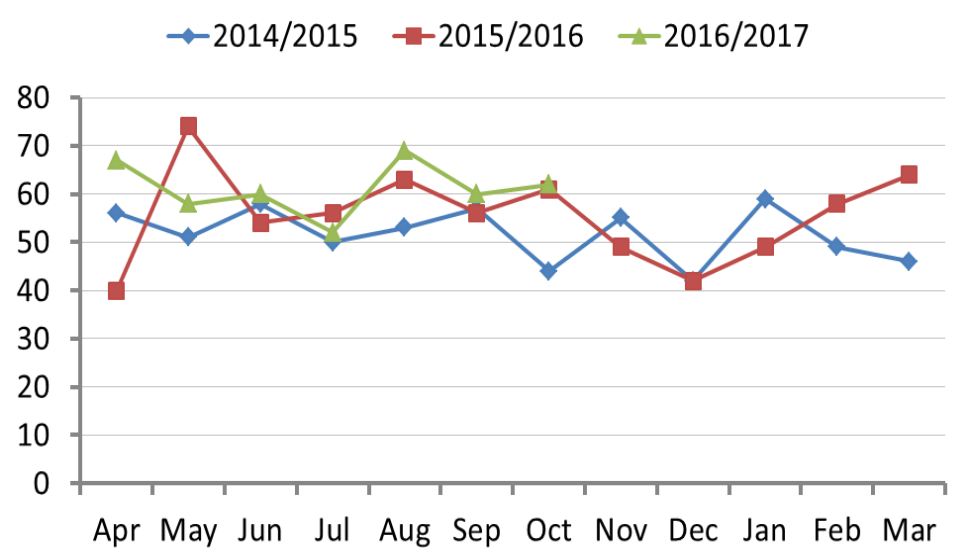
Percentage of Emergency BRI spells patients aged 75 years and over



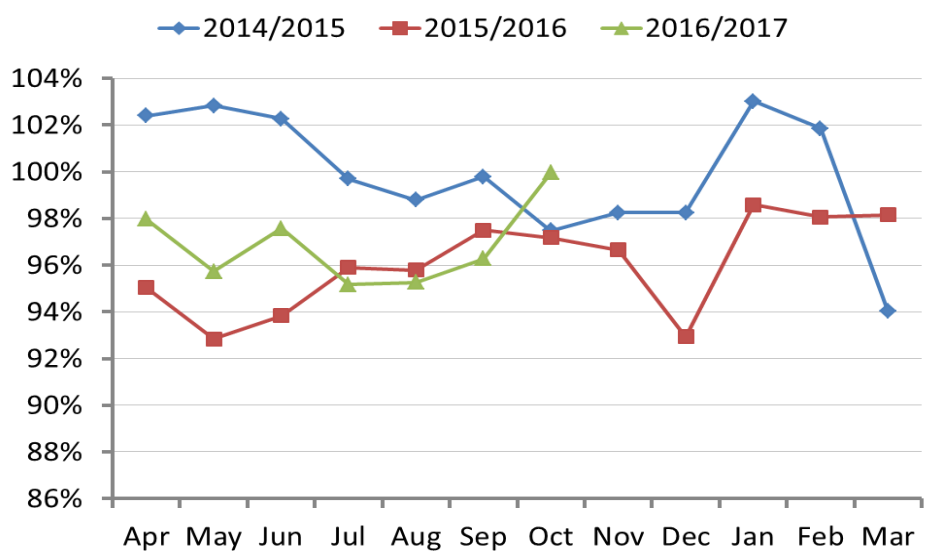
Over 14 day stays



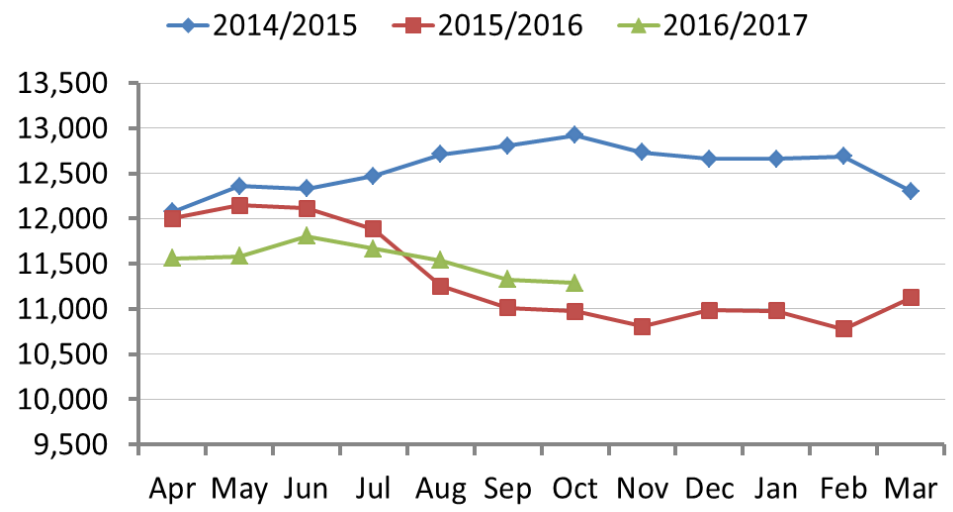
Delayed discharges (Green to Go)



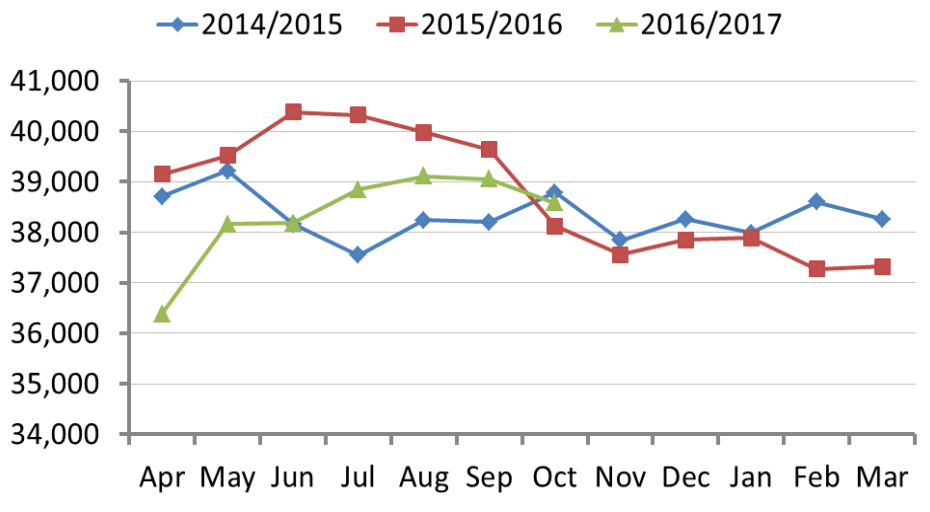
BRI Bed Occupancy



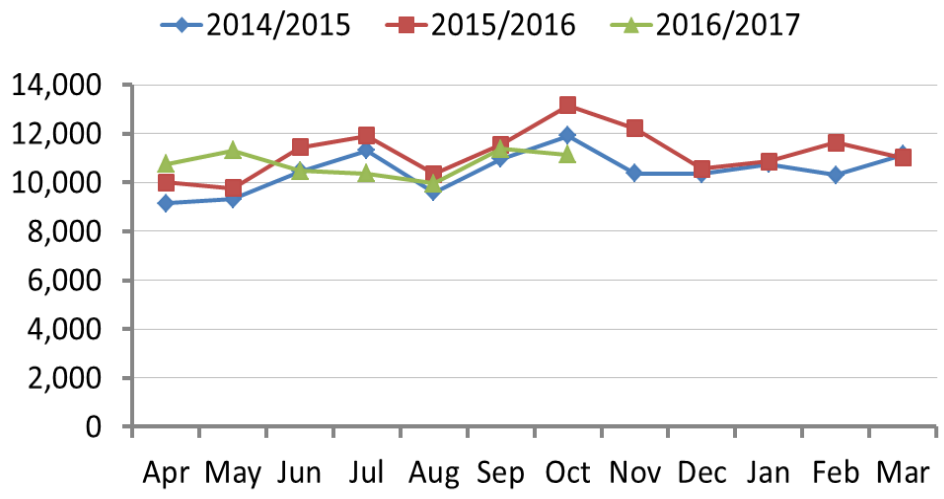
Elective waiting list size



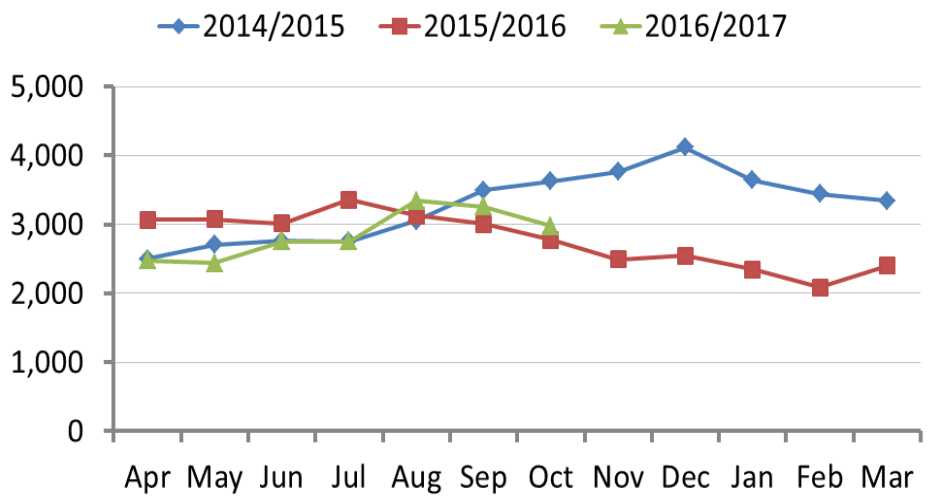
Outpatient waiting list size



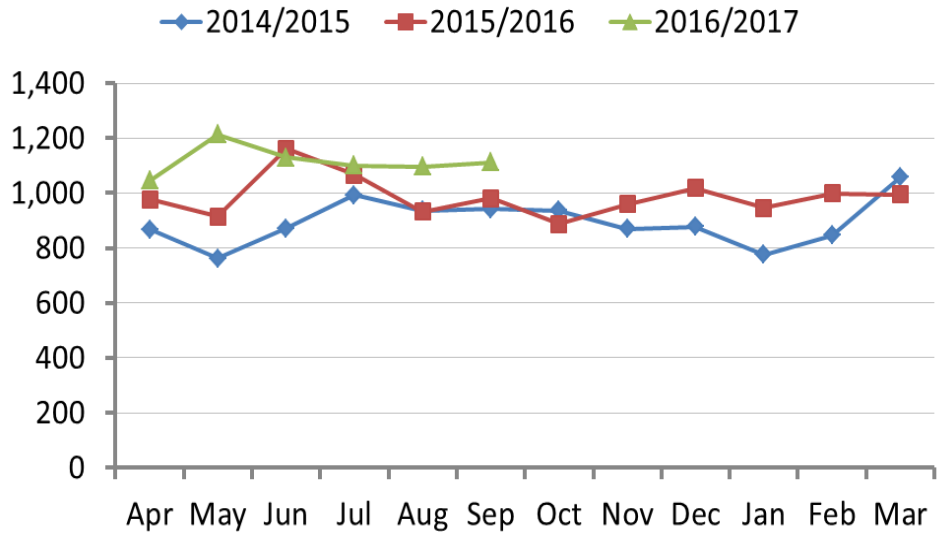
Number of RTT pathways stopped (i.e. treatments)



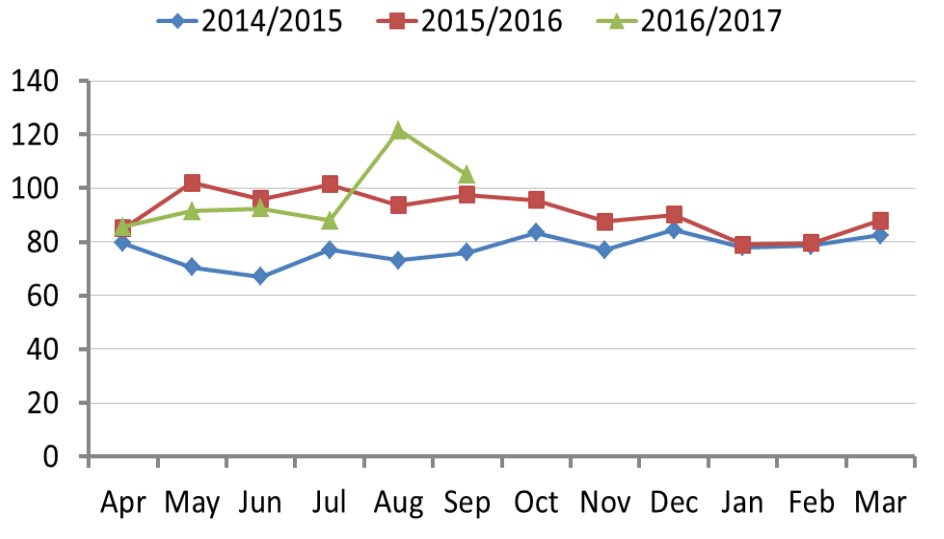
Number of RTT pathways over 18 weeks



Cancer 2-week wait – urgent GP – referrals seen



Cancer 62-day GP referred treatments



Trust Scorecards

SAFE, CARING & EFFECTIVE

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	15/16	16/17 YTD	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
		Patient Safety																		
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	3	3	3	3	3	0	0	0	0	0	0	0	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	DA03	C.Diff Cases - Monthly Totals	40	19	3	6	4	2	4	2	5	1	3	2	5	1	10	8	10	1
	DA02	MSSA Cases - Monthly Totals	26	21	2	2	2	1	0	2	3	3	7	4	2	0	3	8	13	0
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	7	9	12	14	17	0	1	2	3	4	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	97%	98.1%	98.1%	96.4%	97.7%	96.8%	96.6%	97.3%	98%	96.9%	98.4%	94.9%	97%	97%	97.3%	96.8%	97%
	DB02	Antibiotic Compliance	87.6%	86.7%	86%	90.6%	86.5%	88.2%	86.1%	84.4%	85.3%	83.9%	88.2%	86.5%	86.8%	90.9%	86.9%	84.5%	87.4%	90.9%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	94%	94%	94%	95%	94%	95%	95%	95%	96%	97%	95%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	95%	95%	96%	95%	96%	96%	96%	96%	97%	97%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	32	9	5	6	4	10	3	8	2	6	8	1	4	20	13	15	4
	S02a	Number of Confirmed Serious Incidents	55	16	8	4	5	4	5	3	7	1	4	1	-	-	14	11	5	-
	S02b	Number of Serious Incidents Still Open	5	14	1	1	1	0	0	0	1	1	1	6	1	4	1	2	8	4
	S03	Serious Incidents Reported Within 48 Hours	84.1%	90.6%	44.4%	100%	100%	100%	100%	66.7%	100%	100%	83.3%	87.5%	100%	100%	100%	92.3%	86.7%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	90.6%	-	-	-	-	-	66.7%	100%	100%	100%	87.5%	100%	75%	-	92.3%	93.3%	75%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	74.1%	100%	66.7%	60%	60%	63.6%	100%	100%	100%	100%	100%	100%	100%	100%	66.7%	100%	100%	100%
Never Events	S01	Total Never Events	3	2	1	1	0	0	0	0	0	0	1	0	0	1	0	0	1	1
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	7194	1149	1167	1190	1196	1226	1145	1216	1258	1173	1139	1263	-	3612	3619	3575	-
	S06b	Patient Safety Incidents Per 1000 Beddays	44.72	46.86	45.34	46.17	44.59	48.19	46.64	44.93	46.85	49.96	45.02	44.27	50.28	-	46.43	47.23	46.48	-
	S07	Number of Patient Safety Incidents - Severe Harm	97	41	8	15	5	6	3	2	8	9	10	10	2	-	14	19	22	-
Patient Falls	AB01	Falls Per 1,000 Beddays	3.94	4.32	3.79	4.15	3.56	3.59	4.15	4.24	3.93	4.57	4.57	3.81	4.38	4.76	3.77	4.24	4.25	4.76
	AB06a	Total Number of Patient Falls Resulting in Harm	30	19	3	5	2	3	5	1	4	3	3	3	3	2	10	8	9	2
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.221	0.138	0.079	0.158	0.15	0.242	0.114	0.275	0.154	0.04	0.077	0.194	0.159	0.073	0.167	0.157	0.143	0.073
	DE02	Pressure Ulcers - Grade 2	61	23	2	4	3	6	3	7	3	1	2	5	4	1	12	11	11	1
	DE03	Pressure Ulcers - Grade 3	7	2	0	0	1	0	0	0	1	0	0	0	0	1	1	1	0	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%	99.1%	98.1%	97.4%	97.1%	95.6%	96.9%	99.3%	99.1%	99%	99.1%	99.1%	99%	99%	96.5%	99.2%	99.1%	99%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	95.9%	93.5%	94%	93.6%	96%	94.5%	94.8%	96.3%	96.6%	97.3%	95.7%	94.1%	97%	94.7%	95.8%	95.8%	97%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	88.8%	91.6%	93.2%	90.4%	89.9%	91.4%	83.6%	94%	86.3%	89.4%	89.8%	89.7%	86.5%	90.6%	88.5%	89.6%	86.5%
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	-	84.5%	-	-	-	-	-	-	-	80.8%	-	-	88%	-	-	80.8%	88%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.7%	99.8%	100%	99.9%	99.9%	100%	99.8%	100%	98.9%	99.6%	99.9%	100%	99.6%	99.9%	99.6%	99.9%	99.6%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Quarterly Totals 15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0.33%	1.39%	1.2%	1.28%	0.42%	0.41%	0%	0.51%	0%	0.55%	0%	1.01%	-	0.7%	0.16%	0.51%	-
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.56%	0.62%	1.03%	1.49%	0.66%	0.69%	0.93%	0.63%	0.56%	0.6%	0.38%	0%	0.65%	0.92%	0.73%	0.33%	0.65%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	98.1%	95.9%	97.9%	97.2%	96.7%	97.3%	97.1%	97.7%	98.3%	98.4%	98.6%	98.6%	97.6%	97.1%	97.7%	98.6%	97.6%
	AK04	Safety Thermometer - No New Harms	98.6%	98.9%	97.9%	99.1%	98.8%	98.9%	99.4%	98.9%	98.7%	98.7%	99.2%	99.2%	99.2%	98.4%	99%	98.8%	99.2%	98.4%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	90%	91%	90%	86%	86%	88%	87%	100%	79%	82%	95%	94%	94%	86%	89%	90%	94%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.7%	11.1%	9.6%	11%	9.6%	9.6%	8.1%	7.5%	7.2%	7.8%	8.7%	7.3%	7.1%	10.1%	7.6%	7.9%	7.1%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.4%	19.2%	22.1%	21.9%	22.3%	23.3%	23%	22.3%	23.4%	23.1%	21.1%	22.3%	21.9%	22.5%	22.9%	22.2%	21.9%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	6748	836	1002	911	926	990	971	952	991	1007	909	939	979	2827	2914	2855	979
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	103.3%	104.8%	104.8%	105.9%	103.2%	103.1%	104.7%	104%	103.1%	104.3%	102.7%	101.9%	102.6%	104.1%	103.9%	103%	102.6%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.7	-	-	97.7	-	-	98.7	-	-	-	-	-	-	-	98.7	-	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	90	83.5	95.4	76.4	97.7	97	95.9	79.6	80.9	84.4	93.6	79.3	-	-	96.8	81.6	86.6	-
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.84%	2.82%	2.87%	2.67%	2.66%	1.5%	1.74%	1.56%	1.7%	1.76%	2%	2.29%	-	2.27%	1.67%	2.01%	-
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	60.8%	63.9%	63.4%	62.7%	60.1%	62.5%	66.6%	61%	56.4%	62%	61.5%	59.6%	58.8%	61.8%	61.2%	61%	58.8%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	71.2%	76.5%	66.7%	76%	78.6%	80%	87.5%	74.1%	72%	73.5%	61.3%	58.3%	73.7%	78.2%	77.6%	65.2%	73.7%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	75%	94.1%	86.7%	80%	78.6%	84%	83.3%	81.5%	72%	79.4%	64.5%	58.3%	89.5%	80.8%	78.9%	68.5%	89.5%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	51.6%	70.6%	60%	60%	64.3%	68%	70.8%	59.3%	44%	52.9%	35.5%	37.5%	68.4%	64.1%	57.9%	42.7%	68.4%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	44.4	44.8	50.2	47.5	40.5	35.8	61.4	44.1	44.4	72.2	53.5	49.4	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	63.3%	59.5%	56.8%	62.5%	77.4%	60.6%	69.2%	67.6%	65.9%	59%	51.4%	63.4%	-	66.1%	67.7%	58.3%	-
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	90.2%	91.9%	91.9%	91.7%	96.8%	84.8%	88.5%	88.2%	93.2%	92.3%	85.7%	92.7%	-	91.1%	90%	90.4%	-
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	69.6%	62.5%	47.1%	71.4%	80%	80%	58.3%	68.8%	61.5%	76.5%	71.4%	80%	60%	77.3%	63.4%	76.5%	60%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	95.1%	97.2%	95%	93.4%	94.7%	96.7%	94.5%	95.8%	94.1%	98%	96.3%	93.2%	93.1%	94.9%	94.8%	96%	93.1%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	97.9%	96.9%	98.4%	95.7%	96.3%	96.8%	96.8%	97.8%	98.1%	98.1%	97.8%	100%	96.8%	96.2%	97.5%	98.6%	96.8%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	96.4%	83.3%	100%	100%	100%	100%	95.2%	100%	100%	100%	100%	85.7%	100%	100%	97.2%	92.3%	100%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	72.7%	72.7%	-	93.8%	100%	75%	-	-	-	-	-	-	96.2%	75%	-	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9651	4770	548	712	1232	805	1073	930	589	745	600	616	461	829	3110	2264	1677	829

SAFE, CARING & EFFECTIVE (continued)

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	15/16	16/17 YTD	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	90	91	90	90	89	92	92	90	91	92	91	91	90	91	91	91
	P01g	Patient Survey - Kindness and Understanding	-	-	95	94	95	94	93	96	96	94	93	96	96	95	94	95	95	95
	P01h	Patient Survey - Outpatient Tracker Score	-	-	88	89	89	89	89	88	90	90	90	90	89	88	89	89	90	88
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.5%	36.5%	20.4%	20.6%	21.9%	22%	26.3%	35.2%	42.4%	40.5%	36.5%	36.8%	30.7%	33.7%	23.3%	39.4%	34.6%	33.7%
	P03b	Friends and Family Test ED Coverage	13%	15%	16.4%	13.9%	15.8%	16.7%	12.3%	14.8%	13.5%	15.5%	12%	16.8%	15.5%	17.3%	14.9%	14.6%	14.7%	17.3%
	P03c	Friends and Family Test MAT Coverage	22.7%	21.4%	20.2%	20.3%	15.7%	24%	33.7%	16.2%	26.3%	19%	24.4%	20.4%	21.1%	22.6%	24.3%	20.5%	21.9%	22.6%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	96.9%	96.5%	95.6%	96.7%	96.1%	95.9%	97.1%	95.8%	97.2%	95.9%	97.4%	96.9%	98.2%	96.2%	96.6%	96.7%	98.2%
	P04b	Friends and Family Test Score - ED	75.4%	77.6%	76.2%	80%	77.7%	73.7%	71.5%	80.2%	78.1%	74.4%	71.8%	79.6%	78.6%	79.3%	74.4%	77.5%	77.1%	79.3%
	P04c	Friends and Family Test Score - Maternity	96.6%	97.2%	96.9%	97.7%	94.9%	97.6%	95.8%	96.6%	98.9%	95.5%	96.2%	97.8%	97.3%	97.7%	96.2%	97.2%	97%	97.7%
Patient Complaints	T01	Number of Patient Complaints	1941	1177	148	116	143	183	150	176	146	198	200	155	162	140	476	520	517	140
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.255%	0.219%	0.19%	0.225%	0.268%	0.221%	0.272%	0.218%	0.296%	0.315%	0.246%	0.24%	0.204%	0.238%	0.262%	0.266%	0.204%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	83.2%	59.5%	50.8%	68.1%	71.8%	86.1%	81.6%	73.1%	73.8%	86.8%	90.6%	86%	92.3%	74.6%	76.2%	88.1%	92.3%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	90.5%	81%	90.5%	91.5%	84.6%	100%	87.8%	92.3%	95.2%	89.5%	94.3%	81.4%	92.3%	91.8%	91.6%	88.8%	92.3%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	11.54%	4.76%	6.35%	2.13%	7.69%	8.33%	8.16%	9.62%	16.67%	10.53%	13.21%	-	-	5.74%	11.19%	12.09%	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	0.89%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	1.42%	1%	0.69%	1.18%
	F01a	Number of Last Minute Cancelled Operations	713	388	51	39	68	71	108	63	59	61	63	30	39	73	247	183	132	73

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Quarterly Totals 15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	91.6%	92%	91.8%	92.4%	93.2%	92.2%	92.3%	92.6%	92.1%	92%	90.5%	90.4%	91.2%	92.6%	92.3%	91%	91.2%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	2491	2544	2349	2083	2397	2480	2442	2753	2749	3344	3256	2978	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	1	0	0	2	0	0	0	0	0	0	0	1	0	2	0	1	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	200	22	15	15	14	26	24	22	14	27	33	27	53	55	60	87	53
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	863	81	86	75	68	77	80	80	85	117	113	179	209	220	245	409	209
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	93.9%	95.8%	94.8%	93.7%	98%	96.6%	94.5%	94.6%	93.5%	95.4%	93.7%	91.6%	-	96.1%	94.2%	93.6%	-
	E01c	Cancer - Urgent Referrals Stretch Target	93%	93%	-	66.9%	-	-	-	-	-	64.8%	68%	65.3%	67.6%	68.4%	67%	-	-	66.1%	67.6%	-
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	96.3%	98.6%	97.8%	98.5%	97%	97.7%	91.5%	96.2%	96.7%	99.1%	96.5%	97.4%	-	97.8%	94.9%	97.6%	-
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	98.2%	100%	98.9%	96.1%	100%	99%	97.7%	100%	97.3%	97.5%	97.7%	99.1%	-	98.3%	98.3%	98.1%	-
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	93.2%	100%	98%	97.6%	97.9%	95%	80%	94%	97.7%	97.1%	92.6%	98.4%	-	96.9%	90.2%	96.1%	-
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	96.1%	97.6%	97.4%	97.9%	96.7%	98.6%	97.9%	98.4%	96.8%	96.7%	95.2%	92%	-	97.8%	97.7%	94.5%	-
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	76.7%	82.3%	86.7%	84.2%	74.2%	84.7%	77.2%	70.5%	70.8%	73.3%	84.8%	80.5%	-	81.1%	72.7%	80.1%	-
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	50.8%	71.4%	50%	50%	60%	70%	41.7%	35.3%	85.7%	66.7%	55.6%	44.4%	-	64.6%	47.2%	55.6%	-
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	89.2%	92.7%	100%	81%	92.9%	100%	75.9%	86.6%	96.9%	89.3%	91.1%	92.5%	-	92.1%	86.8%	90.8%	-
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	0.89%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.96%	1.03%	0.46%	0.6%	1.18%	1.42%	1%	0.69%	1.18%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	388	51	39	68	71	108	63	59	61	63	30	39	73	247	183	132	73
	F02c	Number of LMCs Not Re-admitted Within 28 Days	20	20	76	37	3	2	1	6	12	23	2	2	4	3	0	3	19	27	7	3
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.48%	1.67%	1.18%	1.86%	1.36%	1.68%	1.35%	1.82%	1.14%	1.5%	1.12%	1.33%	2.11%	1.63%	1.43%	1.31%	2.11%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	646	99	66	105	80	99	79	112	72	92	73	87	131	284	263	252	131
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	72.2%	78%	81.8%	75%	59.4%	63%	83.8%	55.2%	66.7%	70.5%	76.6%	75%	-	66.7%	69.8%	74%	-
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	92.8%	95.1%	95.5%	92.5%	93.8%	85.2%	100%	93.1%	83.3%	88.6%	93.6%	97.2%	-	90.9%	92.7%	92.9%	-
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	97.2%	99.37%	99.2%	98.69%	99.11%	99.2%	98.34%	98.55%	96.25%	96.09%	95.51%	96.88%	98.91%	99.01%	97.68%	96.17%	98.91%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.9%	12.2%	10.6%	13%	12.3%	11.8%	13.1%	14%	12.4%	12.6%	12.4%	11.8%	11.6%	10.9%	12.4%	13%	11.9%	10.9%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	41	30	19	33	31	34	23	22	29	31	25	30	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	10	4	5	5	10	3	6	4	5	6	5	4	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	39	33	42	49	48	59	48	50	46	60	45	56	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	10	9	7	9	16	8	10	10	6	9	15	6	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.13	4.11	4.12	4.04	4.03	4.3	4.23	4.16	4.14	3.89	4.24	4.21	4.02	4.13	4.18	4.11	4.02

RESPONSIVE (continued)

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	88.19%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	83.47%	89.32%	88.89%	82.94%
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%	88.19%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	88.99%	89.33%	90.01%	87.33%	82.94%	83.47%	89.32%	88.89%	82.94%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	87.4%	81.56%	89.43%	86.83%	75.72%	79.13%	75.11%	79.8%	87.73%	81.8%	83.73%	83.71%	80.78%	73.39%	76.61%	83.17%	82.77%	73.39%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	90.56%	93.46%	84.97%	86.7%	89.12%	84.67%	85.59%	93.02%	93.84%	95.11%	93.58%	97.29%	91.57%	90.65%	86.39%	94.01%	93.94%	90.65%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	99.48%	98.96%	99.83%	99.71%	99.83%	99.6%	98.94%	99.33%	99.54%	99.24%	98.65%	98.61%	99.26%	98.06%	99.44%	99.37%	98.84%	98.06%
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	4	0	0	6	0	6	0	1	0	0	0	1	2	12	1	1	2
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	97.1%	99.6%	99%	98.8%	99.3%	97.5%	96.2%	98.2%	94.7%	97%	97.9%	97.3%	98.3%	98.5%	96.4%	97.4%	98.3%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	92.3%	94.1%	93.8%	92.7%	92.9%	94.1%	93.3%	94.2%	92.1%	91.7%	91.8%	91.2%	91.8%	93.2%	93.2%	91.6%	91.8%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	53.4%	49.8%	53.1%	52.6%	45.3%	45.8%	55.2%	51.7%	51.7%	51.1%	56.5%	55.2%	52.8%	47.8%	52.8%	54.2%	52.8%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.6%	99%	98.9%	98.7%	98.6%	98.6%	98.8%	98.9%	98.5%	98.3%	98.9%	98.5%	98%	98.7%	98.7%	98.6%	98%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.4%	3.1%	3.5%	3%	3.7%	3.1%	3%	2.4%	2.3%	2.2%	2.2%	2.3%	2.4%	3.3%	2.6%	2.3%	2.4%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.3%	2.4%	2.2%	2.6%	2.7%	2.5%	2.1%	2%	2.5%	2.9%	1.8%	2.2%	2.6%	2.6%	2.2%	2.3%	2.6%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	751	86	104	236	153	140	62	72	114	77	125	140	161	529	248	342	161

EFFICIENT

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			15/16	16/17 YTD	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3
Sickness	AF02	Sickness Rate	4.2%	3.9%	4%	4.3%	4.5%	4.6%	4.5%	3.9%	3.7%	3.8%	3.8%	3.8%	3.7%	4.6%	4.3%	4.5%	3.7%	
		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	8393.1	8197.6	8199.8	8224.1	8229.4	8258.8	8241.7	8239	8304	8334.2	8364.5	8364.5	8393.1	8199.8	8258.8	8304	
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8427.7	8198	8180	8233.9	8246.6	8319.4	8339.7	8277.5	8315.7	8322.1	8398.3	8436.4	8427.7	8180	8319.4	8315.7	
	AF13	Percentage Over Funded Establishment	0.7%	0.4%	0%	-0.2%	0.1%	0.2%	0.7%	1.2%	0.5%	0.1%	-0.1%	0.4%	0.9%	0.4%	-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	376.3	339.3	336.1	342.8	361.7	350.9	337.2	370	394.7	429.9	437.9	410.7	376.3	336.1	350.9	394.7	
	AF11A	Percentage Bank Usage	4.2%	4.5%	4.1%	4.1%	4.2%	4.4%	4.2%	4%	4.5%	4.7%	5.2%	5.2%	4.9%	4.5%	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	149.1	156.1	134	152.1	144.9	153.4	156.4	131.9	138.3	149.8	148.5	157.4	149.1	134	153.4	138.3	
	AF11B	Percentage Agency Usage	1.8%	1.8%	1.9%	1.6%	1.8%	1.8%	1.8%	1.9%	1.6%	1.7%	1.8%	1.8%	1.9%	1.8%	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	404.5	420.1	431.3	412	422.3	361	305.8	380	439.2	494.8	452.7	404.5	404.5	431.3	361	439.2	
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	4.9%	5.2%	5.3%	5.1%	5.2%	4.4%	3.8%	4.7%	5.3%	6%	5.5%	4.9%	4.9%	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	109	148	120	137	154	148	229	191	137	169	367	205	109	120	148	205	
	AF10	Workforce Turnover Rate	13.4%	13.1%	13.9%	13.8%	13.9%	13.6%	13.4%	13.6%	13.3%	13.1%	13.4%	13.3%	13.3%	13.1%	13.8%	13.4%	13.3%	
		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%	-	91%	91%	92%	92%	91%	-	-	-	-	-	-	-	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%	85%	88%	88%	-	-	88%	
	AF21b	Essential Training Compliance - Annual Training	-	75%	-	-	-	-	-	-	56%	63%	66%	67%	73%	75%	-	-	63%	
	AF21c	Essential Training Compliance - Induction	-	96%	-	-	-	-	-	-	96%	95%	96%	94%	96%	96%	-	-	95%	
	AF21d	Essential Training Compliance - Resuscitation Training	-	81%	-	-	-	-	-	-	78%	79%	79%	77%	81%	81%	-	-	79%	
	AF21e	Essential Training Compliance - Safeguarding Training	-	89%	-	-	-	-	-	-	88%	88%	89%	86%	88%	89%	-	-	88%	
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		

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
NBT	North Bristol Trust
NICU	Neonatal Intensive Care Unit
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
PICU	Paediatric Intensive Care Unit
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 October 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%	91%	90%	89%	90%	88%	89%	86%
Annual (Fire and IG)	75%	87%	72%	74%	80%	70%	83%	73%
Induction & Orientation	96%	98%	99%	95%	96%	94%	97%	95%
Resuscitation	81%	76%	N/A	82%	81%	82%	88%	79%
Safeguarding	89%	93%	88%	91%	89%	88%	91%	83%

Safeguarding Adults and Children

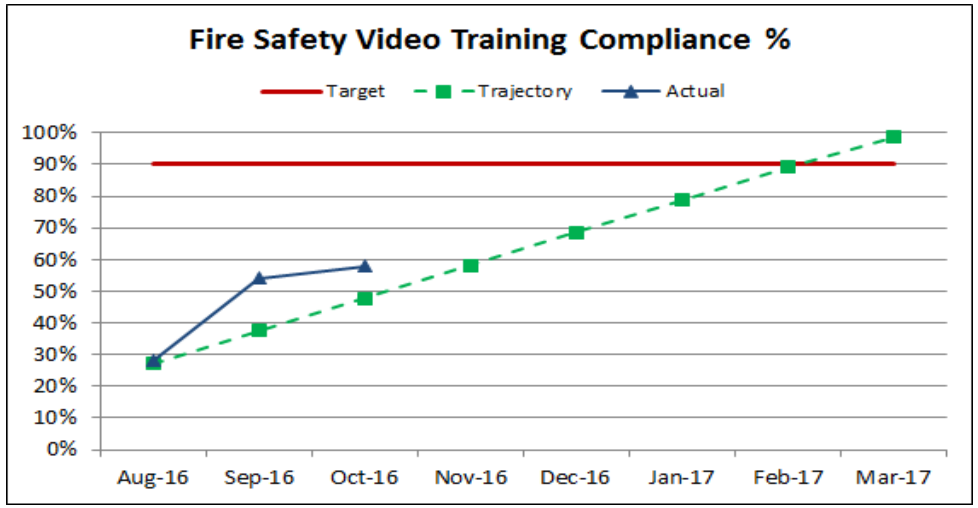
	UH Bristol	Diagnostics and Therapies	Facilities And Estates	Medicine	Specialised Services	Surgery Head and Neck	Trust Services	Women's And Children's
Safeguarding Adults L1	90%	94%	91%	89%	89%	85%	92%	87%
Safeguarding Adults L2	88%	93%	76%	92%	91%	89%	87%	82%
Safeguarding Adults L3	61%	100%	-	65%	70%	57%	71%	23%
Safeguarding Children L1	92%	93%	90%	90%	87%	88%	88%	
Safeguarding Children L2	88%	90%	88%	90%	87%	88%	88%	92%

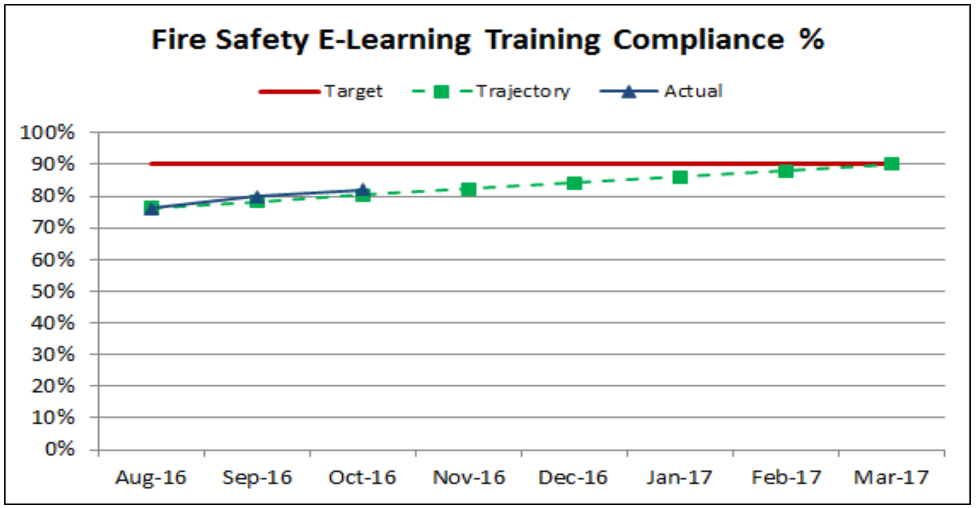
Child Protection level 3

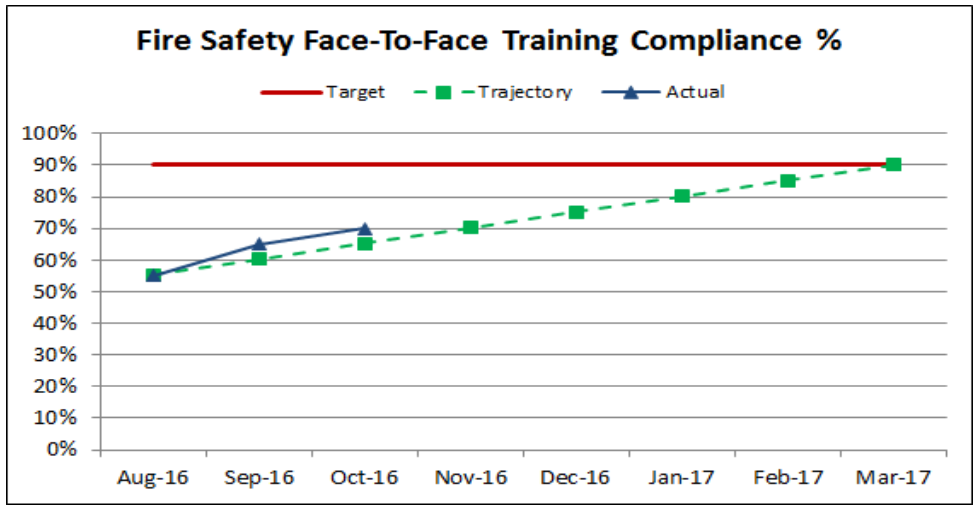
	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women`s and Children`s
Core	72%	83%	65%	59%	63%	100%	73%
Specialist	73%	-	-	-	-	100%	73%

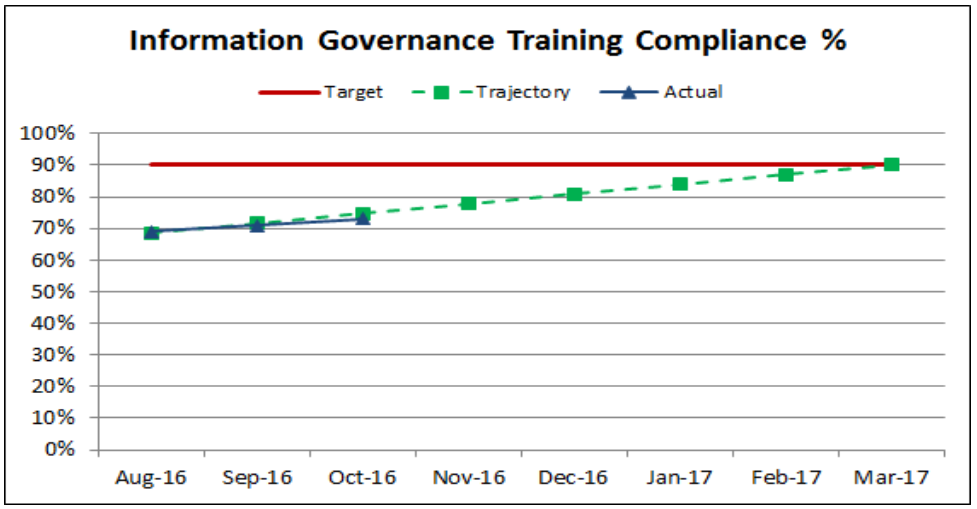
Appendix 2 (continued)

Performance against Trajectory for Fire and Information Governance









Note, there are two types of fire training represented in these trajectories, two yearly and annual fire training, with different target audiences. In addition, there are a fixed number of staff who require an additional training video under the previous fire training requirements. This will not be a requirement in the future once all are trained. The starting point for the trajectories is the same as the actual compliance figure for August 2016.

Appendix 2 (continued)

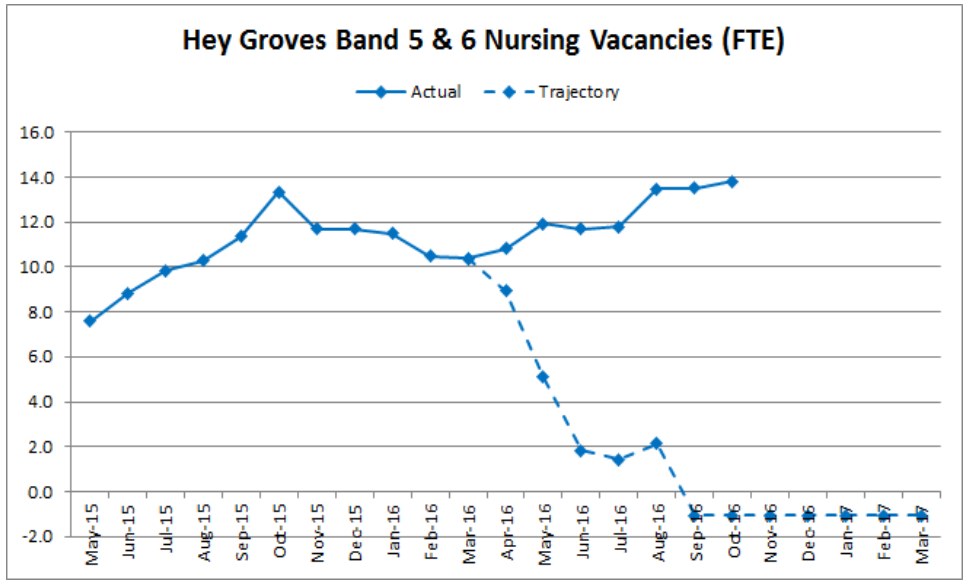
Agency shifts by staff group for 26th September to 17th October 2016

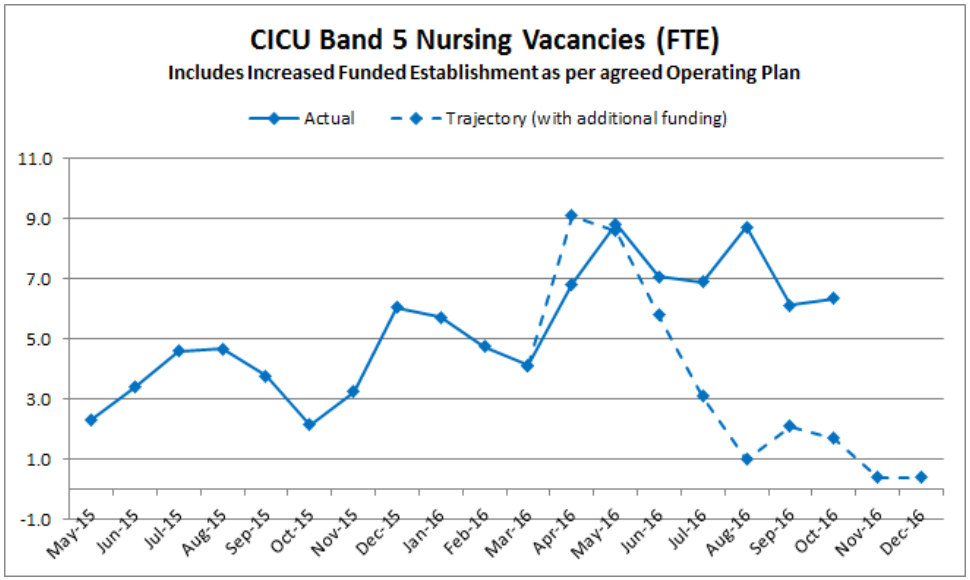
This report provides the Trust with an opportunity to do a retrospective submission to NHS Improvement of all our agency activity for the preceding four calendar week period, confirming over-rides with agency rates, worker wage rates and frameworks.

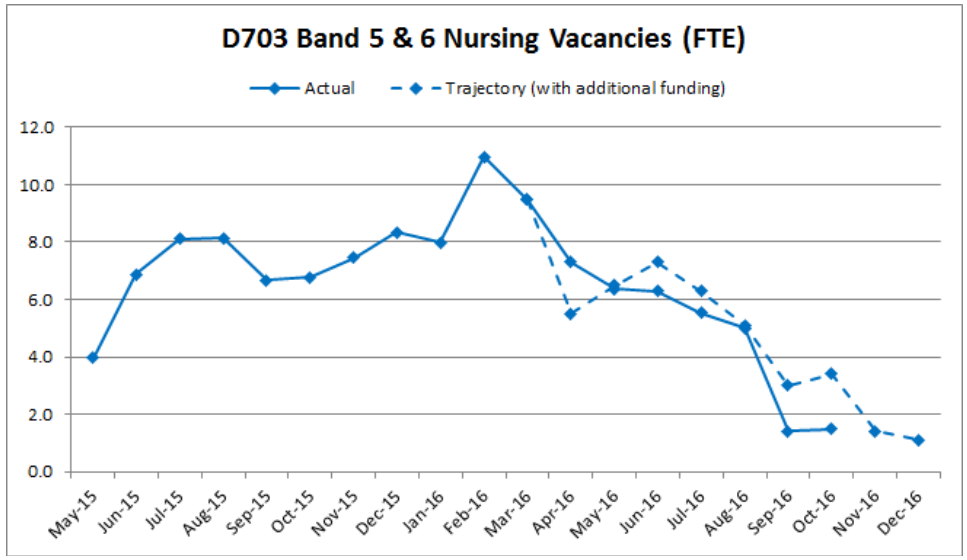
Staff Group	Within framework and price cap	Exceeds price cap	Exceeds wage cap	Non framework	Non framework and above both price and wage cap	Non framework and above price cap	Exceeds price and wage cap	Non framework and exceeds wage cap	Total
N&M /Health visiting	1	29	3	0	402	0	1008	0	1443
HCA & other Support	4	30	64	0	7	0	20	0	125
Medical & Dental	0	0	7	0	0	0	80	0	87
Scientific , therapeutic and technical (AHP)	15	0	80	0	0	0	29	0	124
Healthcare Science	0	0	0	0	0	0	0	0	0
A&C and Estates	1080	0	0	0	0	0	0	0	1080
Other	0	0	0	0	0	0	0	0	0

Appendix 2 (continued)

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 Quarter 2 2016, including national average performance for the same tumour site

Tumour Site	UH Bristol	Internal operational target	National
Brain*	100%	-	89.7%
Breast†*	90.0%	-	94.9%
Gynaecology	61.1%	85%	77.9%
Haematology (excluding acute leukaemia)	89.2%	85%	77.8%
Head and Neck	82.4%	79%	68.0%
Lower Gastrointestinal	70.3%	79%	71.6%
Lung	72.6%	79%	73.4%
Other*	77.8%	-	73.1%
Sarcoma*	83.3%	-	71.9%
Skin	91.7%	96%	95.4%
Upper Gastrointestinal	73.4%	79%	74.2%
Urology*†	42.9%	-	76.6%
Total (all tumour sites)	**80.1%**	**85.0%**	**82.2%**
Improvement trajectory	**83.7%**		
Performance for internally managed pathways	**87.4%**		
Performance for shared care pathways	**57.0%**		
Performance with breach reallocation/CQUIN applied	**83.3%**		

*10 or fewer patients treated in accountability terms

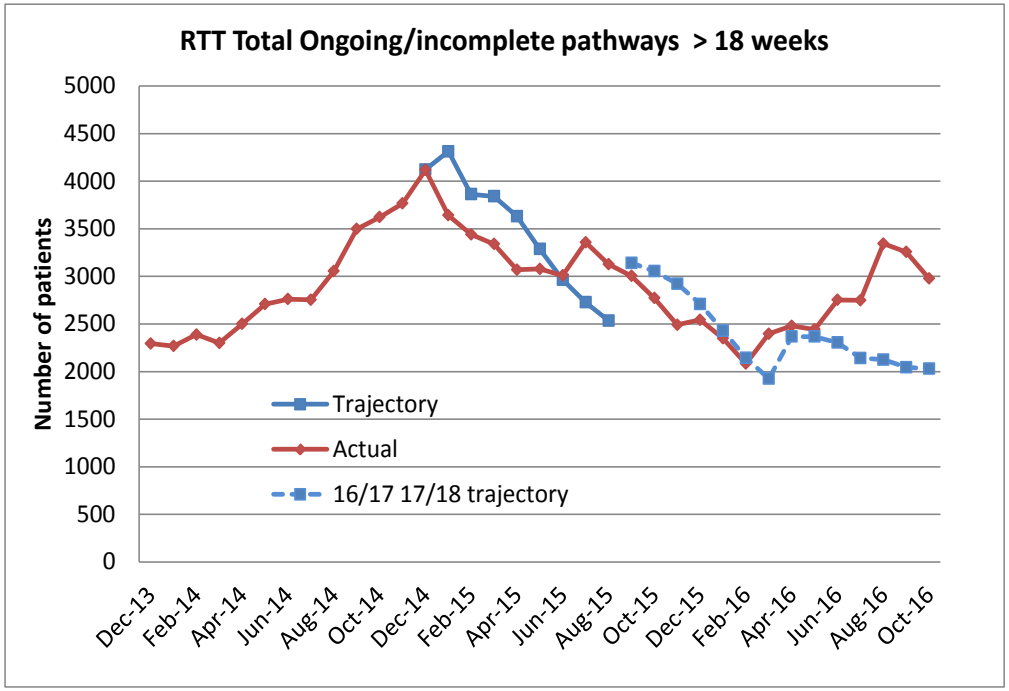
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

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 October 2016

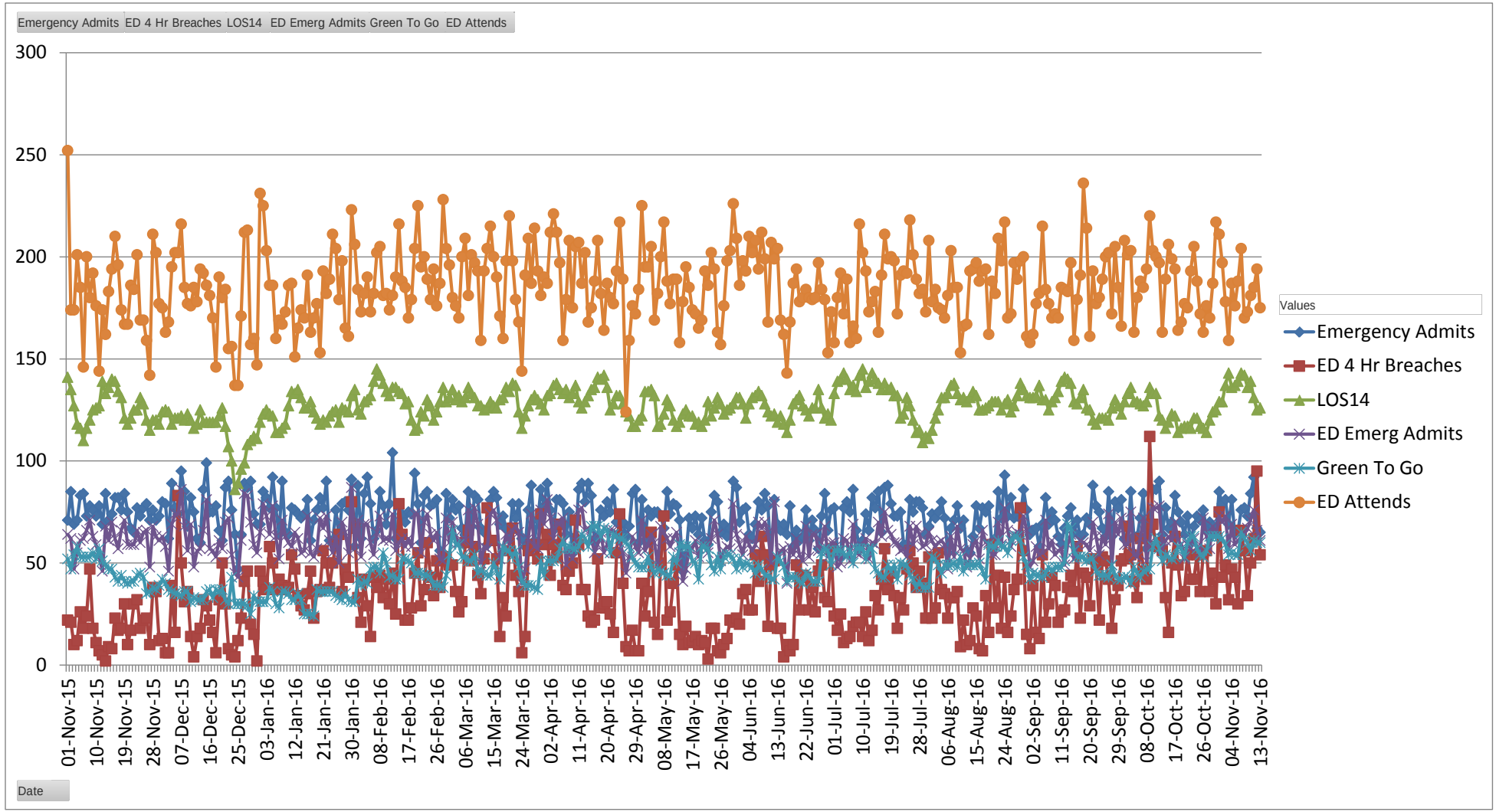
RTT Specialty	Ongoing Over 18 Weeks	Ongoing Pathways	Ongoing Performance
Cardiology	173	1,852	90.7%
Cardiothoracic Surgery	19	245	92.2%
Dermatology	150	2,145	93.0%
E.N.T.	66	2,189	97.0%
Gastroenterology	48	491	90.2%
General Medicine	0	44	100.0%
Geriatric Medicine	1	169	99.4%
Gynaecology	160	1,534	89.6%
Neurology	95	432	78.0%
Ophthalmology	224	5,103	95.6%
Oral Surgery	143	2,168	93.4%
Other	1,773	15,125	88.3%
Rheumatology	27	481	94.4%
Thoracic Medicine	18	889	98.0%
Trauma & Orthopaedics	81	1,147	92.9%
Grand Total	**2,978**	**34,014**	**91.2%**



	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16
Non-admitted pathways (target/actual)	1190/1460	1364/1479	1364/1480	1364/1796	1202/1741	1185/2189	1106/2060	1140/1852
Admitted pathways (target/actual)	735/937	1004/1001	1004/962	940/957	940/1008	940/1155	940/1196	890/1126
Total pathways (target/actual)	1925/2397	2368/2480	2368/2442	2304/2753	2142/2749	2125/3344	2046/3256	2030/2978
Target % incomplete < 18 weeks	93.9%	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%
Actual target % incomplete < 18 weeks	92.2%	92.3%	92.6%	92.1%	92.0%	90.5%	90.4%	91.2%
Recovery forecast	N/A	N/A	N/A	N/A	N/A	N/A	N/A	90.8%

Appendix 3 (continued)

BRI Flow metrics



Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11:00 am – 1:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	12
Meeting Title	Trust Board	**Meeting Date**	**29 November 2016**
Report Title	Bristol, North Somerset & South Gloucestershire Sustainability and Transformation Plan		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff. c.	☐	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

Purpose

To receive the Sustainability and Transformation Plan for Bristol, North Somerset and South Gloucestershire.

Key issues to note

The local Sustainability and Transformation Plan is being organised across three broad, interrelated themes:

- Prevention, early intervention and self-care
- Integrated primary and community care
- Acute Care Collaboration

This work is being supported by a number of enabling work-streams particularly including workforce, digital and finance.

The Sustainability and Transformation Plan in its current stage of development includes: a shared assessment of the service and financial challenges facing the local health and care system, a summary of the case for change and our vision for working together and working differently to meet this challenge.

Following a 'checkpoint' review by NHS England, the Sustainability and Transformation Plan will now be progressed leading to the development of specific plans and proposals.

This further detailed work will be informed through local engagement with local people, patients and carers, and other stakeholders.

Recommendations

Members are asked to:

- **Agree** the Sustainability and Transformation Plan in its current stage of development as the basis for further detailed work leading to implementation of relevant portfolios, programmes and projects; and
- **Agree** to receive further updates as this work is progressed

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Report	

Agenda Item : Sustainability and Transformation Plan for Bristol, North Somerset & South Gloucestershire

1 Purpose

The purpose of this report is to receive the Sustainability and Transformation Plan for Bristol, North Somerset & South Gloucestershire

2 Recommendations

The [Governing Body/Board] are recommended to:

2.1 Agree the Sustainability and Transformation Plan in its current stage of development as the basis for further detailed work leading to implementation of relevant portfolios, programmes and projects

2.1 To agree to receive further updates as this work is progressed

3 Background

Following on from the Five Year Forward View for the NHS in England, Sustainability and Transformation Plans (STPs) are a new approach to planning health and care services across over the next 5 years.

Local organisations are required to work together to develop a shared understanding of the challenges and to agree joint plans for addressing these.

The principal aims are to:

- Improve the health and wellbeing of local people
- Improve the quality of local health and care services
- Deliver financial stability and balance throughout the local health care system

Locally, *Bristol, North Somerset and South Gloucestershire* (BNSSG) are working together as one of 44 agreed local areas across the UK.

The initial development of the local STP has involved15 local organisations responsible for planning and providing your health and social care services (see table below).

Table: Local STP partners for Bristol, North Somerset and South Gloucestershire

- Bristol City Council, North Somerset Council, South Gloucestershire Council
- Bristol CCG, North Somerset CCG, South Gloucestershire CCG
- North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, Weston Area NHS Health Trust, South West Ambulance NHS Foundation Trust, Avon and Wiltshire Partnership
- Bristol Community Health, North Somerset Community Partnership, Sirona care & health
- NHS England (as the commissioners for Primary Care and for Specialised Services)

The development of the STP is overseen by an executive programme board on behalf of the existing BNSSG System Leaders Group, and is led by the Chief Executive of University Hospitals Bristol NHS Foundation Trust in the role of 'Senior Responsible Officer' for the local STP.

4 Discussion

The local Sustainability and Transformation Plan is included as an Annex to this report

The local STP is being organised across three broad, interrelated themes

- Prevention, early intervention and self-care
- Integrated primary and community care
- Acute care collaboration

This work is being supported by a number of enabling work-streams particularly including workforce, digital and finance

The STP in its current stage of development includes; a shared assessment of the service and financial challenges facing the local health and care system, a summary of the case for change and our vision for working together and working differently to meet this challenge.

Following a 'checkpoint' review by NHS England, the STP will now be progressed leading to the development of specific plans and proposals.

This further detailed work will be informed through engagement with local people, patients and carers, and other stakeholders.

5 Communication and engagement

The development of the STP to date has been undertaken with reference to existing information on people's view of local health services. This includes; feedback through public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports.

There will be opportunities for local people, patients and carers, and other stakeholders to get involved and have their say in the development of specific plans and proposals, and where a significant change is involved there will also be formal public consultation before changes are made.

6 Finance implications

There are no additional financial implications arising from the recommendations in this report.

The STP includes an assessment of the combined financial challenge for the whole health system.

7 Legal implications

There are no specific legal implications arising from the recommendations in this report

8 Risk Implications

A high level assessment of risks and mitigations is included in the STP. Risk identification and risk management will be undertaken through the STP programme management arrangements.

9 Implications for health inequalities

The development of the STP has been informed with reference to local health needs assessments including the current Joint Strategic Needs Assessments available for Bristol, North Somerset and South Gloucestershire respectively.

Further consideration of health impact assessments will be undertaken where indicated as part of specific portfolios and programme of work.

10 Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

There are no specific implications for equalities arising from the recommendations in this report.

Further consideration of any implications for equalities will be undertaken where indicated as part of specific portfolios and programme of work

Annex BNSSG Sustainability and Transformation Plan (October Technical Submission)

Report prepared by: Ben Bennett, Director of Strategic Projects - South Gloucestershire Clinical Commissioning Group

Report presented by:

Appendix A – Programme Approach

Programme Governance Key Terms of Reference

System Leadership Group (SLG) – Key role

The overall owner of the STP, the SLG steer and make decisions on the development and delivery of the STP. Members of the SLG have the authority to make decisions on the scope of the programme on behalf of their respective organisations. All work stream SROs within the programme are accountable to the SLG for delivering their agreed share of the benefits of the programme.

STP Executive Board (STP EB) – Key role

The STP EB supports the development of the STP, providing oversight of planning, implementation, benefits realisation and assurance. It membership is drawn from the System Leadership Group and will be supported by an STP project group.

Clinical Cabinet – Key role

The Clinical Cabinet provide a forum where collective knowledge on clinical issues can be shared and provided to the BNSSG system leadership group (SLG) and for SLG to seek clinical views across the system. It also creates a mechanism for increased participation in and advice from clinicians and other health and social care professionals in developing the Five Year Forward View strategy and model of care for BNSSG as part of the emerging sustainability and transformation plan

STP Programme Group (STP PG) – Key role

The STP PG bring together all the delivery work streams and ensure a coherent direction. The STP PG act as the conduit for project work streams, such as tracking of progress, monitoring benefits realisation, managing dependencies and interdependencies and identifying mitigating actions for issues and risks.

Prioritisation Group - Key role

The Prioritisation Group will report to the clinical cabinet and thus has a clinical focus (i.e. will not look at issues such as back office, estates, workforce, etc.).

The group is expected to review the existing prioritisation tools that CCGs, Public Health Departments and Providers have developed and also existing benchmarking tools developed by NHS-E and PHE e.g. Right Care although it is recognised that these often focus on cases for investment only and comparisons of activity without reference to outcome or need.

The focus should be two-fold:

1. Identify areas for disinvestment / resource reduction based on an evaluation of local and outside area comparable data
2. Identify priorities for investment and service re-design based on population need and whole system cost.

Programme Resourcing

The resources required for the STP programme that will span the BNSSG footprint, are identified below. The full resource requirements for all of the STP specific transformation programmes / work streams are being identified in line with the development of their delivery plans that are still to be formally confirmed and agreed. The expectation

is that each programme / workstream will require full-time dedicated programme and project team resources, which will either comprise of new recruits, or provided by the reprioritisation & reallocation of existing staff working on transformation opportunities within the organisations across the BNSSG footprint.

Summary of dedicated resource requirement - Initial BNSSG STP programme level

Governance level	Status
STP Executive Board	
✓ Independent Chair	In progress
✓ STP Senior Responsible Officer	In post
STP Programme Group	
✓ Programme Director	In post
✓ Programme Manager	In post
✓ Finance Officer	In progress
○ Engagement Officer	To be agreed
✓ Programme Support Officer	In post
BNSSG PMO	
○ PMO Manager	To be agreed
✓ Business Analyst	In progress
○ PMO Support Officer	To be Agreed

To help ensure there is an equitable level of programme resources from across the BNSSG footprint, the key leadership roles within the STP Programme have been filled from the commissioner and provider organisations affected.

Table of Key STP Roles and Individuals involved

BNSSG STP Portfolio	Organisation	Job Title	Organisation	Job Title
Overarching STP Programme	University Hospitals Bristol Foundation Trust	Chief Executive	BNSSG STP	**STP Programme Director**
Integrated Primary Care	Bristol Community Health	Chief Executive	Bristol CCG Bristol Community Health	Head of Strategic Planning Head of Business Development
Sustainable Primary Care	NHS England	Director of Commissioning & Assurance	NHS England	Head of Primary Care
Prevention, Early Intervention and Self Care	West of England Public Health Partnership	Chair	West of England Public Health Partnership	Consultant in Public Health
Acute Care Collaboration	North Bristol Trust	Chief Executive	University Hospitals Bristol Foundation Trust Bristol CCG	Head of Strategy and Business Planning Head of Strategic Planning
Workforce	Avon & Wiltshire Health Partnership	Chief Executive	Avon & Wiltshire Health Partnership	
Estates	To be Confirmed	To be confirmed	University Hospitals Bristol Foundation Trust	Director of Facilities & Estates
Digital	University Hospitals Bristol Foundation Trust	Chief Executive	South West Commissioning Unit	Connecting Care Programme Director
Engagement	South Gloucestershire CCG	Chief Officer	South Gloucestershire CCG	Director of Strategic Projects
Finance and BI	Weston Area Health Trust	Chief Executive	Bristol CCG Bristol CCG	Head of Strategic Planning Head of Performance and Information

Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

Appendix B1 – Plan on Page

***Please note this documented has been formatted to print on A3.**

Publication November 2016

Prevention, Early Intervention and Self Care

Making Every Contact Count (MECC) Project

Aim

To champion a culture and environment of health improvement where health becomes everyone's business.

Current State

Unhealthy lifestyles are a significant contributor to premature death, disability, inequalities and NHS costs. Almost 75% of premature mortality is due to 4 main diseases- cancers, cardiovascular disease, respiratory disease and liver disease. The main risk factors for these diseases are lifestyle related- smoking, poor diet, lack of physical activity and alcohol. These 4 lifestyles contribute to around 50% of premature death from these diseases alone.

Evidence from the JSNAs for BNSSG have shown that lifestyle behaviours are not equally distributed, and that socioeconomic status and lifestyles behaviours are clearly correlated with those from the most deprived backgrounds suffering the worst consequences.

Figure 1: Percentage of adults with unhealthy lifestyles in BNSSG.

Objectives

- To ensure that the prevention of poor physical and mental health becomes everyone's business within key provider organisations.
- To promote health and healthy lifestyles and wellbeing to all staff working with adult patients

Projects

- Making Every Contact Count (MECC) is an approach to behaviour change that utilises day to day interactions to support people in making positive changes to their physical and mental health and wellbeing.
- The project will ensure that each organisation has a 0.5 MECC co-ordinator in each of our main provider organisations for 12 months
- The role of the co-ordinators would be to work with senior leaders and workforce leads within their organisations to champion a culture and environment of health improvement where health becomes everyone's business.
- They will develop a sustainable MECC programme, rolling out MECC training to all frontline staff to ensure they have the skills and confidence to have opportunistic and sensitive conversations about healthy lifestyles and wellbeing.
- The co-ordinator will monitor and evaluate the impact of MECC and will, with partners across other providers, the local authorities and the South West region, ensure a consistent and system wide approach to MECC.
- They will be supported by MECC leads within local authorities and Public Health England and provided with tools, training and resources to support the delivery within their organisations.

Risks

- It is difficult to estimate the exact financial benefits from MECC at this stage
- The evidence base for outcomes from MECC programmes is still in its infancy.

Benefits

- Senior leaders will champion the importance of prevention across their organisations, building a culture and environment that supports health improvement
- Staff will be trained in the skills and will confidently and sensitively deliver brief healthy chats around smoking, diet, physical activity, alcohol and mental wellbeing to the patients they come into contact with and signpost patients to support where needed
- The lifestyles and health of the workforce and the patients they come into contact with will be improved and inequalities in health will be reduced.

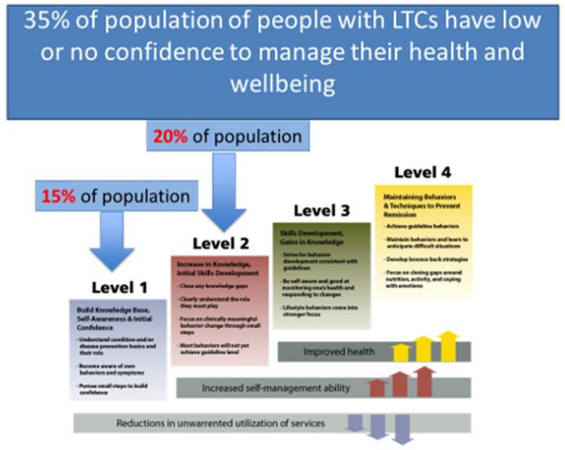
Self-Care and Social Prescribing

Aim

To deliver social prescribing, based on effective models of social prescribing and self-management at scale across BNSSG targeting the population at risk of emergency admission and ED attendance due to long term conditions.

Current State

There are currently a number of initiatives already in place that could be up-scaled across BNSSG - including Bristol Community Resource leads based in primary care, South Gloucestershire Community Connectors and Health Champions. The potential to self-care has been defined in terms of 'Patient Activation', which describes the knowledge, skills and confidence a person has in managing their own health and health care. It has been robustly demonstrated that levels of patient activation are related to most health behaviours, many clinical outcomes, health care costs and patient experiences.



Objectives

- to activate patients with Long Term Conditions to make their care more effective, increase wellbeing, and make better use of NHS resources
- To address low levels of patient activation; social isolation/loneliness and low activity levels
- To reduce avoidable emergency appointments and OP appointments
- To reduce DTOCs
- To reduce re-attendances within 30 days

Project

This project will:

- Coordinate, align and upscale existing initiatives such as SG Community Connections, Health Champions and BCH Community Resource Leads to ensure equity of access across BNSSG
- Deliver using a cluster model of service delivery outlined in the IPCC workstream
- Develop links to MECC, Healthy Living Hubs, Healthy Living Pharmacies and Voluntary and Community Sector

Risks:

- It is difficult to estimate the exact financial benefits from social prescription at this stage

Outcomes

- A range of interventions to enable self-care with a focus on social prescribing
- Upscaling of work shown to reduce demand on health and social care services across BNSSG
- A network of community health champions
- A network of peer led self-management groups

Supported Self-Care (Digital)

Aim

To improve people's ability and confidence to self-manage, through information, participating in a structured educational and monitoring programme, or by receiving and responding to text messages designed to support positive behaviours, co-ordinated through a clinically staffed, central 'hub'.

Current State

In the UK, 80% of GP consultations, 60% of days spent in hospital and two thirds of emergency admissions are related to long term conditions. However more than 80% of the care is undertaken by the patient or their carer. A small scale, eight month 'Champion' project in Bristol with one surgery and a total of 93 patients in three cohorts, tested how a range of people with varying health needs and preferences could be supported to better manage their conditions. While not designed as a statistically significant study, outcomes of the project showed a reduction in secondary care emergency attendances, admissions and out-patient appointments as well as reduced primary and community care contacts.

This local work is complemented by intelligence gained form a similar, larger scale service currently running in Liverpool which evidenced reductions in emergency admissions by a cohort of patients with LTCs of between 22- 32%.

Objectives

- to activate patients with Long Term Conditions to make their care more effective, increase wellbeing, and make better use of NHS resources
- To address low levels of patient activation; social isolation/loneliness and low activity levels
- To reduce avoidable emergency appointments and OP appointments
- To reduce DTOCs
- To reduce re-attendances within 30 days

Project

The project will deliver a range of interventions as part of a structured programme to enable self-care across BNSSG, focussing on those with Long Term Conditions at the highest risk of emergency admissions, using risk stratification, complex case management, traditional healthcare, information, education and signposting and, including the use of technology.

It will use the infrastructure and clinical workforce located in the Health and Care Single Point of Access (SPA) (see Integrated Primary and Community Care business case), from where patient alerts and data will be monitored and responded to, and technical and healthcare advice and support provided. The Health and Care SPA will work with GPs, case managers and other staff in the Multi-Disciplinary Teams (see Integrated Primary and Community Care business case) , including mental health staff, who will provide the hands-on care and treatment for patients on the programme.

Risks

- Full savings may not be realised
- Project has critical dependencies on other workstreams such as procurement of risk stratification and case finding tools, which may not be realised at speed required of the self-care programme
- Model and financial assumptions have not yet been fully described

Outcomes

- Improved clinical outcomes for patients
- Improved knowledge, skills and confidence to self-manage
- Improved quality of life and better experience for patients and carers
- Improved communication between care teams and breakdown of organisational silos
- Better care coordination
- Increased capacity through greater productivity and efficiency

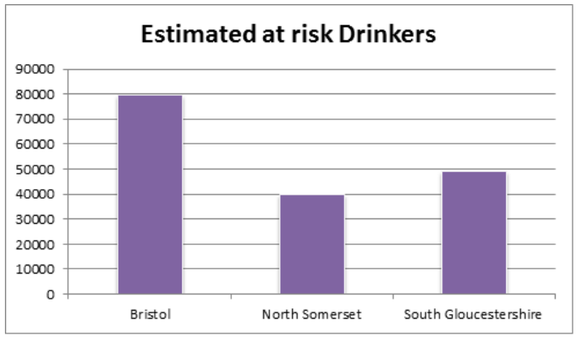
Alcohol Harm Reduction

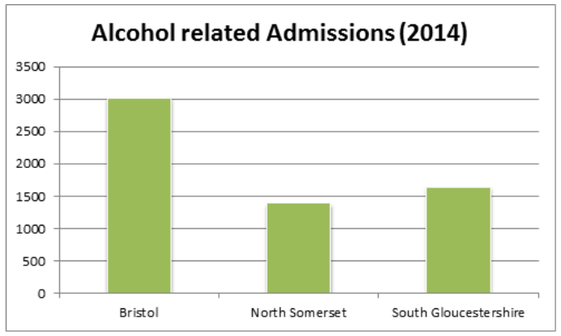
Aim

To reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions.

Current State

Current provision of Alcohol Identification and Brief Advice (IBA) across Bristol, North Somerset and South Gloucestershire (BNSSG) is variable across primary, community and secondary care. It is estimated there are the following:-





Objectives

- to strengthen the provision of Alcohol IBA across Bristol, North Somerset and South Gloucestershire (BNSSG) to ensure a consistent approach to IBA commissioning
- to improve the links between primary, secondary and community care including the wider workforce eg pharmacists
- to contribute to Alcohol harm reduction, which is a key priority for the STP within the Prevention, Early Intervention and Self Care (PEISC) workstream
- to reduce alcohol related hospital admissions, re-admissions, length of stay and ambulance call outs as well as the reduction in the burden of excessive alcohol consumption on the NHS, police and social care from high volume service users
- to tackle the poor understanding of alcohol-related health risks among patients and health care professionals
- to develop a more proactive approach to the earlier identification of people with chronic liver disease
- to explore opportunities for alternative ways to deliver diagnostic tests

Risks

- Full savings will not be realised

Project: Alcohol IBA

The Alcohol Identification and Brief Advice (IBA) programme aims to reduce the risk of harm to individuals from their alcohol consumption, by encouraging lower consumption which can result in fewer alcohol-related conditions and hospital admissions. The main objective is to tackle the poor understanding of alcohol-related health risks among patients and health care professionals using the following methods:

- Training of healthcare staff working in primary and secondary care settings (GP practices, hospital wards and community pharmacies)
- Increasing screening of patients (for example by use of the Audit-C scratch cards)
- Providing simple brief advice on alcohol consumption to cover potential harm and strategies to reduce alcohol intake
- Referral for specialist treatment where relevant

The two primary workstreams in this project are as follows:

- New primary care liver/alcohol pathway to identify those at risk of significant health and psychological issues caused by alcohol. The new liver/alcohol pathway seeks to standardise investigation and treatment of liver disease across the region and ensure equity of treatment. It would also ensure that liver referrals are appropriate and reduce hospital admissions and attendances for those in crisis by enabling earlier recognition and care planning of these high risk patients. Currently, more than one million liver function tests are requested a year, 70% of which are requested from primary care. Savings will also be obtained from a reduction in ultrasound scanning.
- Alternative pathways for diagnostics in primary care (for example testing for liver fibrosis using fibroscans) to identify those patients at highest risk of liver cirrhosis. This is expected to save significant resource in secondary care. The fibroscan service will be piloted in Bristol before the eventual roll out of the service across BNSSG.

Outcomes

- Consistent approach to Alcohol IBA provision across BNSSG
- Improved links between community, primary, secondary care and auxiliary healthcare professionals
- Reduced systems costs from avoidance of or reductions in alcohol related admissions, readmissions, Length of Stay and ambulance call outs
- Better understanding of alcohol related risks
- Earlier diagnosis of chronic liver disease and improved long term health outcomes

Integrated Primary and Community Care

Sustainable Primary Care Programme

Aim

- Sustainable, effective and accessible primary care
- Absorb the expected rise in demand by 2020/21 through new ways of working that include supported self-care, an MDT approach and deployment of non-clinical services.
- Make Primary Care a satisfying career choice

Current State

- Deficit of Clinical workforce availability to continue to provide care in its current form. Need to consider new models of care and meet increasing needs of the population
- Difficulties for patients in accessing primary care services
- GP estate is not fit for purpose in many cases given practice mergers and the percentage of work needing to move into an out of hospital setting current and this is causing system wide pressures.
- Variations in quality of care provision

Objectives

- Absorb the expected 12% rise in demand by 2020/21
- Management of patients as risk of admission in the community setting
- Delivery of primary and secondary prevention interventions
- Early identification and intervention to manage demand for both urgent and elective care
- Reduce variation of practice and improve consistency of outcomes by operating standardised policies, processes, procedures and documentation, including the digital record. Right care first time.
- Patient education, activation and involvement are in planning and delivery
- Reduce the need for patients and carers to repeatedly tell their story. This will be enabled through regular MDT meetings, health passports, close working relationships and enabling IT
- Promote and develop inter-professional team-working in order to achieve a multi-disciplinary service delivery
- GPs day de-cluttered so that they do what only they can do
- Move non-medical appointments from Primary Care to the voluntary / community sector, freeing high cost resource and capacity
- Maximise contribution of Community Pharmacy sector
- Maximise contribution of voluntary sector and other community assets
- Ensure the first care / treatment option offered is the most cost effective which delivers the identified health, care and wellbeing outcomes
- Provide training which is consistent across BNSSG, supporting the delivery of clinically effective intervention and care without variation
- Driving improvement through innovation and research
- Enable inter-professional collaboration and decision making by blurring organisational boundaries
- Ensure MDT workforce is appropriately skilled and trained to manage the local population's health, care and wellbeing needs
- Digital enablement to the above
- Buildings that enable the above
- An organised Primary care sector with a single provider voice

Projects

- A patient and their GP will be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This will occur in general practices which are recognised as places in each community, developing community resilience and supporting our citizens to stay as well and as healthy as possible.
- High quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home as well as general medical services.
- To be organised in different ways depending on local circumstances but based on a defined geographical patch, reflecting natural communities of 30-50k, within which they are responsible for the health and wellbeing of the population. The units (circa 18 across BNSSG) will be large enough to be organisationally resilient whilst hosting smaller clinical teams at a local level of different specialisms. They will form the basis for delivery of seven day services and enhanced primary care, including Mental Health.
- Local care organisations will work with similar organisations across the BNSSG system to provide a seamless service to patients through defining new community care pathways and sharing a common patient record.

General Practice Pilots

These pilots are underway and include:-

- Piloting mental health workers, physiotherapists and pharmacists to develop multi-disciplinary teams to support better patient access to services and GP workload
- Developing a 7 day access model in primary care across BNSSG
- Piloting use of web based technology for GP consultations and improving patient access to web based self-help information
- Improving telephone access through the review of telephony systems
- Reviewing back office functions and processes to improve practice efficiency

The GP sustainability and transformation of general practice programme will be responsible for reviewing the evaluations and business cases of the above pilots to understand whether these initiatives are something the system may wish to take a view on continuing or not in the longer term.

Temperature Check Project

This project aims to work with GPS across BNSSG to undertake a 'temperature check' of general practice in November 2016. This will put together data and understanding of the current system. The project will then meet with groups of practices to discuss their results from the temperate check, to have proactive discussions and develop a 'resilience and transformation plan for the local area' with go live on a number of initiatives from December 2016. This will also help inform the programme plan further for the GP sustainability and delivery programme.

Development of Primary Care Capacity

This project aims to maximise benefits of Clinical Pharmacy Pilot, spread of pilots relating to practice based physio, mental health nurses, IAPT, health trainers and introduce new partnerhsips with community pharmacies for both urgent care and LTC management. It will work closely with with 7 day working multidiciplinary work project and the development of the SPA project to ensure the work delivers a clear offer for patients and staff working within the system.

Risks

- Lack of a 'Primary Care ready' MDT workforce
- Current contracting arrangements
- Project management and business case development resource
- Expertise on new funding models
- Funding for transformation and investment in technology
- Baseline data for demand and activity across both community services and primary care

Benefits

- Improved health outcomes and reduced inequalities
- Reduce demand for secondary care services
- Reduce the number of consultations conducted by GPs by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Decrease the number of home visits, surgery visits and outpatient appoints by up to 15% through the use of home monitoring and remote consultation
- Reduced admission to care homes.

Health & Care Single Point of Access (Design and Technologies)

Aim

The aim of this project is to replace the current multiple points of access to health & social care for adults by establishing one BNSSG SPA for professionals (and possibly patients on care plans and their carers) to support admission avoidance and discharge to underpin the Urgent Care System to meet the aims, objectives, and outcomes outlined in the STP.

Current State

Currently the process of referring people to the most appropriate services in the community is not very easy to navigate and lacks consistency of approach, where the physical, mental and social health teams work quite separately.
Other issues with the current model include problems with technology and information sharing, inconsistent call handling timescales and processes (it can take anything from 5 minutes to 1.5hrs for a community referral to be processed, depending on the time of day), duplication of work and repeat assessments, inefficient use of clinical time (often spent trying to identify and then get through to the most appropriate person), fragmented and complex system, with no single call to access clinical advice, lack of consistency in accessing community services every day of the week and significant costs associated.

Objectives

- Provide a sustainable, high quality service that enables Bristol, North Somerset and South Gloucestershire population to receive the right care, in the right place, at the right time by providing seamless coordinated care;
- Design a service specification and model of care that meets the requirements of IPCC model in the STP and delivers the savings and benefits assumptions;
- To enable the appropriate, effective and timely sharing of relevant user data across and between providers;
- To improve clinical decision making through access to user records;
- Improve the co-ordination of services between primary, community, social and secondary care provision;
- Increase cost effectiveness by bringing functions together and working in a new way to achieve the economies of scale, which can be done by maximising the use of existing services in terms of workforce skill mix, knowledge and competencies;
- To provide a service that can respond to a user's needs early in the pathway, linking into services across the community without the need for repeated assessments and information at each stage;
- Assist in increasing the accessibility to right services based on need;
- Improve appropriateness and the quality of care provision as well as releasing clinical time;
- Improve pathways for high intensity users;
- Work with the providers of community beds and acute providers in relation to step-up and step-down provision;
- Deliver a rich set of information on unmet need, demand and capacity gaps and so contribute to workforce development by shaping/reshaping the workforce to meet user's needs and delivery of the urgent care model now and in the future;
- Reduce conveyances by linking the SWAST clinical desk function provided by the Ambulance Service with the BNSSG SPA to ensure patients are cared for in the most appropriate place (including at home or within the community), reducing the need for conveyances and emergency admission to hospital;
- To ensure changes to urgent care services in BNSSG are coordinated with the work led by the Severn Urgent & Emergency Care Network;
- Support delivery of cluster working & MDTs in the community.

Project

The project will:-

- To identify all current SPA services in BNSSG (pop. C900 000);
- To identify all SPA related projects and work streams in progress or planned across BNSSG, and their underpinning assumptions/benefits, delivery mechanisms, timeframes and membership;
- Establish a common service specification for a BNSSG SPA for adults, which takes into account current local services and all future aspirations;
- Develop an outline service model in response to the agreed output specification;
- Identify the required workforce and skills, whether they are currently in the system and where there are gaps;
- Identify the underpinning infrastructure likely to be required to deliver the functions (a strategic outline business case for capital has been submitted to NHS England as part of a call for applications under the Urgent Care Review recommendations. The £3 457 300 submitted was done at short notice and requires validation);
- Identify the membership and governance arrangements for this project;
- Review STP assumptions and work up a SPA activity model to inform an indicative cost (capital and revenue);
- Identify funding/resources across organisations which could be diverted to fund the BNSSG SPA;
- Profile the delivery of the SPA incrementally in line with the current STP Plan, which sees the SPA fully implemented in 2018/19;
- Develop a detailed implementation plan.
- Commission and implement the new service.

Risks

- There is a risk that we will not have sufficient capital to invest in establishing a SPA, including accommodation and technology solutions to enable the service to be established.
- There is a risk that the contract expiry dates across the BNSSG may not be aligned and may result in double or over paying for services.
- Conflicting local priorities and inability to agree on a service specification and scope among providers and commissioners.

Outcomes

- Reduction in emergency admissions
- Reduction in ED attendances
- Reduction in re-admissions
- Reduction in length of stay
- Reduction in excess bed days
- Reduction in conveyances
- Increase utilisation of Community Beds
- Increase telehealth usage
- Also several other qualitative benefits e.g. improved patient and service user's experience & outcomes by better coordinated care with a single contact, provision of alternatives to emergency admissions to avoid older people deteriorating during extended stays in hospital and with no need for repeat assessments

SPA Services Rapid Response

Aim

To deliver an expanded Rapid Response service accessed via the health and care hub, with support from the full multidisciplinary team this will include rapid access for diagnostics, prescribing of medication, urgent social care and nursing support, all community and primary care based.

Current State

The mounting pressures on Emergency Departments across the BNSSG geography illustrates the need to transition to a more sustainable model of care, which may involve caring for more patients in the community and preventing unnecessary deconditioning of patients.

Bristol, North Somerset and South Gloucestershire are also experiencing significant challenges in terms of demand for urgent care services. This is impacting on the quality of care and delivery of key performance targets and, most importantly, on patient experience and outcomes.

Nationally, Better Care has set out the need for services provided by health and social care to be better co-ordinated and integrated and concentrate on strengthening clinical triage and advice service to allow for smoother pathways for both clinicians and patients navigating the complex system.

Objectives

- Reduce the number of unnecessary non elective admissions to hospital.
- Reduce the number of readmissions to hospital
- Define equitable good quality 7 day services available on the basis of need
- Provide care that centres on patient needs with timely interventions**.**

Projects

- To identify all current Rapid Response services in BNSSG (pop. C900 000);
- To identify all related projects and work streams in progress or planned across BNSSG, and their underpinning assumptions/benefits, delivery mechanisms, timeframes and membership;
- Develop an outline service model in response to the agreed output specification;
- Identify the required workforce and skills, whether they are currently in the system and where there are gaps;
- Identify the membership and governance arrangements for this project;
- Review STP assumptions and work up an activity model to inform an indicative cost (capital and revenue);
- Develop a detailed implementation plan.

Risks

- There is a risk that investment in diagnostic services and step up beds is reliant exclusively by disinvestment from the acute providers. The Primary and Community care providers are unable to assume that risk unless agreement can be reached.
- It is not possible to rain workforce and recruit to new roles to deliver new models of care
- Existing community services do not have the capacity to meet increasing demand. Lack of capacity could effect ability to achieve outcomes.

Outcomes

Direct shift of appropriate activity from A&E

There are additional savings to be made in mental health, dementia, diabetes and respiratory emergency admissions.

Also qualitative benefits including:

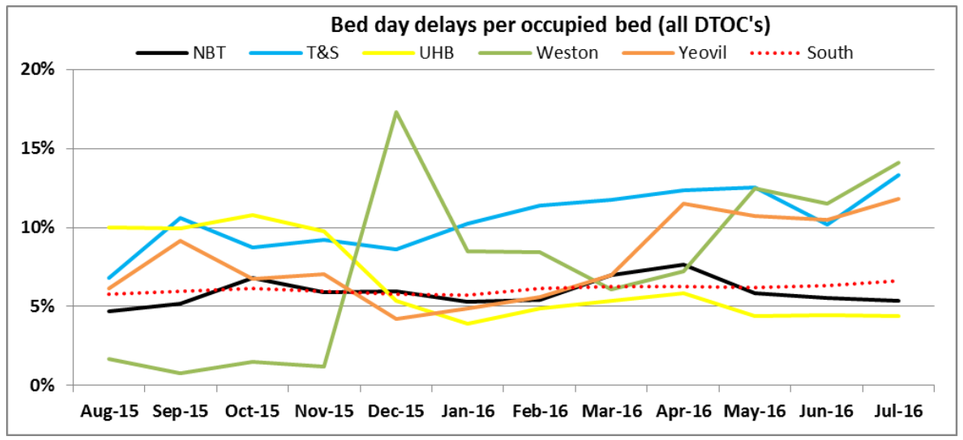
- Improved patient and service user's experience & outcomes by better coordinated care with a single contact, provision of alternatives to emergency admissions to avoid older people deteriorating during extended stays in hospital and with no need for repeat assessments;
- Immediate advice and basic treatment to enable the patient to remain in their home.
- For those experiencing a short term crisis immediate health intervention or support during breakdown of care.
- Improved system resilience by operating at larger scale across the three geographies resulting in improved use of services and the skills of all staff;
- ensuring a robust interface for emergency services, acute hospitals and primary care;
- Increased number of people being treated in their own home or closer to home in community facilities;
- Improved the effectiveness of health interventions and wellbeing and management of mental alongside physical health;
- Reduced duplication and fragmentation by standardising processes and criteria, reduced variation in access and referrals, integrated teams and development of trusted assessor roles and procedures;
- Closer working and understanding between the health and social care staff working together.

Health and Care Single Point of Access – Delayed Transfers of Care (Part A)

Aim

Requirement to have a consolidated plan to ensure that Delayed Transfer of Care (DTOC) levels are within 2.5-3.5% parameters & address longer term issues re bed utilisation, length of stay (LOS) and model of care for Frailty. To ensure that plans for community and primary care developments are aligned with wider BNSSG Transforming Care Plan (TCP) requirements.

Current State



Objectives

- To maximise opportunities for patients to go directly home to their usual place of residence, spending the shortest time possible within a hospital or inpatient setting.
- To standardise, simplify and reduce variation within our approach to discharge, maintaining configuration for individual patient need but simplifying and reducing processes, options and decision making at key points in the patient journey.
- To maintain and develop the current D2A pathways across BNSSG to ensure that DTOC levels are reliably and consistently within the national 2.5%- 3.5% parameters.
- One key element of addressing LOS and expanding the principles of D2A will be a restructuring of all therapy services to create a new flexible clinical and operational model. This model will include all current therapy resources distributed across health and social care to support early discharge and prevention of readmission.
- To reduce overall LOS within hospitals for all patients including 'simple' discharges with a target of approximately 200 beds across the local system.
- To ensure there is optimal use of current bedded assets footprint wide including South Bristol Community Hospital, North Somerset (Clevedon) Community Hospital, the proposed developments at Frenchay and Thornbury, other rehabilitation settings and D2A Pathways 1-3.This will include establishing what facilities will be required to support a sustained reduction in LOS across a broad range of patient pathways
- To integrate within the proposed locality/cluster and MDT models across BNSSG and supporting admission avoidance work and long term conditions management.
- To make optimal use of other related service elements such as long term residential care beds , homecare, voluntary sector services and also self-care/support for carers especially in the context of extreme pressure on social care budgets

Projects

Work to continue to reduce DTOC's to the 2.5/3.5% national target as part of a BNSSG-wide Discharge to Assess (D2A) programme.
Formalise the discharge to assess pathways provided by North Somerset
Work across BNSSG on flexible use of all (bedded) pathways based on need rather than GP registration.
Maximise the discharge to assess offer at the front door, including the inpatient assessment units
Embedding of trusted assessment across the patch is also key, and links to the business case submitted by the Local Authorities

Focus on simple / routine discharges and overall reductions in length of stay
A change is culture and understanding by staff and patients will be required to embed these new ways of working.
Individual pathways reviews will show areas of opportunity for length of stay reductions though increased use of MDT working and targeted application of the agreed operational standards for discharge. Known areas for development currently include stroke, MSK, neurology and medicine.
A review of end of life care pathways will be required and will link with the STP business cases related to frailty and end of life. This needs to include work on care home market management and quality assurance.
A focus on criteria-led discharge, earlier in the day discharges and weekend discharges, and routine use of discharge / transfer lounge facilities.
Utilising structured supported self-care programmes (see separate IPCC business case) to support earlier discharges for people with Long Term Conditions.
Utilising the expertise and information in the Health and Care Single Point of Access to facilitate early discharge to the right place, with the right support.

Transformation of secondary/primary/community care at scale
Scoping and provision of step up/ step down requirements across BNSSG.
Active case management through the STP proposal of Community MDTs (see separate IPCC business case)
Linked to this would be a transformation of the way therapies are delivered across the system.
Assertive discharge procedures would centre around the board round, which would become the hub and driving force of all discharges
Unbundling of tariff and other funding structures to support financial flows through the system would be required.
A focus on the requirements of mental health DTOC patients, including working with local authority colleagues on suitable housing options and the provision of care home beds for people with complex needs, such as advanced dementia.
A review of staffing ratios and use of bank and agency staffing would be needed, and reduction in use of non-substantive roles would be supported through unification of pathways / providers.
Standardisation of supplies would generate efficiencies and savings for example in community equipment, dressings etc.

In summary, there will be three broad strands to this work, as follows:

1) Simple Discharges– efficiency and productivity will be maximised through changes to internal flow within the hospital systems (including mental health). This element will be largely cost neutral / cost saving.
2) Complex Discharges– efficiency will be maximised through the at scale provision of discharge to assess pathways. For Bristol and South Gloucestershire provision currently matches demand (taking into account developments already underway to increase discharges across all pathways). As discussed, further work is required to understand the needs of North Somerset patients, though systems and processes can be shared easily which would simplify future implementation and aid alignment across the patch.
3) Early Supported Discharge – efficiency would be facilitated through the discharge of patients who, whilst still within tariff structures, can be safely cared for in a lower intensity (cost) setting. This would be a balance between a virtual ward type scenario and convalescence. Obvious examples include fractured neck of femur patients and people ready for stroke rehabilitation.

Risks

- Resources, particularly workforce
- Ability and will of organisations to work collaboratively to develop new models of care and to share risks and benefits
- Work will be required to change patient and carer perception of the best setting for care, particularly during the post-acute phase.
- Transformation and development capacity within organisations to implement and embed the required changes
- Political and public attachment to current operational configuration, especially locality specific services

  Clinical 'buy in' to a significantly transformed model of care which will challenge current ways of working and organising our services.

Outcomes

- Reduced risk of decompensation and loss of independence
- Positive patient stories & single, patient-focused assessments, joint decision making in out of hospital settings,
- A sustained and permanent shift activity from the acute sector to the primary and community sector community
- Flexible, people rather than estates based model that can flex with changes in demand, presentation and patient expectation
- Patients return home more quickly to their place of residence and reduced readmission rates
- Reduced hospital bed days and improved internal flow within hospital which will support the consistent delivery of NHS Constitutional standards.
- Better use of current and future workforce especially registered staff & sustainable and skill orientated work plans for staff
- Improved access to beds to support elective programme and fewer patient ward moves and outlying patients
- Assessment in out of hospital settings which provide a more accurate picture of patients' needs
- Decreased requirement for long term, high cost packages of care following successful periods of reablement at home

Health and Care Single Point of Access – Delayed Transfers of Care (Part B)

Aim

Partners within the STP collaborate to avoid admissions, reduce length of stay for patients, improve patient experience and improve the efficiency of patient flow/discharge processes. Improvements will be achieved through a more consistent, responsive and collaborative team approach to patient flow and hospital discharge at all the acute trusts in the STP area.

Current State

Average LOS are:

- 10.1 days unplanned/ 4 days planned at Bristol,
- 8.6 days unplanned/ 3.7 days planned a North Somerset,
- 8.8 days unplanned/ 3.3 days planned at South Gloucestershire.

The mapping exercise also found that:

- Each of the 3 areas has different weekend and bank holiday cover arrangements.
- Variable amounts of progress in the development of Discharge to Assess (D2A) pathways e.g. North Somerset has still not fully implemented D2A pathways 2 and 3.
- Different processes/paperwork are used for discharge by each of the 3 STP areas even though patients from each area are regularly treated in hospitals in all three areas.
- Different hospital social work models exist in the STP area e.g. with some social workers attached to wards and others operate a referral and allocation model.
- That delays in discharge sometimes occur because likely discharge complexity is not always identified at admission.

Objectives

- Avoid unnecessary admissions to hospital
- Improve patient flow after admission
- Ensure prompt discharge from hospital either for further social care assessment or into a sustainable on-going care setting (community, residential or nursing) when patients are medically optimised.
- Achieve a reduction in the LOS of at least one day for between 10% and 20% of all unplanned spells in hospital by patients aged over 65 in the BNSSG STP area and so save between £1m and £2m p.a.

Projects

Increase the Social Care staff presence within wards and within ED and Medical Assessment Units. The aims are to sign-post people to non-statutory support when it is appropriate to do so, facilitate a prompt and safe discharge process and expedite the assessment of patients as soon as they are “medically optimised”.

Design a single and consistent 7 days a week Hospital Discharge process to operate in each of the 3 main acute hospitals in the BNSSG STP area. The aims are to eliminate waste and duplication, save staff time as they will not have to use different systems/processes depending on which area the patient is resident in, and ensure the patient experience is consistently good.

Consider options for, develop and pilot “Trusted Assessor” arrangements with a sample of large residential/nursing care homes. Aim is to establish if the pilot arrangements are justified by a reduction in discharge delays due to waiting for an assessment by a care provider.

Undertake an analysis of care/nursing home placements made on discharge from hospital by each of the 3 local authorities and CHC funded placements made by the 3 CCG’s in the STP area. The aim is to establish whether there is a business case for a joint BNSSG STP area care home commissioning and brokerage service is justified.

Risks

- **Inability to recruit into the posts** – Posts may not appear attractive in particular into the evening posts and therefore it is possible that high quality staff may not be recruited.
- **A lack of available service provision outside of hospital for people to be discharged to** – This could still limit the impact of this work stream even if patient flow and hospital discharge processes are ideally designed and operate to their optimum.
- Different ICT systems at each hospital may make having 100% identical processes at each hospital difficult. A possible constraint is the extent to which local work arounds that preserve the same overall process at each hospital, but allow staff to use local ICT systems can be developed and will be allowed/supported by Corporate ICT colleagues.
- **A lack of available res/nursing places for people to be discharged to** – This could still limit the impact of this work stream i.e. even if “Trusted Assessment” was in place a delay in discharge could occur while a suitable vacancy was located.
- It is difficult to demonstrate why changes in admission numbers and LOS occur as they are multi-factorial i.e. isolating the “cause” and the “effect” will be difficult. Proving value for money maybe a challenge.
- A lack of available service provision outside of Hospital for people to be discharged to – This could limit the impact of the work streams even if patient flow and hospital discharge processes are ideally designed and operate to their optimum.
- Although a joint unit should be able to maximise placements that are close to patient’s homes and lower the overall average price paid there is a risk that the lowest payer currently will have to pay higher prices.

Outcomes

- Give a financial payback of between 2.667 times and 5.333 times the level of the expenditure proposed.
- Contribute to the acute trusts maintaining patient flow through system and reduce occupied bed days and so ease capacity issues.
- Help to develop the knowledge of acute staff around social care, community health and community support through more contact with social care staff.
- Improve experience for patients with complex needs and achieve a far more consistent experience regardless of where they are treated.
- Support the achievement of the 4 hour target for Emergency Department.
- Support an increase in the numbers of safe evening discharges.

7 Day Multi-disciplinary Team Working

Aim

Our vision is for more care and support to be delivered in the community / primary care setting under the guidance of well-informed, highly skilled Multidisciplinary Teams (MDTs) at GP cluster level. This will improve efficiency, reduce duplication and improve patient experience.

Multidisciplinary teams (MDT) will underpin our new models of care and enable the delivery of the overall STP benefits.

Current State

MDTs are a key enabler for the delivery of the overall STP financial savings target. As an individual way of working, MDTs will create sufficient efficiencies to absorb the expected increase in demand of 12% by 20/21.

Objectives

- Be the expected and primary way of working across BNSSG, community and primary care
- Absorb the expected 12% rise in demand by 2020/21 through;
- Reduce GP appointments by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Reduce the cost of supporting those with Long Term Conditions by 7% through a People Powered Health approach
- Additional capacity of 1 visit per day for field-based workforce through provision and access to fully functioning mobile IT
- Reduce variation of practice and improve consistency of outcomes by operating standard BNSSG wide policies, processes, procedures and documentation (including care plan), using the Fundamental Standards to underpin delivery and monitoring
- Provide the best possible care and support for those with the most complex needs by drawing on the most appropriate MDT expertise and the available community resources
- Support people to remain well through self-care programmes and early intervention and prevention thus preventing or delaying future high cost intervention
- Plan for long-term health and wellbeing at a population and individual level with a focus on achieving personal goals and objectives
- Reduce the need for patients and carers to repeatedly tell their story. This will be enabled through regular MDT meetings, health passports, close working relationships and enabling IT
- To improve clinical decision making through inter-professional collaboration in MDTs
- Engage local people with the development of their local MDT and ensure their views help shape services and service configuration
- Promote and develop inter-professional team-working in order to achieve a multi-disciplinary service delivery
- Move non-medical appointments from Primary Care to the voluntary / community sector, freeing high cost resource and capacity
- Ensure the first care / treatment option offered is the most cost effective which delivers the identified health, care and wellbeing outcomes
- Provide training which is consistent across BNSSG, supporting the delivery of clinically effective intervention and care without variation
- Driving improvement through innovation and research
- Through accurate data and analytics, provide MDTs the information, in real time, which allows them to make the most informed decision possible during patient consultations
- Enable inter-professional collaboration and decision making by blurring organisational boundaries
- Ensure MDT workforce is appropriately skilled and trained to manage the local population's health, care and wellbeing needs.

Projects

The project will work to developed a shared understanding of the current arrangements including financial, operational, IMT, Estate and Workforce, Patient and Staff feedback arrangements which are currently in place and then work up the detail of how a new MDT model could be implemented across BNSSG. This will link closely with the Sustainable Primary Care Model.

Operations

This element of the project would work through the operational detail of how any MDT team might operate including forms of multidisciplinary working; improved access to care through seven-day working; risk stratification, management of people with complex multi-morbidity, approach to care planning and standardising processes and pathways across BNSSG, integrated discharge; Integrated Personal Commissioning (IPC) and Personal Health Budgets (PHB); approach to working with care home residents and links with other project such as social prescribing and health and wellbeing services.

Funding Model

This element of the project will responsible for developing and understanding of the current financial flow and activity and then develop an understanding the financial impact of the model and funding flows which would be required to deliver the model

Governance

This element of the project will work though the clinical, organisational and information governance issues and develop solutions to support the implementation of the new model.

Workforce

The element of the project will work to gain an understanding of existing workforce, consider skill mix and new staffing models

Technology

This element of the project will gain an understanding of the IMT systems in use across the existing organisations and respond to the requirements coming out of the model to consider how to ensure staff have access patient information and link with the supported self care project which include remote monitoring etc

Risks

- Current contracting arrangements
- Project management and business case development resource
- Expertise on new funding models
- Funding for transformation and investment in technology
- Baseline data for demand and activity across both community services and primary care

Outcomes

- Reduce the number of consultations conducted by GPs by up to 27% through diversion of work to more appropriate MDT members and non-clinical services.
- Reduce the cost of supporting those with Long Term Conditions by 7% through a People Powered Health approach.
- Decrease the number of home visits, surgery visits and outpatient appoints by up to 15% through the use of home monitoring and remote consultation
- Additional capacity of 1 visit per day for field-based workforce through provision and access to fully functioning mobile IT
- Reduced admission to care homes will create additional capacity in the system, removing a key block to effective system flow
- Gains in capacity within community services through diversion of activity, focused on early intervention and prevention, via social prescribing
- Increased care in the community / primary care (driven through upskilled GPs, development of specialist health care professional roles and rapid response) will reduce incidents of unrequired acute admission, incurring savings accordingly. This could be a cashable benefit if the bed base could be safe reduced accordingly. (Additional community resource would be required)
- Reshaped pathways will standardise the most clinically effective approaches and appropriate resources, driving down the overall cost of care
- Population profiling enables better decision making on intervention and support. This will enable the delivery of the right care to the right person at the right time, driving down the overall cost of care
- Reduced admission to care homes. This could be a cashable benefit if the bed base could be safely reduced accordingly. (Additional community resource would be required)

End of Life Care Services

Aim

To enable the consistency of service provision for End of Life Care Services across BNSSG, avoid unplanned admissions and to ensure that peoples wishes at end of life with respect to place of death are respected.

Current State

Current providers of End of Life Care Services across BNSSG include Bristol Community Health (BCH), North Somerset Community Partnership (NSCP) and Sirona Care & Health CIC (Sirona).

BCH are currently commissioned to run the Bristol Care Co-ordination Centre (BCCC) service. This service provides a single point of access for end of life care services, as well as signposting and some advisory functions. These services include: -

Palliative Care Home Support (PCHS) – This service is a nurse led service that provides personal and nursing care for patients who have a prognosis considered to be within last days/weeks of life, have a preference for care at home and have a preference for to die at home. BCH provide this service in Bristol (9am – 9pm) and South Gloucestershire (9am – 5pm) seven days a week.

Hospice at Home (HaH) - This service is a nurse-led service which provides night care, plus some day shifts, at home, for patients within their last few weeks of life.

Marie Curie Care (MCC) – This is coordinated by the BCCC service to provide overnight care at home for patients at end of life stage.

The BCCC service currently provides a 'funnel' system designed to capture all referrals to the above services (PCHS, HAH and MCC) with the aim of providing clinical triage, appropriate prioritisation of care and effective coordination.

NSCP are commissioned to provide the Care Co-ordination Centre and Palliative Care services for North Somerset patients.

Sirona are commissioned to provide an End of Life Care Co-ordination Centre service for South Gloucestershire patients.

Objectives

- Provide easily accessible, locally appropriate support for G.P's and hospitals, to prevent admission, expedite discharge and deliver peoples' wishes at the end of life.
- Provide information and guidance to service users and carers to support self- management and self-care, and support for GPs (and MDTs) in their roles as complex case managers.
- Improve co-ordination of care from both a patient and carers' perspective
- Achieve a % reduction on the 2015/16 rate of the number of non- final emergency admissions for people identified as at End of Life across BNSSG.
- Achieve a % reduction on the 2015/16 rate of patients dying in hospital for BNSSG.
- Increase the number of people that have had the opportunity to discuss and agree their preferences for their end of life care.

Risks

- Current contract and staffing arrangements.
- Care and nursing home placement availability.

Projects

End of Life Care Co-ordination – A function within the Health and Care Single Point of Access (see separate business case) to co-ordinate the required End of Life Care service provision across BNSSG. This will be for health professionals, health and social care staff, patients and their families and carers across BNSSG. The service will take responsibility for coordinating the patient's care and services through existing providers.

Palliative Care Home Support (PCHS) – To provide a consistent PCHS service across BNSSG to patients from 9am to 9pm seven days a week all year round. This will include up to 3 visits a day to provide personal care and emotional support for patients who wish to be at home as they approach the end of their lives.

Improved working with the Hospice Sector – Through expanding equitable palliative care services across BNSSG and working in partnership with the Hospice sector, hospital emergency admissions will be reduced and patients are kept out of Hospital, if that is their wish.

Fast Track Nurse Assessor (FTNA) – To provide a consistent FTNA service across BNSSG to work with Acute Hospitals/Care Homes and relatives to ensure that patients who have been identified as approaching end of life are discharged as quickly as possible from Hospitals to Care Homes or their home in accordance with their wishes. This service could be operational seven days a week, 9 – 9, provided that discharges could be arranged from hospitals to care homes during these extended hours, and provided there was sufficient demand. Analysing this data will be part of the project.

Outcomes

Financial Benefits

- Reduction in non-elective admissions and AvLoS: frailty, respiratory, End of Life and from care homes.
- A reduction to unplanned admissions to hospital during the last 12 months of life.

Non-Financial Benefits

- More people to achieve their preferred place of care at the end of their life by establishing an integrated care pathway that is recognised across all services.
- Equitable access to services and expertise.
- Provision of expert end of life advice, training and support to health and social care professionals.
- Ensure that most care and support at end of life is delivered locally, ensuring continuity of care, enabling shared decision making, and providing a whole person/multi-disciplinary approach. This will ensure the best outcomes and experience and achieve our goals of keeping people as well and independent as possible even as they age and develop long term conditions, and even at the end of life.

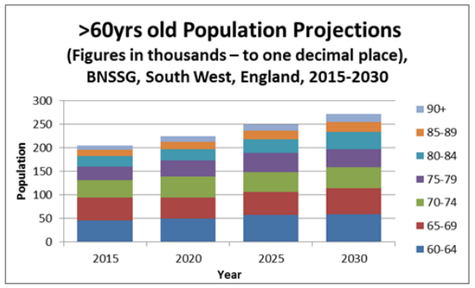
BNSSG Frailty Model of Care

Aim

To provide equity of care across BNSSG for our frail population.

Current State

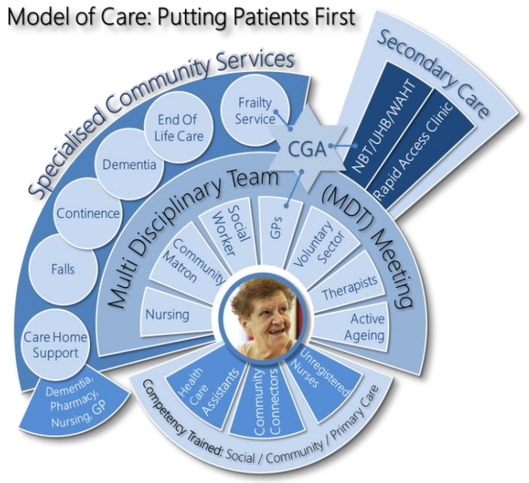
On average the frail population has a larger impact upon all health and social services, in comparison to those aged under 65 years. Across BNSSG the expected population growth for those over 60.



With the average length of stay with BNSSG acute services being 9.45 days for those >65, and an expected increase in this population (>60yr olds) by 32.68%. This can be approximated as an approximate additional 325 bed days per day, across BNSSG by 2030.

Objectives

The primary objective of this scheme is hospital admission avoidance through increasing the quality of care within the community. It focusses support towards Care Homes and aims to work collaboratively with our acute organisations to build upon trusted assessment and provide timely and appropriate access to expertise. This proposed model of care (below – Fig 1) will keep the patient at the centre of all services and undertake a holistic approach for the management of frailty across BNSSG.



Projects

1. **GP Based Multi-Disciplinary Team (MDT) meetings**.

2. **Falls including Multi-Factorial Risk Assessment, Community Based Falls Service, Strength and Balance Training, SWAST pathway people who do not need medical attention**

3. **Dementia Navigators/Advisors**
   Consistent model to be used across BNSSG, building upon current resourced posts from Alzheimer's Society and CCG. Subject to separate business case "Dementia Advisors (Post Diagnosis Support)
4. **Care Home Support**
   A bundle of carehome support has ensured a reduced rate of admissions within some localities in BNSSG. A standardisation of support is required across the BNSSG area.

5. **Competency training across BNSSG**. Upskilling our community teams (registered and no-registered nurses) in frailty care with the following topics

6. **A standardised frailty assessment within Primary Care**. Working upon the principles of completing a <TBD: comprehensive geriatric assessment (CGA)> within primary care. Ensuring GPs with specialist interest are equipped to adequately assess patients and that the wider system is able to act upon this information where required. This is to standardise and instigate the gold standard of care in the community and ensure the use of a common frailty indicator.

7. **Carer Support**. Supporting GP practices to support carers. Immediate identification of carers through Primary care offering double appointments, degree of flexibility. £40k for South Glos.

8. **End Of Life** – End of life care co-ordination centre (described under different business case)
9. **Rapid Access Admission Avoidance Clinics**. MDT with rapid access to diagnostics. The same model of care to be provided across BNSSG.

10. **A&E Front door**, Acute Trust based early senior assessment and access to CGA. [ref. A&E DB Streaming workstream] – please see urgent care project for more detail

11. **Acute Frailty Short stay units:** Standardised across BNSSG.

Risks

- Recruitment to specialist physio and nursing posts
- Nursing homes closing due workforce storage
- Nursing and care homes do not engage with the project

Outcomes

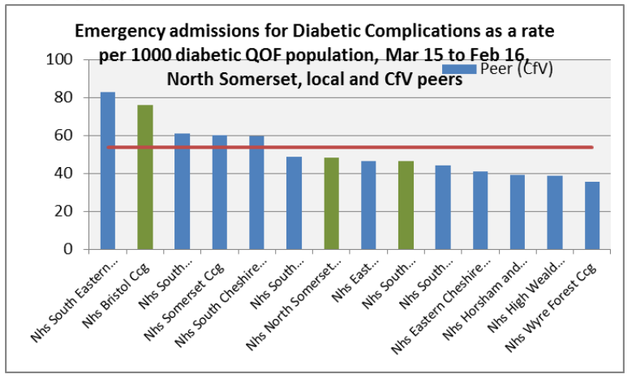
The CCGs recognised this is largely quality driven and the estimation on hospital admissions avoided is conservative. Each one of these directly stated financial benefits is stated within individual CCG business cases, but scope and build up across the BNSSG footprint is required.

Diabetes Programme

Aim

A new efficient model of delivery of diabetes care is proposed; a proactive, integrated, patient-centred service with "barrier-free" working between providers.
The reconfiguration would have an emphasis on delivering as much care as possible in the community setting with the use of care planning and robust, accessible support from specialist expertise.

Current State



The rise in diabetes prevalence between 14/15 and 15/16 across the patch is 4.26%

People with diabetes are also getting older and increasingly have other comorbidities which compound the complexity of caring for these people.

Objectives

- To provide a person with an individualised community diabetes service which is consistent, proven, and effective that optimise both access and sustainability of service.
- Decreased A+E attendances for all diabetes patients
- To decrease the number of lower limb amputations by proactive care planning and early diagnosis and integrated services that meet national and local guidance
- Improved number of patients achieving treatment targets in Hba1c, BP and cholesterol
- An increase in people offered a personalised care/self-management plan which empowers the patient to take an active role within their care.
- Improving the overall quality of diabetes care delivered in primary care
- Reducing variations in the delivery of diabetes care across GP practices
- Up-skilling of practices in delivering diabetes care
- On-going educational support for people, GPs and Practice Nurses
- The start of a reduction in the increase in type 2 diabetes within the lifetime of the programme and the years to come
- Less than 7% growth (current trend) in referrals to Diabetic Medicine (outpatients) by year 5
- Addressing existing health inequalities
- Improved patient and staff experience
- Improved compliance with NICE guidance (as clinically appropriate).
- Reduce the number of acute admissions and early discharge for people with diabetes and other related co morbidities
- Proactively manage patients in community settings when acute exacerbations of a co morbidity impact upon diabetes management.
- Increased uptake of retinal screening

Risks

- The main constraint is a financial one. As CCGs are required to deliver transformation change across the health economy, there is only so much money available within the envelope to deliver wide scale change. Significant investment is required to improve the service with the majority of savings only being realised after five years.
- Given the fact that the 3 CCGs have already introduced diabetes pathways, there may be a reluctance to change those already entrenched due to time and investment already undertaken
- Individual CCGs are not in a financial position to invest in new collaborative diabetes pathways.
- That individual CCGs do not have the resource or capacity to deliver the programme

Projects

Prevention

The programme will implement the national diabetes programme.

Primary Care

Reduction of variation in diabetes care across all GP Practices. Continued up-skilling of GPs and PNs with support from secondary care consultants and both secondary care and community DSNs and dietetics. Identification of diabetes complex patients within GP registers and promote the use of virtual wards with diabetes clinical specialists to ensure better patient outcomes.
Seek funding from the diabetes prevention programme and other educational funding available to improve identification and prevention of those patient who are viewed as pre-diabetes
Look into ways of delivering better personal care plans and how these could link into educational courses.
Seek ways of enhancing advice and guidance between GPs and diabetes specialists where needed.
For practices to follow NICE guidelines and improve coding where appropriate and submit data to the NDA on a yearly basis.
For GPs to follow enhanced guidelines on referring diabetes patients with lower limb complications to the podiatry/foot clinic.

Community Care

To increase diabetes care within the community by working with providers. To reduce diabetes care within secondary care. To promote patient diabetes education within the community and tailor education according to the needs of the community. To understand capacity versus demand and ensure patients referred to education are able to attend a course within a reasonable timeframe. To work with Local Authority/Public Health to identify where closer working could promote better ways of self-management and sign post patients appropriately to local services

Foot Care

To improve the current foot care service between primary care and the foot clinic provider. To enhance referral guidelines and up-skill GPs in understanding appropriate referral and where early intense intervention can reduce unnecessary lower limb amputations. To put into place capacity versus demand so that all patients that need an urgent 24hr consultation are seen within the service level agreement

Outcomes

- Reduced lower limb amputations (Service Specification and improved pathway)
- Enhanced GP and PN Diabetes education
- Increased patient education and uptake of courses
- Increasing diabetes care within the community whilst decreasing secondary care
- Practice review and standardised NICE guidance for yearly patient review
- Reduced number of complications leading to savings across primary, secondary and pharmacy
- Reduced secondary care costs (Surgery and OP)
- Reduced number of referrals to secondary care
- Reduced number of complications leading to savings across the health economy (including primary, secondary and pharmacy)
- Decreased patient treatment costs

BNSSG Respiratory Programme

Aim

The aim of the project is to establish standardised respiratory services across BNSSG that provide consistent, equitable, comprehensive, clinically and cost effective appropriate services for patients with a respiratory condition.

Current State

- Variation in practice
- Gaps in provision
- Discrepancy in estimated prevalence 'v' actual prevalence of COPD
- High emergency admission numbers
- Excess bed day figures
- Benchmarking results (in particular influenza and pneumonia admissions along with respiratory outpatients benchmark high and provide the best opportunity)
- 2016/17 onwards delivery requirements

Objectives

- Agree and implement an integrated approach to both acute and chronic respiratory disease management
- Improved early identification of COPD, self-management and intervention to improve wellbeing of patients with respiratory disease
- Enable multi-disciplinary assessment and treatment, providing seamless care for people with respiratory conditions
- To reduce non-elective admissions and outpatient appointments
- Ensure that for this cohort of patients' admission to hospital is minimised but when it does happen their length of stay is as short as possible
- Improve the patient experience. Maximising a patient's physical and psychological health through lifestyle advice and education on medication, exercise and breathlessness
- To upskill primary care services to ensure potential to support the patient population is maximised
- Ensuring medicines optimisation so the most cost effective therapy is provided at the right time without compromising care whilst reducing admissions e.g. step down programme to reduce pneumonia
- Agree performance measures

Projects

Prevention and Self Care

Education, Self Care, Vaccinations, Smoking cessation

Early Diagnosis

Primary care education, Education course alignment, Spirometry, FEV1 check, Case finding

Ongoing Management

Pulmonary Rehabilitation, Annual reviews, Meds review, O2 therapy, ICS transfer, Inhaler retrieval

Exacerbation Management

Rescue packs, HOT clinics, Pulmonary rehabilitation refresher

Inpatient Management

COPD Bundle, Education, Smoking status recording, Smoking cessation, Meds review, NRT provision, Pulmonary rehabilitation

Early Supported Discharge

Early Supported Discharge, Appropriate follow up, Self Care

Risks

- Inequality in provision of care for patients with respiratory conditions continues
- The number of undiagnosed patients has the potential to increase
- Admission rates continue to increase
- Disease progression rates have the potential to increase.
- This is an incredibly ambitious programme with a significant amount of work to be delivered within the current financial envelope. There are several unknowns and it is therefore very difficult to identify potential costs at this time.
- Variability in stages of progress and services available across BNSSG may hinder momentum of work for individual CCGs.
- Likely shift in activity between providers without processes in place for resource to follow this activity in a timely manner.

Outcomes

- Improved outcomes for patients with respiratory conditions
- Improved patient experience
- Improved prevention and early diagnosis of COPD
- Emphasis of care in the community and self care
- Patients will be consulted and have a better understanding of their condition which will facilitate self-care of their respiratory condition.
- Decreased A+E attendances
- Savings will be derived from the reduction of patients requiring hospital care. Admissions will be avoided and people will spend less time in hospital.
- Savings will be derived from the reduction of inappropriate use of Oxygen

Developing Personality Disorder Pathways for BNSSG with Avon and Wiltshire Partnership

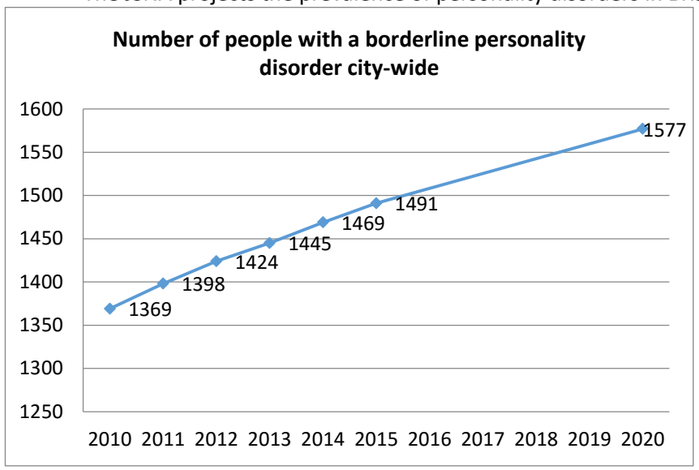
Aim

To scope and develop a personality disorders care pathway for BNSSG as part of the mental health work within the Sustainability and Transformation Plan.

Current State

Cost avoidance

- The JSNA projects the prevalence of personality disorders in Bristol will rise over the coming year as follows:



Source: PANSI; based on the report Adult psychiatric morbidity in England, 2007

In addition to this rising need Avon and Wiltshire Partnership have completed a skill mix review which indicates the caseloads for the Assessment and Recovery service (which currently care co-ordinates people with personality disorders) is operating at 25% above capacity. Whilst these two pieces of evidence are limited to Bristol but in discussion with neighbouring CCGs and AWP, the issues are similar. Unless a prevention focussed pathway is developed to ensure people with personality disorders get timely and effective treatment there will be we can project increased cost pressures on secondary care, crisis services and out of area placements.

Objectives

The aim of this business case is to ensure that across BNSSG people living with a personality disorder are supported to get timely and high quality support to help them stay well.

The objectives are:

- That professionals within the BNSSG System have access to training around personality disorders
- That there are specific interventions available within primary care to avoid people being unnecessarily referred to secondary services or to allow people to be supported to step down from secondary care
- That there is a clear pathway and interventions available within secondary care
- That there is intensive specialist personality disorder interventions available locally so people do not require out of area inpatient support or those who are already out of area can be repatriated.

Risks

- It has not yet been possible to scope the funding requirements of a specialist PD pathway across BNSSG but it is likely this will require an invest to save. Funding is therefore likely to be a constraint
- It is not possible to firmly cost projected savings from a PD pathway
- Developing closer collaborative working across provider and commissioners

Projects

Areas for scoping

The areas to be scoped across BNSSG are as follows. Scoping will include analysis of what is already in place across BNSSG and what needs to be developed:

<u>Training & staff development</u>

- Structured clinical management – supports MH professionals in care co-ordinating people with personality disorder. This will build on work already in place in North Somerset.
- Knowledge and Understanding Framework - training for professionals and non-professionals that explains personality disorders as a condition and identifies techniques for working with people with personality disorders

<u>Enhance primary care support</u>

- Mapping and evaluating and potentially expanding the STEPPS programme across BNSSG
- Consideration of how mental health professionals embedded in primary care could specifically support maintenance of people with PD in primary care

<u>Early intervention</u>

- Scoping a young people's service or early intervention for emerging personality disorders service to support prevention

<u>Secondary care interventions</u>

- Ensuring there is timely access to specialist interventions such as Dialectical Behavioural Therapy (DBT) across BNSSG

<u>Intensive support service to prevent out of area placements</u>

- Scoping an intensive support service that specifically acts as an alternative to or prevention of out of area placements

Once there is clear understanding of current state including patient experience, finance, activity and patient flows, reviewing the evidence base and best practices from other parts of the county we will work up a new service model and then work up the supporting financial model. A decision would then be taken to commission the new service and detailed implementation planning would then lead to a full implementation.

Outcomes

- People with personality disorder have been identified as being 50 times more likely to complete suicide than the general population and therefore an effective local pathway should support a reduction in the suicide rate across BNSSG which will support the five year forward view aspiration for a reduction in suicide rates across the country by 10% compared to 2016/17 rates
- People with personality disorder will be able to be effectively supported within primary care
- Staff across the mental health system will be able to support people with a PD more effectively through increased knowledge, understanding and improved attitudes following KUF training.

Acute Care Collaboration

MSK/T&O

Aim

The brief of the project is to evaluate, develop and implement a revised clinical pathway and service delivery model for MSK services, including acute Trauma and Orthopaedics within BNSSG.

Current State

- Reference Cost Index (RCI) analysis indicates that there are significant excess costs (£13.75m) within T&O in the three acute providers. High elective and non-elective length of stay across all three providers, with 12,730 beds days, or 34 beds opportunity across NBT and UH Bristol between current and upper quartile performance
- £7m Right Care opportunity across BNSSG CCGs
- RTT targets for Orthopaedics have not been sustainably achieved in BNSSG.

Objectives

- Agreement of outcomes which matter to patients
- Agreement of a vision and model for MSK/T&O services across BNSSG
- Ensure that MSK/T&O patients have a positive experience of care
- Improve productivity and efficiency of current service delivery model
- Address issues of sustainability, with a focus on matching capacity to demand across the service

Projects

MSK Clinical Pathways

This project will create a model of MSK care that will integrate and streamline the delivery of services, providing an aligned service for anyone who has an MSK condition. It will enable a greater proportion of patients to self-manage and have their care managed in a community setting. The review will include all MSK services including Core Physio, Enhanced Physio, Podiatry, Orthotics, Orthopaedics, Pain and Rheumatology Services. The first year the project will also seek to deliver some quick wins to reduce demand.

Elective Orthopaedics

This project will focus on the optimal distribution of services across the three acute providers and the independent sector, in order to maximise quality, productivity and efficiency and to realign capacity across the system to meet demand and sustainably deliver improved access for patients.
The project will seek to determine future demand and to develop the required capacity accordingly, in the most appropriate location.

Orthopaedics and Trauma Services
This project will consider how to deliver orthopaedics and trauma services. It will need to consider the interdependencies with other Major trauma services and the extent that it competes for resource with other services i.e. ED, theatres, beds, radiology and staffing.

The project will establish the optimal view of the specific volume and location of the capacity required to deliver the work in this health economy. It will also provide modelling of tariff and pathways that demonstrate a financially viable case mix and will include capacity in terms of theatres, beds and staffing.

Risks

- Failure to deliver RTT constitutional standards
- Poorer clinical outcomes as a consequence of extended waiting times
- Unaffordable clinical model
- Fragmentation of service provision

Outcomes

- Improved sustainability of existing services, including a significantly improved Reference Cost Index across all acute providers.
- Sustainable RTT performance across the providers driven by realignment of capacity, including best use of existing capacity to sustainably balance capacity and demand across the acute providers.
- Increase in proportion of NHS activity delivered in NHS organisations.
- Reduction in use of premium rate sessions to deliver elective activity.
- Sustainable and affordable workforce across all providers – to include a reduction in nursing and medical agency costs, through improved recruitment and retention.
- Reduction in acute Length of Stay across providers.
- Reduction in repatriation delays across the Trauma Network.
- Improvement in performance against fractured NOF Best Practice Tariff across the acute providers.

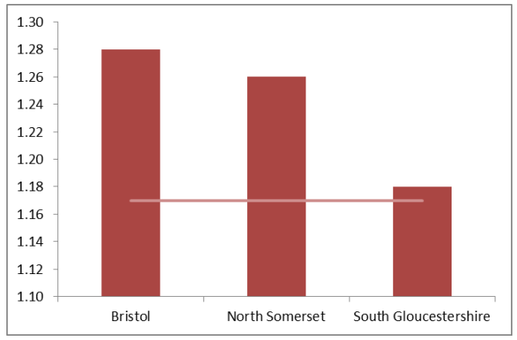
Stroke

Aim

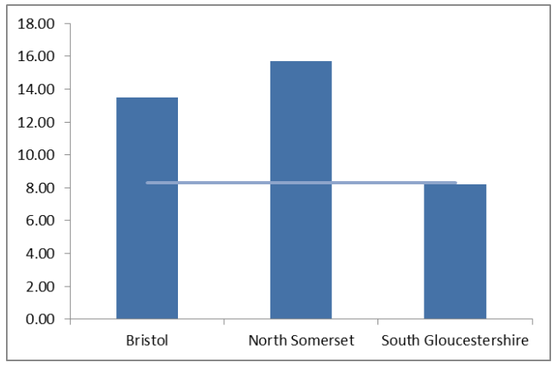
The aim is improve quality, equity and sustainability for stroke care across BNSSG.

Current State

Ranges of benchmarking indicators have identified that Stroke Provision is an outlier when compared to our comparator CCGs. At present there is a plethora of stroke provision across the BNSSG footprint with many services and organisations, including tertiary services that provide stroke care with a variety of different specifications and facilities.



Meeting a benchmark of 75th percentile of similar CCG's might save approx. 30 lives per year.



Meeting a benchmark of 75th percentile of similar CCG's might lead to approx. 100 more patients going home after stroke each year.

Objectives

- Reduce mortality following a stroke
- Reduce the incidence of stroke
- Centralise stroke services
- Improve the quality of care for patients
- Provide an equitable service across the BNSSG footprint
- Ensure a financially sustainable service

Projects

There are three main projects following the patients care journey

Prevention and Primary Care

This project aims to reduce the incidence of stroke by reducing risk factors. The initial focus is to improve detection and treatments for patients with Atrial Fibrillation (AF) and hypertension, and timely attendance at seven day a week Transient Ischaemic Attack (TIA) clinics.

Acute Care

This project aims is to provide an excellent centralised seven day a week acute stroke service in a HASU with step down for those patients who have ongoing acute medical needs to an acute stroke unit(s) (ASU).

The Rehabilitation and Living with Stroke

This project aims consider how to provide out-of-acute hospital rehabilitation for all patients no longer in need of acute hospital care in their own homes or if necessary in bedded community facilities.

Risks

- Finance risk - lack of available data from various sources to inform acute and rehabilitation work streams
- Operational risk - Capacity within programme management and reduced workforce to support projects and admin
- Operational risk - failure in agreement of organisations and adherence to timescales and transfer of bed capacity

Outcomes

Quality

- Reduce mortality following stroke in BNSSG.
- Prevention of stroke leading to a reduction in incidence.
- Patients offered specialist stroke rehabilitation as close to home as possible.
- Reduce long term packages of care and placements.
- Improve care for patients living with stroke.
- Increased evidence of improved performance as measured by SSNAP.
- Conform to national and local drivers and best practice.

Equity

- Provide equitable stroke services across BNSSG.

Sustainability and Finance

- Increased effectiveness, efficiency and economy resulting from centralising stroke services.
- Reduce length of stay in acute hospitals.
- More effective use of scarce specialist workforce.

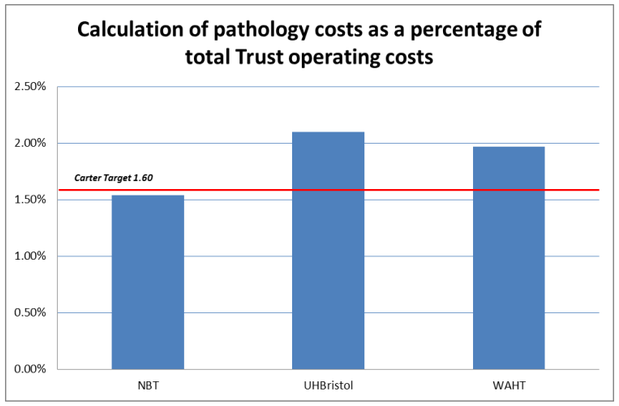
Pathology Programme

Aim

To create a maximally effective pathology service across BNSSG through enhanced networking and support between the three existing providers

Current State

We currently spend more on pathology as a percentage of the total trusts operating costs than the Carter Target at UHB and Weston Area Health Trust.



Objectives

- Ensure pathology services are configured to support delivery of safe and most cost effective clinical pathways
- Minimise cost per test of pathology services
- Maintain quality of pathology results at reduced cost
- Reduce or minimise growth of pathology testing by avoiding non-value add testing
- Drive cost effective clinical pathways through rapid adoption of new pathology testing as the evidence develops
- Ensure Weston has a sustainable pathology service
- Establish BNSSG pathology to enable early adoption of personalised medicine approach as they develop of the Genomic Project and Personalised medicine Strategy

Projects

Cellular Pathology

In May 2016 Cellular Pathology services were centralised at NBT.

Benefits Realisation from LIMS

There is already collaboration underway between providers and a shared LIMS system is currently being deployed. Work is currently underway to ensure this is used effectively across the healthcare system to maximise the benefits.

Transfer PHE to NBT automated bacteriology Lab

From November 2016 PHE bacteriology services will co-locate with NBT bacteriology services at NBT under an agreed collaboration, this will bring all bacteriology from both Bristol and Bath onto a new fully automated system going live early 2017. The remaining PHE services will move to the NBT site from spring 2017

Sustainable model of Weston Histopathology

This will be one element of the Weston Sustainability Model. We will feed in options into the wider Weston Project, in the right timescale to support their programme delivery.

Specialist Testing Review

We will review all the tests currently being sent out of area to identify if any of these could be delivered in BNSSG at a lower cost

Blood Sciences Review

We will consider if there are options for closer collaboration or consolidation of blood sciences services across providers

MES Re-procurement

The MES contract expires and with closer collaboration and consolidations service we will consider what equipment is now needed and what will be needed over the next contract period to deliver services

Demand Management

Reduce inappropriate or no value investigations, ensure repeat testing is correctly timed and promote testing where linked to decision points in care pathways.

Urgent Care Pathways

Develop plan for appropriate support for primary care to maximise care in the community speed urgent pathways

Clinical Service Change

Utilise current and new pathology tests to influence care pathways where reduced overall cost, delayed progression and/or better outcomes can be demonstrated.

Risks

- Individual organisational interest clashes with STP interest preventing maximum benefit being realised
- National storages in specialist staff impact the ability to deliver high quality services
- Excessive reductions in infrastructure reduce resilience resulting in service failure

Outcomes

- Ensure sustainable services with respect to cost and staffing
- Reduce cost per pathology test
- Minimise growth of pathology testing
- Enable access to specialist reporting where appropriate
- Share risks between providers to create resilience and reduce risks of service failure
- Support develop of new care pathways and drive beneficial changes resulting from new pathology testing
- Maintain sufficient resourcing to manage rapid technology change as genomics and personalised medicine develops

Weston Health

Aim

The overall purpose of the North Somerset Programme for Sustainable Services is to redesign and strengthen the Weston and North Somerset health & social care provision models so that they are:

- Fit for the future to meet the changing needs of local patients and communities
- Clinically safe. No proposals will be put forward that clinicians have not agreed are clinically safe and appropriate for the population. Any solution will also need to give assurance that recruitment and retention of the necessary clinical staff is feasible
- Financially sustainable in terms of North Somerset and the wider BNSSG systems, and also for the relevant parts of Somerset

Current State

- Waiting times for urgent and emergency care are not being met and there are high levels of bed occupancy within Weston General Hospital
- Between April-December 2015/2016 there were 27% more patients waiting for community packages to be in place before they could be discharged from Weston General than for the whole of 2013/14. This reflects the high degree of pressure on social care services
- A number of GP practices around the Weston area are under significant pressure
- The Care Quality Commission has highlighted a number of areas for improvement at Weston Area Health NHS Trust, including reducing the numbers of long term locum and agency doctors in certain specialities by ensuring that there are suitable numbers of permanent doctors in post
- A recommendation from the GMC was for the trust to continue to provide effective support, training and supervision to junior doctors. Overnight FY2 A&E doctors been withdrawn
- Both Weston Area Health NHS Trust and North Somerset CCG have recurrent financial deficits and the position is forecast to worsen significantly in a "do nothing" scenario

Objectives

We are currently in the second phase of a 3 phase programme:

- GE Finnamore (health consultancy) was commissioned in early 2016 to complete a review of all the previous assessments of the local system's challenges
- The Programme for Sustainable Services is currently developing a set of options/ proposals based on the Finnamore's work to put to the Sustainability Board. These will be drafted in December
- Once agreed by the Board's/ Governing Bodies of the organisations who make up the Sustainability Board, we will move into a phase of engagement, consultation and implementation

Projects

The purpose of the project is to consider the service configuration options which would allow Weston Area Health Trust to be clinically and financially viable. The process to find a solution is financially driven but clinically led. A Clinical Leadership Group has set up four expert clinical sub-groups to examine the key elements of the system and develop proposals for improving patient care and service pathways. The Expert Clinical sub-groups are made up of senior clinicians/ practitioners from all the service providers who are members of the Sustainability Board. The clinical groups are supported by groups for Analytics, Finance and Communications. Again, these enabling groups are drawn from the membership of the Sustainability Board

A full project for implementation would be developed following public consultation if change is substantial and therefore required In Phase 3 of the Programme. The length of time it takes to complete Phase 3 will depend on the nature and complexity of the changes being proposed. Although this work has its origins in the challenges faced by a single organisation, it is clear that the answer lies in a system solution. We need to make the best use of the vital capacity that the Weston site offers. The live issues that we are currently working on include:

- Leaders in the health and social care system are strongly in of retaining a 24-7 urgent/ emergency care service on the Weston site
- Redirection of elective work to optimise use of the facilities at Weston is likely to be a big part of ensuring the financial viability of the site
- Both University Hospitals Bristol and North Bristol trusts have expressed a commitment to closer working with and at Weston to help deliver the objectives in 1 and 2 above. We also continue to work closely with Taunton & Somerset FT
- Although increased use of Weston elective facilities could be part of the solution, we will still need to take significant costs out of the system to make this programme a success
- Ways to achieve this include reducing delays/pinch points in the patient's journey as they pass from one health or care organisation to another. Another way is to get better at working together to avoid admissions to hospital in the first place, and when patients are admitted help them get home as soon as it is safe to do so
- Clinicians think that a major way to achieve these goals could be closer working between local community, acute and primary care services
- We have included the issue of commissioning sufficient numbers of community hospital beds in our system, given the closure for repairs of part of the Clevedon community hospital site

Risks

- A solution cannot be identified that both balances financially and meets the needs of a relatively geographically isolated population that is growing faster than the national average
- Limited programme management capability and capacity risks the proposals developed by December not being robust enough for engagement and consultation, thereby delaying the timetable for implementation
- Current - There is a risk that appropriate clinical staff cannot be attracted to work at the Weston site, both as part of a long-term solution but also in the meantime as proposals are consulted upon and then implemented
- Proposed - There is a risk that appropriate clinical staff cannot be attracted to work at the Weston site due to uncertainty as proposals are developed and consulted upon.

Outcomes

The Weston/ North Somerset system has been operating under a label of "not sustainable" for a number of years now, with all the attendant instability and uncertainty for staff and patients that this brings with it. There have been a number of previously unsuccessful attempts to reform the health economy over the past few years. The overarching aim of this programme is not to create the perfect system, but instead to remove the label of unsustainably by addressing the structural problems in the current configuration of services, thereby putting the health economy on a level playing field with our peers

- Safe and effective clinical services for the population served by Weston Area Health Trust and the population of North Somerset
- Models of care that are financially suitable and are likely to be able to recruit and retain the necessary clinical staff to deliver them
- Much closer working between acute, primary and community health and care systems – potentially supported by organisational integration as an enabler

Medicine Optimisation

Aim

The aim is to deliver transformational improvement in medicines optimisation in BNSSG. This will deliver cost savings, improve efficiencies, maximise benefits from medicines including cost avoidance, and improve patient outcomes.

Current State

More than £250m pa is spent on medicines in BNSSG; are we really making the most of this investment?
The following information is extracted from national data:

- Do patients take their medicines?
  - Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.
  - Ten days after starting a medicine, almost a third of patients are already non-adherent - of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent.
- How well do we use medicines?
  - A study conducted in care homes found that over two thirds of residents were exposed to one or more medication errors.
  - Over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.
  - In hospitals the General Medical Councils EQUIP study demonstrates a prescribing error rate of almost nine percent.
  - In general practice an estimated 1.7 million serious prescribing errors occurred in the NHS in 2010.
- Is the NHS getting best value from medicines?
  - In primary care in England around £300 million per year of medicines are wasted (this is likely to be a conservative estimate) of which £150 million is avoidable
  - At least 6% of emergency re-admissions are caused by avoidable adverse reactions to medicines
- Are patients getting the right medicines?
  - Analysis of the NHS Atlas of variation highlights unwarranted variations in the prescribing of some medicines across England.

Objectives

The Medicines Optimisation Transformation Programme incorporates a wide range of projects, all of which result in financial and patient benefit. Objectives include:

- Maximisation of biosimilar implementation
- Embedding of e-referral to Community Pharmacy
- Efficiency improvements in high cost drug delivery
- Reduce polypharmacy in care homes
- Implement BNSSG de-prescribing protocols
- Implement centralised dispensing of unlicensed medicines pilot
- Implementation of repeat prescription project
- Improve outcomes from RightCare
- Technology linkage regarding medicines data and information
- Acute service centralisation project efficiencies from Carter
- Centralisation of aseptic dispensing services

Risks

- Risk that the BNSSG Pharmacy services (and clinical colleagues) do not have the capacity or project management support to implement the identified projects.
- Risk that the cost avoidance savings from medicines optimisation (eg improved patient safety, reduced admissions, reduced length of stay) are not recognised as they are not readily measurable.
- Risk that the underlying financial impact of activity increases and the cost of new innovative medicines will mask the direct cost savings available and delivered.

Projects

Biosimilars

To work with medical teams (GI, Rheumatology, Dermatology) and patients to implement the more cost-effective biosimilar pharmaceutical products and manage the transfer to these drugs where clinically appropriate.

E-Referrals

To use available technology to transfer discharge information to community pharmacists to provide follow up care for patients taking complex medicines.

High Cost Drugs

To review the use of the most expensive drugs and ensure they are being used appropriately and consider if improvements could be made.

Polypharmacy (GP guidance & care homes)

To review medicines being taken by the frail elderly, particularly within the care home context, in order to ensure that all medicines are necessary and appropriate.

De-Prescribing

To identify and agree medicines that are considered to have no proven benefit and implement de-prescribing protocols.

Centralised unlicensed medicines dispensing project

To develop a project to manage all unlicensed medicines through a central hospital based service in order to avoid high commercial charges.

Repeat Prescriptions management service pilot

To manage repeat prescription services in order to avoid provision of unnecessary medicines and reduce wastage.

Implementing Right Care to reduce variation

To apply RightCare medicines data on variation to BNSSG to focus on areas for improvement and implement change.

Connecting Care

To develop utilisation of Connecting Care in the context of sharing information and data concerning medicines in order to improve efficiency.

Pharmacy Transformation Plan (Carter)

To implement changes through the acute Trusts' Hospital Pharmacy Transformation Programmes in order to improve service efficiency across BNSSG.

BNSSG aseptic pharmacy services

To plan a BNSSG wide aseptic dispensing services facility to meet strategic STP requirements.

Outcomes

The benefits include the following, (with the assessment in the Carter efficiencies, that for every £1 that is spent on medicines optimisation there is a £5 benefit to the NHS).

- Cost savings; eg Biosimilar implementation results in reduced medicines expenditure; better management of medicines results in reduced wastage
- Cost avoidance; eg Improved medicines optimisation results in reduced readmission rates and reduced length of stay
- Patient harm reduction; eg medicines safety improvements have a direct impact on avoidance of harm and therefore also result in cost avoidance
- Service efficiencies; eg service centralisation in order to focus attention on medicines optimisation

Urgent Care

Aim

To ensure the public get the rapid response to an urgent care need and get to the right service first time.

Current State

The national target is for 95% of people attending ED to be seen within 4 hours, the following table illustrates the current performance for NBT, UH Bristol and WHAT and therefore the need to make change within the BNNSG urgent care system

Trust	April 16	May 16	June 16	July 16	August 16
NBT	77.1%	76.2%	82.2%	80.1%	78.6%
UH Bristol	87.2%	91.7%	89%	89.3%	89.9%
WAHT	76.3%	89.4%	88.1%	84.6%	82%

Objectives

- To ensure the public know where to seek help when they have an urgent need
- To ensure a consistent response regardless of where a patient presents
- To ensure effective assessment and treatment are delivered in a timely way
- To reduce demand on A&E
- To reduce inappropriate presentations at A&E
- To ensure effective use of the whole urgent care system

Projects

Alcohol care teams

The aim of this project is to introduce alcohol care teams in A&E to reduce admissions. Alcohol care teams will be part of multidisciplinary teams which combine clearly defined alcohol pathways with referrals to and from the community, a seven day service with particular focus on Friday, Saturday and Sunday

Urgent Care Pilot

The aim of the project is to establish a primary care led streaming hub and urgent care centre at the front door of the Bristol Royal Infirmary. The evaluation of this pilot will feed into the broader urgent care review.

Urgent Care Project

The aim of the project is to develop a comprehensive understanding of the urgent care system including whole range of providers including 111, pharmacy, GPs, mental health crisis teams, mental health sanctuary/crisis cafes, ambulance service, community optometrists, minor injury units, A&Es, social care duty teams etc. This will include understanding current patient flows, activity, finance and patient experience and the evidence base of what is effective and best practice from other parts of the county. The project will then work with stakeholders to develop the future model of care and ensure consultation with public before making a decision. This will be followed by detailed implementation planning before making the change to the new arrangements. In parallel with the main work programme quick wins will be identified and implemented where it is appropriate to do so.

Risks

- Complexity of a large programme to deliver
- Difficult to get agreement across 3 CCGs and all providers
- Improving urgent care services and informing the public about the changes may create 'provider induced demand' rather than reducing demand on urgent care

Outcomes

- People will be treated in a service that matches the level of acuity for their condition
- Service users and carers will have an improved experience of urgent and emergency care that meets their needs in a more appropriate setting
- Providers will deliver against the 4 hour national target
- The cost of care will be reduced

Appendix B2 Additional Programme Narrative

Prevention, Early Intervention and Self-Care

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

The model is based on four principles:

1. Resource: Ensure that strategic initiatives are costed and adequately resourced
2. Enable: The population and patients need to be enabled to adopt healthy behaviours
3. Align: Alignment of strategies and pathways ensuring consideration of the wider determinants of health
4. Innovate: Finding new and better ways of achieving outcomes through making the best use of available resources (including workforce) and ensure co-production (community involvement in the development of initiatives).

Transformation

We have identified the key decisions necessary to deliver a radical shift towards prevention. These are:

- Self-care and patient activation will be implemented at scale with consistent delivery across our system
- A population health approach will be embedded across pathways (activate the population, carers and health professionals; reduce admissions; increase proactive prevention across the pathway)
- We will enable care settings to be innovative and effective e.g. using digital technology to support self-care
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties)
- In order to achieve the short and medium/long term priorities investment is required for prevention, early intervention and self-care at scale. Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years.

Impact

Our initial priorities are:

- Alcohol harm reduction
- Falls
- Diabetes
- Self-care at scale

These have been chosen because they are evidence based, will improve the health of the target population, have an impact across the system and will reduce hospital admissions. They have been developed based on a life course approach and the need to embed prevention and self-care across the pathway taking into account primary, secondary and tertiary prevention opportunities.

Our priorities are enabled by:

- an established patient-centred Bristol, North Somerset & South Gloucestershire health and care partnership approach
- the development of a new relationship with the public and the delivery of the shift of care from an acute setting to primary and secondary and self-care with a reduced dependency on beds and increased use of health and social care hubs and signposting

- wider definition of workforce to include for example voluntary sector, police, housing, pharmacy; and a non-differentiated workforce across BNSSG with common training and standards.
- digital platforms and technologies such as personal health records, telehealth and app development.

Priority	**Impact**	**Methods to measure impact**
Alcohol - reduce excessive alcohol consumption and associated burden on NHS and Local Authorities (LAs) and wider society	Reduce alcohol-related hospital admissions, re-admissions, length of stay and ambulance call-outs by 2020/21 Reduce the burden on NHS, police and social care services from high volume service users Reduce the impact of parental alcohol misuse on children	Alcohol-related hospital admission (narrow measure): number of admissions (by CCG and LA) Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission (by CCG) For every 3 IBA interventions delivered 1 alcohol-related admission will be avoided[1] Ambulance call-out data
Falls - reduce fractures from repeat falls.	10% reduction in the number of injuries due to falls in people aged 65+ by 2020/21, through improved and more coordinated preventative services	Emergency admissions due to hip fractures in people aged 65+ per 100,000 Patients with fragility fracture and confirmed osteoporosis treated with bone-sparing agent Fracture liaison services can reduce risk of second fracture by up to 50%[2]
Diabetes – prevent cases of Type 2 diabetes and improve management of those with diabetes	Reduce the projected growth in incidence of diabetes Improve support for self-care in people with a diagnosis of diabetes Improve the treatment and care of people with diabetes	Uptake of the NHS Diabetes Prevention programme Incidence of diabetes

[1] Public Health England

[2] Nakayama et al 'Evidence of effectiveness of a fracture liaison service to reduce the re-fracture rate' Osteoporosis International March 2016, Vol 27, Issue 3, pp873-879

Supported self-care at scale	Reduction in emergency admissions of Long Term Conditons (LTC) group with above average risk of admission Develop training for health professionals and population Self care enabled via digital supports	22-32% reduction in emergency admissions of LTC group with above average risk of admission (25%)[3] Patient Activation Measure

Medium and long-term priorities

Our medium and long term priorities for prevention, early intervention and self-care are summarised below. Specific interventions will build upon the implementation of the short term priorities during year 1 and implementation of the medium/long term priorities will begin in year 2. The priorities have been aligned to pathway priorities including those identified within the Integrated Primary and Community Care and Acute Care Collaboration workstreams and with wider determinants of health.

Activity / initiative	**Description**	**Impact**	**Alignment to Drivers of Change**
PATHWAYS			
Healthy lives	Obesity reduction, smoking cessation and continue work on alcohol harm reduction	Reduce related hospital admissions	Consistent pathways A new relationship with the population
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG and build on self-care work already underway*		
Primary prevention - adults	Dementia and stroke prevention	Consistent pathways across BNSSG with prevention integrated across pathway	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on atrial fibrillation and impact on stroke prevention & return on investment*		

[3] BCH/Philips project

Mental health - Children and young people	Provide appropriate support and services focusing on the emotional wellbeing and mental health of children and young people Work with schools, Children's Centres etc.	Consistent pathways across BNSSG with a strong focus on prevention and early intervention prior to any formal diagnosis	Relevant to all 5 drivers
Intervention	*Ensure services reflect need particularly for those sub-threshold in terms of clinical diagnosis.* *Ensure consistent offer across BNSSG and access to appropriately designed prevention and self-care initiative in appropriate settings – base on existing examples of good practice.* *Reduce attendances due to self-harm.*		
Secondary prevention - adults	Secondary prevention: atrial fibrillation, hypertension, hypercholesterolaemia, LTCs (multi-morbidities), cancer prevention via a range of health professionals	Ensure consistent pathways across BNSSG	Relevant to all 5 drivers
Intervention	*Ensure evidence based pathways and interventions consistently applied across BNSSG. Strong focus on evidence for return on investment for health and social care*		
Ambulatory care	Develop/build on prevention and self-care services	Reduce ED attendances and admissions.	Consistent pathways A shift to digital A new relationship with the population
Intervention	*For example develop/build on self-management for COPD; rapid response teams at home; End of Life Care*		
Sexual health	Focus on contraception and return on investment	Reduce associated costs of less effective contraception	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Increase take up of more effective contraception (LARC)*		

Health protection	Flu programme Antimicrobial resistance and link to self-care	Reduced primary and secondary care attendances	Standardise and operate at scale A new relationship with the population A new relationship with staff and organisations
Intervention	*Focus on potential to reduce:* *GP consultation rates for influenza-like illnesses; A&E attendances for respiratory conditions; Emergency admissions for confirmed influenza* *Impact of health and social care reduced capacity and performance due to staff absence; Antibiotic prescribing for secondary bacterial pneumonia (and resultant risk of a rise in antimicrobial resistance); Outbreaks in acute and community settings requiring special management arrangements; Parental leave to care for ill children; Excess winter mortality, particularly in identified at-risk groups.*		
WIDER DETERMINANTS OF HEALTH			
Reduce harm caused by social isolation	Provide adequate support for the frail elderly and reduce the harm caused by social isolation	Reduce ED attendances and admissions.	Consistent pathways A new relationship with the population
Intervention	*Ensure consistent support and signposting across BNSSG with a focus on evidence for return on investment, building on existing support services and social prescribing*		
Expand prevention activities within NHS providers	Create healthier environments in health and care providers and local employers.	Healthier workforce – positive impact on workforce retention	A new relationship with staff and organisations
Intervention	*Ensure consistent messaging conveyed to the workforce. Include link to enabling those with LTCs to work. Consistent approach to workplace health across BNSSG starting with health and care providers and broadening out to other employers*		

Inequalities	Take a BNSSG approach with a focus on inequalities within BNSSG rather than regional comparisons	Equal access to the right prevention/early intervention/self-care initiative in the right place at the right time	Relevant to all 5 drivers
Intervention	*For example review excess winter deaths and link to inequalities*		

1. Agreement that PEISC stakeholder group is overseen by WoE PH Partnership and that the STP and prevention is a new workstream within this partnership. This will ensure close working and allocation of BNSSG DsPH and PH Consultants as appropriate to STP-related work.

2. As agreed at WoE PH Partnership business cases submitted to the STP/CCG commissioning process are based on the initial priorities as above but MECC and health protection also included in this first tranche:

- Alcohol harm reduction
- Falls
- Diabetes
- Self-care at scale
- Making Every Contact Count
- Health protection (flu vaccination and AMR).

Alongside the above first tranche of business cases from this workstream we have submitted an overarching PEISC covering business case that highlights the need for dedicated funding for prevention in order to deliver not only the immediate priorities but to also deliver the medium/long term priorities and support those cross-cutting pathway focused workstreams currently under review (diabetes, MSK, stroke) and other pathways reviewed going forward as agreed by the Clinical Cabinet and prioritisation forum – dedicated investment is required if the system is to reduce demand on the health and social care system that it cannot support in the future.

Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years. It is proposed that rather than being reliant on individual business cases submission that a resource/fund is identified for prevention to enable delivery of STP prevention, early intervention and self-care priorities and cross-cutting pathway reviews across the three STP workstreams.

Integrated Primary and Community care

IPCC programme has agreed the delivery structure, developed the overarching PID and relevant terms of reference for the proposed programme board and strategy and design group. The programme board has met twice and the steering group has not yet met but the focus has been on testing with key stakeholders the elements of the model and the development of project briefs in support of the overall target impacts previously set out in the June submission.

There has been significant engagement across commissioners and providers to consider at a high level the component parts of the model. This has involved recognising the different starting points across BNSSG in each of the areas, understanding the shared BNSSG blueprint or end point for the model and considering the high level milestones to achieve this. Encouragingly , there has been a very high degree of consensus for each area and a good platform has been developed for moving this forward into project delivery.

There have been the beginnings of greater engagement with mental health colleagues and a testing of where mental health needs to be integrated into the overall model and where it needs to be specifically represented a particular pathway or model.

Given the degree of engagement that has been required to date to develop this consensus, the normal timeline associated with understanding properly the evidence base, engaging with clinicians developing complex transformation and the lack of resources specifically allocated to this work, the following represents the progress to date in developing the impacts further:

- We are unlikely to shift the numbers in this iteration for this element of the model and therefore these remain as high level targets based on high level evidence.
- activity and finance impacts remain group for the whole model but could be disaggregated t if useful with efficiency benefits hanging off the model and specific numbers for avoided admissions etc hanging off the pathways which would enable incorporating any cross over with ACC or prevention (e.g., diabetes pathways)
- we note the email in which the risk rating on IPCC projects was lifted so we are now theoretically aiming at maximum saving
- individual business cases may have better, more accurate costing models to get underneath the 40% reprovision assumption but it is unlikely
- the next stage will be to resource and deliver the required project work to develop the granularity required and in some cases this will take a considerable level of engagement based on the suggested programmes of work.

The key impacts modelled for the IPCC workstream were:

The impacts of the integrated, cluster based teams on:

- Admissions and;
- Outpatients and associated follow-ups for key conditions/patient groups.

This was also tested against national evidence as outlined in background information and to a degree local experience where that existed.

A further potential efficiency impact from new ways of working (including diverting activity away from primary care e.g. social prescribing) on future projected activity was worked up, including:

- Impact on primary care and community care contacts and;
- Community beds efficiency improvements.

The SPA and any other elements of the new IPCC model were considered to be wrapped up in (or enablers to) the above – and therefore no additional impacts were calculated for these.

The acute care collaboration workstream similarly has 40% reprovision which might be regarded as potential investment within IPCC and needs clarifying, attributed to:

- Reductions in bed days (elective and non-elective)
- MH reduction in admissions and LOS

General Practice Sustainability and Transformation Delivery Programme

Sustainable primary care, what is the problem we are trying to fix

Primary care continues to be the foundation on which healthcare has been provided since the inception of the NHS in 1948. We know that high-quality primary and community services is the key that unlocks the potential for preventative, proactive management of patients, reducing the need for acute and bed-based care, and addressing many of the health inequalities that exist across our population. However, there are significant challenges being faced by primary care and General Practice in particular. The growing workload and need to manage increasing numbers of patients with multiple and complex health needs, coupled with the uncertainty of future workforce, means we need to radically rethink the model of General Practice if we are to make it sustainable beyond the current decade.

The current state of play in primary care across BNSSG:

- With practice mergers and the percentage of work needing to move into an out of hospital setting current GP estate is not fit for purpose in many cases and this is causing system wide pressures.
- The biggest issue facing all contractor groups is the availability of the clinical workforce to continue to provide primary care in its current form lending us to consider new models of care.
- We know from feedback from Healthwatch, MPs and patients there are problems getting access to primary care services in some parts of our patch,– this challenge will continue as we have seen the number of patients making contact about waits to see their GP and dentists growing.

Our top five challenges are:

1. Urgent action is needed to tackle significant variations in quality.
2. Challenges including an increasing workload; an expanding population; people living longer and with increased care needs.
3. We need to see significant changes to the numbers, skills and roles in the workforce that are needed across our primary care system.
4. We need to get better at educating our systems about pharmacies and other resources to divert large numbers of patients from GP surgeries and service such as A&E.
5. We recognise the problems facing primary care cannot be solved by silo working and wish to see pharmacy being considered as part of the solution.

We must collectively across the system ensure that our primary care colleagues possess the necessary skills, workforce and infrastructure to deliver an efficient, resilient and sustainable service for our population and we set out within this section our plans to support this more suitable future both in general practice. With the issue of key policy documents such as the 'General Practice Forward View' a burning platform like never before places emphasis on a programme of rapid transformation that drives quality and sustainability.

It is clear that general practices in BNSSG are under strain and are bearing the brunt of pressures to meet increasing and changing health needs. Our vision for general practice is that it operates without borders, and in partnership with the wider health and care system. A patient and their GP will be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care. This will occur in general practices which are recognised as places in each community, developing community resilience and supporting our citizens to stay as well and as healthy as possible.

We think that new models of general practice can in the main only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations which we are already seeing happen across the SW, with 40 general practices merging with others already over the course of the previous 12 months to create larger and more resilient providers. This really gives rise to us turning our heads and focusing effort into re-energising primary care and GPs in the main to sustaining an area of our system that provides a service for over 80% of our population not simply the most costly 2%..

We have created a BNSSG wide primary care strategy, initially focussing on general practice. This sets a clear direction of travel towards integrated service delivery by local care organisations covering a geographical footprint with small enough teams to retain the GP practices' very personal relationship with patients and a sense of continuity of care, whilst being large enough to assure long term sustainability and capacity to meet the demands of the wider system. We want to see these primary care at scale organisations providing high quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home as well as general medical services. They will be organised in different ways depending on local circumstances but will be based on a defined geographical patch, reflecting natural communities, within which they are responsible for the health and wellbeing of the population. They will be large enough to be organisationally resilient whilst hosting smaller clinical teams at a local level of different specialisms. Local care organisations will work with similar organisations across the BNSSG system to provide a seamless service to patients through defining new community care pathways and sharing a common patient record.

As mentioned above we are currently working across BNSSG to define the GP localities. North Somerset and South Gloustershire CCGs are more advanced in their configurations than Bristol. During October and November Bristol CCG are working with their GP members and Governing body to move this conversation on, the GP localities will be built around the following principles:

1. Based on population health needs, with weighted populations of circa 30-50k;
2. Demarcated geographical footprints;
3. Will provide a platform for delivery of GP Forward View, including seven day access;
4. Will provide a platform for delivery of mental health and integrated community services;
5. Will provide a basis for commissioning of enhanced primary care services.

These footprints will be the basis for the planning and delivery of services, irrespective of who owns or operationally runs a general practice. If a GP practice sits across a border in it will be expected to organise delivery of care according to the needs of the population within that defined geography.

In BNSSG the CCGs, working in collaboration with NHS England South (South West) are supporting a number of initiatives which will deliver a sustained transformation of primary care via the funding a three year programme which facilitates the coming together of various organisations and arm's length bodies to support local areas to sustain general practice not just for tomorrow but for the coming years. New roles in primary care will be critical to its sustainability and this programme of work will focus its efforts on exploring this concept in more detail to build a programme of delivery including community education provider

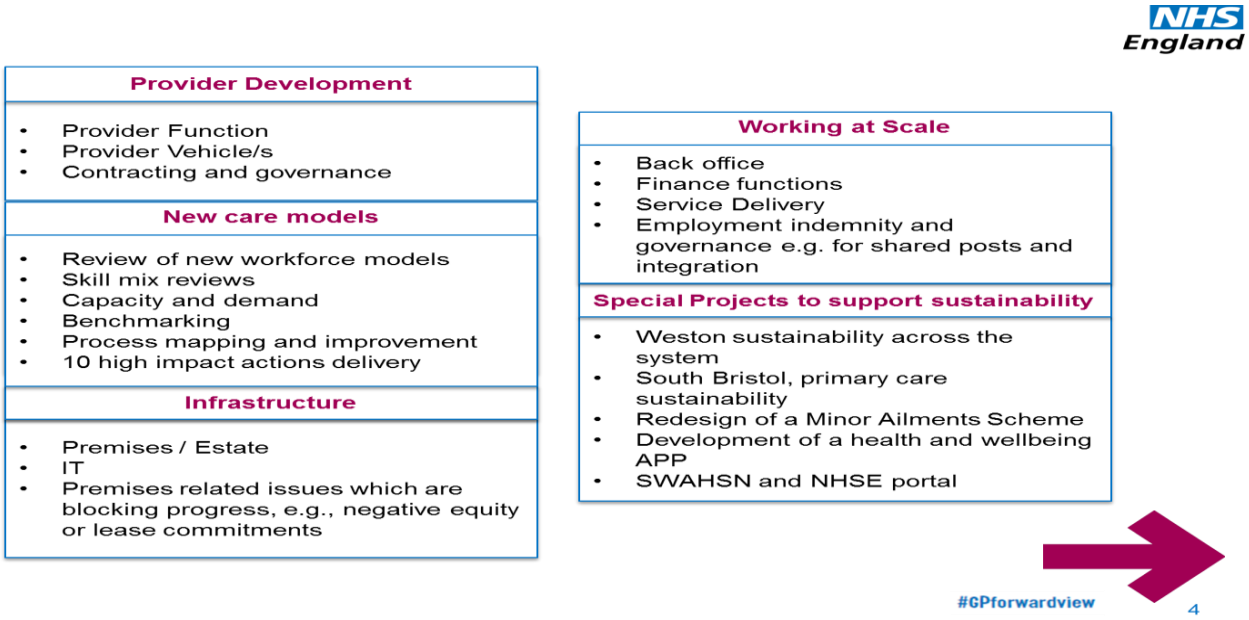
networks. We will also work with providers to explore more efficient ways of working across clinical, management and administrative functions by sharing expertise and resource throughout the SW, which will strengthen the capacity of practices to develop new services out of hospital. We recognise that greater integrated working particularly in primary care could yield significant benefits in terms of efficiency effectiveness and patient outcomes.
The way general practice is organised will need to change; this applies to the standard GP contract timing 0800am-18.30pm and out of hours. This programme will also take a view on organising care and delivery of the GP access fund for 16/17 and 17/18. Already across BNSSG new and innovative access to general practice pilots have been established by One Care Consortium who nationally obtained £9.6m of new monies via the GP Access Fund.

This money has been used over the previous three years to pilot new ways of working including:

- Piloting mental health workers, physiotherapists and pharmacists to develop multi-disciplinary teams to support better patient access to services and GP workload;
- Developing a seven-day access model in primary care across BNSSG;
- Piloting use of web based technology for GP consultations and improving patient access to web based self-help information;
- Improving telephone access through the review of telephony systems;
- Reviewing back office functions and processes to improve practice efficiency.

The GP sustainability and transformation of general practice programme will be responsible for reviewing the evaluations and business cases of the above pilots to understand whether these initiatives are something the system may wish to take a view on continuing or not in the longer term.

The immediate priorities for action and oversight of the GP sustainability and transformation delivery board are:



Temperate check of general practice

Across BNSSG in November commissioners will undertake a 'temperate check' of general practice throughout November, this will also include the bringing together of denoted 'resilience areas' via the national £40 resilience of general practice fund launched as part of the GP Forward View announcements recently. The resilience areas will be brought together to discuss their results from the temperate check, to have proactive discussions and develop a 'resilience and transformation plan for the local area' with go live

on a number of initiatives from December. This will also help inform the programme plan further for the GP sustainability and delivery programme.

The temperate check will collect the following data (per practice) via a web tool:

- Number of appointments available for the week (by professional working at the practice);
- Demand for appointments for the week (by professional working at the practice);
- What the gap is between capacity and demand;
- What happens to the patients when demand is reached;
- How much of the demand (by Health Care Practitioner) could have been delivered by another member of the team or moved to self-care.

Developing System indicators - helping STP's understand what is going on in primary care

- Number of GP practices
- Number of potentially vulnerable GP practices: (looking for downward trend) *
- % GP practices working in a formal collaboration (looking for upward trend) *
- % vulnerable GP practices working towards sustainable solution (looking for upward trend and any that are not named and identified as a key risk)*
- Workforce (from national return) -number (? and %) practices with combined clinical staffing numbers/1000 practice population (think this is probably more useful than no of GP's) below national average (looking for downward trend)*(AHSN)
- Workforce (from national return) % clinical staff >age 55 (potential risk identifier)*(AHSN)
- No and % of practices with CQC requires improvement rating (risk identifier/looking for downward trend)**
- No and % of practices with CQC inadequate rating (risk identifier/looking for downward trend)**
- No and % of practices identified for GPOS review (Risk identifier/Looking for downward trend) **
- No and % of practices >6 GPHLI > 6 outliers (Risk identifier/Looking for downward trend) **
- No and % of practices with application for list closure in last 6 months (Risk identifier/Looking for downward trend)**
- No and % of practices with QOF score<80% (Risk identifier/Looking for downward trend) *
- No and % GP practices with referral rate increasing by (?) >5% (System outcome indicator/Looking for downward trend)***
- No and % GP practices with referral rate reducing by (?) >5% (System outcome indicator/Looking for downward trend)***
- No and % GP practices with unplanned admission rate increasing by (?) >5% (System outcome indicator/Looking for downward trend)***
- No and % GP practices with unplanned admission rate reducing by (?) >5% (System outcome indicator/Looking for downward trend)***

Source of data: * - PMO ** - NHSE Primary Care contracting team *** - CCG/STP

13

Estates and technology transformation funding (ETTP)

In 2015 NHS England released details of a 'Primary Care Infrastructure Fund' which is a four year £1billion investment programme to accelerate improvements in GP premises and infrastructure like Information Technology. CCGs in BNSSG are currently in the process of finishing their 'strategic estates plans' to inform the release of monies attached to any strategic priorities identified. This is creating opportunities for collaborative work between providers and local communities to identify the best way of utilising/developing existing infrastructure.

Technology

- Technology is a key enabler for delivery of a transformed and sustained primary care and currently we are not doing enough to really bring the NHS into the modern era via use of modern methods of technology.
- There is a BNSSG Digital Road Map and IT strategy for BSG and NS CCGs. These need to be aligned to this piece of work to ensure focus is in the agreed areas to enable achievement of key priorities.
- The ETTP process is a potential source of funding, that could fund some of the areas to move at pace, however although CCGs will work together with Avon IM&T Consortium to put bids forward that are a priority to the system, there is no guarantee that bids will be successful .
- Summary Care Record (SCR) is in the process of roll out to community pharmacy its introduction will be of particular benefit to the South West where there is a high population of visitors and this introduction will support greater safety in the delivery of emergency supplies and in general dispensing. It is recognised however to realise our ambition of fully integrating community pharmacy with practices read write access to patient records will be necessary and all of this looks set to support General Practice sustainability.

Estates

How we will improve General Practice Infrastructure in 2016/17

- Premises play an important role in the delivery of healthcare historically, GP premises have not been developed at the same pace as modern General Practice and Primary Care. Some premises are barely fit for purpose, lacking facilities for disabled patients, have no additional capacity or are poorly located.
- Where development has occurred much of it has been excellent-however, there has not been enough development, and the growth in demand means that the developments don't have the necessary capacity to deal with the increased number of patients and additional service requirements.
- GP premises could be ideally placed within their communities to develop as hubs, coordinating care across health and social provision. The identification of the needs of the community should drive the development of premises within the broader locality setting, rather than the responsibility resting with contractors alone.
- If premises were located on the basis of population need and were centres for wellbeing, they could contribute significantly to addressing the inequalities in health outcome however due to lack of land and lack of capital and revenue costs we are constrained slightly by what the future could look like for delivery of out of hospital care in BNSSG.
- We are also aware of low occupancy rates of some existing buildings with potentially high patient access in community pharmacy that could further support the wider system in its estate utilisation and ongoing estate issues.

What the programme aims to deliver

1. Baseline capacity, demand audit of all BNSSG practices
2. A resilience plan for each area
3. A training needs analysis to support delivery of a new workforce model across primary care supported by partners Health Education England (HEE), Wessex Academic Health Science Network (WAHSN) and South West Academic Health Science Network
4. Test different organisational forms across the spectrum from informal collaborations through to formalised new business models
5. Testing of new models of care and services configurations
6. Create a more sustainable and resilient primary care through eradication of contractual silos especially across Pharmacy and General Practice
7. Development and testing of new roles in Primary Care
8. A range of case studies which can support delivery in other areas of the SW

9. Roll out across general practice of the 10 high impact actions.

With the above in mind the general practice sustainability and transformation delivery programme will discuss and formulate answers too:

- How we will reduce variations in quality.
- How we will make significant changes to the numbers, skills and roles in the workforce that are needed across our primary care system working with partners such as HEE and AHSNs.
- Education of patients – how we do this better to divert large numbers of patients from GP surgeries.
- Provider Development – how we work with providers to explore more efficient ways of working across clinical, management and administrative functions by sharing expertise and resource throughout the network, which will strengthen the capacity of practices to develop new services out of hospital.
- Where areas in the UK have explored and adopted social prescribing to support a reduction in demand on GP appointments – (in Rotherham for example 21% of A&E and use of GP appointments reduced by introducing a social prescriber to the PC team.
- To explore and develop the idea of care coordination in primary care.

Provider voice – moving to one provider "voice" to represent for General Practice providers across BNSSG was established in the summer of 2016 with One Care being asked by all member practices to act as its provider voice at the BNSSG systems leaders group.

Acute Care Collaboration (ACC)

The STP foot print has agreed a series of principles as part of our model of care, which is about the acute care system and not individual providers. These principles were outlined in the 30th June checkpoint submission and can be summarised as follows;

A collaborative provider model, supported by a single commissioning approach.

- Eliminate variation from best practice for both quality and efficiency
- Provide services locally where possible, centralised where necessary making best use of available estate and workforce
- Work together across care pathways so that patients receive right care first time in the most appropriate setting
- Support primary and community care with a consistent offer from all Trusts
- Improve patient care across pathways by improving speed and quality of information sharing

Reducing utilisation of acute hospital bed base

- Ambulatory care maximised (all Ambulatory Care Sensitive conditions to be reviewed and harmonised across Acute Trusts)
- Hospitals including paediatric and acute mental health have bed occupancy that allows efficient flow of patients
- Best practice in whole hospital flow embedded to include optimal theatre utilisation, avoiding cancellation and flow from acute hospital to mental health settings
- Immediate discharge or transfer when acute hospital based care (including mental health) is no longer required
- Lean outpatient work delivered in a place that patients want which avoids waste and supports community based care

Using our acute hospital resources to support the wider health and care system.

- Sharing the acute and mental health hospital facilities, physical assets, clinical skills and staff to support patients to stay out of hospital when possible.
- Utilising our scale to provide resilience to the health and care system including infrastructure, shared corporate services and workforce development.

Building on Principles to Establish New Ways of Working

Notable progress has been made in developing the outline principles above into the consideration of new ways of working. University Hospitals Bristol, North Bristol Trust and Weston Area Health Trust have agreed that working together to improve services and pathways for patients is a primary aim of the STP ACC workstream. We want to ensure we deliver the most effective and efficient configuration of services for patients, by collectively using the resources at our disposal.

BNSSG has already delivered a very ambitious change plan over the period 2005-15 which saw major service transformation, including the transfer of services between UH Bristol and NBT to consolidate services in the right place together with a new PFI at Southmead and a new Community hospital in South Bristol. We have delivered big change to the benefit of patients and commissioners on a wide range of services such as trauma outcomes, children's services, the vascular network model, urology, breast, ENT, head & neck and pathology. They were well

considered/planned and executed changes which also make us fit for the new NHS England South specialised commissioning proposals around Major Trauma Centres and Cancer alliances.

Therefore, the BNSSG system has a strong track record of working together to achieve significant change and - through the Sustainability Transformation Planning process - we intend to develop closer working at a range of different levels, such as specialties, clinical support services and corporate support services

We want to build on this track record of success through continuing to develop our ways of working together. In practice this means there needs to be a consistent emphasis on those working within the acute sector thinking and working on a system basis, to design service configurations that meet the needs of local populations in an equitable, high quality and efficient way. This will importantly include clinical teams joining up to deliver pathways of care, irrespective of location or organisation.
This could lead to more standardisation across three or more sites, or it could be differentiated/ graduated between sites as circumstances require. In some cases we may supplement this model by agreeing joint appointments and changes to referral flows and case mix. We would also like in some cases to see these new networks extend into primary and community care; for example in respiratory, diabetes and cardiology.
We do not want to see services constrained by the buildings that they have historically been delivered in. Naturally we will engage and consult with all staff to ensure that this work is done in an appropriate and constructive way.
We believe that services should be driven by what makes sense clinically, rather than by what has grown up historically. We want form to be shaped by function, rather than the other way round. We understand that we may have to consider changing or challenging some payment approaches and funding flows to support delivery of a model that makes best clinical sense rather than allow this to be a major constraint to change. Consideration will be given to alternative models of joint working and learning will be sought from the 13 Acute Care Collaboration Vanguards who are at various stages of developing and implementing alternative models of working.

It is acknowledged that Acute Care Collaboration Vanguards are designed to spread excellence in hospital services and management across multiple geographies and that some of these approaches could present significant benefits and opportunities for the acute sector within BNSSG.

It is understood that three of the key approached being taken within the Vanguards are;

1. Excellently-performing individual NHS hospitals able to form NHS Foundation Groups to raise standards across a chain of hospitals (a model of hospital ‘chains’).

2. Individual clinical services at local District General Hospitals being run on site by specialists from regional centers of excellence, where a smaller trust draws in expertise from larger and surrounding trusts through a mixture of both networking and franchises.

3. Forming ‘accountable clinical networks’ integrating care across District General Hospitals and teaching hospitals for key services, including cancer and mental health.

It is acknowledged that these are just three of the approaches being explored nationally and the BNSSG leadership will develop learning from the Acute Care Collaboration vanguards to develop new arrangements between hospitals for staff, services and resources to improve the quality of care provided to patients, the clinical viability of smaller hospitals, and the productivity of each participating hospital.

Transformational Change - Themes to projects

The BNSSG acute sector transformation plan has four major work streams:

- Best use of hospital capacity
- Effective clinical pathways
- Specialist services and networks
- Sustainable services at Weston General Hospital

Emphasis is now being placed on building on the actions outlined in the previous submission, to develop these themes into specific and deliverable projects. Each project has been selected as a priority based on the scale of opportunity and potential to impact on reducing our known gaps in Care and Quality, Finance and Efficiency and Health and Wellbeing.

It is well understood that the acute care asset base in BNSSG is expensive, with city centre estates and state of the art modern hospital facilities contributing to a higher cost base. Improved productivity is therefore a key focus of the developing projects, with specific emphasis placed on the need to maximise the use of acute facilities through improved productivity at all levels, reducing costs, duplication and variation where possible and potentially reconfiguring or redistributing services between the three acute providers, using the principles outlined above, if this provides greater opportunity for services to develop and thrive. The new and developing ways of collaborative working are providing a new framework in which models for the provision of services in BNSSG can develop with the common and shared agenda of improving pathways for our patients.

Common principles for acute care services have been agreed and are jointly owned by the system. The approach taken in developing these principles and themes into action is to start by establishing a smaller number of high impact projects to both realised ‘quick wins’ in closing the gaps, but also to establish and build confidence in new ways of working and collaborating as a system.

The phase one priority projects identified are;

1. Stroke pathways
2. Trauma and Orthopaedic and Musculoskeletal services
3. Pathology consolidation
4. Medicines optimisation
5. Corporate services consolidation
6. Weston sustainability

It is recognised that the following five areas are also clear priorities within BNSSG. There is significant work and energy across the system already focussed on improving services in these areas, however, the role of the STP and Acute Care Collaboration work stream will be to harness this existing energy to provide a point of focus to maximise the benefits afforded by a whole system view and to provide joint leadership where required.

1. Mental Health – Personality Disorders
2. Acute mental health beds and out of area placements
3. Developing Specialised Services and Networks
4. Urgent and Emergency Care – Including Urgent Care Network
5. Cancer – Development of Cancer Alliances

Projects are also developing within the workstream in the following areas and will be scoped and implemented using the same common principles as the phase one projects;

1. Cardiology
2. Neonatal Intensive Care
3. Interventional Radiology
4. Optimising outpatients

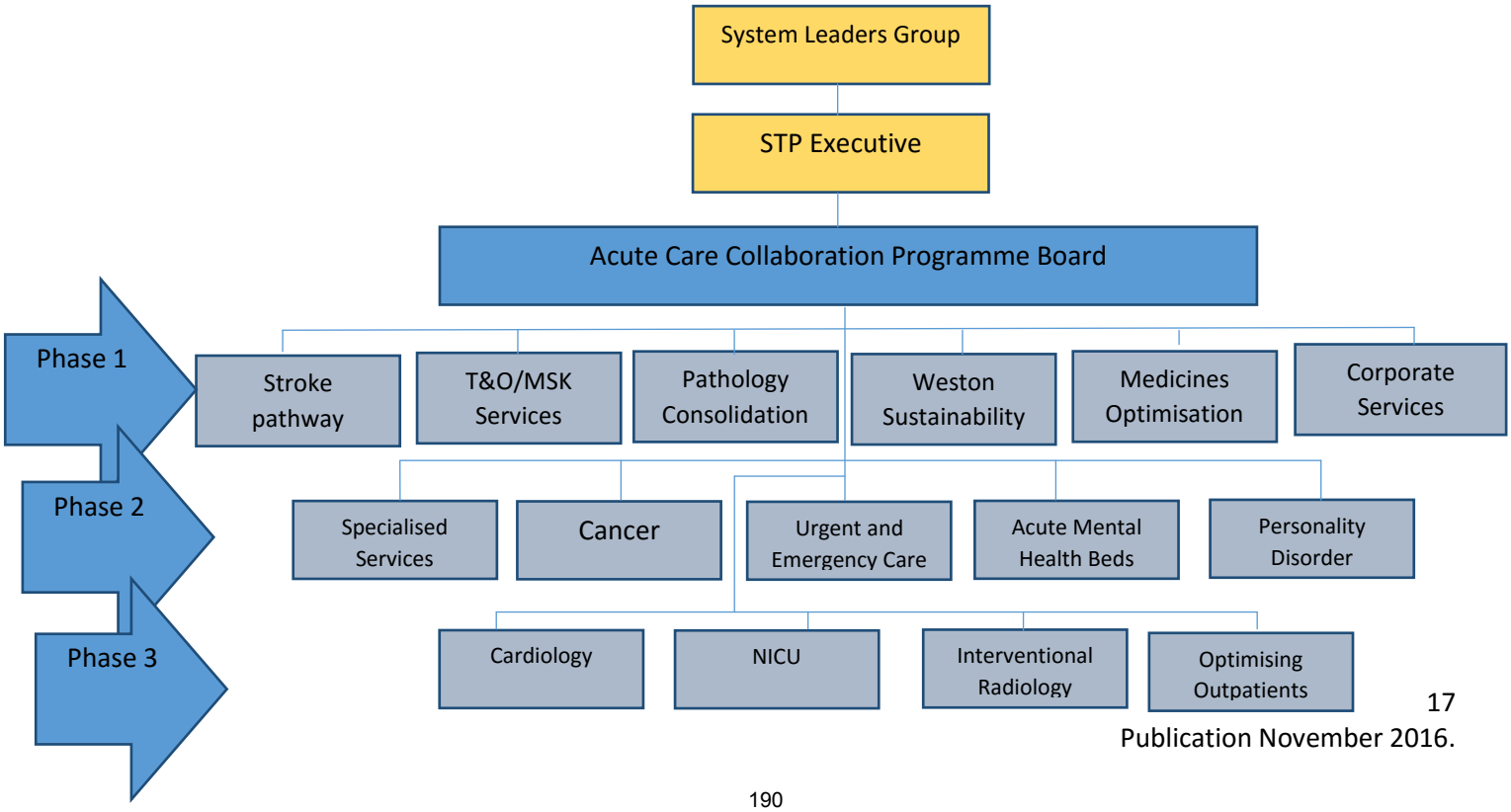
In addition, there are a number of projects developing in the other two STP model of care workstreams which are key enablers to improving utilisation within the acute sector and importantly to ensuring that only the patients who require treatment in an acute setting are in hospital. These projects include specialty pathway work in respiratory, diabetes and the frail elderly, as well as reducing delayed transfers of care, primary care sustainability and self-care initiatives. The role of digital will also be fundamental to realising innovations in the acute sector, with UH Bristol recently being identified as a National Digital Exemplar presenting further opportunity to maximise the benefit over the next five year period.

Acute Care Collaboration – Governance, Delivery and Impact

There has been a clear focus on the rapid development of the phase one projects outlined above. These are all now at the stage of having produced a project initiation document, or outline business case, outlining the high level milestones and delivery plans, including how each of these projects contribute to the overall planned impacts on the systems. Leadership teams have been established and project teams are being mobilised, ensuring plans for stakeholder engagement as required.

The Acute Care Collaboration work stream project structure is outlined below, with multidisciplinary, senior membership from across the system holding to account the delivery of each of the projects.

STP Acute Care Collaboration – Proposed Structure



The table below outlines the proposed membership and required roles within the ACC programme and each of the constituent project groups.

It is proposed that each of these roles hold clear accountability and responsibilities and that each of the key roles for delivery are appointed to, or allocated as dedicated roles. This would include Programme and Project management roles (recommended at least 0.5-1wte for the ACC programme manager role and 0.5 wte for each of the projects, with supporting administration, depending on scale of project). These may come from existing roles from within the organisations in the system, or through realigning those already engaged in delivering work in these areas. It is recommended however, that by allocating specific roles, there will be the capacity to deliver the scale of change required and post holders will be clear on the requirements of the role and accountability for delivery.

Consideration needs to be given to BI, finance, communications and workforce capacity to undertake roles and clinical time may need to be freed up through allocating Pas to dedicate to specific stages of the projects.

ACC Programme Board Membership

- Chair – SRO
- Programme Manager
- Administration
- Medical Directors – All Acute
- Directors of Strategy – All Acute
- Leads/SROs for each project
- Finance Lead
- Estate Lead
- Digital Lead
- Workforce Lead
- Commissioning Lead (CCG)
- Specialised Commissioning Lead
- Community Care Lead
- Mental Health Lead
- Communications Lead
- Local Authority Lead

Project Groups (minimum)

- Chair – SRO
- Project Manager
- Administration
- Clinical Leads
- Operational/Business Leads
- Finance Lead
- BI Lead
- Estate link (as required)
- Digital link (as required)
- Workforce link(as required)
- Communications link
- Representation from key stakeholders, to include Commissioning, Acute, Community Care, Mental Health, Authority as required.

Specialised Services STP Plans

More than 30% of the capacity of acute hospital Trusts in Bristol is occupied with specialist commissioned services which support care for a large regional population. Most specialist services in Bristol are delivered by a single provider working at scale. The specialist capacity needs protection so that it is available for delivering urgent and complex care beyond the STP foot print boundaries. This requires effective networks supported by specialist commissioners that ensure rapid repatriation of patients to local settings and rehabilitation pathways of sufficient capacity to avoid delays.

The key actions within the STP plans, which may have a consequence for specialised commissioned pathways are as follows:

- Support commissioner led review of specialist rehabilitation pathways focussed on neurosurgery, trauma, vascular and stroke patients (largely NBT based).
- Support continued development of the Operational Delivery Networks and a Cancer Alliance hosted by the acute Trusts to enhance their ability to deliver effective pathways.
- Review clinical leadership and management oversight for the level 3 neonatal units (NICU) in Bristol so that they meet the required designation standards within available resources.
- Build on the successful and nationally recognised model of delivering Child and Adolescent Mental Health services with a new provider partnership model including third sector members.
- Review the capacity, demand and cost profile of Trauma and Orthopaedic services to manage the increasing demand in a system that already has a back log of work and high reference costs
- Develop stroke pathways that provide the highest quality care in the hyper-acute setting and rapid discharge to an out of hospital rehabilitation environment at the earliest opportunity
- Address the poor outcomes of diabetic care that result in increased amputation rates and other complications
- Maximise care in the community for patients with respiratory disease with pathways that reduce the seasonal increase in admissions in the winter
- Address the high cost and variation in hospital length of stay in cardiology
- Work with Mental Health providers, acute Trusts, community and primary care to make most appropriate use of acute mental health bed capacity and ensure patients receive physical and mental health care rapidly in the most appropriate setting, aiming for care close to home whenever appropriate, avoiding out of area placements.
- 10% reduction in patients treated out of area (specifically at London Trusts at a higher MFF) on specialised pathways.

UH Bristol Potential Plans (Not covered above)

- **Clinical Genetics** – discussions with Taunton and Somerset NHS Foundation Trust regarding transfer of Clinical Genetics activity to UH Bristol.
- **Genomics** – Potential future changes to commissioning following 2 year project.
- **Paediatric Emergency activity** – significantly high recent growth levels.
- **Adult oncology and haematology** – significantly high recent growth levels.
- **Neonatal Surgery** – National review to be conducted, may impact on other units ability to deliver activity if standards not met, resulting in increased flow of activity to UH Bristol.
- **Thyroid surgery** – Potential redistribution of activity between NBT and UH Bristol (Head and Neck activity).
- **HPB surgery** – Potential transfer of RUH patients currently going to Basingstoke for surgery, to UH Bristol.

- **Congenital Heart Disease** – Impact of recent designation exercise. May see impact of increased flows from other providers.
- **PICU** – Associated impact of any increase in CHD activity, but also potential growth to meet current standards, not associated with CHD.
- **SRT** – Delivery of impacts of recent tender.
- **Intestinal Failure** – Tender.
- **Complex Cancer Surgery –** Thoracic, HPB, OG, Colorectal, H&N, Gynae. Need to understand potential changes in demand and patient flows across region associated with Specialised Commissioning STP briefing.

Appendix E - Engagement & Communications

Updated public narrative

The earlier public narrative has been updated and expanded to accompany the October checkpoint.

The focus of this is on:

- The case for change - rising demand for services at time of ongoing resource constraint leading to a requirement for significant changes in the way we plan, organise and provide services in order to continue meet the health needs of our local population. The STP as an opportunity to work together including with local people and with our workforce in order to develop a shared understanding of the challenges and to agree joint plans for meeting these
- An explanation of the three core and interdependent themes within the STP and the emerging details of the scale and scope of these

Audiences

For the June checkpoint we outlined three broad target audiences groups and how we would engage with them pre and post the 30 June.

- Internal: defined as: all 15 partner organisations involved in the BNSSSG STP
- Stakeholders: defined as: all local groups, organisations, scrutiny panels, boards
- The Public: defined as: service users, local population, general public

As STP plans develop we are now evolving these conversations and taking a more targeting approach to engagement to ensure we establish a two way dialogue with interested parties. Using some of the tactics outlined later in this section: we have, and continue to, proactively engage with all three audiences, starting the awareness raising phase by sharing of the emerging thinking via a designed power point slide deck. Our approach is outlined below.

Internal

Engaging staff

Our workforce is central to the successful implementation of the local STP.

Employees within each of the 15 organisations are the most important stakeholder group; and act as brand ambassadors, sharing the positive message of change with other stakeholder groups.

With over 25,000 working for the local NHS and an extended workforce involved in health and care services beyond this, we need to ensure they understand the STP and how they can get involved and inform the big picture. Research from the Kings Fund (2014) shows that engaged employees lead to better outcomes for NHS organisations and patients. Engaging with staff forms a key part of the strategy between now and the New Year.

The plans we are developing will involve both clinical and non-clinical staff working in new and different ways for example to support the centralisation of support functions or to enable staff and expertise to be shared between hospitals, between hospital and community and across the wider system

The definition of workforce for our STP extends beyond the 15 partner organisations to encompass, for example, the voluntary sector and the police.

Clinician leaders and operational managers are already playing a role in shaping the STP and considering the implications and requirements for our workforce.

A specific staff awareness raising campaign will be undertaken in parallel with the campaign being progressed with local people and other external stakeholders. This will focus on raising awareness of the high level principle underpinning the STP (e.g. operating at scale, eliminating variation, local where possible/centralised where necessary).

Subject to the outcome of the October checkpoint our staff and their representatives will have an opportunity to be involved in development of specific proposals for changes to services.

As plans proceed to detailed development stage it is anticipated that individual bespoke staff communication and engagement plans will be developed in respect of specific projects or programmes of change.

As part of this appropriate consideration will be given to any requirement for formal staff consultation where indicated.

Engagement Activity and Channels – Communications & engagement

INTERNAL ENGAGEMENT ACTIVITY TO DATE

- Collated all partner established communications channels
- Internal update issued to all staff via established channels
- Summary presentation of the emerging thinking shared internally via established channels for reference only
- Second more detailed version of the slides shared via established channels and uploaded to intranet sites, included in staff bulletins and newsletter.
- Presentation of slides by SROs at team meetings.

STAKEHOLDER ENGAGEMENT TO DATE

- Two meetings with the three Healthwatch organisations to discuss emerging thinking and how they can support with ongoing engagement
- Briefing with Karin Smyth, Bristol MP
- Presentations of the emerging STP presented at:
    - Bristol CCG AGM
    - South Gloucestershire CCG AGM
    - North Somerset CCG Stakeholder Event
    - North Somerset HOSP closed session
    - South Gloucestershire HOSP closed session
    - Academic Health Science Network Annual Conference
    - Health and Well Being Chairs Board

PUBLIC ENGAEGMENT ACTIVITY TO DATE

- Each of the BNSSG STP partner organisations have created a page for the STP on their websites and uploaded an introductory narrative
- An updated narrative and the summary STP slides were uploaded to the website and included in established stakeholder communication channels.
- A feedback box and details on how to register interest to be kept informed on further developments was added to the website
- Slides have been shared with Matthew Hill at BBC Points West
- Background briefing with Sid Ryan at Bristol Cable.

Tactics - Channels

The table below outlines the communication and engagement channels and tactics available to us. The table has been designed to help understand the values behind the tactics. For each area of engagement we will assess which tactics are the most appropriate to target specific audiences we need to reach to ensure that engagement is relevant and proportionate.

Channel	Tactic	Rationale
Website	Having the same content across all 15 partner sites shows partnership working.	Planned news updates will ensure that information is easily accessible and will show openness and transparency. Content and documents will be updated and uploaded as there is new information that requires communication. NOTE: As this is a five year plan there will become a point when a dedicated website for the BNSSG STP will be required given the volume of information this is likely to hold. The pages on the CCG website will then be used to signpost to the external website.
Social Media	Established a hashtag for the BNSSG STP that keeps online content grouped together and shows partnership working. As the STP evolves consider benefit from a dedicated twitter account to help give the STP its own voice as a project that has many partners. This account would need to be managed as a dedicated communications channel and is one that all key partners can follow and share content with	Proactive social media management using the key messages will allow for the targeted promotion of any consultations. It also provides an opportunity to share content across multiple platforms. This channel allows for two-way engagement, which will help to ensure audiences are involved in the process We can more effectively disseminate important messages and receive views on what people think, firmly establishing our social media communication as a two-way process. We can use social media to provide opportunities for open, honest and transparent engagement with stakeholders, giving them a chance to participate and influence decision making.

Channel	Tactic	Rationale
	their own followers. Other tactics to be explored to raise awareness include: Facebook content Live Twitter Q&A Sharing key content. Video online NOTE: Someone would need to be appointed to manage the account in order to respond to questions, and manage any reputation risk.	
Blog networking	Identifying and engaging with influential bloggers who write for our key audiences will help raise awareness of any engagement activity. These will need to be researched and contacted to promote engagement with the project. Traffic will be driven from blogs to the online content to promote the work of the STP, and encourage participation in surveys and the consultation process.	Bloggers are influential with their readers, thus securing their third party endorsement will raise awareness and encourage participation.
Survey management	The editing, uploading, promotion, reporting and closing of surveys.	For each area of the STP that requires consultation, surveys can be created to gather feedback. Ensuring consistency in messaging across all surveys and platforms will help understanding of the work being undertaken. We will use plain English increase understanding of the surveys which will support informed feedback. Timely creation, sign-off and upload of the surveys will ensure no delays affect audience participation.
Video(s)	A welcome video is a good way to increase engagement and help explain complex initiatives.	Video(s) can be uploaded to each partners website and shared across social media platforms, and made available for engagement events organised by the PPI teams.

Channel	Tactic	Rationale
	It will help embed the key messages and will humanize the project. Video can be used to put a face to key players within the process, humanising and providing credibility.	This channel will also allow for engagement of audiences through sign language and other languages. In addition (for extra cost), videos can be created or subtitled in minority languages.
Case Studies	Case studies help to humanise a story and create engagement. Audiences find them easier to identify with, thus helping to explain a situation or explain and complex scenario.	Case studies can be used to detail a patient journey within the five year STP. These will be useful later in the strategy and will form a key part of the strategies that support the individual areas of consultation.
Infographics	Infographics are a great way to visually communicate complex data in a meaningful and memorable way.	Infographics would be a useful tool to communicate some of the complex messaging around pathways. They can also be used to visually explain the STP and what it will achieve. These make complex information more digestible for a range of audiences.
Media relations	Development of a briefing document, including FAQs, to prepare project staff for interviews.	Identify key BNSSG commissioner staff for interview opportunities. Interview time with local media will need to be booked to coincide with key periods of engagement and consultation.
	Writing, sourcing quotes, editing and distributing press releases announcing the consultation and soliciting engagement.	This tactic will be most useful once we start raising awareness of specific areas for engagement within the STP. Creating carefully crafted press releases using the key messages will help share the work that we are doing with a wide range of stakeholders via local newspapers, broadcast media, websites.
Newsletter	Develop a list of all stakeholder newsletter distribution dates. It is important to use these channels to provide regular updates to	Key messages will be used in the content to support the STP messaging and promote ongoing consultations. To maximise engagement instead of full articles teasers would be included with links to drive audiences back to the main site. This will remain the central information source.

Channel	Tactic	Rationale
	ensure the STP is kept front of mind. As the STP becomes more established create a newsletter dedicated to the STP that can be sent to all Stakeholders for cascade within their organisations.	
Power Point Presentation	To support engagement activity one power point presentation that provides the narrative that can be shared across all partner websites. Inclusion of a feedback or comment function will also enable people to engage with us.	This will ensure all partners are sharing the same information and speaking with one voice.
Budget dependent ideas:		
Online Advertising	Online pay-per-click (social media) advertising Note: There is a cost attached to this tactic and therefore the ROI needs to exceed that achievable by other means.	Management of a targeted, flexible advertising campaign promoting consultation and engagement from very specific target audiences. Adverts would drive traffic to each CCG website and can be targeted at specific audience groups. This is a very flexible way of advertising and will allow for the targeted engagement of minority groups, as well as other desirable audiences. It's also an effective cross-promotion tool for offline marketing (i.e. print advertising), utilizing similar creations and providing a secondary reinforcement of a campaign by targeting our demographic online.
Marketing materials	Leaflets Note: There is a cost attached to this tactic and therefore the ROI needs to exceed that achievable by other means.	The main purpose of a leaflet would be to raise awareness of the overall STP. It would be a timeless piece of collateral that can be created to last the duration of the project. This will make it more cost effective. The collateral would be designed to direct readers to the CCG websites where they would be able to find out more about any specific consultations. It will also ensure consistency of messaging when partners are engaging with stakeholders.

Channel	Tactic	Rationale
		Leaflets can be handed out at PPI events, sent to GP surgeries, acute trusts, community care facilities, voluntary organisations, local authority direct mail, parish magazines, door drops etc …

For each target audience we will look at the most appropriate channels and tactics to reach them. We will also ensure that we meet the requirements of the easily accessible information standard and will work with our equalities colleagues across all partner organisations to achieve this.

Appendix F – Estates

Supplementary information relating to existing estates projects, STP Initiatives, implementation priorities and financial impacts.

Estates Efficiency Themes:

The majority of Estates efficiencies will be generated through improvements within the Reference Cost Index (RCI) Benchmarking and Carter recommendations as required for Acute Trusts. In most cases, land disposals will enable reinvestment into higher quality and a more efficient estate to meet demand.

Estates leads are now working with the Model of Care (MoC) groups to ensure that the planned estates mapping best meets the demand mapping.

Our Estates Strategy poses a number of significant questions that we will need to address as an STP in order to achieve the optimum value from our estate. These are set out in the table below.

Bristol, North Somerset and South Gloucestershire STP Estates Workbook
October 2016 Submission

STP Estates Workbook - Contents

STP Service Strategy & Implications

Key STP Service Strategy Themes:

In order to avoid the need for 240 more acute beds, almost 600,000 more GP contacts and 12% more capacity in community services, estates will need to generally provide a higher efficiency.

The new MoC that will enable providers change how healthcare services are delivered. This will be implemented through three major transformational work-streams:

1. Integrated primary and community care
   - 7 day model of care
   - Delivery of specialist care in the community
   - Reduction of inappropriate use of hospital beds
   - More efficient use of digital solutions and joint estate options at scale
2. Prevention, Early Intervention and Self Care
   - Reduce dependency on acute beds
3. Acute care collaboration
   - Best use of hospital capacity

Estates Efficiency Themes:

The majority of Estates efficiencies will be generated through improvements within the Reference Cost Index (RCI) Benchmarking and Carter recommendations as required for Acute Trusts. In most cases, land disposals will enable reinvestment into higher quality and a more efficient estate to meet demand. Estates leads are now working with the Model of Care (MoC) groups to ensure that the planned estates mapping best meets the demand mapping.

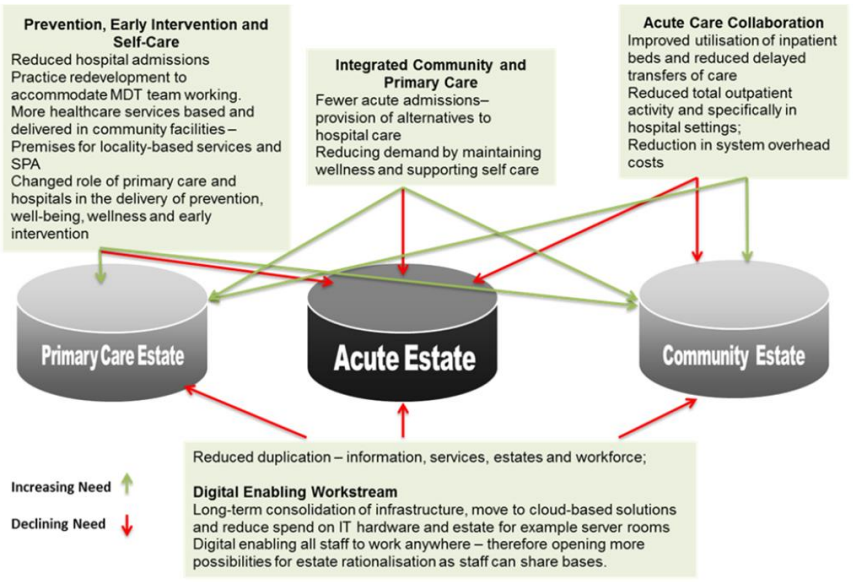
Enabling Implications for Future Estate

1. Integrated primary and community care:
   - Transformation of community facilities to allow mental and physical health services to be delivered locally from "Clustered" GP Premises.
   - Efficient use of joint estate options with other public sector bodies.
   - Surplus estate is removed from the system, estate running/operating costs are reduced and estate delivers value for money.
   - Investment in the estate with poorer quality buildings that are no longer fit for purpose replaced with new facilities.
2. Prevention, Early Intervention and Self Care
   - Shift of care from an acute setting to primary and secondary care making best use of available resources.
3. Acute care collaboration
   - Utilisation of fit for purpose existing estate is maximised (Lord Carter targets) with consolidation of activity and sharing of premises.
   - Sharing the acute and mental health hospital facilities and physical assets.

STP Service Strategy & Implications

Enabling Implications for Future Estate

An overview of the impact on estate arising from the 3 work-streams is given below:



Performance Indicators:
2020/21 Success Metrics (STP Footprint)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£187m pa for 475,216 sqm (£394/m2)	Rationalisation of estate and subsequent increased efficiency	STP wide response. Metrics for the individual organisations can be found in Annex 2
Non-Clinical Space (%) (Carter Metric max 35% for Acute)	164,558 sq metres, equivalent to 34.6%	Continued compliance with Carter metric	STP wide response. Metrics for the individual organisations can be found in Annex 2
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	10,495 sq metres, equivalent to 2.21%	Continued compliance with Carter metric	STP wide response. Metrics for the individual organisations can be found in Annex 2
Functional Suitability	75% of the assets are in an acceptable condition / satisfactory performance	Improvement in estate and subsequent improvement in Functional Suitability	STP wide response. Metrics for the individual organisations can be found in Annex 2
Condition	6% of estate is pre 1948 22% of estate is '65 – '74 58% of estate is '85 –'94 4% of estate is '95 – '04 10% of estate is '05 to '14 Back-log maintenance of £27.3m	Rationalisation of fit for purpose estate and reduction of backlog maintenance	STP wide response. Metrics for the individual organisations can be found in Annex 2

Estates projects

Supplementary information relating to existing estates projects, STP Initiatives, implementation priorities and financial impacts.

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Southmead site rationalisation and re-provision of Mental Health services	AWP	Acute Care Collaboration	Critical	-£360k	-£3m	Project Implementation Stage	2018/19	Yes
Part disposal part development of Frenchay Hospital	NBT	Acute Care Collaboration	Critical	£0	-£45k	Final stages of sale	2017/18	YES
Improve utilisation of Core Estate (SBCH / LIFT / PFI)	All	Integrated Primary and Community Care	Critical	TBC	-£100k	Project Implementation Stage	2017/18	YES
Additional GP facilities in Weston Villages (New Build)	NS CCG	Integrated Primary and Community Care	Critical	- £360k to - £600k	-£3m to -£5m	Awaiting ETTF decision due Oct-16	2018/19	YES
Disposal and re-provision of Thornbury Hospital	NBT	Acute Care Collaboration	Critical	+£800k	-£125k	Negotiating with Sirona	2017/18	YES

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Consolidation of Back Office Functions	All	Integrated Primary & Community Care	High	TBC	TBC	Project Implementation stage	2018/19	Yes
Re-provide Central Health Clinic building	UHB	Acute Care Collaboration	High	TBC	TBC	Project Implementation stage	2018/19	Yes
Weston / Worle / Urban (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes
Nailsea and Long Ashton (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes
Mendip Vale, Congresbury (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes
Clevedon, Portishead, Pill (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	Yes

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Banwell and Winscombe (Extension / New Build)	NS CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Lawrence Weston Community Hub (New Build)	Bristol CCG	Integrated Primary & Community Care	High	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2018/19	YES
Bishopston Medical Centre (New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2018/19	YES
North and West Locality Strategy (Extension / New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Inner City and East Locality Strategy (Extension / New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
South Locality Strategy (Extension / New Build)	Bristol CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Thornbury, Pilning and Almondsbury (Extension / New Build)	SG CCG	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Filton, Cribbs Causeway and Patchway (Extension / New Build)	South Glos	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
Yate (Extension / New Build)	South Glos	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES

Summary of existing projects

Review of existing projects /initiatives considered to align with STP (top 10/20 projects)

Project / Location	CCG / Trust	Strategic Objective	Priority / Importance	Est Revenue impact £m (+/-)	Net Capital impact £M (+/-)	Project Milestone	Estimated Delivery Year	STP Alignment (Y/N)
Charlton Hayes (Extension / New Build)	South Glos	Integrated Primary & Community Care	Medium	-£216k to -£360k	-£1.8m to -£3.0m	Awaiting ETTF decision due Oct-16	2019/20	YES
BNSSG Health & Care Single Point of Access (This may cross many sites, but mapping is yet unknown)	BNSSG	Integrated Primary & Community Care	High	-£420k	-£3.5m	Operational development	2017/18	YES
Bentry - Disposal	AWP	Acute Care Collaboration	Medium	TBC	+£800k	Early stages	2018/19	YES

Sustainability & Transformation Initiatives

In order of priority - X new projects identified where implementation required to enable wider STP strategy (revenue savings >£1m pa)

STP initiative	Estates Impact and Enablers	Est. Net Revenue Benefits (£m pa)	Project Status	Est. Deliver Year	Gross Capital Required (£m)	Disposal receipts (£m)	Comments and Interdependencies
1. Acute Care Collaboration	Rationalisation of Southmead site and re-provision of Mental Health services	-£360k	Identified as opportunity only	2018/19	-£3m	£0	Land to be transferred from AWP to NBT at Net Book Value
2. Prevention, Early Intervention and Self Care	Part disposal part development of Frenchay Hospital	TBC	Outline planning consent. Final stages of sale	2018/19	-£45k	+£3.5	Sale is currently in abeyance as Council have publicly consulted on a condition precedent for 'Town and Village Green' status of a large part of the site. Decision due Nov-16
3. Integrated Primary and Community Care	Improve utilisation of Core Estate (SBCH / LIFT / PFI)	+£1.5m to +£2m	Identified as opportunity only	2017/18	-£100k	£0m	Utilisation studies to be undertaken within LIFT buildings
4. Integrated Primary and Community Care	Additional GP facilities in Weston Villages to accommodate growing population	-£360k to -£600k	ETTF bid submitted. NHS England decision due end of Oct-16	2018/19	-£3m to - £5m	£0	Option appraisal required to determine capacity and condition of neighbouring estate
5. Prevention, Early Intervention and Self Care	Disposal and re-provision of Thornbury Hospital	+£800k	Negotiating with Sirona	2017/18	-£125k	+£3m	Site to be sold to Sirona for nursing home and extra-care housing

Implementation priorities

Key next steps towards delivery

Key next step	Challenges	Resources	Indicative timeline	Comments
Rationalisation of Southmead site and re-provision of Mental Health services	AWP / NBT combined Estates Strategy to be agreed for non-PFI areas of estate	Specialist resource (1 No Project Manager and £100k budget). To develop masterplan that meets need of both organisations	Within 6 months (by Apr-17)	Discussions have commenced between AWP and NBT
Part disposal part development of Frenchay Hospital	Planning is currently in abeyance	1 No specialist planning consultant is required to assist with complex planning issues	Within 12 months	Community site is not linked to the remainder of the site. Negotiations are on-going with Sirona
Improve utilisation of Core Estate (SBCH / LIFT / PFI)	System is requesting additional space but Core Estate is not being fully utilised	Utilisation surveys of all Core Estate is required (£100k plus implantation and delivery team). 1No Project Manager	Utilisation of LIFT buildings to be undertaken within 6 months. Strategy to utilise space to be undertaken in 2017/18	Surveys of all core estate is required, not just CHP property
Additional GP facilities in Weston Villages to accommodate growing population	Additional GP facilities may be required in Weston Villages area to cope with significant increase population	Appointment of 1 No Project Director and 1 No Project Manager and £250k budget for technical support team to undertake option appraisal / Business Case	ETTF due diligence decisions are anticipated by Oct-16	Option appraisal must take into account wider implications of Weston Town and Weston General Hospital Sustainability issues
Disposal and re-provision of Thornbury Hospital	Disposal opportunity	1 No specialist planning consultant (could share with Frenchay disposal) is required to assist with complex planning issues	Within 12 months	Negotiations are on-going with Sirona
Capacity and implementation of ETTF bids	Fund is not sufficient to cover all projects. Management arrangement required to ensure delivery	1 No Project Director, 1 No Project Manager (could be shared with Weston Villages) and £500k budget to manage ETTF programme and ascertain non-ETTF options	ETTF due diligence decisions are anticipated by Oct-16	Alternative funding route required to pick up short fall in ETTF funding

Headline Financial Impacts

Investment Pipeline summary

Investment requirement (strategic objective)	Estimated investment capital £m	Committed (OBC stage)	Uncommitted (Pre OBC)	Estimated timeline	Capital Proceeds £m	Gross Estate Running Cost Savings £m pa	Service savings £m pa
High risk back-log maintenance programme	£6.1m	£3.1m	£3.0m	2018/19	£0	£0	£0
Service re-configuration/ consolidation	£6.77m	£0	£5.97	2020/21	£7.3	TBC	TBC
Estate subject to ETTF funding	£27.4m to £44m	£0	£27.4m to £44m	2019/20	TBC	TBC	TBC
Other	£0	£0	£0	N/A	£0	£0	£0
Totals	**Dependent on Control Totals**	**Dependent on Control Totals**	**Dependent on Control Totals**	**As above**	**£7.3m subject to Control Totals**	**TBC**	**£0**

Disposal Opportunities

Disposal Status	No. of sites	Land Area (Ha)	GIA (m)	Estimated disposal value £m	Timeline for disposal (year)	Estimated Housing Units	Gross Running Cost reduction £m	Cost to Achieve (where known) £m
1. Marketing ongoing	3	4	2,500 to 3,500	£7.3m	2018/19	32	£1m	£220k
2. Declared surplus / OBC approved	0	0	0	£0	N/A	0	0	0
3. Feasibility Stage	**0**	**0**	**0**	**£0**	**N/A**	**0**	**0**	**0**
Totals	**3**	**4**	**2,500 – 3,000**	**£7.3m**	**2018/19**	**32**	**£1m**	**£220k**

Critical Decisions

Critical Decisions:

Decision Required	Significance/ impact on STP strategic objectives	Owner	Action By:
Rationalisation of Southmead site and re-provision of Mental Health services – Co-ordination between acute and central commissioners for specialist Mother & Baby unit to provide additional beds that can not be economically provided on site combined with quality of existing inpatient environment	Rationalisation of estate and reduction in non-functional space	AWP / NBT	Within 6 months
Part disposal part development of Frenchay Hospital – Outcome of local planning decision required to allow disposal of site allocated to Health and Social Care Centre. Decision is due by November 2016	Disposal of surplus land	NBT	Nov-16
Improve utilisation of Core Estate (SBCH / LIFT / PFI) – Commissioners to confirm requirement for additional space within Core Estate following outcome of utilisation surveys	Rationalisation and best use existing core estate	Bristol CCG	Within 12 months
Additional GP facilities in Weston Villages to accommodate growing population – Funding to be confirmed to allow appointment of Project Director and Technical Support team	Provision of integrated primary and community care services at scale	North Somerset CCG	Within 2 months
Disposal and re-provision of Thornbury Hospital – Negotiations between NBT and Sirona to be completed to allow transfer of land between the two organisations	Disposal of surplus land	NBT	Nov-16

Annex 1: STP Estates Data Summary

Estates Composition (1 of 4)

Portfolio Summary

Portfolio	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m) (rent, s'charge, FM)	Back-log Maintenance £m
GP owned	124	Not available	76,484	54%Freehold 8.9% Leasehold 37.1% Unknown	Not available	Not available
NHS PS	54 All properties	Not available	57,528	53% Freehold 47% Leasehold	8.39	Not available
CHP	5	Not available	20,215	100% Leasehold	8.94	£0
Provider estate	83	99	440,971	24% Freehold 14.5% Leasehold 61.5% Unknown	203.25	42.01
Mental Health Trusts	23	16.59	41,266	95.5% Freehold 4.5%Leasehold	10.35	2.48
Public Health Estate	16	Not available	6,876	31.25% Freehold 68.75% Leasehold	Not available	Not available
Other (SWAFT)	13	contained with aggregated data in ERIC	Contained with aggregated data in ERIC	Contained with aggregated data in ERIC	Contained with aggregated data in ERIC	Contained with aggregated data in ERIC
Totals	**318**	**115.59**	**643,339**		**230.93**	**44.49**

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Estates Composition (2 of 4)

Functional Use Summary

Functional Uses	No. Properties	Footprint Size (Ha)	Size GIA (sqm)	Percentage Tenure split Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £m
Clinical/clinical support	76	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC Incomplete data	contained with aggregated data in ERIC
Back Office (self contained unit)	7	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC	contained with aggregated data in ERIC
Other (eg w'house or workshop)	No Data	No Data	No Data	No Data	No Data	No Data
Totals	**83**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**	**contained with aggregated data in ERIC**

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Estates Composition (3 of 4)

High Cost Sites: Estate Running Costs

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £k	Cost per sqm	Current Site Strategy
Southmead Hospital	6.8	174,930	Freehold/PFI	100.3	11,500	573.37	Retain
Bristol Royal Infirmary	10	192,342	Freehold	72.4	19,971	284.36	Retain
Weston General Hospital	10.6	36,825	Freehold	14.7	9,060	233.67	Retain
Callington Road Hospital	4.8	12,095	Leasehold/ PFI	6.21	PFI	513.77	Retain
South Bristol Community Hospital	13.5	11,000	leasehold	6.11	PFI	556	Retain

Highest Cost Locations : Backlog Maintenance

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Freehold / Leasehold	Estate Running costs pa (£m)	Back-log Maintenance £k	Cost per sqm	Current Site Strategy
Bristol Royal Infirmary	10	192,342	Freehold	72.4	19,971	284.36	Retain
Southmead Hospital	6.8	174,930	Freehold/PFI	100.3	11,000	573.37	Retain
Weston General Hospital	10.6	36,825	Freehold	14.7	9,060	233.67	Retain
Drove House	0.4	1190	Freehold	.006	141.2	5.1	Retain
Long Fox Unit	3.14	4,439	Leasehold	1.8	18.9	403.51	Retain

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Estates Composition (4 of 4)

PFI and LIFT Utilisation

Highest Cost Sites	Footprint Size (Ha)	Size GIA (sqm)	Estimated Utilisation (%)	Estate Running costs pa (£m)	Cost per sqm (GIA)	Proposed STP Site Strategy
Southmead Hospital PFI	6.8	174,930	Not available	100.3	573.37	Retain
Callington Road Hospital PFI	4.8	12,095	Not available	6.21	513.77	Retain
Hampton House health Centre LIFT	Not available	3,261	40% (assumed)	1.17	359.7	Retain
Fishponds Primarycare Centre LIFT	Not available	2,313.4	40% (assumed)	1.05	454.7	Retain
Shirehampton Healthcentre LIFT	Not available	1,854	40% (assumed)	.79	426.9	Retain

DISCLAIMER: INFORMATION COLLECTED FROM SHAPE (OCTOBER 2016). FURTHER CLARIFICATIONS ARE REQUIRED

Annex 2: Performance Indicators for Individual Organisations

Performance Indicators: 2020/21 Success Metrics (AWP)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£14.1m pa for 51,704 sqm (£273/m2)	Currently no board agreed target. No Carter target for mental health	Further cost improvements desired, but limited by 35% PFI estate, and high private leasehold costs following disposals. Therefore costs must reduce by consolidation on existing owned estate and vacating leases.
Non-Clinical Space (%) (Carter Metric max 35%)	23,929 sq metres, equivalent to 31.7 % of occupied space	No board agreed target Estate Strategy under review	No Carter target for mental health
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	2,650 sq metres, equivalent to 5.5 %	Currently no board agreed target. Previous AWP strategies targets similar to Carter . Current schemes in progress will reduce this to 3.8%.	Remaining reduction will require AWP Southmead services redesign
Functional Suitability	96% of the assets are acceptable for functional suitability	Investment / build addressing functional suitability and improved space utilisation of the Long Fox facility on the WAHT main site	Key development requirement
Condition	Almost all estate post-1985. 14% at condition C. Back-log maintenance of £2.7m	Investment / build addressing operational viability and backlog of services currently at AWP on the Southmead site	Key development requirement

Performance Indicators: 2020/21 Success Metrics (BCH)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£2.76m pa for 6,992 sqm (£395/m2)	Reduce absolute by 10% by 2020/21 (£0.276/m)	The only method BCH have of reducing cost is by reducing space occupied
Non-Clinical Space (%) (Carter Metric max 35%)	4,055 sq metres, equivalent to 58%	Reduce to 10% by April 2020	Not all relevant information is available. Also, BCH deliver the majority of its clinical services in patients homes so the Carter metric is not totally appropriate
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0 %	Maintain 0% by April 2020	All BCH leased space is occupied, success for BCH will be in reducing space by optimising use of existing space
Functional Suitability	50% of the assets are in an acceptable condition / satisfactory performance	See Comments	BCH have little direct impact on investment in the sites they occupy.
Condition	TBC	TBC	TBC

Performance Indicators: 2020/21 Success Metrics (NBT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£102.93m pa for 196,646m2 (£523.41/m2)	Reduce cost of retained estate (see comments)	Benchmarking and the Lord Carter Dashboard shows that this is in the upper quartile – the retained estate has a total E&F cost of £389/m2 which we will aim to reduce to £360/m2 – however the PFI Brunel building is over inflating the costs of the estate compared to larger freehold estates
Non-Clinical Space (%) (Carter Metric max 35%)	54,794 sq metres, equivalent to 27.9%	To remain under 35%	The development of the Pathology phase 2 expected this year is expected to further decrease Non-Clinical Space
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0%	To remain under 2.5%	There is currently a building unoccupied and part demolished to facilitate further development but isn't classed as unoccupied space within the ERIC definitions
Functional Suitability	70% of the assets are in an acceptable condition / satisfactory performance	Replace unsuitable space (see comments)	The Women and Children's Hospital is due to replacement.
Condition	82% age between 1985 and 2014 Risk Adjusted Back-log maintenance of £5.1m	See comments	At this stage the potential replacement of the Women's and Children's Hospital has not been included in these figures but is projected to be required for replacement

Performance Indicators: 2020/21 Success Metrics (NSC-P)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£1.75m pa for 4,967m2 (£381.83/m2)	Reduce costs by £500k per annum. Reduce £381.83/m2 to £251.16/m2	NSC-P are required to make 30% on its annual estate costs equivalent to £500,000
Non-Clinical Space (%) (Carter Metric max 35%)	3,632 sq metres, equivalent to 73%	Non-Clinical space may reduce if total floor spaces reduces by April 2020	Carter metric is not applicable to NCS-P
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0 %	Maintain 0% by April 2020	All offices and clinical space are fully occupied. There are no regularly vacant offices/clinic rooms within NSC-P estate
Functional Suitability	60% of the assets are in an acceptable condition / satisfactory performance	See Comments	NSC-P have little direct impact on investment in the sites they occupy.
Condition	TBC	TBC	TBC

Performance Indicators: 2020/21 Success Metrics (SWAFT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	Unknown	Unknown	Unable to break down at the moment
Non-Clinical Space (%) (Carter Metric max 35%)	Unknown	Unknown	Not applicable
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	524 sq metres, equivalent to 5.36%	Reduce to 2.5% by April 2020	Figures are for the whole Trust
Functional Suitability	97% of the assets are in an acceptable condition / satisfactory performance	To be confirmed	3.21% below condition B currently. Target to be set.
Condition	To be confirmed	To be confirmed	6 facet survey about to be undertaken

Performance Indicators: 2020/21 Success Metrics (UHBT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£58.7m pa for 206,690 sqm (£284.36/m2)	2% annual year on year revenue saving required	E&F Annual savings within 2017/18 Operating Plan - £623k to be submitted December 2016
Non-Clinical Space (%) (Carter Metric max 35%)	68,527 sq metres, equivalent to 33%	Reduce to 35% by April 2020 – Target met	Target met
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	0 sq metres, equivalent to 0% following disposal of Old Building	Less than 2.5% by April 2020 – Target met	Target met
Functional Suitability	70% of the assets are in an acceptable condition / satisfactory performance	See comments	Lifecycle capital needed as per current plan to reduce risks of estate not sustaining stability as non PFI
Condition	13.5% of estate is pre 1948 52% of estate is '65 – '74 6.5% of estate is '85 –'94 6.5% of estate is '95 – '04 21.5% of estate is '05 to '14 Back-log maintenance of £10.5m	Reduction in backlog maintenance	

Performance Indicators: 2020/21 Success Metrics (WAHT)

Indicator	Current	Planned	Comments
Estate Running Costs (£/m2)	£7.1m pa for 30,409 sqm (£233.67/m2)	Trust is planning to remain as per the recommendation of under £320 m2 Estates running costs by 2020/21	Figures provided and verified by WAHT
Non-Clinical Space (%) (Carter Metric max 35%)	9,621 sq metres, equivalent to 33.2%	Trust is planning to remain as per the recommendation of under 35% for non-clinical space by 2020/21	Figures provided and verified by WAHT
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	7,845 sq metres, equivalent to 1.79%	Trust is planning to remain as per the recommendation of under 2.5% for unoccupied floor space by 2020/21	Figures provided and verified by WAHT
Functional Suitability	75% of the assets are in an acceptable condition / satisfactory performance	Estates capital programme will prioritise investment to remain above 75%	Figures provided and verified by WAHT
Condition	82% of estate is '85 – '94 12% of estate is '95 –'04 6% of estate is '05 to '14 Back-log maintenance of £9m	The Trust has occupies 3 buildings. The main part of the estate is the General Hospital. The 2 other buildings are part of the children's services. This service is currently out to tender and potentially they may not be part of WHAT by 2020/21	Figures provided and verified by WAHT

Annex 3: Summary of transformation by sectors

Summary of transformation by sectors

Model	Secondary	Community	Primary	Admin
ESTATE TO REDUCE / DISPOSE	No plans	Part disposal part development of Frenchay Hospital Disposal and re-provision of Thornbury Hospital Brentry Hospital	Outputs from Option Appraisals (possible 6 No practices)	Back office functions being review may impact on future of South Plaza
ESTATE TO INCREASE (by 2020/21)	No plans	Outputs from Option Appraisals. Primary and Community services to be delivered at scale	Outputs from Option Appraisals. Primary and Community services to be delivered at scale	3 No CCG's forming one organization. New Head Quarters needs to be identified
ESTATE TO OPTIMISE	Southmead site	CHP Estate (5 No) AWP Mental Health Estate (PFI)	Outputs from Option Appraisals.	CCG and other admin functions moving out of clinical space

Appendix H – Digital

STP Themes

STP Theme *(Includes some references from slides)*	**Local Digital Roadmap links to the STP Theme**
Prevention, early intervention and self-care *Achieving a radical shift towards prevention, early intervention and self-care across the patient pathway.* Enabling care settings and workforce to be innovative and effective in supporting self-care e.g. using digital technology A system-wide approach that takes account of the needs of specific groups	• **Connecting Care** Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care • **The Information Engine** Fully utilising our electronic data and intelligence to power our planning and delivery engine. Devising new and innovative ways to use information, integrated population analytics and data driven decision making.
Integrated primary, community and social care *Improve resilience of local primary care services* *Integrated health & social care teams* *An integrated health and care single point of access* A single integrated approach with multi-disciplinary teams based around the primary care clusters A single service provided across BNSSG and aligned to each acute hospital, preventing admissions and supporting timely discharge, including for	• **Primary Care At Scale** Focuses on maximising digital across GP practices and Out of Hours services. Supporting primary and community care reconfiguration, new integrated team working and maximising efficiency of practices through shared ways of using technology. This is also about how we can better support people and communities out of hospital • **Paperless 2020** Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records. • **Infrastructure & Support** Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes). This will include a strong focus on enabling mobile working across our community teams.

STP Theme *(Includes some references from slides)*	**Local Digital Roadmap links to the STP Theme**
people at end of life who wish to return home	
Acute care collaboration *A collaborative approach to acute care for both mental and physical health* Providing services locally where safe and effective to do so; centrally where necessary for quality and effectiveness Achieving a step-change in the speed and quality of information sharing Simplifying arrangements for sharing buildings, equipment, staff and expertise	• **Infrastructure & Support** Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes). • **Paperless 2020** Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records. • **Connecting Care** Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care

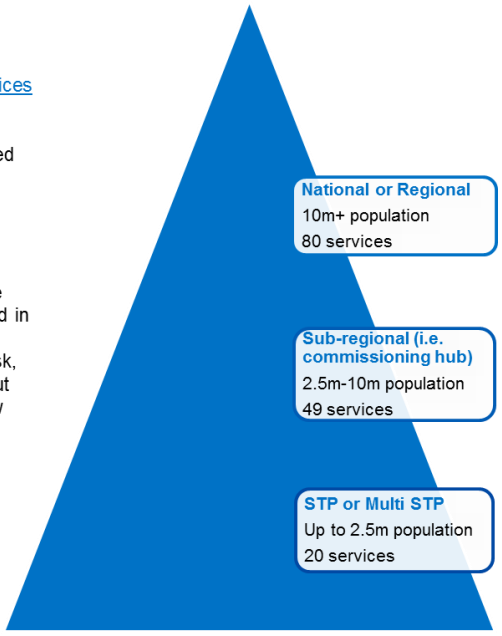
Appendix C – Specialised Commissioning

South of England – Specialised Commissioning and STP's:

Next Steps following Triangulation events

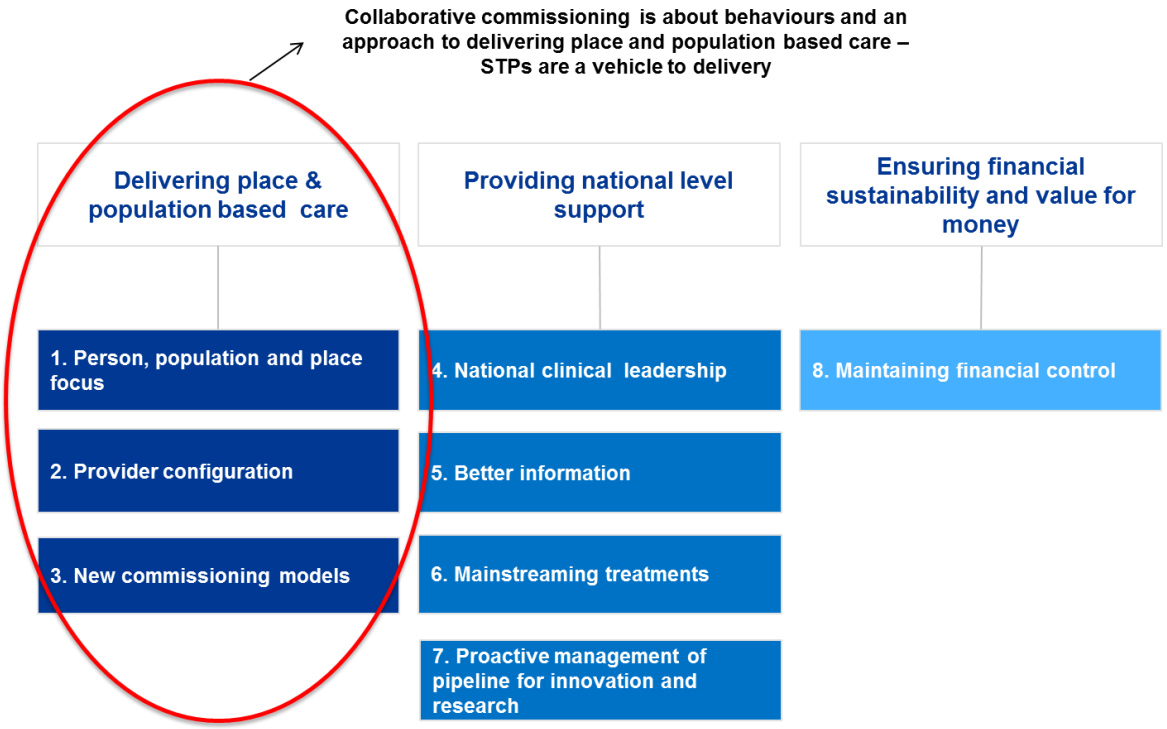
Background: For specialised services, appropriate commissioning levels might vary

- To support the move to place and population-based approaches for specialised commissioning we have differentiated the 149 specialised services by population footprint. This can be found in the Specialised Services Commissioning Intentions for 17/18-18/19.
- This exercise has suggested which services could be planned and delivered at the:
  - National/regional level
  - Sub-regional/collaborative hub level
  - STP or Multi STP footprint level*
- All four regions were engaged in this exercise to determine the appropriate segmentation into the commissioning levels. The North region was involved in the original national exercise. This involved use of a segmentation tool to classify, based around five factors (patient numbers, provision, financial risk, service specifications and strategy. The other three regions then carried out their own exercises independently and used these to collaboratively review the national exercise. Programme of Care Boards were also invited to comment on the initial list.
- The focus of the collaborative commissioning programme is on supporting STPs and Regional Teams to adopt population based approaches for the commissioning of specialised services.
- There is an exercise still to be done to develop a policy position as to the commissioning models on the place-based spectrum that would be appropriate for individual specialised services regardless of which commissioning level they sit within – particularly in relation to full devolution. We are working closely with the devolution programme on this and the development of the policy framework.



*For the purpose of this exercise we have not explored services which could be planned and delivered on a CCG footprint level.

Strategic Framework for specialised commissioning centred around place-based care



Four options being developed to support the move to place-based commissioning

Below is the spectrum of options available within the current legislative framework to support a move to placed-based commissioning of specialised services.

National Service Specifications will still apply regardless of which model of place-based commissioning is pursued.

We expect all STPs to have a 'seat at the table' by 2017/18

By 2020 we expect all STPs to take on greater responsibility for relevant services

Spectrum of place-based commissioning

Model 1 - 'Seat at the table'
- No legal change, or material organisational impact across the parties involved
- Decisions about a function are taken by the function holder but with input from another body
- Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)

Model 2 – Joint arrangements
- Two or more bodies with separate functions that come together to make decisions together (e.g. S.75 partnership arrangements)
- Accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)

Model 3 – Delegation
- Exercise of the function is delegated to another body (or bodies)
- Decision-making and budget rest with the delegate(s)
- Ultimate accountability and responsibility for function remains with original function holder (including budgetary responsibility and funding for overspends)

Model 4 – Devolution
- Function transferred to another legal body on a permanent basis (meaning responsibility, liability, decision-making, budgets and everything else) by a transfer instrument under the Cities and Local Government Devolution Act provisions.
- Accountability and responsibility for those functions transfers to the new 'owner' (including budgetary responsibility and funding for overspends) who will be accountable to the relevant national body for the function in question

STP's and Specialised Commissioning in the South of England.

Specialised Commissioning (South) Delivery Director is now a part of the STP

NHS England recently held 7 triangulation events across the South of England (Exeter, Bristol, Oxford, Southampton, Brighton and London), including one for all Mental Health Trusts. These events highlighted:

- Areas of alignment between STP planning and that of Specialised Commissioning
- Areas where further work will be required in order to coordinate pathways across different STP footprints and NHS England regional boundaries
- Areas where alignment of commissioning within STP's brings about opportunities to improve planning, contract and transformational delivery.

The Vision for Specialised Services in the STP:
Through collaborative work within and across STPs to develop plans to commission high quality, evidence based, patient focused and efficient models of care to enable the delivery of high performing specialised services. **This supports:**

The STP Ambition:
Equity and excellence to the provision of specialised care through patient-centred, outcome based commissioning processes. This requires coordination between provider organisations to ensure that care is delivered in specialist departments where necessary with local repatriation where possible. **Which will be:**

Based on clear principles:
- High quality care
- Focus on outcomes
- Planning 'footprints' determined by evidence base
- Minimise pathway variation within & between providers
- Eradication of occasional practice
- Network solutions to address access and
- Optimise use of existing infrastructure
- Strong clinical leadership
- Multidisciplinary design
- PPV engagement.

To support our:

Proposal:
Through collaborative work within STPs to develop plans to commission high quality, evidence based, patient **focused** and efficient models of care – enabling the delivery of high performing specialised services grounded in:
- Catchments
- Consolidation
- Clustering
- Compliance

To address ….

The challenges we recognise:
The STP must
- Address variation
- Resolve derogations
- consolidate provision where required
- The current state is inefficient (Carter) and not sustainable
- Specialised Commissioning within and across STPs needs to deliver an ambitious QIPP to support financial recovery
- Service fragility and fragmentation must be addressed where required
- Services must be compliant with specifications and deliver the best outcomes
- Change will result in better training opportunities
- We must plan for the future and drive required changes collaboratively

Finance and QIPP Delivery

NHS England Specialised Commissioning (South) has calculated financial allocations based on the utilisation of Specialised Services by the STP (constituent CCGs) population. These allocation will contribute to the STP control total

The do nothing scenario for Specialised Commissioning within the STP sets out the financial impact of assumed growth based on national indicators for population growth for the CCGs in the STP

In order to close the gap (to break even) and deliver against its element of the financial gap Specialised Commissioning is planning for both Transactional and Transformational QIPP which will be cumulative over the duration of the STP

- Transactional QIPP will include areas that have historically delivered savings for example High Cost Drugs and Devices
- Transformational QIPP will include areas covered in the draft document attached and are intended to come into effect mid-way through 2017/18 (part year effect assumed as 1.5%)

QIPP has been set at c3% for all providers across the STP and for the duration of the plan. This is split down as follows:

- Transactional – For year one, this will be 1.5% inclusive of c1% for High Cost Drugs and Devices – leaving a balance of 0.5% to be delivered via other transactional means . In future years, we would anticipate transactional QIPP at no more than 1%.
- Transformational – For year one this will be 1.5%, increasing over time

The split is even across providers at the moment but Transformational schemes may have a greater impact on certain services and this will be reflected in reporting during the course of delivery of the STP The split is even across providers at the moment but Transformational schemes may have a greater impact on certain services and this will be reflected in reporting during the course of delivery of the STP

Transformational QIPP Scheme Development

- **Referral Support pathways for surgical pathways**
- **Health Coaching prevention in cardiology**
- **Spread use of GS1 and PEPPOL standards for HCD's and devices**
- **Medicines optimisation**
- **Enhanced supportive care for cancer pathways**

Specialised Commissioning Key Lines of Enquiry

✔Does the plan provide evidence that they are looking to take more responsibility/decision making for the planning and commissioning of specialised services?

✔Have they indicated a plan to pool budgets for specialised services, and have they considered risk/gain share as part of the solution?

✔Does the plan for specialised services focus on the clinical priority areas OR Does the plan for Cancer/Mental Health/Learning Disabilities include specialised services as part of the solution?

✔Does the plan have realistic/credible financial assumptions for specialised services (that are whole pathway inclusive, realistically deliverable, and include robust financial impact assessment) in the context of regional plans?

✔Does the plan provide sufficient assurance around how they have/will engage patients and the public on decisions that will have an impact on specialised services?

STPs: BNSSG and Somerset

Strategic Statement

Specialised Services are mainly provided for, by the Bristol providers for BNSSG and Somerset without duplication with only marginal need for further consolidation

Service Development / Consolidation Opportunities

- Plan for Neonatal intensive care consolidation
- Agree governance model for Weston
- Develop Enhanced supportive care models for Cancer services
- Implement prevention services for cardiology
- Change spinal surgery pathways
- Consolidate medicines optimisation efforts
- Agree process for resolving derogations

Statutory Requirements

Performance issues with Cancer, Epilepsy, Neurosurgery and Spinal Surgery

Current plans are delivering backlog clearance and improvement trajectories

QIPP

- Transformational schemes linked with CCG's to build demand management, pathway development and reduce utilisation rates.
- 3% requirement

Reduction in Spinal surgery
Medicines optimisation
Cardiology prevention
Enhanced support care for cancer services

Co-commissioning Opportunities

Potential opportunities around cancer and spinal surgery

Model of Co-Commissioning – Seat at the Table

Interdependences with other STP's

For Specialised Services, BNSSG has to work closely with the BSW, Gloucester and Somerset STP's.
The Somerset STP looks toward Bristol for the majority of its specialised pathways.

Appendix D – Mental Health

Mental Health - Parity

"In the context of primary and community services, as in others, 'parity' between mental and physical healthcare is best achieved through integrated delivery. This will require a change in resourcing and skills to ensure that physical and mental health needs of patients are addressed fully and together.

Integrated delivery will be achieved in the following ways:

- We will include mental health professionals in the locally-based multi-disciplinary teams at 'GP cluster' level. As we improve productivity through technology and adjust skill mix towards non-medical health professionals (nurses and therapists, mental health nurses, pharmacists), we will create efficiencies. These resources will be redeployed to increase mental health capacity

- All staff within multi-disciplinary teams will have skills to provide psychologically informed interventions and signposting to community and voluntary sector support. Some will additionally provide talking therapies, counselling and social prescribing to address mental health issues, including depression and anxiety. These steps will improve mental health and wellbeing directly, will improve physical health through increased resilience and through better compliance with lifestyle advice and treatment regimes, and will reduce GP, outpatient and ED attendance.

- Mental Health professionals will provide training, advice and guidance to colleagues, in particular healthcare assistants and assistant practitioners, who will develop skills to recognise where mental health support is needed and skills to address the needs of individuals with co-morbid mental and physical health problems.

- The Integrated Health and Care Single Point of Access, (which will provide complex case co-ordination to avoid admissions and facilitate discharges), will include mental health professionals. The mental health and wellbeing needs of patients who present at ED, who are at risk of admission, or who require specific support on discharge will be met in an integrated, timely way.

- Urgent care services for admission avoidance – Rapid Response teams– will also include mental health support.

- Co-ordinated induction and training for all staff in BNSSG will ensure a psychologically minded workforce with core skills to promote mental wellbeing, and staff who recognize their role in prevention and facilitating people to care for themselves."

Appendix G – Workforce

Structure

The Chief Executive at Avon & Wiltshire Mental Health Partnership Trust (Hayley Richards) is the Senior Responsible Officer for workforce and, as such, represents workforce at the STP Senior Leadership Group. She co-chairs the fortnightly workforce programme board with Health Education England (HEE). The aim of the board is to:

- Engage all STP footprint organisations (and other work streams) in STP workforce development.
- Provide an STP Local Workforce Action Board (LWAB).
- Coordinate representation to support care model work streams (Early Intervention, Proactive and Preventative Care, Integrated Primary and Community Care and Acute Care Collaboration) and other enabling work streams (Estates, Digital, Finance) and spotlight areas.
- Facilitate the detailed modelling of changes to workforce which will result in proposals from other work streams.
- Manage the defined projects which resulted from specific direction in the Five-Year Forward View, the STP senior leadership group and the June 2016 submission.

Project Method

HEE will support the STP through provision of a part time workforce programme manager. The workforce programme board provides STP information, develops HR links to work streams and progresses workforce projects. Other work streams are invited to send representatives. The meetings are part information sharing and part workshop in order to make best use of the Human Resource (HR) and Leadership Development (LD) expertise in the room. As part of the HEE requirement for STPs to participate in Local Workforce Activity Boards (LWABs) the workforce programme boards subsumes this role and HEE co-chair the meetings.

Data & Intelligence

HEE have provided workforce data for health and social care providers within the STP footprint and provider organisations have also supplied 'plan on a page' workforce data. Additionally staff have been trained on workforce planning tools including WRaPT and SWiPE. With support from HEE the STP has recently employed a part time project manager to support all provider organisations to use the workforce tools and to facilitate workforce modelling of STP outcomes.

Key Stakeholders

All organisations within the STP footprint including Academic Health Science Network (AHSN) and HEE, Primary Care representatives, Service User/Patient groups, voluntary sector and private provider organisations and Trade Unions, Training Providers.

Co-Production

Workforce projects are assigned to leads from across the STP. Project leads have access to colleagues within the workforce programme board in order to develop projects in consultation with other providers. HEE and the workforce programme manager are co-producing a ready reckoner of HEE support to the STP.

Communications

It is recognised that failure to engage staff, trades unions and other stakeholders presents a risk to achieving workforce transformation. Disaffected staff will have a negative impact on productivity and could threaten the ability to change at pace. The workforce work stream will therefore work closely with the communication and engagement work stream to develop engagement plans. HEE funding has been allocated to support staff engagement activities. Additionally providing opportunities for staff to participate in the development of the workforce transformation programme is a key tenet in the programme methodology.

Workforce Projects

There are a number of workforce projects to support the STP and these are detailed below. In addition AWP are leading on joint workforce planning for the STP. This will focus on the use of the WRaPT tool which is supported by HEE and the interpretation of existing data. HEE will fund a part time project manager for workforce planning who will support organisations' workforce planning leads in creating STP system-wide modelling outcomes demonstrating the impact of activity changes as a result of STP plans. These outcomes will then inform (and are essential to) more detailed workforce transformation planning.

. **Project**	**Project Description**	**Outcomes**
Collaboration working on Apprenticeships	System wide approach to support increased collaboration on apprenticeship schemes. Development of new apprenticeships to ensure opportunities presented by Levy optimised.	HEE funding has been allocated to provide project management resource. . • Will include new roles.
Development of Shared Training for MH and Community Staff	Collaborative working in LD departments. Includes provision of mental health training to staff in all STP organisations including ability to provide psychologically informed interventions. Identify Training Needs Analysis for skills gaps. Alignment of core training standards and alignment to MECC	• Reduces duplication. • Increased quality and consistency of care • Improved relationship with our staff.
Improve Staff Health and Well Being	Project to be run in conjunction with Prevention and Proactive Care Work stream and MECC. Improve baseline data on staff health and wellbeing. Building on organisations' work to achieve CQUINS Define the minimum standard for staff health and wellbeing provision.	• Reduced sickness and turnover. • Increases participation and engagement of staff.
Shared Recruitment	To extend the existing recruitment passport arrangements already in place between NBT, Weston and UHBristol to other NHS organisations across the BNSSG STP.	• Avoids duplication and is an early STP win. • Increases cross organisational collaboration • Signposts further HR streamlining opportunities.
Create a common culture	To provide a common vision and purpose for our workforce to support recruiting and retention on a footprint basis. To provide for staff engagement events in conjunction with the communications work stream. Develop opportunities for staff participation in STP development and workforce transformation. Up-skilling staff to deliver continuous improvements within their own teams and deliver and participate in transformation projects To provide OD facilitation to support workforce transformation.	HEE funding has been allocated to support staff engagement and to resource OD facilitators. • Vital for workforce change management • Supports STP work streams in delivery of projects • Support system leadership
STP Workforce Transformation	In addition to skills, scope and generic HR support to the STP a number of new workforce projects will be undertaken in conjunction with other work streams and these will include (but are not limited to): • 7 Day primary care and multi-disciplinary team working • Workforce as advocates of population health approach including MECC • Supporting new ways of working resulting from single point of access, enabling discharge and increased care out of hospital.	• Reduced sickness and turnover. • Increases participation and engagement of staff. • Increased quality and consistency of care • Improved team working and collaboration

Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

October 2016 Submission

KEY INFORMATION SUMMARY

FOOTPRINT AREA: Bristol, North Somerset & South Gloucestershire (BNSSG)

FOOTPRINT LEAD: Robert Woolley,

Chief Executive University Hospitals Bristol FT

PARTNER ORGANISATIONS:

CCGS/COMMISSIONERS: Bristol, South Gloucestershire and North Somerset CCGs, NHS England

LOCAL AUTHORITIES: South Gloucestershire, Bristol and North Somerset Local Authorities which includes the West of England Public Health Partnership

PROVIDERS: Weston Area Health NHS Trust, North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, Sirona Care and Health, Bristol Community Health, North Somerset Community Partnership, South Western Ambulance Service NHS Foundation Trust

Version: 1.1

Date: 21 October 2016

Contents

Appendix

1. Introduction

1.1 Key messages

Our Sustainability and Transformation Plan (STP) has evolved from the Checkpoint submission made in June. In developing our October submission, we have drawn upon the feedback received from NHS England and have described the progress we have made in defining and developing our interventions.

The focus of our STP remains on achieving the triple aims of improved population health, quality of care and cost-control, by successful integration and removal of the boundaries between mental and physical health (Parity of Esteem), primary and specialist services, health and social care.

1.2 NHS England Feedback

Set out below is the feedback we received following our June submission. We have highlighted how this submission addresses the feedback received and referenced the relevant sections for easy identification.

NHS England feedback	**BNSSG Response within this submission**	**Section**
Great depth and specificity, with clear and realistic actions, timelines, benefits, resources and owners.	Articulation of the key priority projects that we are taking forwards in years 2 & 3 of the STP and inclusion of summary business cases for each of these. Finance & workforce schedules	Sections 4.1, 4.2 & 4.3 Appendix B
Year on year financial trajectories.	Finance schedule	Chapter 7.2 & Separate Financial Templates
Articulate more clearly the i**mpact on quality of care.**	We are developing our approach to the management of quality with the support and participation of the Academic Health Science Network.	Section 5.2
Include **stronger plans for primary care and wider community services** that reflect the General Practice Forward View, drawing on the advice of the RCGP ambassadors and engaging with Local Medical Committees.	We have established an Integrated Primary Care portfolio within our Integrated Primary and Community Care Workstream, which details how we are tackling the General Practice Forward View.	Chapter 4.2
Set out more fully your **plans for engagement.**	Engagement approach and materials included in the submission.	Chapter 6.1 & Appendix E
Trajectories for performance on A&E, RTT and GP Access	This information is work in progress and trajectories are being developed as part of the Operational Planning process.	N/A

NHS England feedback	BNSSG Response within this submission	Section
Capital funding	Finance section on expectations around capital funding.	Chapter 7.2
Information technology investment	LDR submission due 31/10/16 Short update on LDR development, governance and resourcing included in this STP submission.	Chapter 6.4 & Appendix H
Mental Health Plans and Investment	Explanation of our approach to redesigning and increasing investment in Mental Health Services.	Chapter 5.5 & Appendix D
Governance arrangements to ensure strong collective leadership for the STP	Outline of our emerging Governance Framework for delivering the STP.	Chapter 3.1 and Appendix A
Recommend that all **organisations contribute an equitable level of resources** to the programme to support leadership and ensure sufficient capacity to accelerate implementation.	Outline of our approach to resources.	Chapter 3.1 and Appendix A
Pathways for acute and specialised services	Updates on the key programmes within the Acute Care Collaboration are set out in this document. This includes the work being undertaken with regards to specialised services.	Chapter 4.3 & Appendix B and C
Workforce implications of the plan and how they will be managed.	Approach to full integration of the workforce programme within the core STP is set out in our response.	Chapter 5.2 & Appendix G

1.3 Context and approach

The development of our STP is being undertaken in a difficult organisational context, with a number of our partners currently subject to external intervention as a consequence of the financial challenges they face. Aligning these interventions with the development of the STP is critical if we are to optimise their impact and create a successful and sustainable system for the future.

In our original submission we defined and acknowledged the scale of the challenge in delivering a sustainable health and care system and set out the case for change. Since then, we have been working together to establish the new relationships, behaviours, systems and processes that will be required to address the "wicked issues" we face. The STP approach has created a new culture and environment within which our organisations need to operate and we recognise that we are at the start of our collaborative journey. As we progress the STP, we will develop our approach further and learn new ways of working together for system benefit.

This submission reflects the progress we are making and recognises the challenges that lie ahead. Our intention is therefore to:

- Reaffirm the model of care we are developing;
- Demonstrate how the programmes and projects we are undertaking will contribute to the delivery of the model of care;
- Provide greater detail on the projects we are undertaking, the outcomes they are seeking to achieve and their relationship to the overall model of care;
- Begin to illustrate the impact these projects will have on the experience and outcomes for our population, the quality and accessibility of our services, the roles and opportunities for our staff and the financial sustainability of our care system;
- Describe the way we will enable change through the transformation of our service delivery, workforce, our deployment of technology and the optimal use of our estate; and
- Articulate how we will use the operational planning and contracting processes to embed the STP approach and incentivise the delivery of the model of care.

Since our June submission, we have continued to develop our new model of care through three major transformational workstreams: Prevention, Early Intervention and Self-Care; Integrated Primary and Community Care; and Acute Care Collaboration. Our focus in the last three months has been on defining and initiating our short and medium term priority projects within each of these programmes and assessing the impact these will have on the overall sustainability challenge. We have also sought to ensure that mental health is effectively integrated within all three workstreams.

In developing our STP, we are building on the advances we have made in our local infrastructure. These include our use of digital technology to support care, the redesigned estate at the Bristol Royal Infirmary campus, South Bristol and Southmead hospitals and the combination of general, specialist and tertiary services that we offer and help to make BNSSG an attractive place to work.

The analysis required to estimate the impact of the new model of care is ongoing and we are using the Operational Planning timetable and requirements as the framework through which the intended impacts will be built into service contracts. At this stage of the process our planned interventions will only generate part of the financial savings we need. This reflects two things:

- The limited evidence base that exists for achieving the scale of change needed; and
- The multifactorial influences that determine the demand for care services.

At the heart of our STP will be a drive to improve our collective understanding and analysis of the influences on demand for our services and how the respective interventions that we make (e.g. shared decision making or self-care) can positively influence these at a scale previously not achieved. We also acknowledge the evidence around the influence that 'supply' can have on the demand for a service and will seek to take bold collaborative decisions to manage supply in areas where there is unwarranted variation in demand.

We know from the scale of our quality, accessibility and sustainability challenge that there is more we need to do to identify and define the significant transformational changes that are required. In support of this, we are evolving our governance structures to facilitate effective decision making. We are also utilising the opportunities presented by the two year Operational Planning process to ensure organisations are incentivised to operate in a manner which aligns with the goal of our STP.

Our discussions around the organisational forms that will be required in the future are still in progress, as our focus at this moment is on delivering the short to medium term changes we have defined. We will, however, increasingly focus our attention on the implications of the changes in our model of care for existing organisations and the opportunities presented by organisational reform.

In this regard, our STP is deliberately both ambitious and pragmatic, ensuring that we build momentum through our new ways of working, strengthening our relationships and improving our effectiveness as we create the model of care for the future.

1.4 Case for change update

In our original submission we set out the case for change which largely remains as previously described. Where our thinking has developed further we have included short updates.

Health and Wellbeing Gap

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

Care and Quality Gap

Our care system continues to experience the significant performance challenges that were set out in our original submission. We recognise that addressing these performance challenges is central to the development of our STP and are using the Operational Planning process to help define and embed the performance improvement measures that we will collectively pursue.

Affordability Gap

Since our submission in June we have reviewed and refined the financial and activity modelling that underpins the 'Do nothing' option in the STP. The most significant factor in this change was to update the modelling from its original baseline of 2015/16 forecast activity, to the 2016/17 operating plans that BNSSG organisations are now working to. The 'Do Nothing' positions and financial savings for the period to March 2020/21 were signed off and

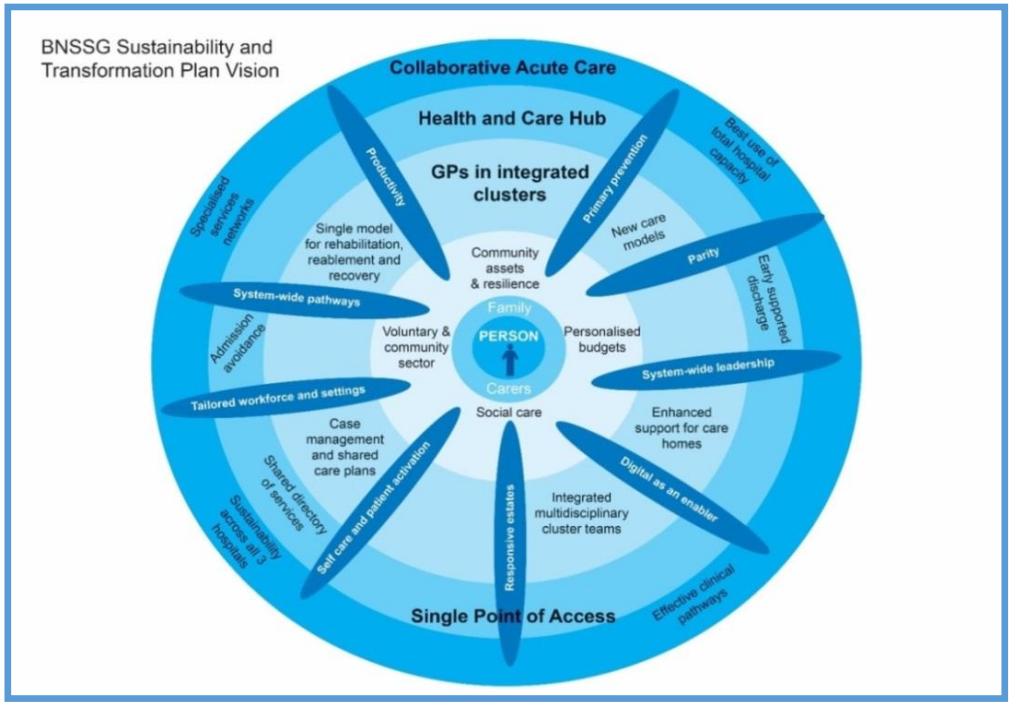
submitted by Directors of Finance on the 14th October 2016. The 'Do Nothing' deficit across the BNSSG STP as at 31st March 2021 totals £305.5m as reflected below.

Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**
Providers	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)
North Bristol NHS Trust (NBT)	(80.6)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)
South Western Ambulance Service (SWAST)	(3.2)
Community Interest Companies (CiCs)	(15.0)
Sub-total Providers	**(184.3)**
Commissioners	
Bristol CCG	(60.9)
North Somerset CCG	(30.3)
South Gloucestershire CCG	(30.0)
Sub-total Commissioners	**(121.2)**
System Wide	
Total Organisational Financial Plans	**(305.5)**

2. Vision

"Health is made at home; hospitals are for repairs" – African Proverb

In our June submission we defined the model of care that we are aspiring to create using the image on the right.



Our model of care starts with people in families and communities; with individuals encouraged and enabled to care for themselves; services delivered locally by integrated teams focused on the needs of the individual; and simplified access points to acute care and specialised services.

In our model, prevention, early intervention and self-care will be targeted on areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across commissioners, service providers, the wider workforce and stakeholders including local government, public /community representatives, and the voluntary sector.

The design of our model, the principles on which it is based and the key programmes through which it will be delivered remain the same as in our previous submission, but since June we have been working to better define, design and assess the impact of the changes that will make the model reality.

3. Our programme approach

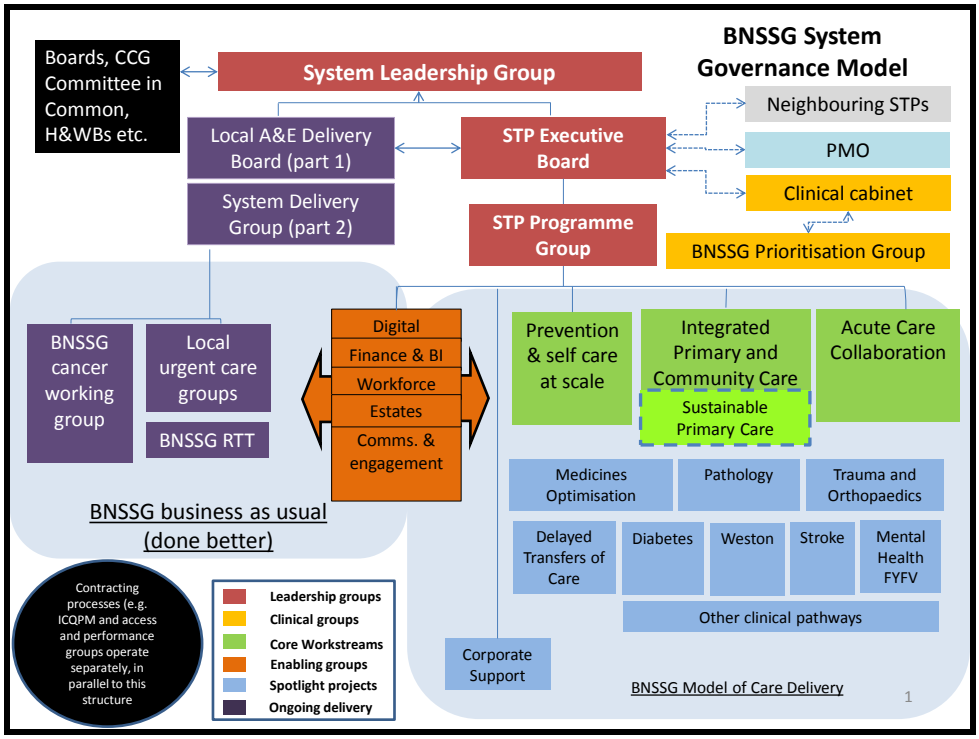
3.1 Governance & Leadership

With the recent appointment of an STP Programme Director, further development of the governance structure has been initiated. The STP Governance will soon be further strengthened, we hope, by the appointment of an independent Chair.

In further developing the STP governance we are using the following elements as our design principles to establish our Governance:

- **Shared common purpose:** A core shared purpose that is understood, owned and rigorously followed by all organisations. This needs to be owned by all the organisations involved and incorporate all of their objectives.
- **Mechanisms for managing financial risk and benefit:** Local agreements that govern financial flow to ensure that all organisations are incentivised to achieve the shared goal of service model redesign
- **Shared understanding of where we are competing and collaborating:** Failure to have a shared understanding of this can cause whole system working to collapse. This is particularly true for systems that are attempting to reconfigure acute services with multiple current suppliers, or where there are opportunities to compete for community services between acute, community and primary care providers.
- **Process for escalation, resolution / arbitration**: Systems need to agree upfront, prior to any disagreements, how disputes will be resolved. Failure to agree this causes systems working to fail at the points of greatest tension.
- **Clinical defensibility**: It is essential for sustainable change that any plans are based on the best available clinical evidence and knowledge.
- **Quality of interpersonal relationships**: Strong interpersonal relationships between organisational leaders are essential and can secure success even when fault lines appear in the five areas above. Whilst it must be acknowledged where there have been rapid and frequent changes to leadership, it is still possible to galvanise relationships in new groups of leaders.

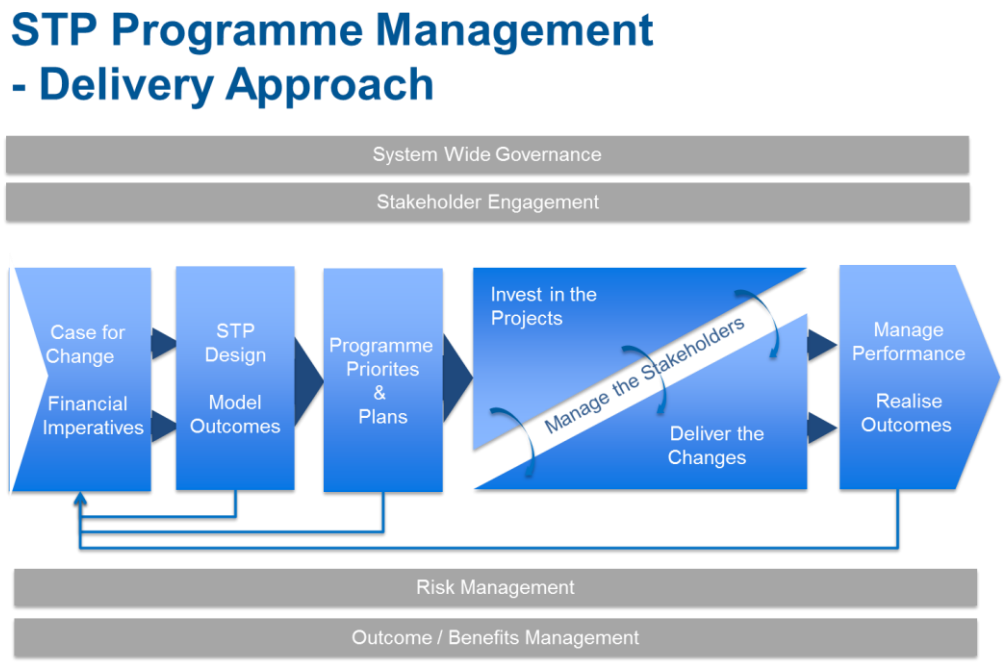
BNSSG STP Programme Governance Structure



Programme Management Environment – Key Elements

In developing the STP programme we have used the following to guide the creation of the right programme environment for success:

- Create and articulate a shared understanding/common narrative;
- Allocate the time for people to focus on the transformation (small, purpose built and dedicated teams);
- Reset the balance between organisational sovereignty and doing the right thing;
- Unblock the money, by not letting the contractual framework be a barrier to change;
- Listen and respond proportionately/appropriately to the feedback from stakeholders involved and / or impacted by change.

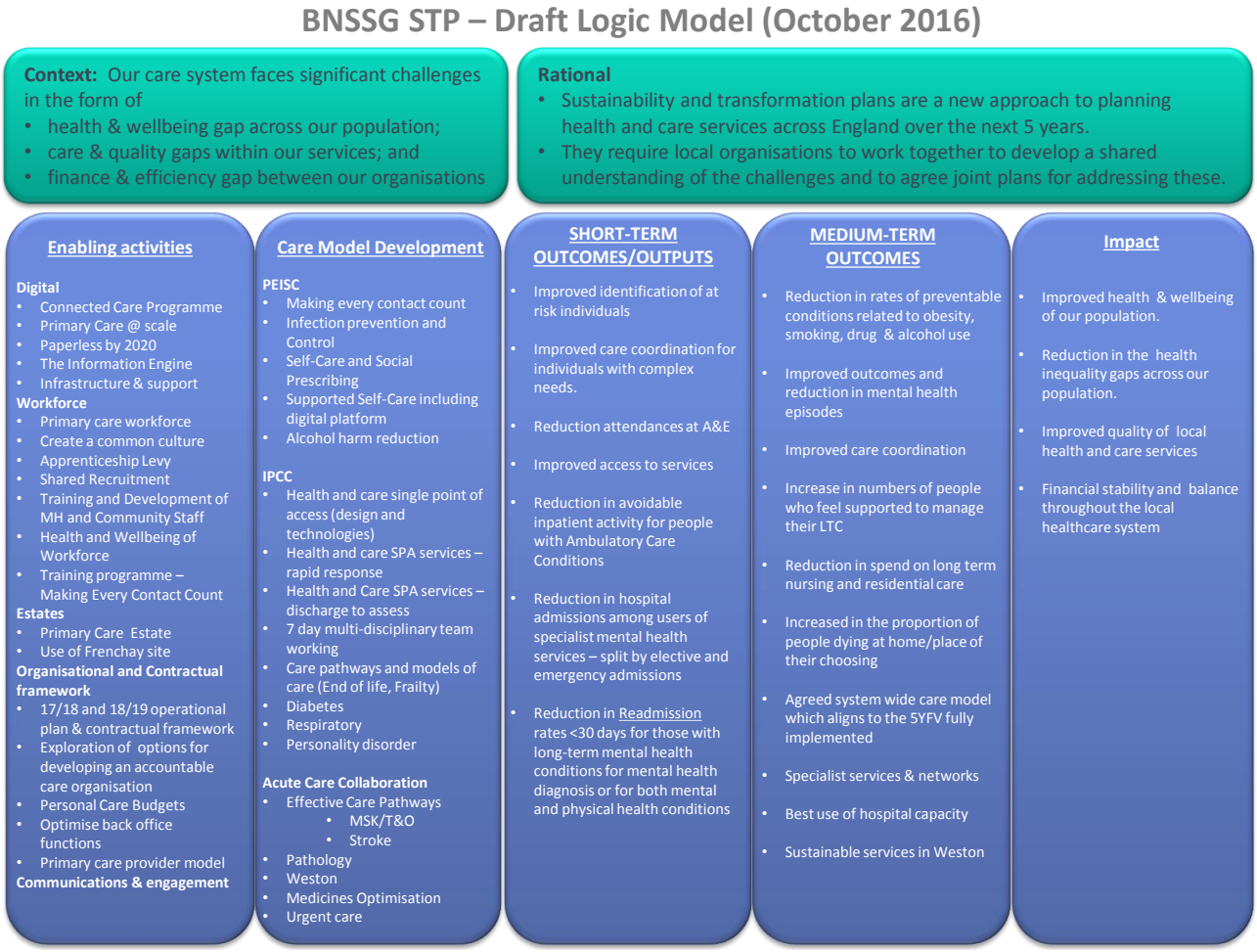


Our programme management approach will enable us to have full line of sight of our Development, Enabling and Delivery projects for Case for Change to Realisation.

See appendix A for Governance and Resourcing.

4. BNSSG overview

Our June submission included a Plan on a Page as a mechanism for providing an overview of how our STP would operate. We are currently transitioning the Plan on a Page into a Logic Model to more explicitly demonstrate how the projects that we are prioritising in the early years of our STP will lay the foundations for achieving the outcomes described.



Our STP initiatives are coordinated through three core transformation portfolios:

- Prevention, Early Intervention and Self-Care
- Integrated Primary and Community Care
- Acute Care Collaboration

We are also undertaking a range of enabling programmes (Digital, Estates and Workforce) which will underpin delivery.

Set out in the following chapter is a summary of each Portfolio, Programme and Project that we are taking forward. The projects selected at the start of our STP have been chosen because of their potential to either unlock further improvement opportunities or deliver early wins. Underpinning our redesign approach will be a focus on tackling unwarranted variation within our care system. This will be reinforced by putting *'individual goal setting'* and *'shared decision making'* between individuals and the care providers who support them at the centre of every care conversation (Making Every Contact Count).

4.1 Prevention, Early Intervention and Self-Care

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

The model is based on four principles:

1. Resource: Ensure that strategic initiatives are costed and adequately resourced.
2. Enable: The population and patients need to be enabled to adopt healthy behaviours.
3. Align: Alignment of strategies and pathways ensuring consideration of the wider determinants of health.
4. Innovate: Finding new and better ways of achieving outcomes through making the best use of available resources (including workforce) and ensure co-production (community involvement in the development of initiatives).

Transformation

We have identified the key decisions necessary to deliver a radical shift towards prevention. These are:

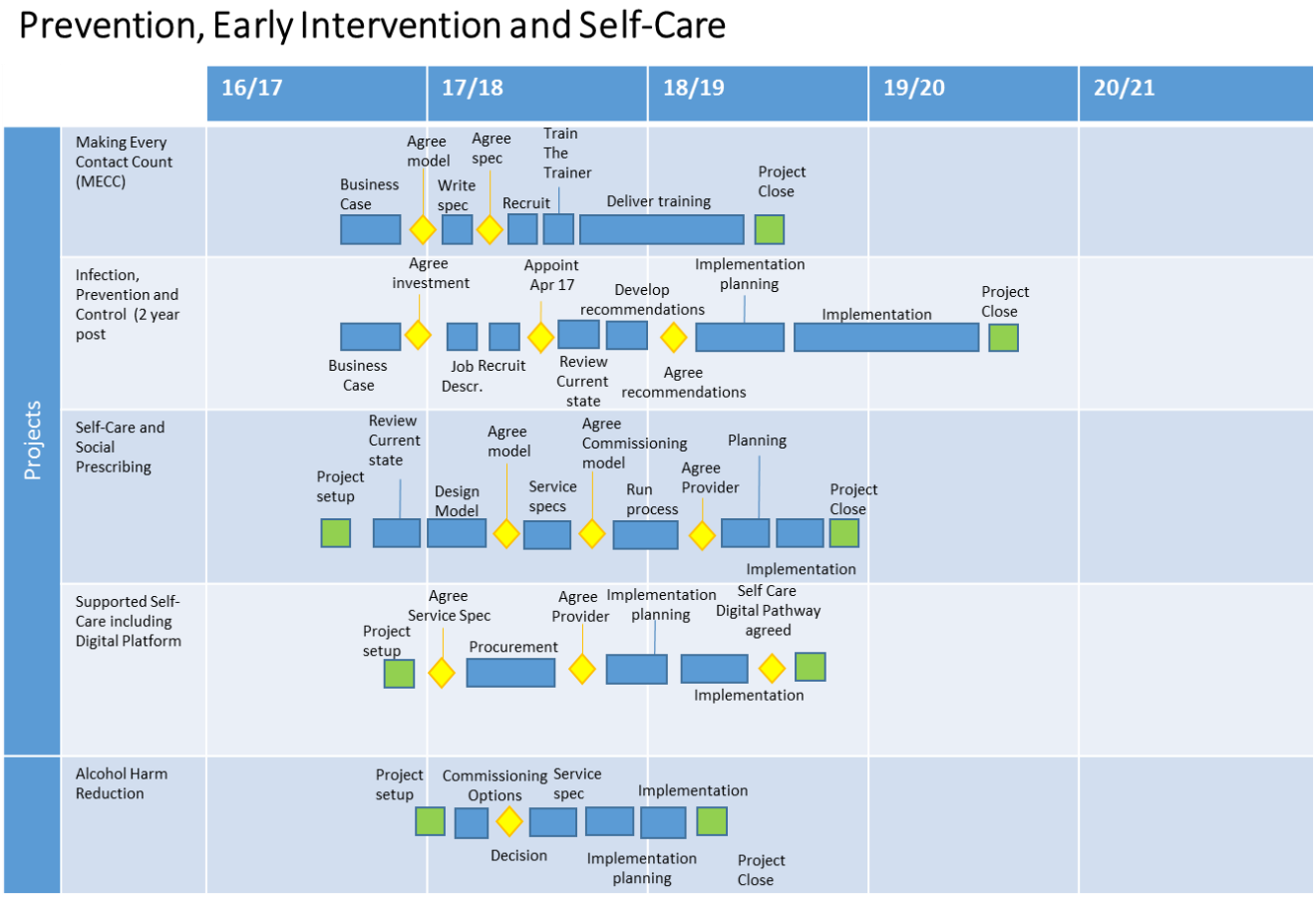
- Self-care and patient activation will be implemented at scale with consistent delivery across our system.
- A population health approach will be embedded across pathways (activate the population, carers and health professionals; reduce admissions; increase proactive prevention across the pathway).
- We will enable care settings to be innovative and effective e.g. using digital technology to support self-care.
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties).
- In order to achieve the short and medium/long term priorities investment is required for prevention, early intervention and self-care at scale. Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years. Through the Operational Planning process we will assess the realism of BNSSG transitioning to achieving this level of investment in prevention and wellbeing.

Initial projects

Our initial priorities are:

- Making every contact count
- Infection prevention and control
- Self-care and social prescribing
- Supported self-care (digital)
- Alcohol harm reduction

These have been chosen because they are evidence based, will improve the health of the target population, have an impact across the system and will reduce hospital admissions. They have been developed based on a life course approach and the need to embed prevention and self-care across the pathway taking into account primary, secondary and tertiary prevention opportunities.



Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.

4.2 Integrated Primary & Community Care (IPCC)

The overarching objectives of the new IPCC model are to improve peoples' care and experience through:

- Early intervention and management to keep people as well as possible, improving the stability of their health and wellbeing.
- Supporting independence, so that people enjoy the best quality of life possible in their places of residence.
- Personalising care and support planning to ensure patients and their families have increased choice, flexibility and control over their health, care and wellbeing.

Programme outcomes

The expected outcomes of the IPCC Programme and new model are both quantitative and qualitative:

Quantitative

- Delivering a best case 15% avoidance of primary and community health contacts.
- Overall 30% reduction in admissions and attendances by STP year 3 for certain LTCs, from care homes and at end of life.
- Reduced Length of Stay and Pre-Operative Assessment in acute hospitals for people with mental health issues
- Reduction in outpatient appointments by 15%
- Reduction in LOS of 20%
- More effective utilisation of community beds by streamlining access via the Health and Care Single Point of Access.
- Savings in consolidating and reducing premises

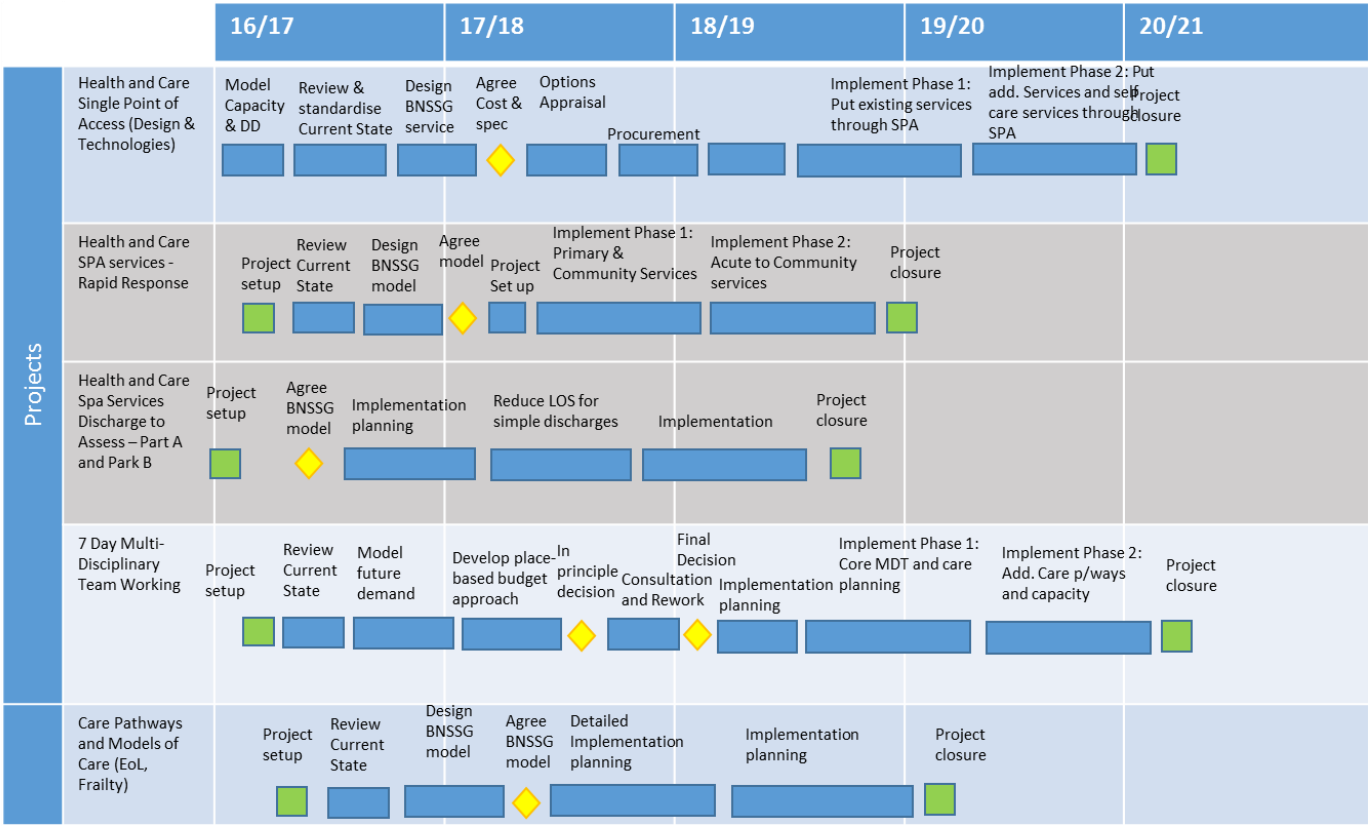
Qualitative

- Addressing health inequalities across BNSSG.
- Increased independence and improved patient and carer satisfaction.
- More people achieving their preferred place of death.
- Improved GP and health and care staff satisfaction.
- Improved health outcomes for people with LTCs.
- Reduced variation in practice across clusters and localities, leading to improved efficiency.

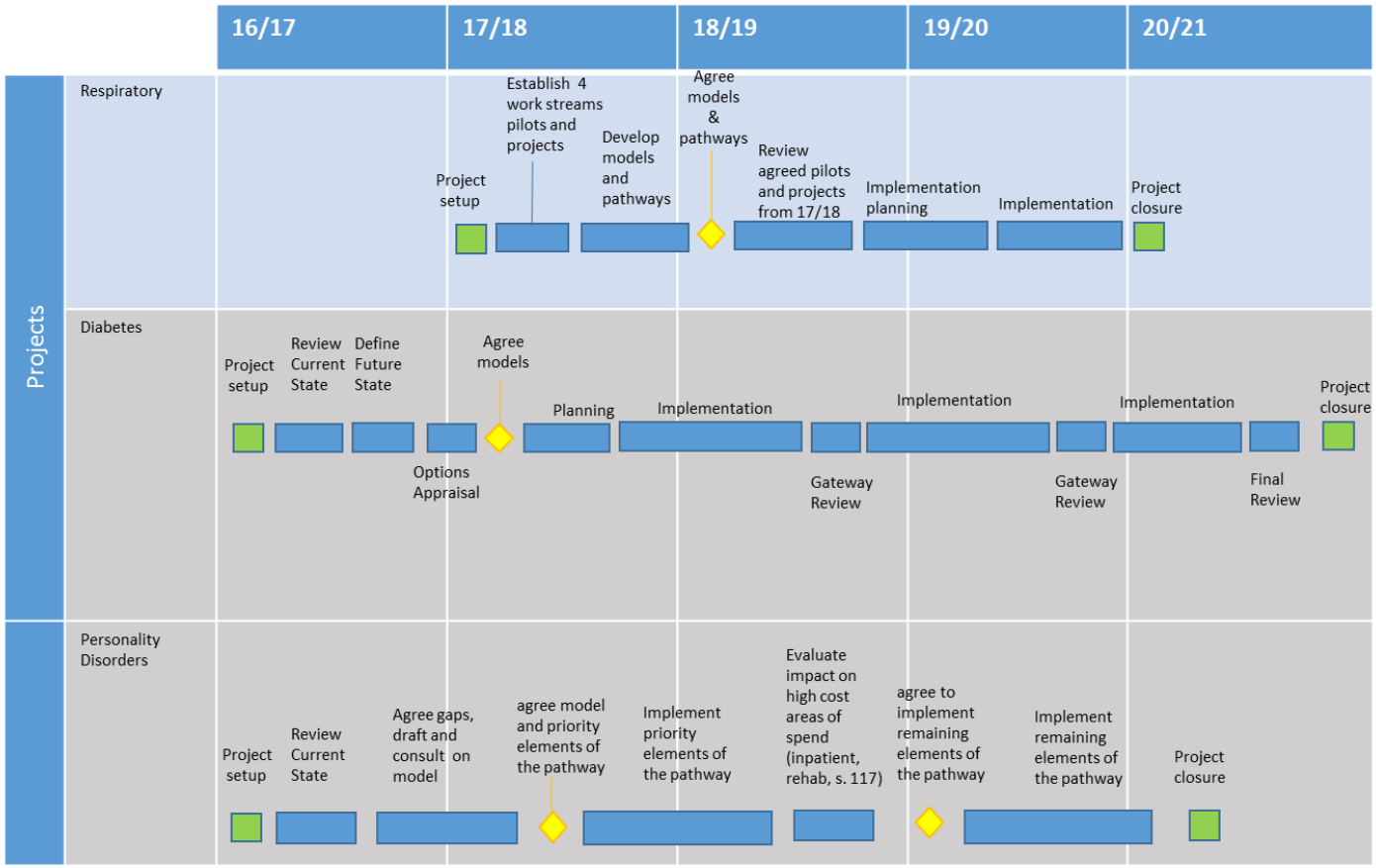
This includes the following projects:

- Sustainable Primary Care (Timeline to be developed shortly by NHS England)
- Health and Care Single Point of Access (Design & Technologies)
- Health and Care SPA services - Rapid Response
- Health and Care Spa Services -Discharge to Assess – Part A and Part B
- 7 Day Multi-Disciplinary Team Working
- Care Pathways and Models of Care (End of Life, Frailty)
- Diabetes
- Respiratory
- Mental Health

Integrated Primary and Community Care

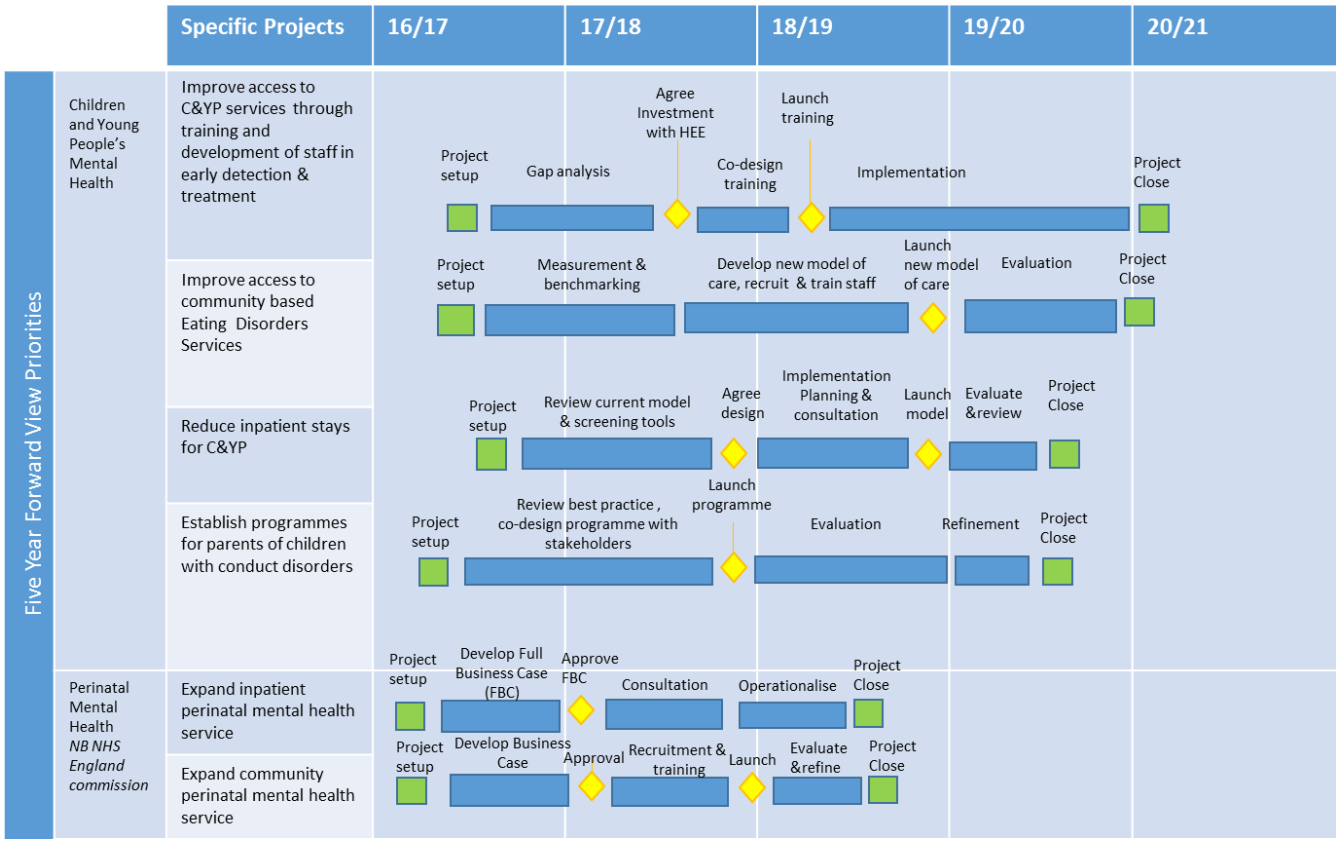


Integrated Primary and Community Care - Clinical Pathways

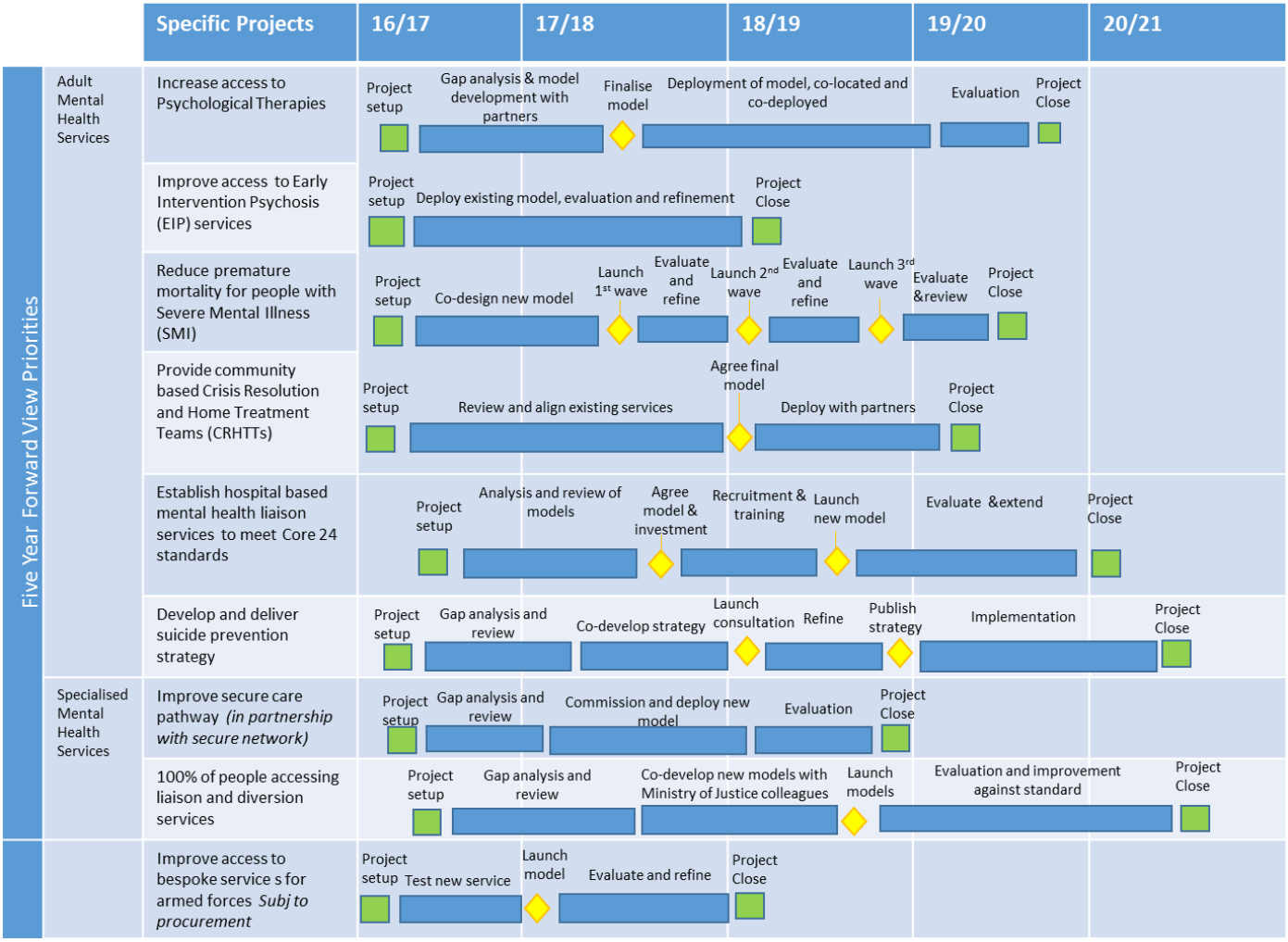


Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.

Mental Health – Women, Children and Families



Mental Health – Adult Mental Health & Specialised Services



4.3 Acute Care Collaboration

The overarching objectives are:

- Best use of hospital capacity
- Effective clinical pathways
- Specialist services and networks
- Sustainable services at Weston General Hospital

These themes have been converted into specific and deliverable projects. Each project has been selected as a priority based on the scale of opportunity and potential to impact on reducing our known gaps in Care and Quality, Finance and Efficiency and Health and Wellbeing.

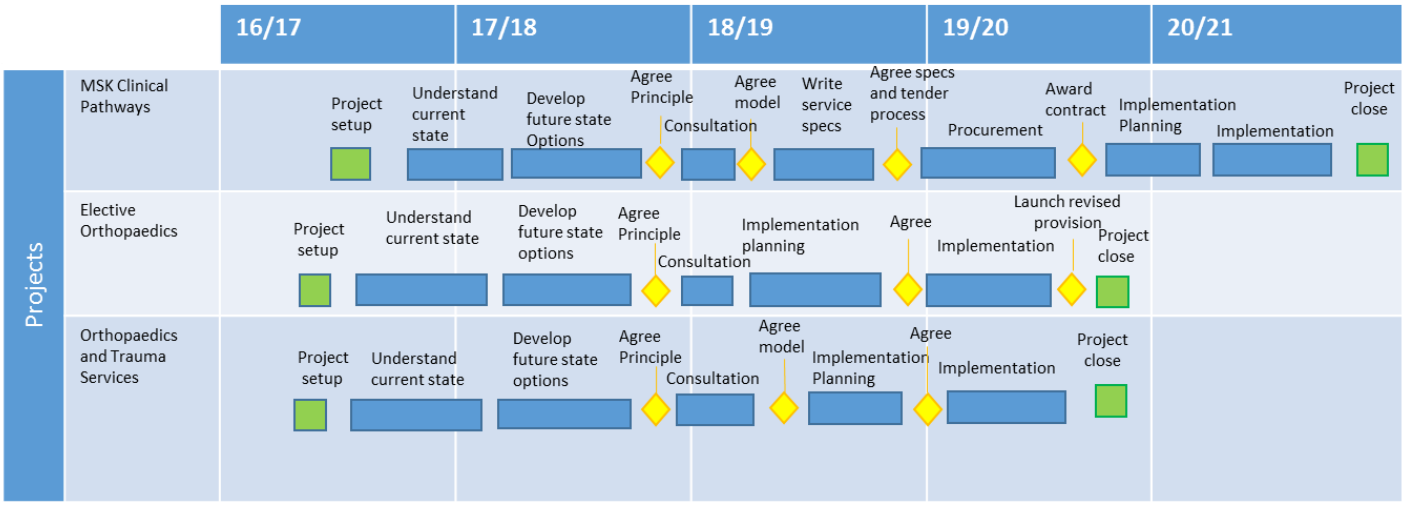
The phase one priority projects identified are;

- Effective Care Pathways
  - Musculoskeletal (MSK) / Trauma & Orthopaedic
  - Stroke
- Pathology
- Weston
- Medicines optimisation
- Corporate services consolidation
- Urgent Care
- Specialised Services

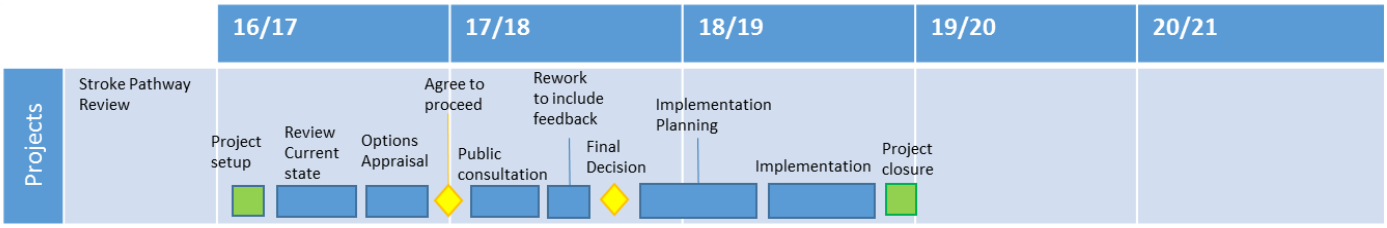
Example – Urgent Care:
The STP approach will ensure the system undertakes a comprehensive review of urgent care services so that it delivers for patients in need of urgent care. This will include:

- Effective and responsive NHS 111 service and primary care out of hours provision - a functionally integrated urgent care service, primarily through the establishment of a "clinical hub", in line with recommendations from NHS England.
- A single point of access for BNSSG that provides professionals with one number to support access to rapid responses and crisis services, supporting the community. This will support coordinated discharge and access to rehabilitation, recovery and reablement services. This will combine health and social care professionals, using up to date IT to enable rapid response.
- Links from that single point of access to a joint "front door" at the acute hospital staffed by primary and acute care clinicians, enabling appropriate streaming of care and comprehensive assessment for frail older people .
- Achievement of the 4-hour emergency access standard through:
  - **Admission avoidance and prevention**: Ensuring community alternatives to hospital admission are easily accessible by patients and Primary Care and other healthcare professionals in their local communities.
  - **Improving flow through hospitals** by ensuring the patient journey through hospital is efficient and the patient is not subjected to any unnecessary delays.
  - **Enabling discharge**: Ensuring that patients are discharged as soon as they are no longer in need of acute hospital care
  - **Frail & elderly care**: Ensuring there is holistic, multi-disciplinary end-to-end care for people living with frailty and complex conditions.

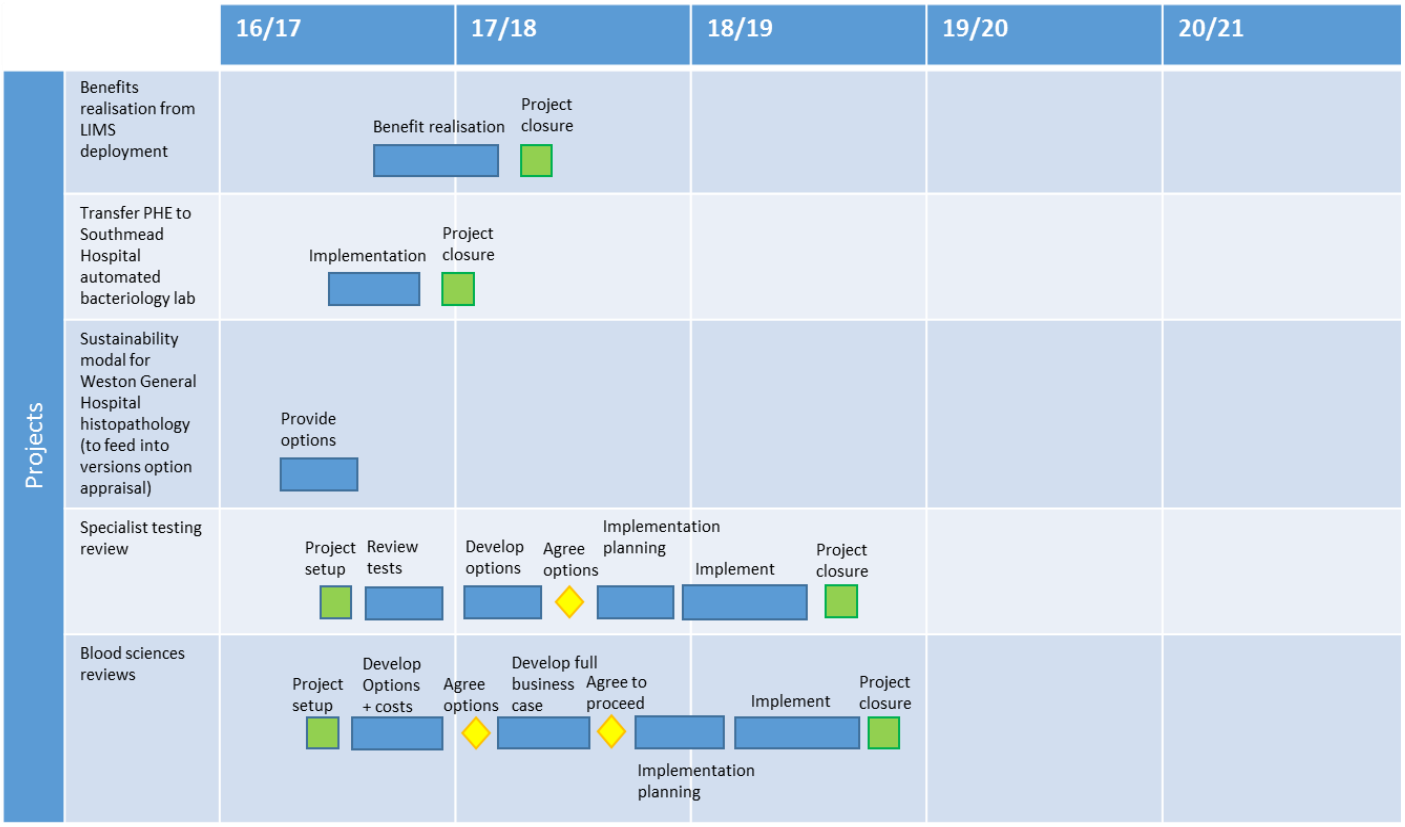
MSK Programme



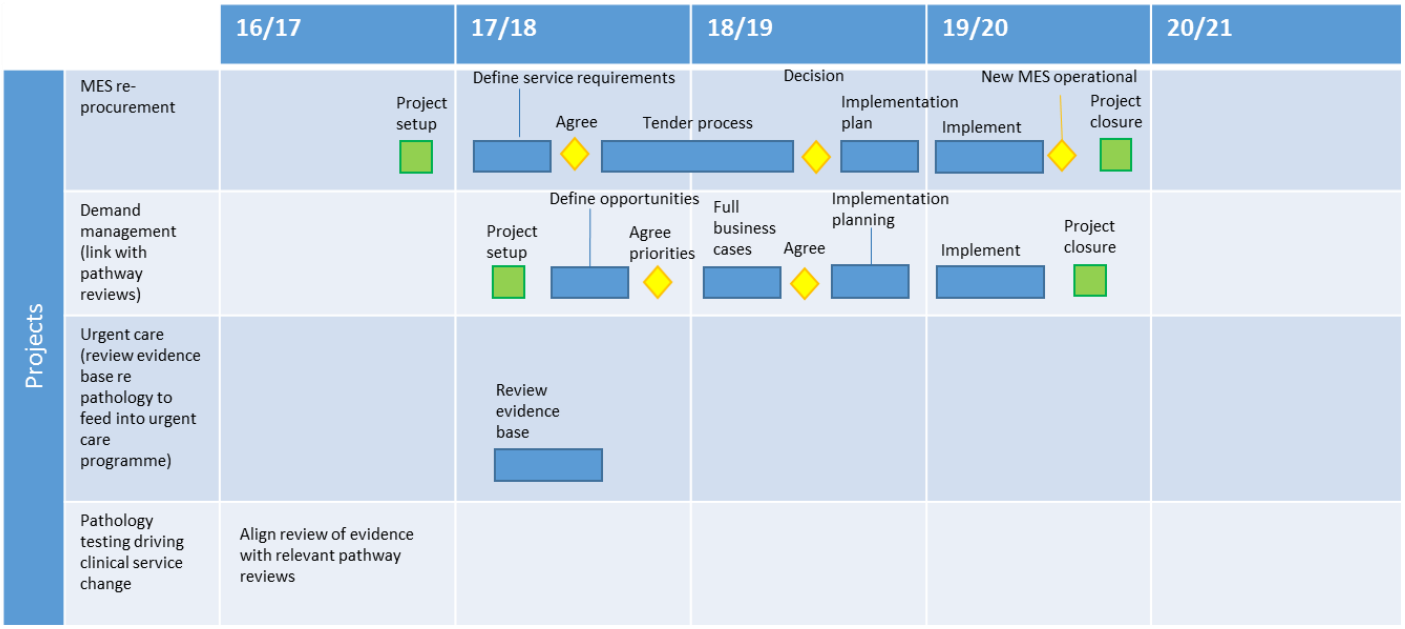
Stroke Pathway Review



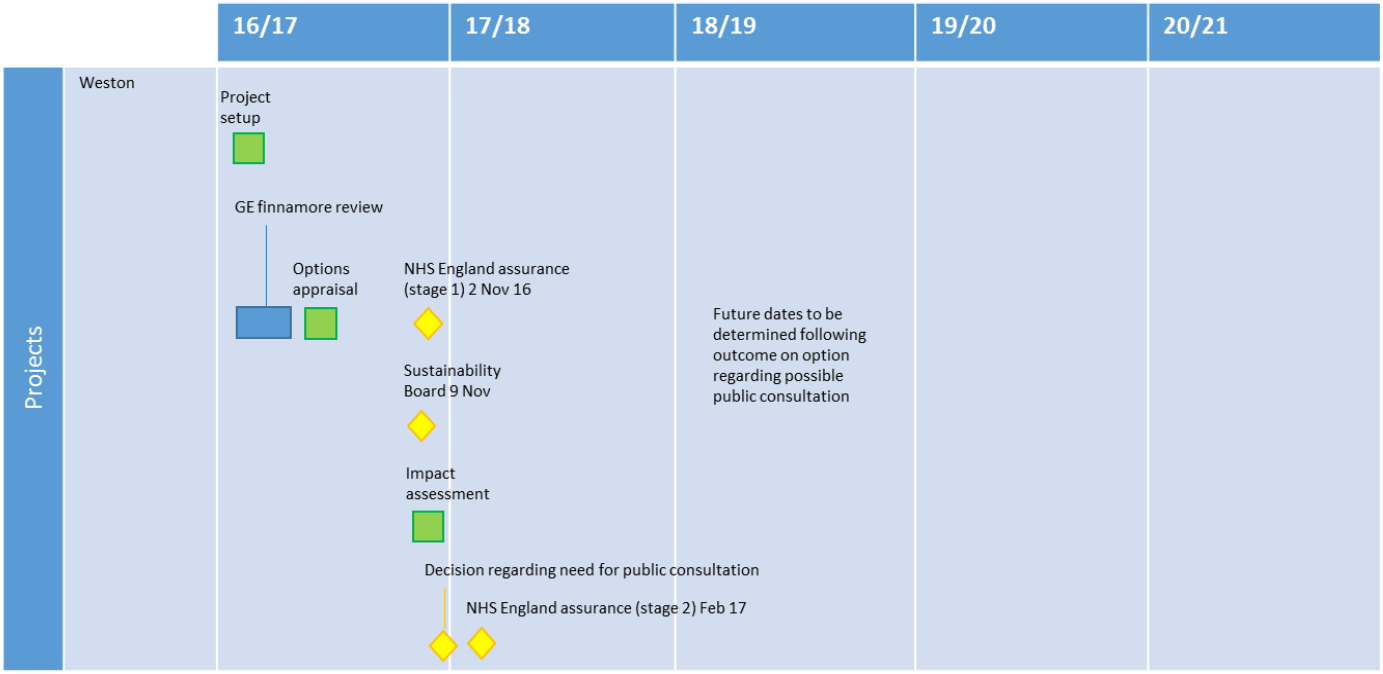
Pathology Programme



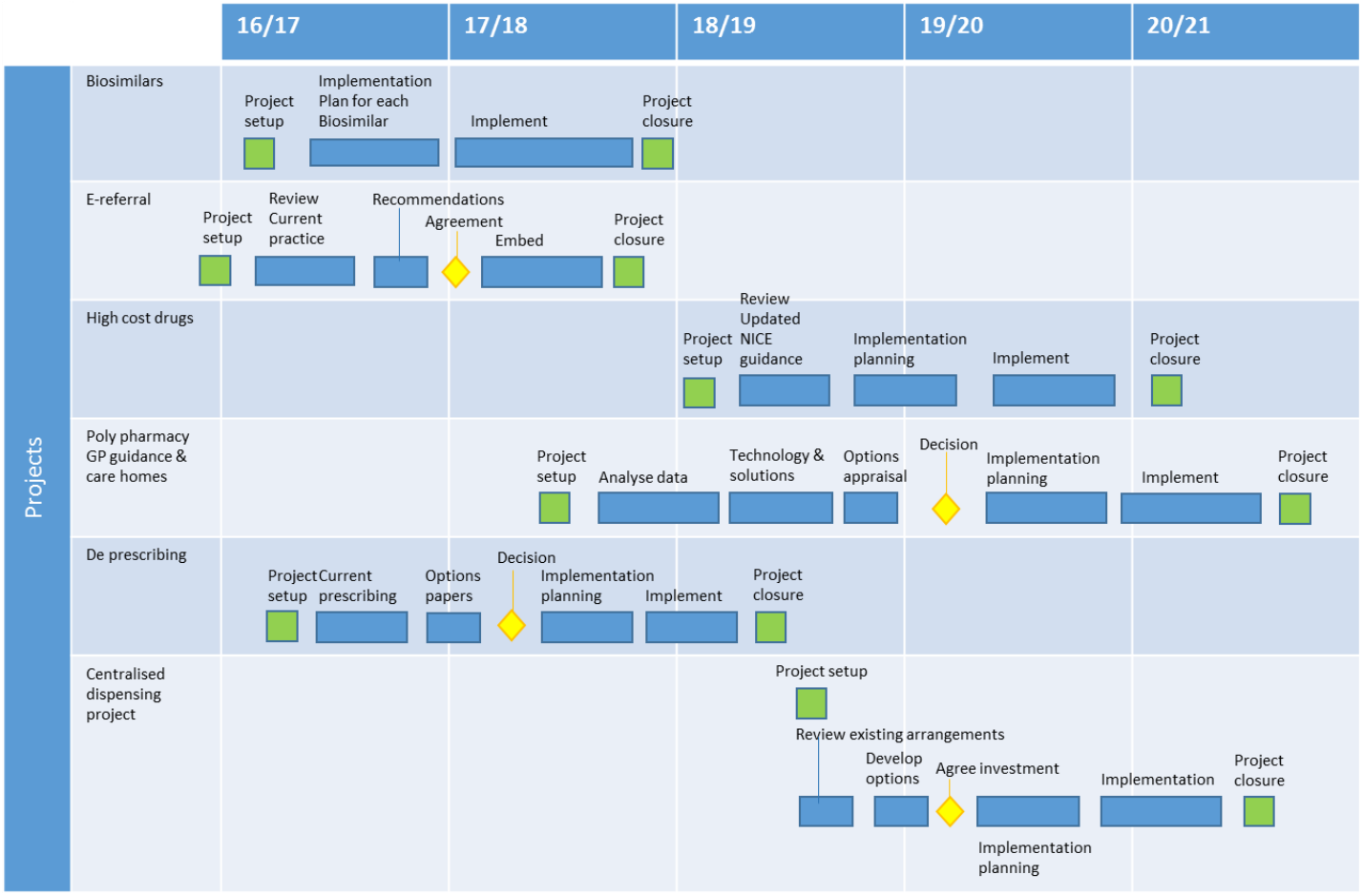
Pathology Programme continued



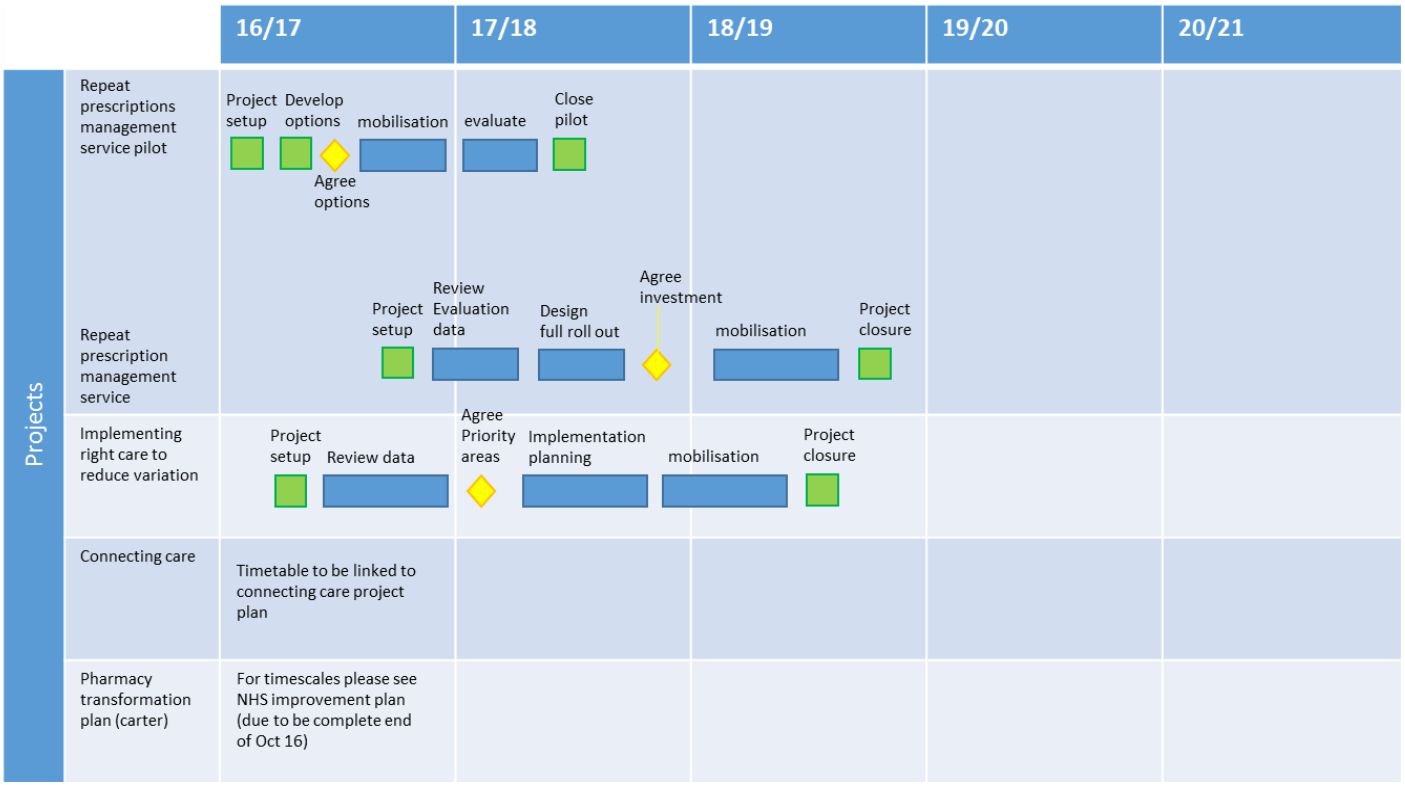
Weston Sustainability



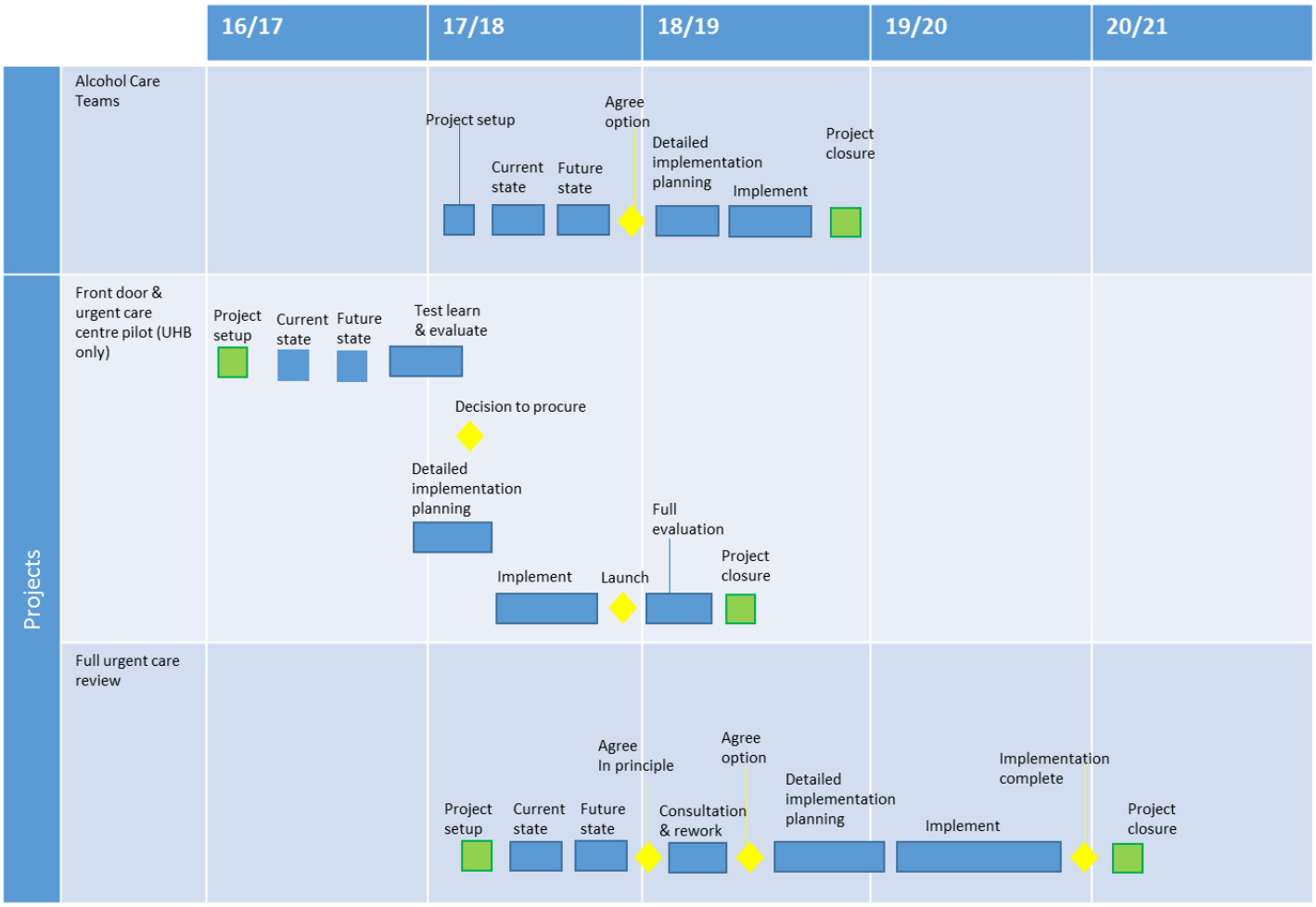
Medicines Optimisation Programme



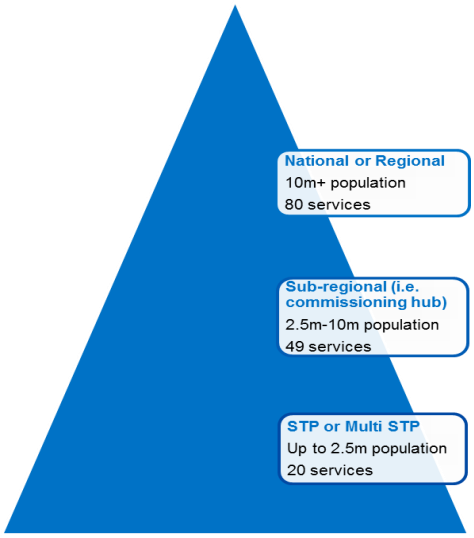
Medicines Optimisation Programme continued



Urgent Care Programme



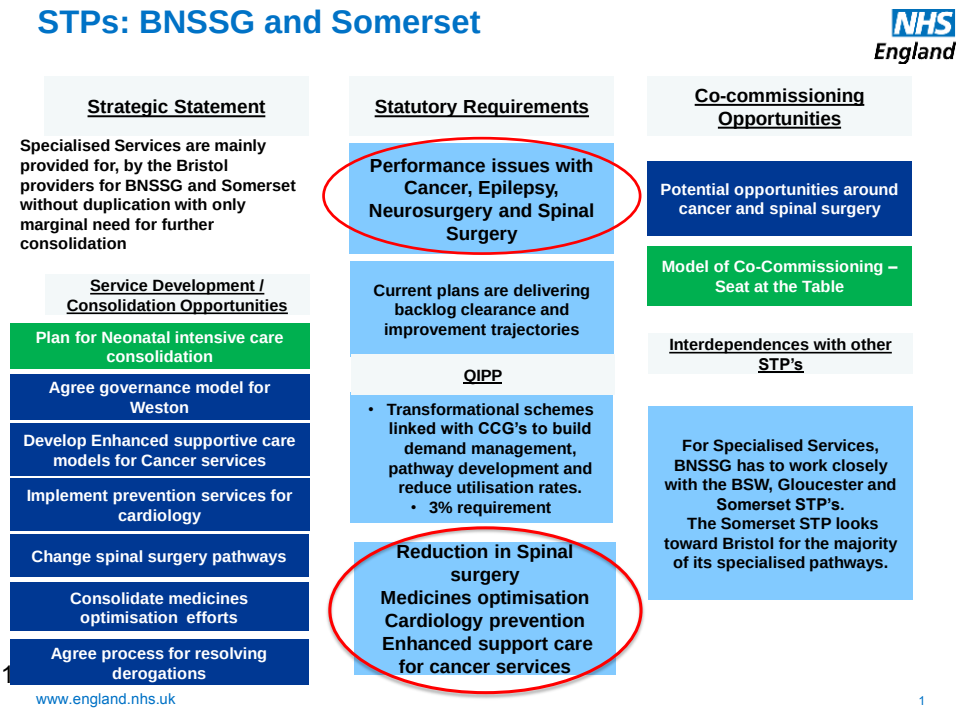
Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.



4.3.1 Specialised services

More than 30% of the capacity of the acute hospital Trusts in Bristol is occupied with specialist commissioned services which support care for a large regional population. Most specialist services in Bristol are delivered by a single provider working at scale. The specialist capacity needs protection so that it is available for delivering urgent and complex care beyond the STP foot print boundaries. This requires effective networks, endorsed by specialist commissioners, that ensure rapid repatriation of patients to local settings and rehabilitation pathways of sufficient capacity to avoid delays.

The STP will collaborate with Specialised Commissioners to deliver the approach to specialist service provision illustrated below.



Please see appendix C for more information regarding specialised commissioning.

5. System approach to our challenges

5.1 Health & Wellbeing

The table below illustrates the prevalence of lifestyle and mental health issues within our STP area. This highlights the importance of working across our core programmes (PEISC, IPCC, ACC and MH) to ensure a coordinated response.

		Bristol	North Somerset	South Glos
Smoking	Prevalence (av) (QOF)	21.5%	17%	15.9%
	Prevalence (highest)	38.6%	42.3%	24.6%
	Ex-smokers (GP survey data)	25.5%	32.1%	27.9%
Alcohol	Estimated risk drinkers	79,387	39,762	49,068
	Alcohol related admissions	3018	1387	1641
Weight	Obese	21.7%	22.2%	23.3%
	Overweight	56.9%	62.7%	63.2%
Mental Health	Depression (av)	7.6%	9.2%	7.7%
(All QOF)	Depression (highest)	13.7%	5.9%	14.7%
	Long term MH condition (av)	5.9%	5.3%	4.3%
	Long term MH condition (highest)	14.7%	11.9%	9.7%

5.2 Care & Quality

As an STP we will:

- Adopt a system-wide methodology for quality improvement working with the Academic Health Science Network (AHSN);
- Recognise the need for a system wide approach to health and wellbeing for our workforce;
- Address mental and physical health and wellbeing in every pathway; and
- Assign a board champion for mental health on each provider board.

The business case templates we are using for STP initiatives specifically ask project leads to describe how they impact on the three elements of quality:

1. On the clinical effectiveness/clinical outcomes expected,
2. How the case supports a safe system of working and to ensure that the experience of the user/patient is considered alongside their engagement.
3. Having the right intervention first time, at the right time benefits the individual as well as promoting better efficiencies within the system.

5.3 Health & Social Care

At the core of our approach to integration of health and social care is the development of cluster based care, operating with community multi-disciplinary teams and improved care coordination, focused on proactive case management of those at greatest risk within our population.

Our principles for integration are that health and social care organisations will:

- Share common objectives and pursue common outcomes, working together effectively
- Build services around people and communities at both efficient and effective scale that enable their needs, aspirations, capabilities and skills and build up personal autonomy and resilience;
- Prioritise prevention and rehabilitation, reducing inequalities and promoting equality and independence;

- Constantly seek to improve performance and reduce costs;
- Are open, transparent and accountable;
- Adopt a commonality of structure that works for local communities and for all commissioning and provider partners in BNSSG.

North Somerset, South Gloucestershire and Bristol City Councils are seeking to create a Social Care Collaborative based on a commitment to working together:

- **With individuals** as partners in planning their own care and support.
- **With carers and families** as partners in the support they provide to the people they care for. We will ensure the support carers and families can sometimes require for themselves is recognised.
- **With communities** as partners in shaping the care and support available and in providing opportunities for people to get involved in their communities.
- **With organisations** across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.
- **With our staff** as partners in developing and delivering our vision, valuing their knowledge, skills and commitment to health and social care.
- **To improve** demand management across the system and make best use of technology and on line digital services

5.4 Mental Health

BNSSG leaders recognise that the STP presents an opportunity to address the holistic health and care needs of our populations, including mental health and wellbeing. Current mental health service commissioning arrangements result in variable access, varying service specification, waiting times and treatment outcomes across the three CCGs. We have not yet developed fully integrated social, mental and physical health care, focussed in the community and pro-actively delivered at the earliest opportunity. There are fragmented care pathways, with both duplication and gaps in provision.

In BNSSG we are committed to achieving an uplift in mental health investment over the next four years to bring spend in line with the national benchmark.

Our aim is to ensure that all forms of care consider and value mental and physical health equally, so that people receive the treatment to which they have a right and are supported effectively in their recovery.

Our approach for mental health rests on the five core principles we have established for the STP:

1. We will standardise and operate at scale:
   The move to a single commissioning voice enables mental health to standardise service specifications, for example, a single 'offer' from IAPT for long term conditions. We will develop regional specialist provision such as perinatal inpatient care and will work in partnership to create maximum impact for the most vulnerable populations across the region, including Secure Services and other specialised services.

2. We will develop system-wide pathways of care:
   For mental health, this means we will address the current commissioning gaps in service lines across the three CCGs. We will act positively to ensure equity of access to services, prioritising investment in those areas with least access. Starting with prevention, and through closer working with Public Health and primary care, our actions to reduce harm from alcohol and smoking will improve population mental wellbeing yet will include targeted attention for those with severe mental disorder (SMI). Similarly, screening programmes will proactively identify mental ill-health in schools, acute hospitals, care homes and pregnant women, and will positively target those with SMI. In year one, our plan begins to address geographical disparities in specialist provision for

children and young people, perinatal women, early intervention in psychosis, liaison services and crisis services. The five year plan will refocus provision away from hospitals and into the community.

3. We will develop a new relationship with the population:
   Simplifying access to all services through a single point of access ensures the earliest, most appropriate signposting to care. Staff and patients will perceive fewer interfaces in their health and social care pathway and the implicit cultural message is inclusive, reducing stigmatisation.

4. We will develop new relationships between organisations and staff:
   We will increase and simplify access, reduce stigma and improve health outcomes through a deliberate focus on integration of physical and mental health provision. Early success with control room and street triage has created common understanding and has changed behaviour in favour of least restrictive interventions. Inter-organisational, multi-disciplinary teamwork in liaison, services for medically unexplained symptoms, and perinatal and primary care will defend against 'diagnostic overshadowing', will encourage mutual aims in prevention and early intervention, will reduce duplication and will result in 'whole person' care.

   Our workforce enablers include IT and shared HR systems but a more radical change comes from the focus on staff development, retention, health and wellbeing. STP partners are developing the mechanisms: harmonised terms and conditions, training passports and core skill sets enable staff to work and move across organisations. Training for all staff groups in brief intervention and psychologically minded treatment will equip our workforce for the future as will training to work with older people. Apprenticeships, roll out of STP-wide quality improvement training, extended, rotational and innovative roles will attract and retain staff for whom the workplace offer includes stress reduction, psychological support , weight reduction and clinical supervision.

5. We will build on our existing digital work as a driver and enabler of cultural change:
   Access to care records across STP partners will facilitate safe, coordinated care planning and delivery for all patients and will promote integrated care, including shared and co-created risk assessment. For staff, access permits targeted intervention in keeping with our principle of 'least intervention at the earliest opportunity', including opportunity in years two and three for online and virtual therapy and symptom and medication monitoring.

5.4.1 STP Governance and Mental Health

Our governance structures are designed to ensure we deliver:

- parity of esteem, investment and innovation between mental and physical health, to improve the mental health, wellbeing AND physical health of the population;
- increasingly integrated services;
- national mental health indicators;
- the five year forward view for mental health; and

The Clinical Cabinet of key senior clinical experts will apply a 'parity test' to new developments and will assess pathways against the aims of integration and the Five Year Forward View for Mental Health.

All STP partners commit to assign board-level champions for mental or physical health and a board champion for mental health in a provider of physical healthcare.

As the largest NHS provider of mental health services across two STP footprints, Avon and Wiltshire Mental Health Partnership will work with accountable officers through the Mental Health Strategy Group, to advise both on strategy for local and specialist regional and national provision and to align trust clinical strategy appropriately.

As we review our plans, we will be assessing how effectively they support the Five-Year Forward View for Mental Health and how the STP will bring local spend on mental health up to national benchmarks, by demonstrating percentage growth year-on-year.

See appendix D: Mental Health - Parity

5.5 Commissioning Approach

Commissioning & Contracting 2017/18 & 2018/19

In preparing our STP submission, our System Leadership Group have considered how the evolution of commissioning and contracting processes will accelerate delivery of our STP in the short and longer term.

Desired future state

There is agreement that the current model of contracting does not support our agreed long term goals of system outcomes and financial balance. We recognise that we need to achieve improved system (patient) outcomes and reduced health inequality, supported by a financial framework that rewards parties for doing this. Achieving this will take time, trust and collaboration between partners, necessitating its inclusion within the wider STP.

Single version of the truth

There is a need for a single agreed version of the truth in relation to system finances. This includes an open and transparent approach to understanding system income and expenditure, including:

- Risks (to individual organisations & patient care)
- Constraints
- The existence of and approach to managing perverse incentives
- The existence of and approach to managing 'subsidies'
- Sunk costs resulting from changes in the Model of Care

System control total

The development of a system control total is recognised as a potential way to move towards our desired end state, with agreement that a necessary pre-condition would be the single version of the truth described above.

Consistent approach

The adoption of a consistent approach between all 3 commissioners is an essential element of our approach and should be extended to include specialised commissioning. In the short term, we are not intending to adopt multilateral negotiations (all providers in the same room) but will implement a consistent, open book approach between all providers and commissioners.

Key steps for 17/18 & 18/19

Our aim is to divert the energy consumed in taking the traditional annual approach to contracting into creating a 'good enough' understanding of system finances to ensure that the contract settlements move us towards a desired future state. System leaders have committed to:

- consider how multiple contracts create additional system financial risk when there is a finite pot of money and how these risks might be shared;
- continue the development of a single system savings plan; and
- achieve contract signature in a way that moves us towards a system financial framework that safeguards individual organisations and rewards the achievement of patient outcomes.

5.6 System Governance

As system leaders, we recognise that organising ourselves on lines closer to an accountable care system may bring significant benefits in the delivery of the vision we have set out in this STP. Our consideration of these opportunities is at a formative stage, but we are building specific activities into our STP programme to ensure we address them at the appropriate time ('form follows function').

As an early step towards supporting system change the three CCG's have embraced the need for a single commissioning voice and have already taken steps to establish a Joint Commissioning Structure across BNSSG. The two major acute providers in Bristol have also announced their intention to look at options for formalising a closer collaboration between them (that does not involve a merger).

6. Enablers

6.1 Engagement & Communication

As an STP Partnership we are committed to public and patient involvement. We will continue to listen and act upon public, patient and carer feedback at all stages of the STP development cycle because of the evident added value of commissioning and providing services that are informed by the experiences and aspirations of local people.

Within the individual projects, patient and public involvement that is proportionate to the changes that are being considered will be undertaken. In the case of any significant changes to services, appropriate formal public consultation processes will be implemented.

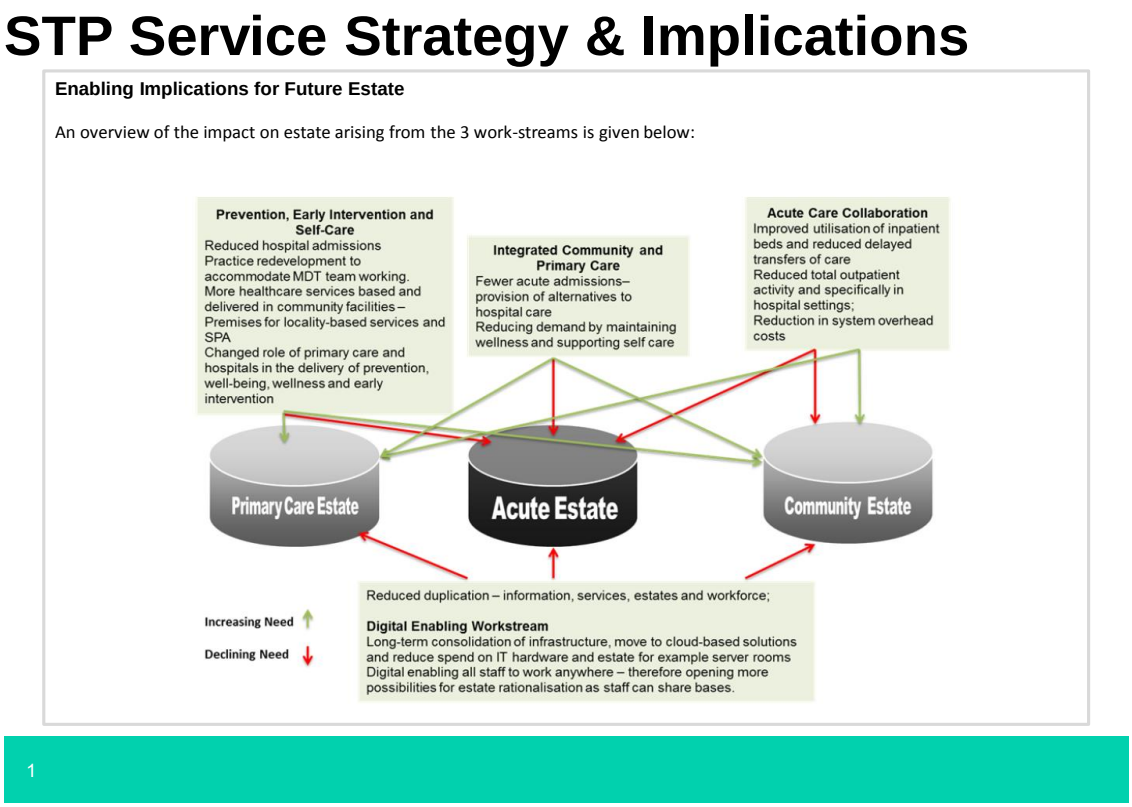
The emerging STP plan has been informed by existing feedback from service users, carers and the public. This includes information from recent public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports. This ensures that our thinking is being shaped by the issues that the people who rely on our services have told us is important to them**.**

- Phase one of this plan outlines how we will further our conversations and engage locally to ensure stakeholders understand the case for change. This plan will evolve as more detail emerges from the STP to ensure timely and meaningful engagement with all stakeholders.
- Phase two of the plan will look at key tactics used to engage with others, including MPs, Councillors and influential groups.
- Phase three of this plan will evolve as we move into the engagement phase should there be any proposed changes to the way services are delivered across BNSSG. Specific consultation and engagement plans will be developed in response to these.

Further detail on our Communications and Engagement approach is set out in Appendix E.

6.2 Estates

Our estates strategy is being developed to both enable the delivery of our new Model of Care and optimise the efficiency of our estate. Set out below are the priorities that we will be undertaking.



Enabling implications for future estate

1. Integrated primary and community care:
    - Transformation of community facilities to allow mental and physical health services to be delivered locally from “Clustered” GP Premises.
    - Efficient use of joint estate options with other public sector bodies, by maximising utilisation across the wider public estate.
    - Surplus or expensive estate rented from the private sector is removed from the system, where possible to support a reduction in estate running/operating costs and estate delivers value for money.
    - Investment in the estate with poorer quality buildings that are no longer fit for purpose replaced with new facilities where appropriate funded by a reduction in the overall estate to support the cost of future investments.
2. Prevention, Early Intervention and Self Care
    - Shift of care from an acute setting to primary and community care making best use of available resources.

3. Acute care collaboration

    - Utilisation of fit for purpose existing estate is maximised (Lord Carter targets) with consolidation of activity and sharing of premises.
    - Sharing the acute and mental health hospital facilities and physical assets.

Supplementary information relating to existing estates projects, STP estates initiatives, implementation priorities and financial impacts are contained in Appendix F.

6.3 Workforce

The engagement of our workforce is key to the delivery of all aspects of the STP. The introduction of new models of care, new roles (including the Nursing Associate and Physician's Assistant, using our workforce as advocates of the prevention agenda and changes to how and where staff work require considerable adaptability and careful engagement and change management. Workforce transformation also requires detailed baselining of data across the footprint, which has started, as well as collaborative working across organisations and work streams. We have also developed a modelling capability in BNSSG to respond to change and produce detailed implementation plans.

> Better use of data and technology has the power to improve health, transforming the quality and reducing the cost of health and care services. It can give patients and citizens more control over their health and wellbeing, empower carers, reduce the administrative burden for care professionals, and support the development of new medicines and treatments".
>
> *Personalised Health & Care 2020 – Using Data & technology to Transform Outcomes for Patients and Citizens* – A Framework for Action

Project objectives and desired outcomes

The workforce work stream is an enabling work stream and as such will respond to the outcomes of the three care model work streams (Prevention, Early Intervention and Self Care, Integrated Primary and Community Care and Acute Care Collaboration). This response will include project management of transformational changes to workforce and also scenario modelling to support the cases for change. In addition a number of workforce projects have been defined to contribute to the STP approach to the challenges of wellbeing, quality and affordability of care.

In addition to joint workforce planning, the workforce work stream has identified six projects which support the BNSSG STP. These are:

- Collaborative working on apprenticeships
- Development of shared training of Mental Health and Community Staff
- Improve Staff Health and Well-being
- Shared Recruitment
- Create a common culture
- STP Workforce Transformation

The workforce work stream is working closely with Health Education England (HEE) and AHSN, and increasingly with colleagues in other work streams, including links into the Community Educational Provider Network (CEPN) initiative, to determine the timescales required to achieve workforce change. The requirement for consultation, the length of medical training pipelines and the visibility and clarity of the changes required dictate the timescales for change. The workforce work stream is therefore setting the conditions for success by developing a joint workforce planning capability, progressing the defined projects and building the relationships across the STP community and with other key stakeholders.

The purpose of the CEPNs is to:

- Support workforce planning by responding to local workforce need.
- Co-ordinate educational programmes and ensure educational quality with a faculty of trainers.

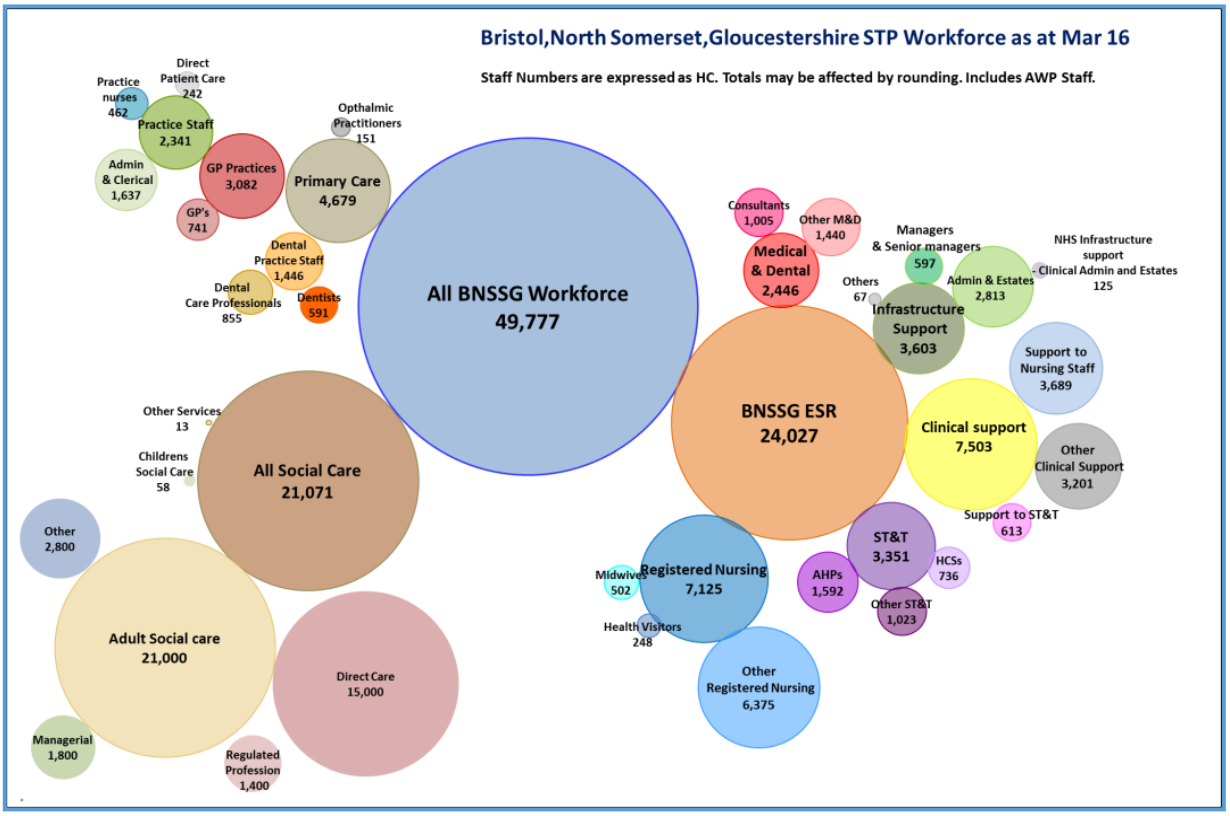
Promote and plan for the development of the existing workforce. We have also undertaken to convene a Social Partnership Forum (SPF) in order to facilitate early engagement with Trades Unions on the STP.

The workforce work stream has identified that Organisational Development facilitation is required to support transformational change and deliver continuous improvement. HEE funding is being used to resource facilitators to support all work streams to deliver change. The facilitators will utilise existing programmes, such as the Calderdale Framework, and 'train the trainer' packages..

The Calderdale Framework is a tool to develop and manage a consistent competence level among practitioners. The original focus of the tool was to provide a level of assurance and risk management for those tasks delegated to the unregistered workforce in clinical settings. The framework seeks to reduce risk ratings, increase patient satisfaction, increase activity, improve attendance and support organisational reviews of skill mix. It has been backed up by research and has been introduced in a number of Trusts in the country as well as in Australia and New Zealand.

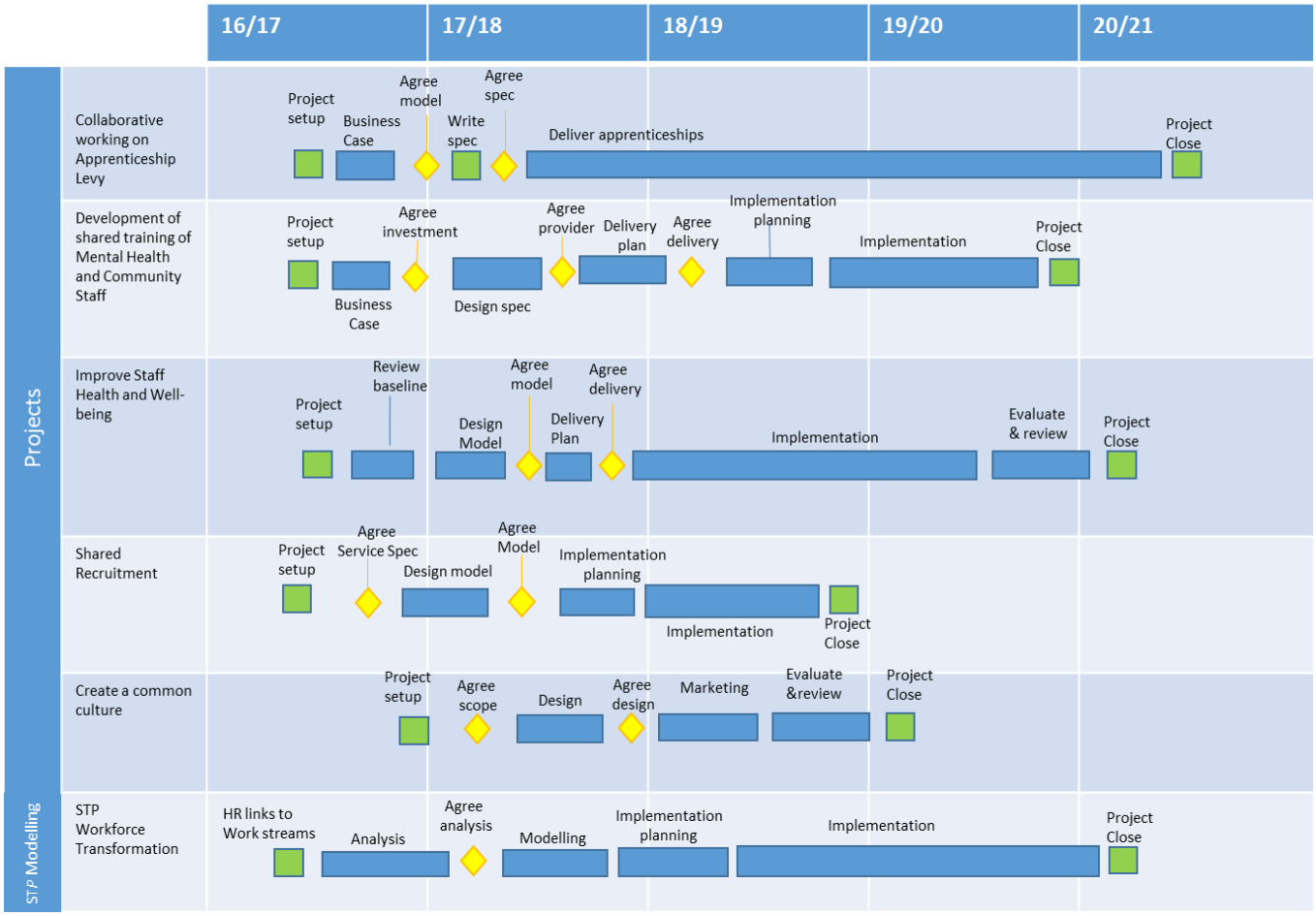
http://www.calderdaleframework.com/

Illustrated below is the workforce across our STP. The independent and voluntary sector makes a significant and valuable contribution as part of this workforce. As the STP develops the workforce work stream will develop further links with these sectors to both better understand the baseline data and ensure coherency in terms of workforce development.



The timeline for delivery can be seen below:

Workforce



For more information about each of the projects and further workforce please see appendix G.

6.4 Digital

Introduction

We understand that technology has a key part to play in helping us **meet our financial challenges** – as well as **improving efficiency**, enabling **better care and quality**, and **closing the wellbeing gap**.

Like the rest of England, we have some significant challenges to overcome if we are to deliver the standard of health and social care that our population requires and deserves, within the very real operational and financial constraints that exist. Our work together on digital transformation has proven that we can collaborate to deliver real, system-wide transformation.

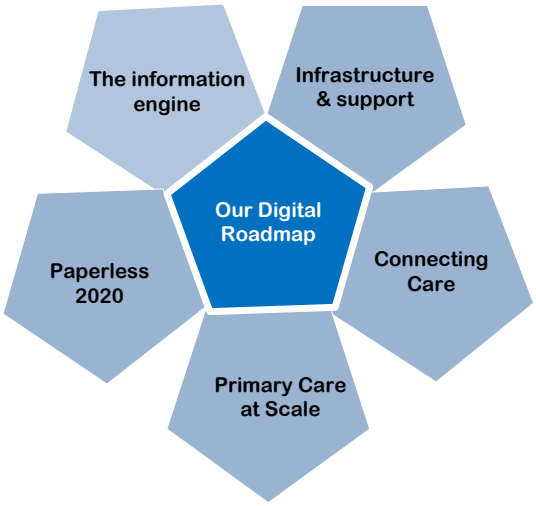
Local Digital Roadmap - building blocks

Our focus in our roadmap is on five key building blocks –

1. Primary Care At Scale – focus on maximising digital across GP practices and Out of Hours services.
2. Paperless 2020 – Embedding digital records in acute, community, mental health and social care.
3. Connecting Care - Information sharing to include putting citizens at the heart of their 'personal health records'.
4. The Information Engine – Fully utilising our electronic data to power our planning and delivery engine.
5. Infrastructure & Support - Ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism that enables mobile working.

We will deliver these five major themes locally, but in full alignment with our local *Sustainability and Transformation Plan* and the *National Information Board* strategy.

- Primary Care At Scale – focuses on maximising digital across GP practices and Out of Hours services. Supporting primary and community care reconfiguration, new integrated team working and maximising efficiency of practices through shared ways of using technology. This is also about how we can better support people and communities out of hospital



- Paperless 2020 – Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records to support mobile working.

- Connecting Care – Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care

- The Information Engine – Fully utilising our electronic data and intelligence to power our planning and delivery engine. Devising new and innovative ways to use information, integrated population analytics and data driven decision making.

- Infrastructure & Support - Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes).

For more information about Digital please see appendix H

7. Impact of our STP

The introduction of our new model of care will have significant impacts across our care system. Where evidence of improvement is available from elsewhere, we have utilised this to help us estimate the impacts we might achieve.

Set out below is a summary of the impacts modelled so far as part of the STP. These are being further developed as part of the Operational Planning process, which provides the mechanism for embedding intended improvements within contracts.

7.1 Performance impacts

The NHS organisations within our partnership are mandated to achieve all NHS performance standards and it is a key expectation that the STP ensures they are met on a sustainable basis. Presently provider contract management processes monitor in-year performance and improvement trajectories where in place. Where providers are under-performing they are being reviewed and recast. This process will feed into the operational planning process to inform CCG and provider plans for 2017/18 and 2018/19, which will be incorporated into the STP. The need to monitor performance and respond at the STP level is critical with the creation of an STP dashboard for 2017/18 identified as a priority.

7.2 Financial modelling update

The approach and methodology

Finance Directors and Chief Officers have been meeting for three months to support the STP process pro- actively.

The methodology used is as follows:

- Director of Finance review and sign off of 2016/17 position for all bodies in accordance with the recent guidance issued by NHS England;
- Assess the underlying position and document the drivers for any declared underlying deficit;
- Document the medium term financial plans for the period 2017/18 – 2020/21 including underlying positions, inflation, cost pressures, savings, activity growth, sustainability funding, cost of activity and other factors specific to individual organisation. Recurrent and non-recurrent cost analysis was included; and
- The impact of 2017/18 tariff changes and SLA changes have not been included.

The assumptions used include the following:

For Providers

- Inflation at 2.1% from 2017/18 onwards;
- National efficiency requirement of 2.0% pa from 2016/17 to 2020/21;
- General assumption that changes in activity volume require 85% cost of delivery and therefore provide a margin contribution toward Providers financial positions.
- Corporate overhead savings are assumed and included within the identified savings plans; and
- Pathology savings and productivity are assumed and included within the identified savings.
- The Community Interest Companies (CICs) combined deficit (assessed as £15m in June 2016) are included in the overall STP financial position.

For Commissioners

- CCG and NHS England allocation assumptions including growth and distances from target were published in January 2016 for the period 2016/17 to 2020/21, the first three years are fixed, the final two years are indicative.
- The accumulated commissioner RAB outstanding on exit of 2016/17 is not considered in the financial savings plans.
- CCG expenditure plans include national expenditure growth assumptions for demographic growth, tariff price inflation, non-demographic activity and quality cost pressures and nationally mandated priorities.
- CCGs are committed to funding activity volume growth at 100% of National Tariff.
- Corporate overhead savings are assumed and included within the identified savings plans.

What is the financial position?

2.1 'Do Nothing' and 'Do Something' Position

The 'Do Nothing' positions and financial savings for the period to March 2020/21 were signed off and submitted by Directors of Finance on the 14th October 2016. Across the BNSSG STP, the position can be summarised as follows:

1. The 'Do Nothing' deficit as at 31st March 2021 totals £305.5m;
2. Sustainability and Transformation Funding of £61m is received;
3. Savings of £138.9m have been identified to date;
4. Savings of £7.4m are assumed relating to the Weston Sustainability plan;
5. The level of unidentified savings to date is £104.4m; and
6. System wide Transformation savings schemes are work in progress. These solutions require further development including triangulation with provider income and capacity plans. These will be subject to verification and sign off by nominated Director of Finance leads as part of the Operational Planning process.

The overall position is summarised in the table 1 below.

Table 1: Overall BNSSG STP Position

		"Do Something" Solutions				
Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**	**STF Funding**	**Identified Savings**	**Unidentified Savings**	**Weston Sustainability**	**Total BNSSG STP**
Providers	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)	13.3	36.1	4.4		6.2
North Bristol NHS Trust (NBT)	(80.6)	14.0	65.0	1.6		(0.0)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)	3.1	10.1	0.0	7.4	(0.0)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)	0.7	4.6	12.0		(0.0)
South Western Ambulance Service (SWAST)	(3.2)	1.5	1.6	0.1		0.0
Community Interest Companies (CiCs)	(15.0)			15.0		0.0
Sub-total Providers	**(184.3)**	**32.6**	**117.4**	**33.1**	**7.4**	**6.2**
Commissioners						
Bristol CCG	(60.9)		8.0	52.9		0.0
North Somerset CCG	(30.3)		3.7	26.6		0.0
South Gloucestershire CCG	(30.0)		9.8	20.3		0.0
Sub-total Commissioners	**(121.2)**	**0.0**	**21.5**	**99.8**	**0.0**	**0.0**
System Wide		28.4		(28.4)		0.0
Total Organisational Financial Plans	**(305.5)**	**61.0**	**138.9**	**104.4**	**7.4**	**6.2**

'Do something' solutions

The £305.5m 'Do Nothing' deficit can be tackled by the following measures

1. Organisational savings (including corporate overheads, pathology, productivity)
2. Major, system wide transformational changes.
3. Receipt of Sustainability Funding

Organisational Savings

The summary below in table 2 shows, by organisation the identified savings for the period 2020/21. To date BNSSG STP has identified £138.9m savings to the period 2020/21.

It needs to be noted that these savings are subject to organisational risk assessment using the normal processes both in terms of delivery and the impact on clinical services. Consideration still needs to be given to the impact on workforce, activity and any capital investment requirements to deliver. The BNSSG footprint has not progressed this required level of detail yet.

It is recognised that the delivery of these organisational savings are, in part, facilitated by the major system wide transformational changes, which will themselves cause us to alter our model of commissioning care delivery.

Regarding methods of payment to be adopted, these will be developed in line with the new commissioning approach as described in paragraph 4.5

Table 2: Organisational Identified Savings for the Period 2020/21

Organisatonal Savings	UH Bristol	NBT	Weston	AWP	SWAST	NHS Bristol CCG	NHS North Somerset CCG	NHS South Glos CCG	Total
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Continuing Care	-	-	-	-	-	3.0	-	4.4	**7.4**
Corporate / Commercial Opportunities	10.3	11.0	0.6	1.1	1.6	-	-	-	**24.6**
Corporate Overheads	1.7	-	0.6	0.8	-	1.0	0.5	1.0	**5.6**
Facilities and Estates	4.0	0.7	0.7	0.4	-	-	-	-	**5.8**
GP Prescribing	-	-	-	-	-	4.0	3.2	4.4	**11.6**
Medicines Savings	5.9	-	0.4	-	-	-	-	-	**6.3**
Operational Productivity	1.8	35.3	2.5	1.2	-	-	-	-	**40.7**
Other Pay (Not Included in Productivity)	-	8.2	3.2	0.5	-	-	-	-	**11.8**
Pathology	-	-	-	-	-	-	-	-	**-**
Reducing and Conrolling Non Pay	12.5	9.7	1.8	0.7	-	-	-	-	**24.7**
Technology	-	0.1	0.3	-	-	-	-	-	**0.4**
Grand Total	**36.1**	**65.0**	**10.1**	**4.6**	**1.6**	**8.0**	**3.7**	**9.8**	**138.9**

Major System Wide Transformation Changes

The system wide workstreams (PEISC, IPCC and ACC) have been tasked with identification, design and development of cross organisational transformation opportunities. These workstreams are led by a Senior Responsible Officer and supported by their respective Director of Finance. The projects within these workstreams are at various stages of development, but are not yet at the level of maturity required that we can include any numbers to the detail and confidence expected to date. We are working to ensure that where the impacts of system wide changes occur in 2017/18, the required modelling and assumptions are developed sufficiently for inclusion within the Operational Planning submissions in December. These system wide changes will be further developed thereafter as the route to addressing the £104m in savings over the whole period.

There is an indicative capital requirement of circa £60m, which is over and above any business as usual requirement. The requirement for capital funding will be further developed in light of the STP transformational goals, aligned with any NHSE Estates and Technology Fund (ETTF) submission.

Sustainability Funding

Sustainability funding of £61m has been notified by NHS England and included in the STP financial position accordingly.

For further financial information please see the separate financial templates, which have been sent separately to NHSI and NHSE

8. Key risks

Our STP represents an ambitious and challenging transformation programme. In this context the risks associated with the programme are significant and will need careful management by the programme leaders. Set out below in the table below are the key risks identified to date and the initial mitigation plans that we are developing in order to manage these risks.

Description of risk	Proba-bility	Impact	Risk Score (P x I)	Decision made or mitigating action to be taken	Mitigated Risk Score and RAG rating
Benefits The system is unclear about the impact of the proposed changes as the programmes and projects move into start up or design phase, leading to difficulties aligning with required enabling workstreams of finance, estates, workforce and/or digital	5	4	20	Put in place appropriate governance and dedicated resources ensure programmes and projects are progressed quickly with dedicated finance resource are able to assess their impact	8
Leadership Organisational alignment is insufficient to deliver the system transformation at pace	4	5	20	Undertake a review of the governance and decision making alignment to be undertaken, which includes a formalised assurance process	8
Communications and Engagement Failing to bring public, communities, patients and staff with us in developing and delivering system transformation, resulting in resistance to change implementation	4	4	16	Implement communication and engagement plan and continually review and develop in response to stakeholder feedback	10
Capacity Insufficient resources are dedicated to programme and project delivery, resulting in projects not being able to deliver at the pace required	5	3	15	STP Programme Director to scope out resourcing requirements with support from programme and project leads across the organisations and agree a resourcing approach with SLG	10
Capability Staff involved in transformational change have not got the skills or knowledge to deliver or support the required transformation changes at scale	5	3	15	Workforce SRO to develop a system-wide approach to system transformation and start to implement	10

9. Conclusion - Our Way Forward

The STP approach has created a new culture and environment within which our organisations have started to operate. We recognise the three gaps cannot be achieved by working within our organisational boundaries and we need this new collaborative way of working to deliver system wide improvements.

This submission reflects the progress we are making and recognises the challenges that lie ahead. In our submission we have:

- reaffirmed the model of care we are developing;
- demonstrated how the programmes and projects we are undertaking will contribute to the delivery of the model of care;
- provided greater detail on the projects we are undertaking, the outcomes they are seeking to achieve and their relationship to the overall model of care;
- begun to illustrate the impact these projects will have on the experience and outcomes for our population, the quality and accessibility of our services, the roles and opportunities for our staff and the financial sustainability of our care system;
- described the way we will enable change through the transformation of our service delivery, workforce, our deployment of technology and the optimal use of our estate; and
- articulated how we will use the operational planning and contracting processes to embed the STP approach and incentivise the delivery of the model of care.

Our STP builds on a successful track record of delivering major change, including the centralisation in Bristol of ENT surgery, OMF surgery, Breast and Urology Services, specialist paediatrics and cellular pathology, of using digital technology to support shared care across BNSSG through the Connecting Care Programme, as well as the redesigned estate at the Bristol Royal Infirmary campus, South Bristol Community and Southmead hospitals. The learning from these has reaffirmed that clinical leadership is a key success criterion and we will ensure our continuing transformational change is clinically led, focused on people and not organisational boundaries.

Our next steps are to ensure our organisations are fully aligned to support our priority programmes and projects. Our enhanced governance arrangements will ensure we are able to manage and track progress and provide focussed support, as required. We will ensure our early priority projects start to deliver benefit and build confidence in our ability to deliver system wide change.

We do not underestimate the scale of the challenge but across the STP footprint we are strongly committed to delivering the transformation needed for the people of Bristol, North Somerset and South Gloucestershire.

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11:00-1:00pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	13
Meeting Title	Public Trust Board	**Meeting Date**	**29 November 2016**
Report Title	Finance Report		
Author	Paul Mapson, Director of Finance & Information		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff. c.	☐	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.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

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 £9.086m (before technical items) for the first seven months of the year. This includes £7.014m of sustainability funding – the position represents a surplus of £2.072m without this funding. The NHS Improvement plan requires a surplus of £9.488m at month seven, therefore the Trust is £0.402m adverse against this plan.

Recommendations
Members are asked to: • **Note**

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☒	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
	25 November 2016			

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £9.086m (before technical items) for the first seven months of the year. This includes £7.014m of sustainability funding – the position represents a surplus of £2.072m without this funding. The NHS Improvement plan requires a surplus of £9.488m at month seven, therefore the Trust is £0.402m adverse against this plan.

It is important to understand the position regarding receipt of sustainability and transformation funding (S&T).

- Core S&T funding – this represents 70% of the total of £13m.
- Performance S&T funding represents 30% and is dependent on delivery of cumulative performance trajectories for RTT, Cancer and A&E targets.

To date, the pre-performance financial plan has been achieved hence the 70% of S&T funding is included in the Trust's income position.

However as performance trajectories are not being achieved the level of loss of S&T funding has grown to £0.568m in month 7, hence the adverse variance of £0.4m shown in this report. This issue now represents the biggest risk to the non-delivery of the Trust's Control Total of £15.9m surplus as the position is likely to deteriorate.

The overspend in Clinical Divisions and Corporate Services for October decreased this month. The adverse variance was £0.530m compared with £1.706m in September and £1.508m in August. The year to date overspend is now £7.257m compared with the operating plan trajectory to date of £1.805m.

The Corporate share of the income under-performance adds £0.011m to the adverse movement in October, £0.229m in September and £0.378m in August.

The subjective analysis is shown below:

(Adverse)/Favourable	Oct £m	Sept £m	Aug £m	Quarter 2 £m	Quarter 1 £m	2016/17 to date £m
Nursing & midwifery pay	(0.612)	(0.450)	(0.350)	(0.963)	(1.154)	(2.730)
Medical & dental staff pay	(0.073)	(0.203)	(0.235)	(0.453)	(0.419)	(0.945)
Other pay	0.280	0.211	0.144	0.506	0.630	1.419
Non-pay	(0.592)	(0.498)	(0.190)	(0.938)	(0.926)	(2.460)
Income	0.467	(0.766)	(0.877)	(2.179)	(0.832)	(2.541)
Totals	**(0.530)**	**(1.706)**	**(1.508)**	**(4.027)**	**(2.701)**	**(7.257)**

The improved position for October reflects an improvement in income and within medical and dental staff pay. Of particular concern is the continuing acceleration in both nursing and non-pay overspending. In particular 7/12th of additional CQUIN income of £0.350m for the year was issued to Divisions. The nursing overspend now represents a considerable deterioration compared to the 2015/16 position which was a £2.8m overspend for the year (after £1.4m of 1:1 costs were funded). The 2016/17 month 7 year to date already reports a £2.7m overspend.

The cumulative income under-performance on activity based SLA lines is £2.7m, of which £2.0m relates to elective activity (mainly out-patients). Whilst this is an improvement of £0.2m from last month, the Trust has not achieved its Referral to Treatment (RTT) performance in month and is predicted to fail this target in the rest of quarter three.

The delivery of the control total of a £15.9m surplus remains a high risk not only due to the consequential loss of S&T funding through failure to meet activity targets but also the concerning run rate overspend. The level of adverse variance against the Divisional Operating plans being £7.3m versus the planned £1.8m to Month 7.

2. Main Financial Drivers

The five significant financial drivers key to controlling the Trust's financial position to achieve the 2016/17 financial plan are:

a) Sustainability funding;
b) Nursing and midwifery pay;
c) Medical and dental pay;
d) Clinical activity; and
e) Savings programme.

These are described in the following sections.

a) Sustainability Funding

The Trust's financial position to date includes £7.014m of sustainability funding, £0.568m behind the plan to date of £7.582m. Earning sustainability funding in quarter 1 only required the agreement of the access standards trajectories with NHS Improvement / NHS England.

For October, the Trust assessed its delivery of the net surplus Control Total excluding STF. The year to date net surplus of £2.072m exceeded the Control Total net surplus requirement of £1.903m. Therefore, delivery of the net surplus Control Total in October earned STF of £0.758m and triggers the Trust's eligibility for the remaining 30% of the STF available based on the Trust's performance against the access trajectories.

To date, the Trust delivered the A&E access trajectory to month 7 worth £0.542m. The Trust's delivery of the RTT access trajectory for August and September is subject to appeal. The Trust now believes it is unlikely that the appeal will secure the RTT element. The Trust did not deliver the Cancer access standard in October. Again, the Trust now believes it is unlikely that the appeal will secure the available funds therefore showing achievement in August only. The position is summarised in the table overleaf. Further detail is provided in Appendix 9.

Trajectory to date	Q1	July	August	September	October	Total YTD
Control Total delivery	Achieved	Achieved	Achieved	Achieved	Achieved	
STF earned	£3.250m	£0.758m	£0.758m	£0.758m	£0.758m	£6.282m
A&E trajectory delivery	Agreed	Achieved	Achieved	Achieved	Achieved	
STF earned	*£0.405m*	£0.135m	£0.136m	£0.135m	£0.136m	£0.542m
Cancer trajectory delivery	Agreed	Failed**	Achieved	Failed**	Failed	
STF earned	*£0.163m*	£0.000m	£0.054m	£0.000m	£0.000m	£0.054m
RTT National target delivery	Agreed	Achieved	Failed**	Failed**	Failed	
STF earned	*£0.405m*	£0.136m	£0.000m	£0.000m	£0.000m	£0.136m
Total	£3.250m	£1.029m	£0.948m	£0.893m	£0.894m	£7.014m

** subject to appeal
Italics represents notional values

b) Nursing & Midwifery

The nursing and midwifery pay variance for the month is £0.612m adverse. The table below shows the analysis between substantive, bank and agency for the last three months, previous quarters and year to date. The 2015/16 position is shown for comparison.

	October £m	Sept £m	August £m	Quarter 2 £m	Quarter 1 £m	2016/17 to date £m	2015/16 Outturn exc. 1:1 funding £m
Substantive	0.615	0.786	0.725	2.466	1.264	5.310	10.099
Bank	(0.511)	(0.488)	(0.591)	(1.599)	(1.438)	(3.549)	(5.684)
Agency	(0.716)	(0.748)	(0.484)	(1.830)	(1.945)	(4.491)	(7.268)
Total	**(0.612)**	**(0.450)**	**(0.350)**	**(0.963)**	**(1.155)**	**(2.730)**	**(2.853)**
Restated for agency			(0.277)	(0.387)	-	(0.387)	
Reversal of 15/16 accrual				0.387		0.387	
Total	**(0.612)**	**(0.450)**	**(0.627)**	**(0.963)**	**(1.155)**	**(2.730)**	**(2.853)**

The adverse variance on nursing continues to be driven by high bank and agency usage, offset by a favourable variance on substantive posts due to vacancies.
The adverse variance of £0.612m in October shows a significant deterioration compared to September. The favourable variance on substantive staff reduced reflecting increased recruitment in a number of areas. The number of substantive whole time equivalent (wte) in post increased by 42. The Women's and Children's Division saw the greatest increase of 27wte, Specialised Services increased by 7wte and there were smaller increases across the rest of the Trust. Whilst some of these were newly funded posts, the majority were filling previous vacancies.

Temporary staffing costs remained high and did not reflect expected reductions due to the additional capacity provided by substantive staff.

The following table shows the Nursing and ODP price and volume variance for October. Overall, it shows that Nursing and ODPs were £0.649m adverse with £0.399m due to volume above the funded establishment (wte) and £0.250m due to adverse variance on

price. The table also shows that the wards in the Clinical Divisions are responsible for the overspend.

Table: Nursing & ODP Variance –

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	14	(97)	(83)	
	Other	(60)	(76)	(135)	
	ED	(12)	(29)	(40)	
Medicine Total		**(57)**	**(202)**	**(259)**	**130%**
Surgery, Head & Neck	Ward	35	(101)	(66)	
	Theatres	(75)	23	(51)	
	Other	(46)	45	(1)	
	ED	1	(1)	(0)	
Surgery, Head & Neck Total		**(84)**	**(35)**	**(119)**	**128%**
Specialised Services	Ward	(55)	(58)	(114)	
	Other	(7)	9	3	
Specialised Services Total		**(62)**	**(49)**	**(111)**	**134%**
Women's & Children's Services	Ward	(59)	(61)	(119)	
	Theatres	(37)	27	(10)	
	Other	63	(40)	23	
	ED	(2)	(22)	(24)	
Women's & Children's Services Total		**(36)**	**(96)**	**(132)**	**128%**
Clinical Division Total	Ward	(63)	(320)	(383)	
	Theatres	(111)	49	(62)	
	Other	(57)	(54)	(111)	
	ED	(13)	(52)	(65)	
CLINICAL DIVISIONS TOTAL		**(243)**	**(377)**	**(620)**	**130%**
NON CLINICAL DIVISIONS	Other	(6)	(22)	(29)	
NON CLINICAL DIVISIONS TOTAL		**(6)**	**(22)**	**(29)**	
TRUST TOTAL		**(250)**	**(399)**	**(649)**	**130%**

The HR Nursing Controls dashboard is attached at appendix 3 and shows the registered nursing position for each Division against eight Key Performance Indicators (KPIs). Highlights from the KPIs are as follows:

- Sickness – Medicine, 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. The Division of Medicine has the highest at 6.1% , although Medicine and Surgery, Head and Neck both reduced their percentage of vacancies in October.
- Operating Plan for nursing agency wte – all but the Women's and Children's Division are above their Operating Plan position with the Division of Surgery, Head

and Neck being the most concerning with an actual position of 26.0wte against a target of 2.0wte. This higher than planned agency run rate is also reflected in Divisions' percentage of nursing agency against total nursing spend, with all Divisions being above plan.

- Nursing assistant, 1:1 and RMN usage - The Divisions of Medicine, Women's and Children's, and Specialised Services were above the funded level for NA 1:1's and RMN's in October.

c) Medical and Dental

The medical and dental pay variance for the month is £0.073m adverse which is a significant improvement on the September position of £0.203m adverse. The table below shows the analysis between substantive, locum and agency staff types for the last three months, previous quarters and year to date. The 2015/16 position is shown for comparison.

	October £m	Sept £m	August £m	Quarter 2 £m	Quarter 1 £m	2016/17 to date £m	2015/16 Outturn £m
Substantive	0.057	(0.038)	(0.002)	0.215	0.645	0.917	2.387
Locum	(0.146)	(0.131)	(0.197)	(0.469)	(0.630)	(1.244)	(1.803)
Agency	0.016	(0.034)	(0.036)	(0.199)	(0.434)	(0.618)	(2.389)
Totals	**(0.073)**	**(0.203)**	**(0.235)**	**(0.453)**	**(0.419)**	**(0.945)**	**(1.805)**

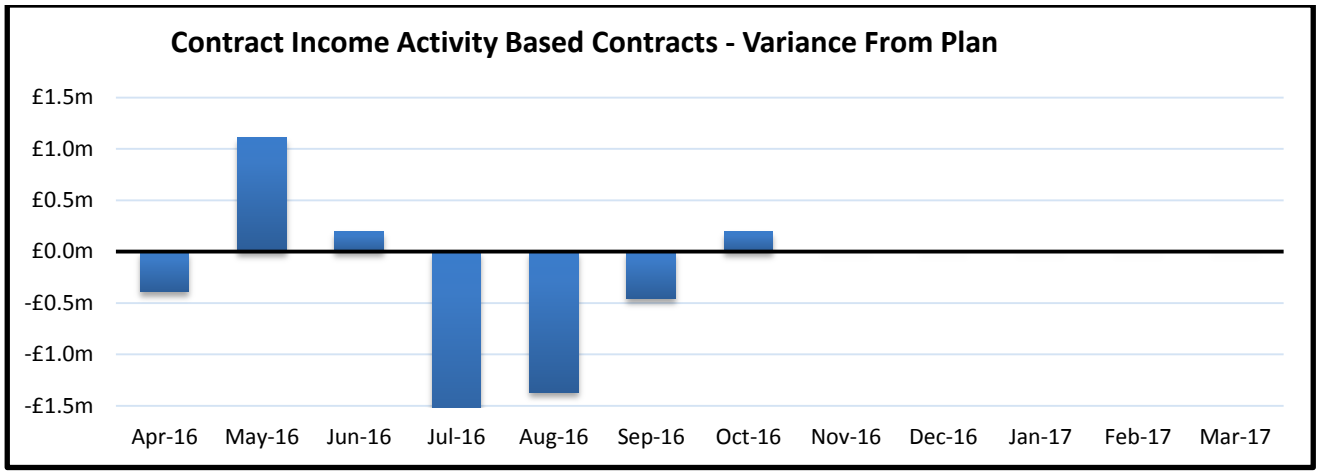
The favourable variance for substantive staff in October reflects a reduction in wte as well as a reduction in the number of additional sessions paid, in particular in Specialised Division (£0.069m reduction in additional payments compared to previous month).

The variance on agency expenditure improved by £0.050m in the month. Whilst there was a reduction in usage within Specialised Services the improvement was also due to a reassessment of aged accruals.

d) Clinical Activity

Activity based contract performance increased by £0.186m in October to give a cumulative under performance of £2.678m. The position improved for Surgery, Head and Neck (£0.126m) and Medicine (£0.153m) but worsened for Specialised Services (£0.071m) and Women's and Children's (£0.079m). Performance at Clinical Divisional level is shown at appendix 5a.

The graph below shows the monthly performance for all activity based contracts.



The table below summarises the overall clinical income by work type, which is described in more detail under agenda item 2.2.

	In Month Variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based				
Accident & Emergency	0.05	9.13	9.41	0.28
Bone Marrow Transplants	(0.37)	4.85	4.40	(0.45)
Critical Care Bed days	0.05	25.65	25.59	(0.06)
Day Cases	(0.06)	22.89	22.56	(0.33)
Elective Inpatients	0.18	29.95	29.65	(0.30)
Emergency Inpatients	0.51	45.42	47.02	1.60
Excess Bed days	0.12	4.07	3.93	(0.14)
Non – Elective Inpatients	(0.33)	16.01	14.13	(1.88)
Other	(0.04)	47.28	47.23	(0.05)
Outpatients	0.08	48.53	47.18	(1.35)
Sub Totals	**0.19**	**253.78**	**251.10**	**(2.68)**
Contract Penalties	0.03	(0.56)	(0.60)	(0.04)
Contract Rewards	0.35	4.74	5.09	0.35
Pass through payments	0.04	50.76	48.70	(2.06)
Sustainability and Transformation Funding	(0.41)	7.58	7.01	(0.57)
2016/17 Totals	**0.20**	**316.30**	**311.30**	**(5.00)**
Prior year income	0.33	-	2.35	2.35
Overall Totals	**0.53**	**316.30**	**313.65**	**(2.65)**

Emergency inpatients and non-elective inpatients improved in total by £0.18m in the month but are £0.28m lower than plan to date. Elective inpatients and day cases together improved by £0.12m, predominantly within upper gastrointestinal surgery, however both are £0.63m lower than plan to date. Bone marrow transplant activity was below plan in both adults and paediatrics and is now £0.45m below plan cumulatively. Outpatient activity improved for the first time since May.

CQUIN reporting began in month 6 and the year to date assessment shows an overachievement against plan of £0.35m. The planning assumption was to achieve 75% however assessment of delivery is at 81.7% for year end.

Performance against penalties was £0.03m above plan this month, reducing the cumulative performance to £0.04m below plan.

Pass through payments were £0.04m higher than plan in October, reducing the adverse cumulative position to £2.06m. The year to date adverse variance relates to excluded drugs (£1.48m), excluded devices (£0.48m) and blood products (£0.21m).

e) Savings Programme

The savings requirement for 2016/17 is £17.420m. Savings of £7.446m have been realised to date, a shortfall of £2.757m against divisional plan. The shortfall is a combination of unidentified schemes of £1.852m and a further £0.905m for scheme slippage. The 1/12th phasing adjustment reduces the shortfall to date by £0.042m.

The year-end forecast outturn has reduced significantly this month by £0.289m of which £0.260m related to nursing savings within Medicine.The revised outturn is now £13.590m, a shortfall of £3.830m against plan, which represents delivery of 78%.

A summary of progress against the Savings Programme for 2016/17 is summarised below. A more detailed report is given under item 2.4 on this month's agenda.

	Savings Programme to 31st October 2016				
	Plan £m	Actual £m	Variance fav / (adv) £m	Phasing adjustment fav/(adv) £m	Total variance Fav/(adv) £m
Diagnostics & Therapies	0.908	0.976	0.068	(0.050)	0.018
Medicine	0.971	0.736	(0.235)	(0.011)	(0.246)
Specialised Services	0.862	0.657	(0.205)	(0.019)	(0.224)
Surgery, Head and Neck	2.833	1.544	(1.289)	(0.058)	(1.347)
Women's and Children's	2.795	1.571	(1.224)	0.090	(1.134)
Estates and Facilities	0.414	0.448	0.034	(0.044)	(0.010)
Trust Services	0.552	0.512	(0.040)	0.134	0.094
Corporate Services	0.868	1.002	0.134	-	0.134
Totals	**10.203**	**7.446**	**(2.757)**	**0.042**	**(2.715)**

The performance for the year by category is also shown below.

	Year to Date			Variance Against Adjusted Plan £m	Forecast Outturn		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Pay	1.486	1.234	(0.252)	(0.280)	2.597	2.297	(0.300)
Drugs	0.693	0.725	0.032	0.116	1.044	1.161	0.117
Clinical Supplies	1.798	1.940	0.142	0.148	3.073	3.474	0.401
Non Clinical Supplies	2.442	2.089	(0.353)	(0.385)	4.241	3.781	(0.460)
Other Non Pay	0.033	0.033	-	-	0.057	0.057	-
Income	1.497	1.022	(0.475)	(0.462)	2.543	2.130	(0.413)
Capital Charges	0.403	0.403	-	-	0.690	0.690	-
Unidentified	1.851	-	(1.851)	(1.852)	3.175	-	(3.175)
Totals	**10.203**	**7.446**	**(2.757)**	**(2.715)**	**17.420**	**13.590**	**(3.830)**

3. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £0.530m in October to a cumulative position of £7.257m adverse to plan. The table overleaf summarises the financial performance in October for each of the Trust's management divisions against their budget and against their October Operating Plan trajectory. Further analysis of the variances against budget by pay, non-pay and income categories is provided in Appendix 2.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)	
	To 30 Sept £m	October £m	To 31 Oct £m	Trajectory To Oct £m	Variance £m
Diagnostic & Therapies	0.083	0.192	0.275	(0.050)	0.325
Medicine	(2.031)	(0.277)	(2.308)	(0.439)	(1.869)
Specialised Services	(0.699)	(0.174)	(0.873)	(0.129)	(0.744)
Surgery, Head & Neck	(2.234)	(0.214)	(2.448)	(0.646)	(1.802)
Women's & Children's	(1.991)	(0.098)	(2.089)	(0.513)	(1.576)
Estates & Facilities	(0.043)	0.029	(0.014)	(0.045)	0.031
Trust Services	0.001	0.013	0.014	0.017	(0.003)
Other corporate services	0.187	(0.001)	0.186	0.000	0.186
Totals	**(6.727)**	**(0.530)**	**(7.257)**	**(1.805)**	**(5.452)**

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 30 Sept £m	October £m	To 31 Sept £m
Pay	(1.700)	(0.276)	(1.976)
Non Pay	(0.133)	(0.354)	(0.487)
Operating Income	(0.316)	(0.021)	(0.337)
Income from Activities	(2.309)	0.567	(1.742)
Sub Total	(4.458)	(0.084)	(4.542)
Savings programme	(2.269)	(0.446)	(2.715)
Totals	**(6.727)**	**(0.530)**	**(7.257)**

Pay budgets have an adverse variance in month of £0.276m increasing the cumulative adverse variance to £1.976m. The significant adverse movements in the month were within Medicine (£0.141m), Specialised Services (£0.067m) and Women's and Children's (£0.180m), offset by a favourable variance in Diagnostic and Therapies (£0.110m). Cumulative adverse variances are within Women's and Children's (£1.588m), Surgery, Head and Neck (£0.246m), Medicine (£0.959m), and Specialised Services (£0.537m) offset by favourable variances in Diagnostic & Therapies (£0.850m) and Trust Services (£0.380m).

For the Trust as a whole, agency spend is £7.167m to date. The monthly average spend has reduced to £1.024m. Agency spend to date is £1.970m in Medicine, £1.453m in Women's and Children's, £1.660m in Surgery, Head and Neck and £1.319m in Specialised Services. Waiting List Initiatives (WLIs) costs to date are £1.606m of which £0.600m is within Surgery, Head and Neck, £0.315m in Women's and Children's, £0.314m in Diagnostic and Therapies and £0.264m in Specialised Services.

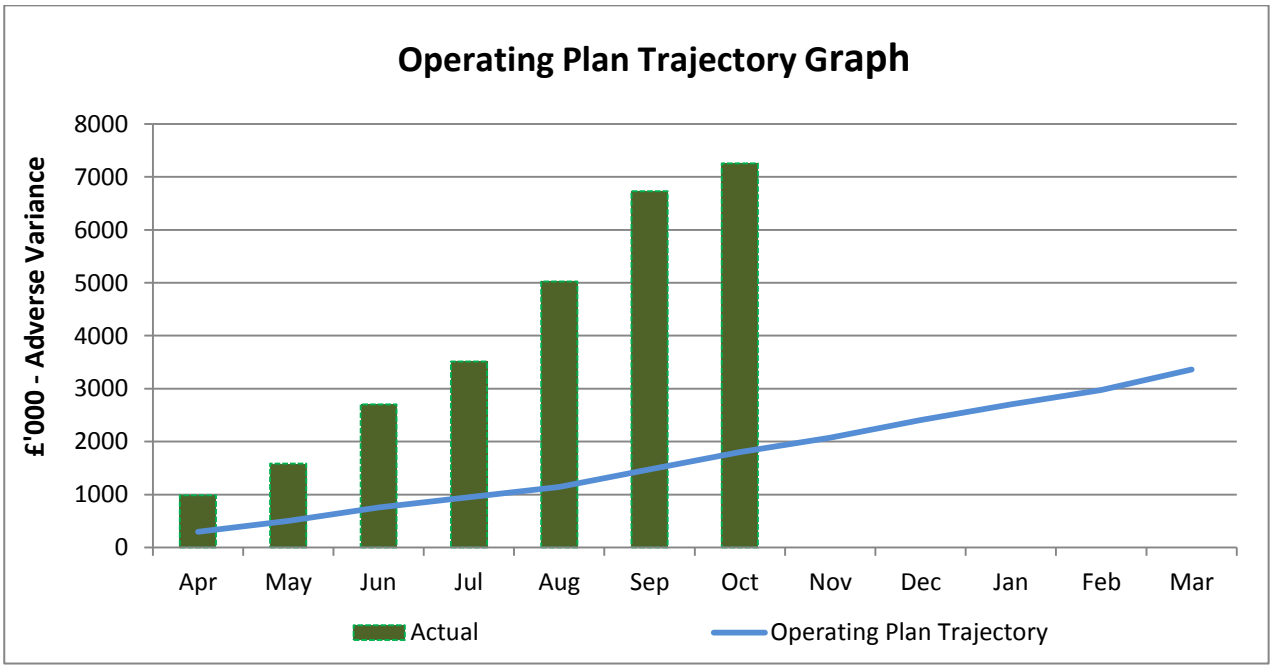
N**on-pay budgets** have an adverse variance of £0.354m in the month increasing the cumulative variance to £0.487m adverse. The movement in the month was within Medicine (£0.165m), Surgery Head and Neck (£0.235m), Diagnostic and therapies (£0.088m) and Specialised Services (£0.075m) offset by Women's and Children's which improved by

£0.210m. Cumulative adverse variances are within Diagnostic & Therapies (£0.619m), Surgery, Head and Neck (£0.668m), Medicine (£0.356m) and Specialised Services (£0.244m) offset by a favourable variance in Women's and Children's of £1.465m.

Operating Income budgets have an adverse variance in the month of £0.021m increasing the cumulative adverse variance to £0.337m. Both the movement in month and cumulative variance is primarily outside of the Clinical Divisions and is offset by non pay.

Income from Activities budgets have a favourable variance in month of £0.567m reducing the cumulative adverse variance to £1.742m.The improvement in month was across all clinical divisions with the most significant favourable variances in Medicine (£0.165m) Surgery, Head and Neck (£0.228m) and Diagnostic and Therapies (£0.117m).The principal areas of under achievement to date are within Medicine (£0.773m), Women's and Children's (£0.874m) and Surgery, Head and Neck (£0.197m).

Variance to Operating Plan:
Clinical Divisions and Corporate Services have an adverse variance of £7.257m against a combined Operating Plan trajectory of £1.805m. The October position is £5.452m above trajectory as shown in the graph below.



Further detail is given under agenda item 2.3 in the Finance Committee papers.

4. 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. The divisional reports at item 2.3 provide further detail

Five Divisions are rated Red for their performance to date

4.1 Division of Medicine

The Division reports an adverse variance to month seven of £2.308m; the Division is £1.869m adverse to its Operating Plan trajectory to date. The Division is reporting a

savings programme year to date adverse variance of £0.246m and a savings programme forecast outturn of breakeven.

The key reasons for the variance are:

Adverse variances

- An adverse pay variance of £0.959m which represents an in month deterioration of £0.141m. Nursing budgets were adverse by £0.762m; nursing expenditure increased in October, the use of RMN's decreased but 1:1 agency usage increased.
- An adverse variance on non-pay of £0.356m, with an adverse variance in month of £0.165m primarily as a consequence of recognising the net cost of the ORLA initiative £0.180m.
- An adverse variance on Service Level Agreement (SLA) income of £0.773m which represents an improvement in month of £0.165m, the main reason for the year to date adverse variance being lower than planned emergency activity £0.377m and the impact of Cystic Fibrosis.

Favourable variances

- A favourable variance on income from operations of £0.027m.

Actions being taken and mitigation to restore performance include:

Ongoing actions/Priorities

- All patients, following a decision to admit (DTA) in The Emergency Department, to be referred on ICE to ORLA for consideration.
- 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.
- The ownership, accountability and responsibility for community bed placements is passed to commissioners with immediate effect.
- Increasing and retaining elective activity volumes and delivering at a margin through the cessation of outsourcing arrangements and better use of existing resources.
- 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 'night clubs' aimed at reducing the number of 1:1 shifts required. The ability to control and manage this action is severely constrained by the lack of mobilisation in the community and the lack of community beds.

Proposed actions /Opportunities

- Specialties have been identified that are able to over-perform against contract, in respect of elective and outpatient activity. These opportunities have been identified with consideration given to the requirement for waiting list initiatives. The planned over-performance will not only assist the Division in its overall recovery of outpatient performance but can also assist in the achievement of Trust wide RTT targets, facilitating, in turn, an ability to earn the STF.
- Development of Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs) within the ED.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- The full management of the ORLA programme – It is difficult to project from where a material operational benefit will arise, when referral sources are varied. It is

important that the Division is fully educated and informed with respect to the financial and operational issues associated with the programme – at individual ward level, the full scale of issues and consequences will not always be clear;
- Continuing high referral rates from Callington Road – these patients are expensive and resource intensive and often cannot be transferred back to Callington Road, following the provision of General Medical care;
- The belief by commissioners that the ORLA programme becomes a baseline initative, delivered by the Trust without the input and support from other community initiatives. The associated cost, both of ORLA itself and the continued high demand for and use of 1:1 nurses, will severely impact the ability to financially recover;
- The continuing occurrence and associated costs of the Emergency Department queue.

4.2 Division of Surgery, Head and Neck

The Division reports an adverse variance to month seven of £2.448m; The Division is £1.802m adverse to its Operating Plan trajectory to date. The key reasons for the variance are:

Adverse variances
- An underachievement of savings resulting in an adverse variance to date of £1.347m. The majority relates to unidentified plans £0.875m, the rest relates to schemes having been removed with regards to outsourcing savings and other slippage on schemes.
- An adverse variance on pay of £0.246m primarily due to high nursing agency and bank usage as well as high levels of waiting list expenditure within Medical Staff.
- An adverse variance on non-pay of £0.668m has been caused by spend on outsourcing work and overspends on clinical supplies offset by underspends relating to support funding.
- An adverse variance on income from activities of £0.197m, the most significant adverse year to date variances are within Ophthalmology due mainly to a low number of follow up outpatients £0.130m driven by vacancies in key posts. Oral/Dental services £0.649m and Colorectal services £0.235m. These being offset by a significant favourable variances within Upper GI services £0.345m, ENT services £0.115m and Private/Overseas Patients £0.196m.

Favourable variances
- A favourable variance on income from operations of £0.010m due to higher than planned research and development income.

Key risks to delivery of the Operating Plan and ongoing improvement include:
- There remains risk around delivery of SLA income which has the potential to be substantial; there is an increased reliance on outsourcing) and recovery is dependent on swift and successful recruitment particularly around oral and dental services.
- The division is continuing to develop plans to recover and deliver SLA income and the key performance targets required. These plans come at a cost. The team is clear that the financial implications of these plans require close management control.
- Lost activity due to bed pressures and lack of anaesthetic cover remains a risk to divisional performance although recruitment has now succeeded in the anaesthetic workforce. The Division is also sighted on the risk of increasing medical outliers placing pressure on the ability to deliver increased elective work over the winter period.
- 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 albeit there has now been a successful round of recruitment to this team.
- The division has been notified that there will be reductions in training numbers into Intensive Care in the autumn which will produce further cost pressures.
- Capacity in the procurement team is causing delays in certain procurement projects that could benefit the savings programme.

Actions being taken and mitigation to restore performance include:

Ongoing Actions /Priorities

- The Division is running a formal process of re-engaging with the service teams, the clinical, management and nursing staff. This engagement is required to identify further actions that can be taken to move the results back towards planned outturn and outcomes for 2016/2017 and will also be valuable in planning for 2017/2018. Good output from this process has been seen in Ophthalmology, Endoscopy, Dental Services, and this will all be incorporated into the operating plans for 2017/2018.
- Nurse performance meetings are being extended to encompass all nursing teams, with the “hotspots” being reviewed monthly and other departments rotating through.
- Key review under way re Adult ITU Staffing to inform the Operating plan and the ITU/CICU project. Meeting scheduled with IM&T, Divisional and Departmental Representatives to review data.
- A non-pay approval process to manage change through Divisional Board is being developed through the non-pay group.
- The Division is keen to continue engaging with the Service Productivity Reviews and to roll these out across the Division and anticipates that the new CIP programme will derive from this work.
- Review of delivery plans to mitigate the requirement for outsourcing and waiting lists in ENT and Endoscopy.
- Review of improved dental delivery in month seven to inform the operational planning for the next two financial years.

Proposed Actions/Opportunities

- The Division is continuing to target improvements in Dental and Oral services, month seven performances has validated this approach. The new General Manager is supporting this work and interviews are in place for a substantive performance and operations manager. The Admin Review project is under way and is actively recruiting to vacancies. This post will also progress ongoing recruitment required to deliver activity.
- Work is ongoing re preparing to implement a managed inventory system; this will produce process mapping, improved systems and stores ahead of any implementation. Clear reviews of current processes and practices across the theatre suites is identifying opportunities for savings ahead of the information system going live.
- Private patient tariffs are being reviewed to ensure that this is a financial benefit to the organisation.

- The Bluespier implementation in theatres is now live. The theatre performance and operations group is introducing a work stream reviewing and challenging performance at a specialty level led by the Divisional Director. Bluespier data is expected to support this project.
- Savings Programme formation is ongoing and the Division is reviewing the possibilities inherent in the Big Hand and Voice Recognition projects for savings within the Divisional teams.

4.3 The Division of Women's and Children's Services

The Division reports an adverse variance to month seven of £2.089m. The Division is £1.576m adverse to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances:
- An adverse variance on pay of £1.588m.
- Nursing agency premiums continue to be above cap leading to a cost pressure.
- Medical staff reports an adverse variance of £0.644m including costs associated with non-compliant junior rotas and significant agency spend for consultants, there is significant levels of maternity leave and sickness in key junior medical rotas with 11 posts on maternity leave.
- An underperformance on the savings programme resulting in an adverse variance to date of £1.134m. The majority of which relates to the level of unidentified savings in the plan £1.057m.
- An adverse performance on SLA income of £0.874m including year to date adverse variances in Neuro, Cardiac and PICU £0.720m and Paediatrics Surgical £0.516m. These adverse variances being offset to some extent by favourable variances in St Michaels £0.640m.

Favourable variances
- A significant favourable variance on non-pay of £1.465m which includes a share of support funding and capacity growth reserves which offset the underachievement of income and slippage on developments.

Actions being taken and mitigation to restore performance:

Ongoing Actions/Priorities

- Children's Winter Flow programme ensuring that winter pressures are managed without a reduction in elective income.
- Delivery of objectives identified in Outpatient Productivity Project on a Page including improved room allocation (including full utilisation of South Bristol Community Hospital rooms), clinic utilisation, reconciliation to job plans, and reducing DNA and hospital cancellation rates.

Proposed Actions/Opportunities

- £0.846m of Financial Recovery opportunities identified and submitted to Executive Directors for review. If delivered in full would allow £0.241m headroom in financial plan
- Stretch CQUIN delivery from £0.139m per annum to £0.415m delivery if 93% performance achieved.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- Continued shortfalls in Children's Theatres leading to reduced elective capacity – mitigated by speeding up recruitment, improving retention, re-invigorated leadership with new Theatres Matron, use of weekend waiting list initiative capacity to recover lost income.
- Maintaining controls on recruitment and additional session payments to junior doctors during transition to new contract

4.4 Division of Specialised Services

The Division reports an adverse variance to month seven of £0.873m. The Division is £0.744m adverse to the Operating Plan trajectory to date.

The key reasons for the variances are:

Adverse variances:
- Cardiac Surgery activity - the Division reports an adverse variance to date of £0.340m after deterioration this month of £0.113m.
- Medical pay budgets show an adverse variance of £0.100m due to agency and WLI costs.
- Non Pay budgets report an adverse variance of £0.244m mainly within Clinical Supplies but also spread across a number of areas.
- Pay budgets are reporting an adverse variance of £0.537m with nursing reporting an adverse variance of £0.401m.
- A year to date shortfall on the savings programme of £0.224m.

Favourable variances
- Operating income reports a favourable variance of £0.065m.
- Cardiology now reports a favourable SLA variance of £0.274m with an in month improvement of £0.130m.

Actions being taken and mitigation to restore performance:

Ongoing Actions/Priorities
- Significant improvements are required for the delivery of Cardiac Surgery activity. Specifically ensuring the availability of beds to deliver required activity levels.
- Additional Nursing Controls in CICU new controls have been put in place within the unit to ensure that acuity and dependency levels are monitored and reviewed on a daily basis with any additional staffing required being escalated to Head of Nursing.
- Reduction of Agency expenditure in Radiotherapy following a catch up on backlogs due to unplanned machine downtime.

Proposed Actions /Opportunities
- Clinical Genetics activity. Plans are in development to address the current waiting list backlogs in this area. Due to the service line being profitable for this area favourable margins are expected.
- Cardiology consumables tender is due for renewal at the end of November. Savings are expected and required out of this process.
- Recruitment to Medical vacancies in the BHOC are expected to increase activity levels further in future months.

Key risks to delivery of the operating plan and future performance include:

- Winter pressures impact on beds and the delivery of activity in the BHI, most notably Cardiac Surgery. The division and trust will need to ensure the protection of Cardiac Surgery beds so as to enable continued throughput through the winter period.
- Continued reliance on agency staff and inability to recruit to specialist areas. Continued effort and focus on recruitment in both the short and long term is required to address current issues being experienced.
- Non pay controls must be maintained to ensure expenditure is minimised and that new policies with regards to the centralisation of high cost devices are adhered to so as to avoid any income losses.

4.5 Trust Services

The Division reports a favourable variance to month seven of £0.014m. The Division is £0.003m adverse to the Operating Plan trajectory to date.

Two Divisions are rated Green for their performance to date

4.6 Diagnostic and Therapies Division

The Division reports a favourable variance to month seven of £0.275m. The Division is £0.325m 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 £0.619m which includes double running costs associated with LIMS £0.141m, Radiology outsourcing costs £0.332m, and adverse variances on clinical supplies and drugs including £0.159m due to drug wastage.
- An adverse variance on operating income of £0.020m.

Favourable variances

- A favourable variance on pay of £0.850m, primarily the result of vacancies in clinical staff. However the run rate on pay is expected to deteriorate for the rest of the year due to recruitment to vacancies in Radiology.
- Adverse variances on non-pay above are offset by a balance of contract transfer funding.
- An favourable variance on SLA income of £0.046m, there is a favourable variance on services hosted by Diagnostics and Therapies of £0.333m offset by adverse variances associated with services hosted by other divisions of £0.325m.
- The savings programme is £0.018m favourable to month seven.

Actions being taken and mitigation to restore performance:

Ongoing actions/Priorities

- Rolling programme of Service Line Reporting meetings being set up with Heads of Service, Radiology have started, order of other services was determined at Divisional Finance Committee.
- Review of Radiology contract income data post HRG move underway, with support from information analyst.
- Specialty review of Radiology, including Waiting List Initiatiives.

New actions/Opportunities

- Division has submitted the required template on Pathology costs as required by NHS Improvement (NHSI). NHSI have asked further questions which are in the process of being responded to.

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.

4.7 Facilities and Estates Division

The Division reports an adverse variance to month seven of £0.014m. The Division is £0.031m favourable to the Operating Plan trajectory to date.

5. Use of Resources Rating

The Single Oversight Framework (SOF) came into effect on 1st October 2016 and assesses the financial performance of providers using the Use of Resources Rating (URR). The URR for the Trust to date is 1, the highest rating. The table below summarises the position.

		31 October 2016		31 March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.45	14.47	11.96	11.96
Metric Rating	20%	1	1	1	1
Capital Servicing Capacity					
Metric Result – times		2.95	2.87	2.77	2.77
Metric Rating	20%	1	1	1	1
Income & expenditure margin					
Metric Result		2.58%	2.48%	2.53%	2.53%
Metric Rating	20%	1	1	1	1
Variance in I&E margin					
Metric Result		0.00%	0.10%	0.00%	0.00%
Metric Rating	20%	1	2	1	1
Variance from agency ceiling					
Metric Result		0.00%	12.26%	0.00%	0.00%
Metric Rating	20%	1	2	1	1
Overall URR		**1.0**	**1.4**	**1.0**	**1.0**
Overall URR (rounded)		**1**	**1**	**1**	**1**

The agency ceiling set by NHSI of £12.793m is based on data submitted in 2015/16 which included medical locums. Following the change in NHSI definition the Trust has split out the locum costs and whilst NHSI support this approach they have yet to confirm whether this requires an adjustment to the ceiling. The recently communicated target for 2017/18 remains unchanged.

At the end of October the Trust is £1.020m adverse against the NHSI ceiling, a deterioration in the month of £0.097m. The table below summarises this position:

	Current month position (October)			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 Agency	-	0.027	-	-	0.980	-
Medical Locum – Zero Hours		0.085			0.570	
Medical Locum – Fixed Term		0.219			1.611	
Nursing Agency (RNs and NAs)	-	0.748	-	-	5.068	-
Other Agency	-	0.155	-	-	1.120	-
Totals	**1.137**	**1.234**	**(0.097)**	**8.328**	**9.349**	**(1.021)**

6. Capital Programme

A summary of income and expenditure for the seven months ending 31 October 2016 is provided in the table below. The Operational Plan of £35.0m shows a profiled planned spend to date of £16.724m. The internal plan reflects the Trust's re-profiled plan.

Operational Plan £m	Subjective Heading		Period ended 31 October 2016			
		Operational Plan to Date £m	Internal Plan £m	Actual £m	Variance £m	Forecast Out-turn £m
	Sources of Funding					
0.273	PDC	0.273	0.273	0.272	(0.001)	0.273
2.732	Donations	2.270	2.270	2.186	(0.084)	2.732
	Cash:					
22.054	Depreciation	12.558	12.558	12.491	(0.067)	22.054
9.941	Cash balances	4.901	1.623	1.953	0.330	9.883
35.000	**Total Funding**	**21.002**	**16.724**	**16.902**	**0.178**	**34.942**
	Expenditure					
(14.244)	Strategic Schemes	(9.224)	(9.641)	(9.618)	0.023	(11.020)
(11.142)	Medical Equipment	(4.642)	(1.862)	(1.694)	0.169	(10.302)
(4.659)	Information Technology	(2.421)	(2.159)	(1.833)	0.326	(4.186)
(2.815)	Estates Replacement	(1.518)	(1.210)	(1.009)	0.201	(2.756)
(13.191)	Operational Capital	(5.197)	(3.638)	(2.749)	0.889	(8.613)
(46.051)	**Gross Expenditure**	**(23.002)**	**(18.510)**	**(16.902)**	**1.608**	**(36.877)**
2.706	Planned Slippage	2.000	1.786	-	(1.786)	1.935
8.345	I&E Variation from Plan		-	-	-	-
(35.000)	**Net Expenditure**	**(21.002)**	**(16.724)**	**(16.902)**	**0.178**	**(34.942)**

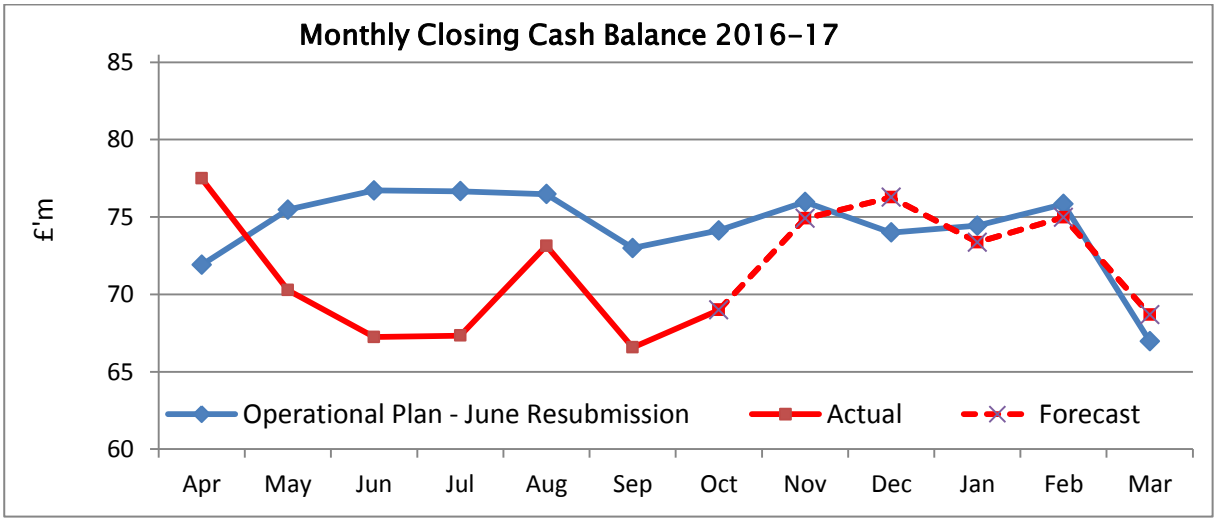
Capital expenditure for the period is £16.902m against an internal plan of £16.724m, a variance of £0.178m. The forecast out-turn remains in line with the Operational Plan. Further information is provided under agenda item 3.1.

7. Statement of Financial Position and Cashflow

Overall, the Trust had a strong statement of financial position as at 31 October 2016 with net current assets of £34.499m, £0.144m higher than last month.

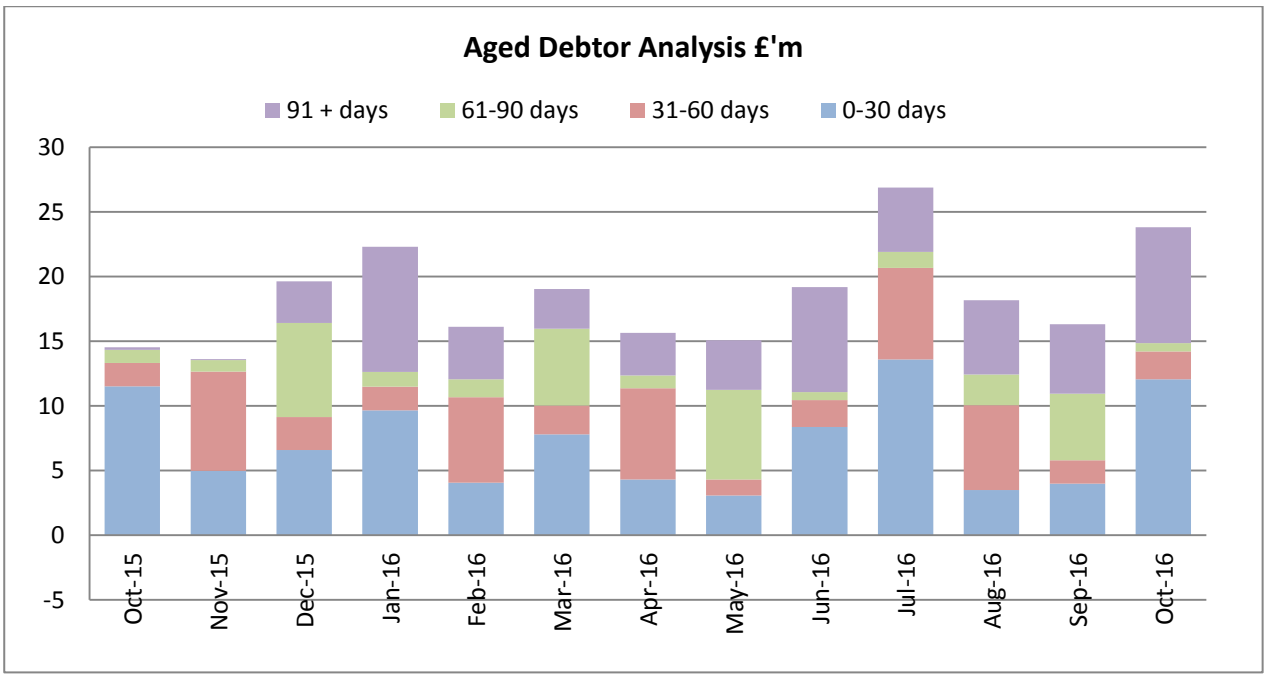
The Trust held cash and cash equivalents of £69.112m at the end of October, £2.433m higher than last month. The cash balance is £5.137m below the plan reflecting continuing payment to date by Commissioners at 2015/16 contract levels and delayed receipt of Sustainability and Transformation Funding.

The forecast year end cash balance is £68.692m reflecting the forecast reduction in capital payments. The graph below shows the month end cash balance trajectory for the financial year.

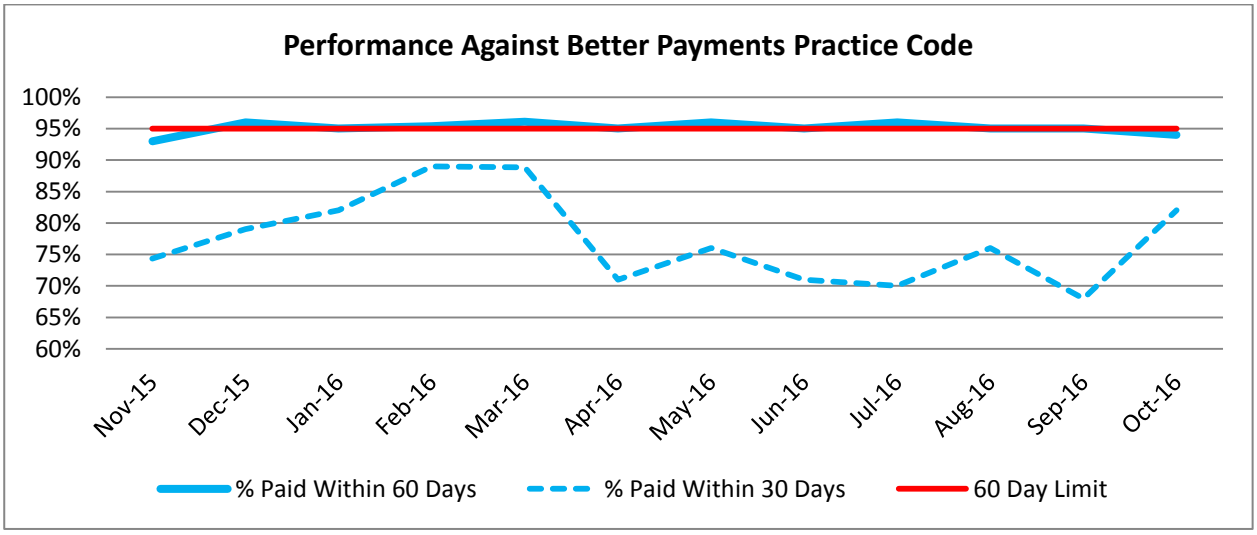


The total value of debtors increased by £7.514m in October to £23.817m. SLA debtors increased by £7.568m and non SLA debtors decreased by £0.054m. The SLA increase relates to the raising of invoices following the quarter two activity reconciliation. The total value of debtors over 60 days old decreased by £0.911m to £9.601m. £0.806m of the decrease related to SLA invoices, and £0.105m to non SLA debtors. The position is summarised in the chart below. Further details are provided in agenda item 4.1.

The chart shows a significant reduction in debtors between 61 to 90 days of £4.527m and a significant increase in debtors over 90 days of £3.616m. This reflects the non-payment by NHS England of £3.769m relating to quarter 1 activity. Originally promised in September it has now been paid in November.



In October the Trust's performance against the 60 day limit dipped slightly below the 95% target reflecting the team focus on resolving old invoices. However the number of invoices paid within 30 days increased to 82%. 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 – Use of Resources 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
Appendix 9 – Sustainability funding and access performance trajectories

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
Finance Report October 2016 – Summary Income & Expenditure Statement

Approved Budget / Plan 2016/17	Heading	Plan	Actual	Variance Fav / (Adv)	Actual to
£'000		£'000	£'000	£'000	£'000
	Income (as per Table I and E 2)				
540,791	From Activities	315,106	314,391	(715)	269,175
90,108	Other Operating Income	52,680	52,182	(498)	44,400
630,899	**Sub totals income**	**367,786**	**366,573**	**(1,213)**	**313,575**
	Expenditure				
(363,544)	Staffing	(212,005)	(214,261)	(2,256)	(183,379)
(210,760)	Supplies and Services	(121,639)	(124,019)	(2,380)	(105,552)
(574,304)	**Sub totals expenditure**	**(333,644)**	**(338,280)**	**(4,636)**	**(288,931)**
(6,544)	Reserves	(4,033)	–	4,033	–
	NHS Improvement Plan Profile	(1,007)		1,007	
50,051	**EBITDA**	**29,102**	**28,293**	**(809)**	**24,644**
7.93	**EBITDA Margin – %**		**7.72**		**7.86**
	Financing				
(22,472)	Depreciation & Amortisation – Owned	(12,801)	(12,492)	309	(10,665)
244	Interest Receivable	142	133	(9)	123
(290)	Interest Payable on Leases	(169)	(171)	(2)	(147)
(3,124)	Interest Payable on Loans	(1,823)	(1,716)	107	(1,470)
(8,509)	PDC Dividend	(4,963)	(4,961)	2	(4,315)
(34,151)	**Sub totals financing**	**(19,614)**	**(19,207)**	**407**	**(16,474)**
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**9,488**	**9,086**	**(402)**	**8,170**
	Technical Items				
–	Profit/(Loss) on Sale of Asset	–	(28)	(28)	(20)
2,732	Donations & Grants (PPE/Intangible Assets)	2,270	2,169	(101)	2,169
(6,436)	Impairments	(1,273)	(1,296)	(23)	(1,296)
385	Reversal of Impairments	–	–	–	–
(1,610)	Depreciation & Amortisation – Donated	(939)	(933)	6	(799)
10,971	**SURPLUS / (DEFICIT) after Technical Items**	**9,546**	**8,998**	**(548)**	**8,224**

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report October 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 30th September	Operating Plan Trajectory Year to Date	Variance from Operating Plan 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											
540,580	Contract Income	316,304	316,304	-	-	(35)	34	-	(1)	-		
	Sustainability and Transformation Funding Variance			-	-	-	(569)	-	(569)	(163)		
-	Fines & Rewards	-		-	-	-	153	-	153	130		
-	Overheads	-	1,408		32	-	1,793	-	1,825	1,501		
36,258	NHSE Income	21,150	21,150	-	-	-	-	-	-	-		
576,838	**Sub Total Corporate Income**	**337,454**	**338,862**	**-**	**32**	**(35)**	**1,411**	**-**	**1,408**	**1,468**		
	Clinical Divisions											
(51,621)	Diagnostic & Therapies	(29,979)	(29,704)	850	(619)	(20)	46	18	275	83	(50)	325
(76,238)	Medicine	(44,731)	(47,039)	(959)	(356)	27	(773)	(247)	(2,308)	(2,031)	(439)	(1,869)
(102,779)	Specialised Services	(59,873)	(60,746)	(537)	(244)	65	67	(224)	(873)	(699)	(129)	(744)
(105,710)	Surgery Head & Neck	(61,677)	(64,125)	(246)	(668)	10	(197)	(1,347)	(2,448)	(2,234)	(646)	(1,802)
(120,254)	Women's & Children's	(69,942)	(72,032)	(1,588)	1,465	43	(874)	(1,135)	(2,089)	(1,991)	(513)	(1,576)
(456,602)	**Sub Total - Clinical Divisions**	**(266,202)**	**(273,646)**	**(2,480)**	**(422)**	**125**	**(1,731)**	**(2,935)**	**(7,443)**	**(6,872)**	**(1,777)**	**(5,666)**
	Corporate Services											
(36,316)	Facilities And Estates	(20,988)	(21,002)	66	(44)	(25)	(1)	(10)	(14)	(43)	(45)	31
(25,843)	Trust Services	(15,383)	(15,369)	380	(335)	(145)	19	95	14	1	17	(3)
(1,482)	Other	(739)	(552)	58	314	(292)	(29)	135	186	187	-	186
(63,641)	**Sub Totals - Corporate Services**	**(37,110)**	**(36,923)**	**504**	**(65)**	**(462)**	**(11)**	**220**	**186**	**145**	**(28)**	**214**
(520,243)	**Sub Total (Clinical Divisions & Corporate Services)**	**(303,312)**	**(310,569)**	**(1,976)**	**(487)**	**(337)**	**(1,742)**	**(2,715)**	**(7,257)**	**(6,727)**	**(1,805)**	**(5,452)**
(6,544)	Reserves	(4,033)	-	-	4,033	-	-	-	4,033	3,500		
-	NHS Improvement Plan Profile	(1,007)	-	-	1,007	-	-	-	1,007	0	-	-
(6,544)	**Sub Total Reserves**	**(5,040)**	**-**	**-**	**5,040**	**-**	**-**	**-**	**5,040**	**3,500**		
50,051	**Trust Totals Unprofiled**	**29,102**	**28,293**	**(1,976)**	**4,585**	**(372)**	**(331)**	**(2,715)**	**(809)**	**(1,759)**		
	Financing											
(22,472)	Depreciation & Amortisation - Owned	(12,801)	(12,492)	-	309	-	-	-	309	241		
244	Interest Receivable	142	133	-	(9)	-	-	-	(9)	1		
(290)	Interest Payable on Leases	(169)	(171)	-	(2)	-	-	-	(2)	(2)		
(3,124)	Interest Payable on Loans	(1,823)	(1,716)	-	107	-	-	-	107	92		
(8,509)	PDC Dividend	(4,963)	(4,961)	-	2	-	-	-	2	(61)		
(34,151)	**Sub Total Financing**	**(19,614)**	**(19,207)**	**-**	**407**	**-**	**-**	**-**	**407**	**271**		
15,900	**NET SURPLUS / (DEFICIT) before Technical Items**	**9,488**	**9,086**	**(1,976)**	**4,992**	**(372)**	**(331)**	**(2,715)**	**(402)**	**(1,488)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	(28)	-	(28)	-	-	-	(28)	(20)		
2,732	Donations & Grants (PPE/Intangible Assets)	2,270	2,169	-	-	(101)	-	-	(101)	(101)		
(6,436)	Impairments	(1,273)	(1,296)	-	(23)	-	-	-	(23)	(23)		
385	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,610)	Depreciation & Amortisation - Donated	(939)	(933)	-	6	-	-	-	6	6		
(4,929)	**Sub Total Technical Items**	**58**	**(88)**	**-**	**(45)**	**(101)**	**-**	**-**	**(146)**	**(138)**		
10,971	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**9,546**	**8,998**	**(1,976)**	**4,947**	**(473)**	**(331)**	**(2,715)**	**(548)**	**(1,626)**		

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%	3.2%	4.5%	4.2%	5.7%					
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%	3.0%	2.7%	3.2%	2.5%	4.1%					
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%	3.9%	5.1%	4.9%	4.1%	4.4%	5.2%					
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	3.8%	3.9%	3.4%	3.7%	4.0%	4.0%	5.0%					

Source: HR info available after a weekend

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%	9.4%	10.6%	7.3%	6.1%					
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%	7.0%	6.8%	5.4%	5.6%					
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%	8.2%	8.1%	6.6%	5.4%					
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%	4.8%	2.5%	2.0%	0.5%					

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	16.9%	16.7%	16.0%	17.4%	15.8%	15.2%	15.3%					
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%	13.2%	13.2%	12.9%	13.3%	12.5%					
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%	13.9%	11.9%	11.7%	11.0%					
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%	10.0%	10.5%	10.9%	11.6%	11.2%	10.9%					

Source: HR - Registered
Note: M4 figs restated

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	203.8	265.4	179.6	245.8					
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	85.2	135.7	129.2	119.5					
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	182.8	245.2	247.3	187.9					
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	219.1	179.2	173.3	176.3					

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	27.9	32.4	27.2	31.1					
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	11.7	14.7	14.4	14.1					
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	27.1	30.2	28.8	26.0					
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	19.7	15.4	19.1	16.8					

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%	11.4%	14.6%	9.3%	13.0%					
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%	6.4%	9.8%	8.9%	8.2%					
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%	10.2%	13.2%	12.3%	9.9%					
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%	6.4%	5.1%	4.9%	4.9%					

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	9,543	9,238	8,621	9,394					
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	4,729	4,829	4,499	4,665					
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	4,431	4,537	4,392	4,643					
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	6,548	6,070	6,470	7,243					

Source: Info web: KPI Bed occupancy

Graph 8 **NA 1:1 and RMN £000 (total temporary spend)**

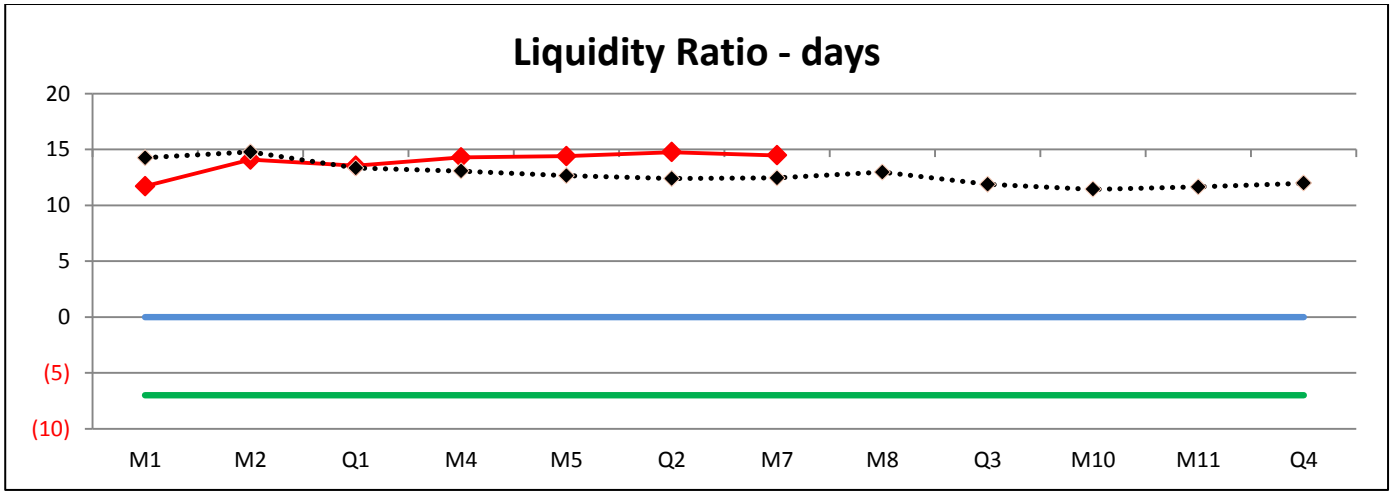
Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	70	66	78	82	84	113	105					
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	23	27	14	24	30	15	29					
Surgery, Head & Neck	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery, Head & Neck	Actual	25	20	31	34	29	26	26					
Women's & Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Women's & Children's	Actual	87	31	10	28	11	20	23					

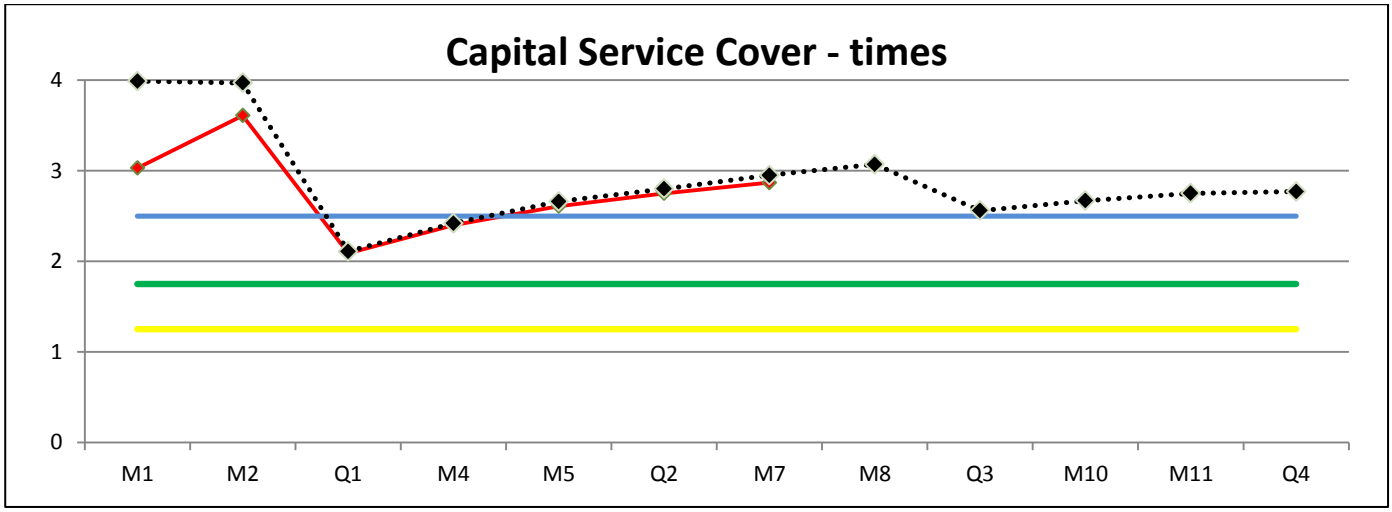
Use of Resources Rating – October 2016 Performance

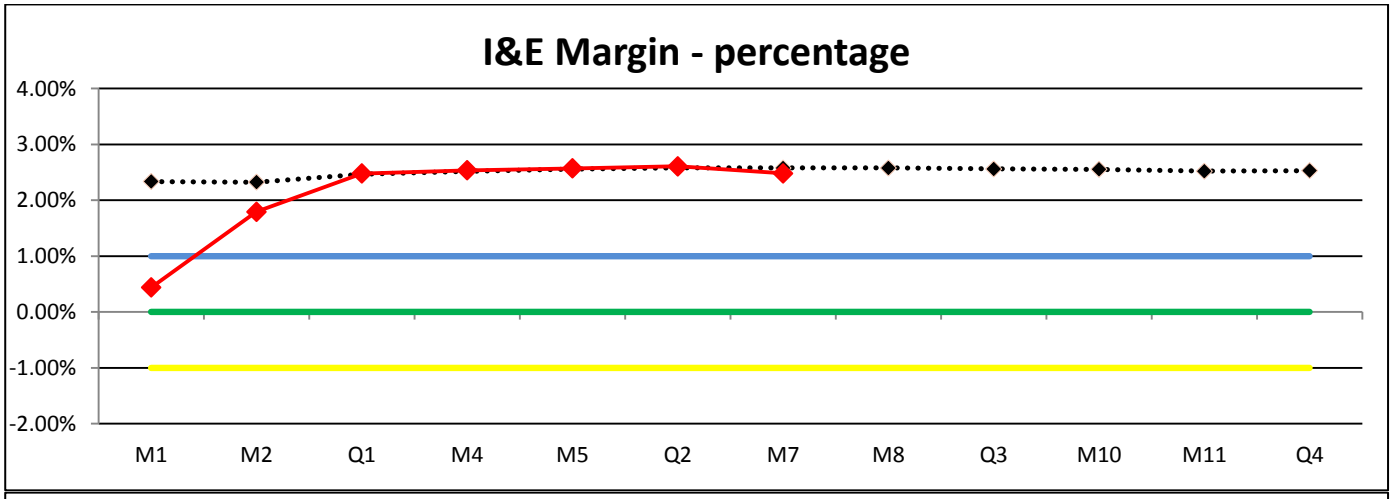
The Single Oversight Framework (SOF) came into effect on 1 October 2016 and assesses the financial performance of providers using the Use of Resources Rating (URR). The URR for the Trust to date is 1, the highest rating. The table below summarises the position.

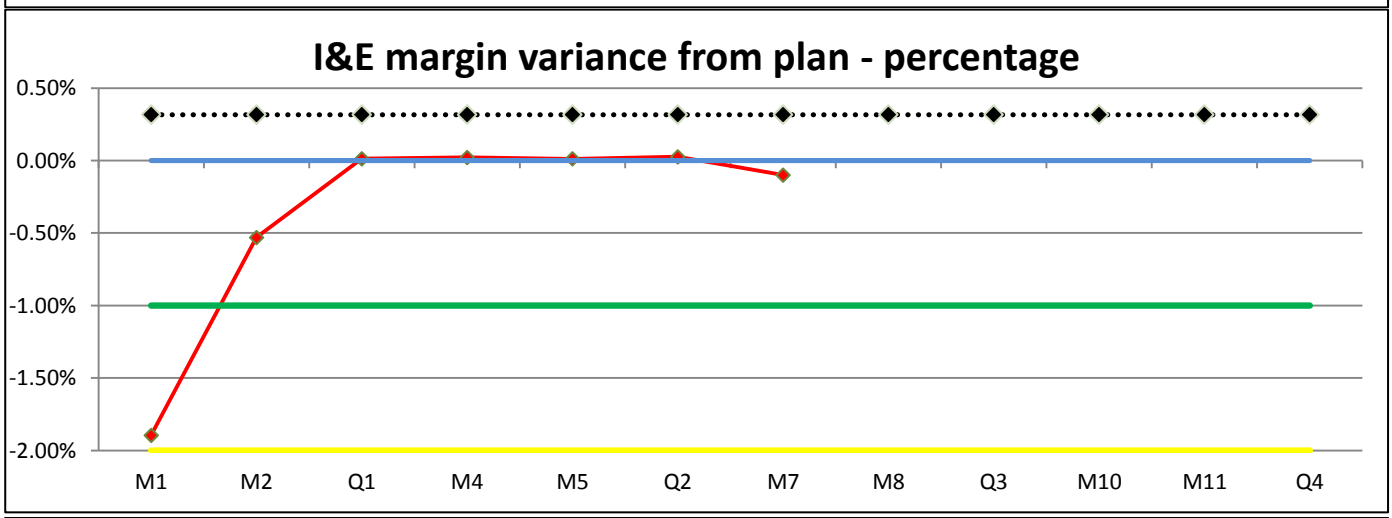
		31 October 2016		31 March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		12.45	14.47	11.96	11.96
Metric Rating	20%	1	1	1	1
Capital Servicing Capacity					
Metric Result – times		2.95	2.87	2.77	2.77
Metric Rating	20%	1	1	1	1
Income & expenditure margin					
Metric Result		2.58%	2.48%	2.53%	2.53%
Metric Rating	20%	1	1	1	1
Variance in I&E margin					
Metric Result		0.00%	0.10%	0.00%	0.00%
Metric Rating	20%	1	2	1	1
Variance from agency ceiling					
Metric Result		0.00%	12.26%	0.00%	0.00%
Metric Rating	20%	1	2	1	1
Overall URR		**1.0**	**1.4**	**1.0**	**1.0**
Overall URR (rounded)		**1**	**1**	**1**	**1**

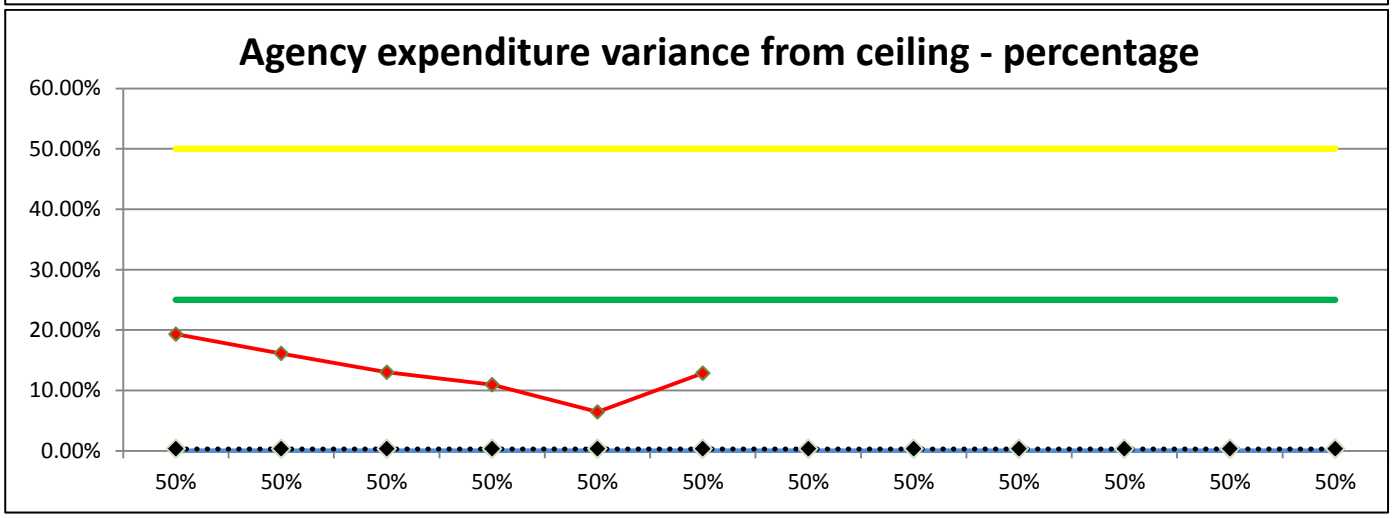
The charts presented overleaf show the trajectories for each of the four metrics. The revised 2016/17 Operational Plan submitted to Monitor on 29th June 2016 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **1 (blue line)**; **2 (green line)** and **3 (yellow line)**.




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


Agency expenditure variance from ceiling - percentage
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
50%
50%
50%
50%
50%
50%
50%
50%
50%
50%
50%
50%

Key Financial Metrics - October 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	3,321	4,394	5,003	6,912	8,749	310		7,578	36,267
Actual	3,388	4,548	4,935	7,042	8,672	310		7,573	36,468
Variance Fav / (Adv)	67	154	(68)	130	(77)	0	-	(5)	201
Year to date									
Budget	23,322	30,623	35,282	48,521	60,910	2,162		52,960	253,780
Actual	23,398	30,038	35,305	48,081	59,722	2,128		52,443	251,115
Variance Fav / (Adv)	76	(585)	23	(440)	(1,188)	(34)	-	(517)	(2,665)
Contract Income - Penalties									
Current Month									
Plan	-	(17)	(2)	(8)	(4)			(53)	(84)
Actual	0	(16)	(2)	(8)	(2)			(30)	(58)
Variance Fav / (Adv)	0	1	0	0	2	-	-	23	26
Year to date									
Plan	-	(115)	(17)	(49)	(20)			(358)	(559)
Actual	(1)	(113)	(12)	(157)	(116)			(205)	(604)
Variance Fav / (Adv)	(1)	2	5	(108)	(96)	-	-	153	(45)
Information shows the financial performance against the planned penalties as per agenda item 5.2									
Contract Income - Rewards									
Current Month									
Plan	472	698	940	967	1,095	71	-	(4,194)	49
Actual	508	751	1,011	1,039	1,177	76	-	(4,157)	405
Variance Fav / (Adv)	36	53	71	72	82	5	-	37	356
Year to date									
Plan	472	698	940	967	1,095	71	-	(4,194)	49
Actual	508	751	1,011	1,039	1,177	76	-	(4,157)	405
Variance Fav / (Adv)	36	53	71	72	82	5	-	37	356
Information shows the financial performance against the planned rewards as per agenda item 5.2									
Cost Improvement Programme									
Current Month									
Plan	149	141	136	418	378	73	66	124	1,485
Actual	163	(13)	112	226	231	75	59	152	1,005
Variance Fav / (Adv)	14	(154)	(24)	(192)	(147)	2	(7)	28	(480)
Year to date									
Plan	908	971	862	2,833	2,795	414	552	868	10,203
Actual	976	736	657	1,544	1,571	448	512	1,002	7,446
Variance Fav / (Adv)	68	(235)	(205)	(1,289)	(1,224)	34	(40)	134	(2,757)

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	247	36	(11)	17	39	39	41	30						191	56
Nursing agency expenditure (£'000)	7	4	12	(6)	-	4	3	4	6						23	(19)
Overall																
Sickness (%)	2.8%		2.4%	2.4%	2.5%	2.4%	2.8%	2.6%	3.1%						2.6%	
Turnover (%)	12.5%		13.3%	13.5%	12.6%	12.5%	11.6%	12.5%	11.8%						11.8%	
Establishment (wte)			1,000.69	958.00	966.08	975.98	979.73	992.70	1,003.55							
In post (wte)			961.64	927.00	928.24	928.28	930.20	950.70	953.75							
Under/(over) establishment (wte)			39.05	31.00	37.84	47.70	49.53	42.00	49.80	-	-	-	-	-		
Nursing:																
Sickness - registered (%)			1.7%	0.0%	0.2%	0.2%	4.1%	0.6%	1.6%						1.2%	
Sickness - unregistered (%)			0.0%	0.0%	10.0%	0.0%	0.0%	0.0%	2.2%						1.7%	
Turnover - registered (%)	4.1%		19.9%	19.2%	13.2%	13.3%	13.3%	12.9%	12.9%						12.9%	
Turnover - unregistered (%)			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						0.0%	
Starters (wte)			1.0	1.0	-	-	-	1.0	-						3.0	
Leavers (wte)			-	-	-	-	-	-	-						-	
Net starters (wte)			1.00	1.00	-	-	-	1.00	-	-	-	-	-	-	3.00	
Establishment (wte)			17.66	17.66	17.66	17.66	17.66	17.66	17.66							
In post - Employed (wte)			16.57	18.75	18.24	18.24	17.57	18.37	20.37							
In post - Bank (wte)			0.16	1.41	2.35	2.80	3.24	2.89	1.75							
In post - Agency (wte)			3.46	0.10	-	0.60	-	-	-							
In post - total (wte)			20.19	20.26	20.59	21.64	20.81	21.26	22.12	-	-	-	-	-		
Under/(over) establishment (wte)			(2.53)	(2.60)	(2.93)	(3.98)	(3.15)	(3.60)	(4.46)	-	-	-	-	-		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 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	1,520	334	239	290	274	320	264	250						1,971	(451)
Nursing agency expenditure (£'000)	1,395	958	256	140	176	193	273	229	251						1,518	(560)
Overall																
Sickness (%)	4.6%		4.4%	3.7%	3.9%	4.4%	5.1%	5.0%	5.5%						4.6%	
Turnover (%)	13.2%		14.9%	15.2%	14.6%	15.4%	14.8%	14.7%	14.4%						14.4%	
Establishment (wte)			1,215.16	1,209.00	1,221.06	1,215.64	1,222.99	1,198.71	1,200.78							
In post (wte)			1,253.43	1,230.00	1,246.58	1,256.53	1,272.56	1,267.60	1,272.91							
Under/(over) establishment (wte)			(38.27)	(21.00)	(25.52)	(40.89)	(49.57)	(68.89)	(72.13)	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.1%		3.1%	1.9%	2.2%	3.2%	4.5%	4.2%	5.7%						3.5%	
Sickness - unregistered (%)	6.5%		7.8%	7.3%	6.2%	6.0%	6.7%	7.4%	7.8%						7.0%	
Turnover - registered (%)	15.1%		16.9%	16.7%	16.0%	17.4%	15.8%	15.2%	15.3%						15.3%	
Turnover - unregistered (%)	25.6%		18.1%	19.4%	19.2%	20.7%	19.6%	20.9%	20.5%						20.5%	
Starters (wte)			11.19	16.94	4.64	7.00	13.60	10.80	22.91						87.07	
Leavers (wte)			13.26	9.16	7.72	12.99	10.31	15.61	8.81						77.86	
Net starters (wte)			(2.07)	7.78	(3.08)	(5.99)	3.29	(4.81)	14.09	-	-	-	-	-	9.21	
Establishment (wte)			769.87	767.62	768.14	772.12	767.57	742.13	743.76							
In post - Employed (wte)			695.64	686.14	686.33	678.04	674.82	673.98	677.40							
In post - Bank (wte)			82.62	88.69	97.90	111.08	100.27	87.21	94.33							
In post - Agency (wte)			36.20	21.30	27.03	30.29	35.69	33.80	37.54							
In post - total (wte)			814.46	796.13	811.26	819.41	810.78	794.99	809.27	-	-	-	-	-		
Under/(over) establishment (wte)			(44.59)	(28.51)	(43.12)	(47.29)	(43.21)	(52.86)	(65.51)	-	-	-	-	-		

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	864	182	196	177	166	206	219	173						1,319	(455)
Nursing agency expenditure (£'000)	410	306	100	110	109	91	134	131	123						798	(492)
Overall																
Sickness (%)	3.6%		3.4%	3.3%	3.2%	3.8%	3.7%	3.1%	4.2%						3.5%	
Turnover (%)	12.4%		14.2%	13.4%	12.7%	12.1%	11.4%	11.7%	11.5%						11.5%	
Establishment (wte)			908.17	937.00	932.51	934.93	946.17	946.48	953.76							
In post (wte)			901.55	933.00	938.46	943.79	968.61	967.35	961.47							
Under/(over) establishment (wte)			6.62	4.00	(5.95)	(8.86)	(22.44)	(20.87)	(7.71)	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.1%		3.2%	3.5%	3.0%	2.7%	3.2%	2.5%	4.1%						3.2%	
Sickness - unregistered (%)	7.4%		7.0%	5.4%	6.6%	9.9%	9.8%	7.7%	8.4%						7.8%	
Turnover - registered (%)	13.3%		15.6%	14.2%	13.2%	13.2%	12.9%	13.3%	12.5%						12.5%	
Turnover - unregistered (%)	18.0%		12.2%	12.3%	14.3%	11.8%	14.4%	13.2%	13.7%						13.7%	
Starters (wte)			6.80	4.60	6.80	8.00	7.13	15.00	9.00						57.33	
Leavers (wte)			6.37	3.00	5.05	5.21	9.55	7.13	7.17						43.48	
Net starters (wte)			0.43	1.60	1.75	2.79	(2.41)	7.87	1.83	-	-	-	-	-	13.85	
Establishment (wte)			480.47	486.02	482.51	483.04	487.18	488.74	495.69							
In post - Employed (wte)			441.23	438.90	442.49	444.68	457.84	450.18	457.37							
In post - Bank (wte)			27.30	37.55	42.33	40.77	34.03	37.71	39.17							
In post - Agency (wte)			12.07	14.14	13.93	13.01	15.54	14.42	15.02							
In post - total (wte)			480.60	490.59	498.75	498.46	507.41	502.31	511.56	-	-	-	-	-		
Under/(over) establishment (wte)			(0.13)	(4.57)	(16.24)	(15.42)	(20.23)	(13.57)	(15.87)	-	-	-	-	-		

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.

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	651	262	252	193	238	242	256	218						1,661	(1,010)
Nursing agency expenditure (£'000)	343	280	219	207	186	204	248	233	191						1,488	(1,208)
Overall																
Sickness (%)	3.7%		3.8%	3.6%	3.9%	3.6%	3.0%	3.1%	4.2%						3.6%	
Turnover (%)	12.1%		14.1%	13.7%	13.6%	14.3%	14.3%	14.1%	13.6%						13.6%	
Establishment (wte)			1,741.45	1,756.00	1,796.48	1,810.54	1,818.49	1,820.94	1,817.20							
In post (wte)			1,785.03	1,772.00	1,773.35	1,775.68	1,782.64	1,794.26	1,777.80							
Under/(over) establishment (wte)			(43.58)	(16.00)	23.13	34.86	35.85	26.68	39.40	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	3.8%		3.8%	3.9%	5.1%	4.9%	4.1%	4.4%	5.2%						4.5%	
Sickness - unregistered (%)	3.7%		7.7%	5.4%	4.9%	4.3%	4.3%	4.2%	6.1%						5.3%	
Turnover - registered (%)	12.1%		14.6%	13.6%	13.3%	13.9%	11.9%	11.7%	11.0%						11.0%	
Turnover - unregistered (%)	21.8%		17.1%	18.1%	16.7%	19.6%	18.6%	19.3%	19.0%						19.0%	
Starters (wte)			4.00	6.37	7.81	4.53	12.80	6.43	20.47						62.41	
Leavers (wte)			8.00	4.50	6.77	10.62	10.59	11.44	5.06						56.97	
Net starters (wte)			(4.00)	1.87	1.05	(6.09)	2.21	(5.01)	15.41	-	-	-	-	-	5.44	
Establishment (wte)			695.49	699.86	726.18	739.12	748.05	747.07	747.78							
In post - Employed (wte)			662.80	658.55	662.38	661.93	666.11	661.99	665.80							
In post - Bank (wte)			49.28	44.54	49.13	58.93	43.57	52.88	45.51							
In post - Agency (wte)			28.85	30.80	27.61	28.22	31.37	28.77	26.79							
In post - total (wte)			740.93	733.89	739.12	749.08	741.05	743.64	738.10	-	-	-	-	-		
Under/(over) establishment (wte)			(45.44)	(34.03)	(12.94)	(9.96)	7.00	3.43	9.68	-	-	-	-	-		

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	558	255	162	131	268	205	239	194						1,454	(896)
Nursing agency expenditure (£'000)	662	495	217	141	117	229	183	188	183						1,258	(763)
Overall																
Sickness (%)	3.8%		3.8%	3.8%	3.5%	3.9%	3.7%	3.7%	4.5%						3.9%	
Turnover (%)	10.8%		10.9%	11.0%	11.2%	11.8%	12.2%	12.2%	11.8%						11.8%	
Establishment (wte)			1,899.46	1,878.00	1,884.05	1,886.26	1,885.88	1,887.72	1,905.56							
In post (wte)			1,932.95	1,898.00	1,890.48	1,894.56	1,884.31	1,923.25	1,931.47							
Under/(over) establishment (wte)			(33.49)	(20.00)	(6.43)	(8.30)	1.57	(35.53)	(25.91)	-	-	-	-	-		
Nursing:																
Sickness - registered (%)	4.0%		3.8%	3.9%	3.4%	3.7%	4.0%	4.0%	5.0%						4.0%	
Sickness - unregistered (%)	5.0%		8.6%	9.5%	9.6%	13.3%	10.3%	8.0%	8.6%						9.7%	
Turnover - registered (%)	10.6%		9.3%	10.0%	10.5%	10.9%	11.6%	11.2%	10.9%						10.9%	
Turnover - unregistered (%)	15.3%		15.3%	12.7%	11.9%	12.6%	12.0%	15.2%	17.3%						17.3%	
Starters (wte)			4.91	10.22	4.03	5.61	16.60	42.25	31.64						115.27	
Leavers (wte)			10.46	11.27	11.91	12.39	23.11	14.75	14.21						98.10	
Net starters (wte)			(5.54)	(1.05)	(7.89)	(6.78)	(6.51)	27.51	17.43	-	-	-	-	-	17.16	
Establishment (wte)			1,112.90	1,118.77	1,122.66	1,123.22	1,118.16	1,120.36	1,138.88							
In post - Employed (wte)			1,078.77	1,075.80	1,075.11	1,067.06	1,072.54	1,086.87	1,114.27							
In post - Bank (wte)			32.38	42.04	37.18	43.56	39.42	41.14	32.18							
In post - Agency (wte)			29.91	19.07	11.44	22.66	17.82	18.35	18.88							
In post - total (wte)			1,141.06	1,136.91	1,123.73	1,133.28	1,129.78	1,146.36	1,165.33	-	-	-	-	-		
Under/(over) establishment (wte)			(28.16)	(18.14)	(1.07)	(10.06)	(11.62)	(26.00)	(26.45)	-	-	-	-	-		

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.
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UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report October 2016 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Inherent Risk (if no action take		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
1843	Failure to deliver the Trust's Operating Plan Control Total surplus of £15.9m	16 - Very High	TBC	Divisions will be formally required to identify and deliver a recovery plan and be set a control total deficit which cannot be exceeded.	PM	12 - High	TBC	4 - Moderate	TBC
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 £3.830m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	OA	12 - High	£3.830m	4 - Moderate	£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	30% of the agreed Sustainability & Transformation Funding is subject to forfeit if core targets are not delivered. The current risk of loss is high.	PM	9 - High	£3.0m	3 - Low	£0.0m
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											
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Total £'000	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	3,365	3,491	3,449	10,305	3,476	24,080	3,440	
	Bank	82	109	93	88	371	31	0.9%	20	21	25	66	29	32	31	92	23	182	26	0.8%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	18	42	39	32	35	106	24	173	25	0.7%
	Waiting List initiative	98	54	95	95	342	29	0.8%	62	35	53	150	72	35	27	134	30	314	45	1.4%
	Overtime	147	94	100	110	450	38	1.1%	47	37	36	120	30	33	41	104	40	264	38	1.1%
	Other pay	9,572	9,648	9,788	9,920	38,927	3,244	94.8%	3,310	3,119	3,049	9,478	3,082	3,244	3,200	9,526	3,247	22,251	3,179	96.0%
	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	3,253	3,376	3,334	9,963	3,364	23,184	3,312	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	189	443	112	115	115	342	112	896	128	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	4,258	12,853	4,244	4,388	4,191	12,824	4,185	29,861	4,266	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	318	880	338	358	290	986	277	2,143	306	6.9%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	290	861	274	320	265	858	250	1,970	281	6.3%
	Waiting List initiative	51	45	56	42	194	16	0.4%	30	30	17	77	3	16	13	32	4	113	16	0.4%
	Overtime	16	21	35	32	105	9	0.2%	8	9	7	23	8	5	5	18	6	47	7	0.2%
	Other pay	11,212	10,941	10,982	11,308	44,443	3,704	85.2%	3,789	3,850	3,796	11,435	3,701	3,784	4,001	11,486	3,919	26,841	3,834	86.3%
	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	4,324	4,483	4,574	13,380	4,456	31,113	4,445	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(170)	(424)	(80)	(95)	(383)	(557)	(272)	(1,252)	(179)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	3,834	11,459	3,829	3,886	3,812	11,526	3,901	26,886	3,841	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	172	425	151	176	122	449	139	1,013	145	3.7%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	177	555	166	206	219	591	173	1,319	188	4.8%
	Waiting List initiative	125	144	156	103	528	44	1.2%	42	58	36	136	21	45	20	86	42	264	38	1.0%
	Overtime	29	29	30	25	114	9	0.3%	8	11	13	32	16	11	9	36	10	78	11	0.3%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,329	3,644	3,515	10,487	3,522	3,587	3,619	10,728	3,593	24,808	3,544	90.3%
	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	3,876	4,025	3,989	11,889	3,958	27,482	3,926	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(79)	(176)	(47)	(139)	(177)	(363)	(57)	(596)	(85)	
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	6,739	6,846	6,785	20,371	6,804	47,065	6,724	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	194	542	229	261	216	706	209	1,457	208	3.1%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	193	707	238	242	256	736	217	1,660	237	3.5%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	98	154	130	382	90	71	45	206	12	600	86	1.3%
	Overtime	38	47	45	41	171	14	0.2%	11	12	9	33	8	11	7	26	10	69	10	0.1%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,144	6,165	6,159	18,467	6,040	6,202	6,389	18,631	6,381	43,479	6,211	92.0%
	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	6,605	6,786	6,913	20,304	6,829	47,265	6,752	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(12)	(240)	134	60	(128)	66	(25)	(199)	(28)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17											
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Jun £'000	Q1 £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Oct £'000	Total £'000	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	7,899	7,950	7,870	23,718	7,954	55,137	7,877	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	172	498	181	194	173	549	119	1,166	167	2.1%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	131	548	269	204	238	711	194	1,453	208	2.6%
	Waiting List initiative	205	169	203	206	783	65	0.8%	33	73	40	146	48	30	62	140	29	315	45	0.6%
	Overtime	23	19	26	35	102	9	0.1%	9	15	17	42	13	11	11	35	17	94	13	0.2%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,749	7,623	7,575	22,947	7,530	7,698	7,735	22,963	7,776	53,686	7,669	94.7%
	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	8,041	8,137	8,219	24,398	8,135	56,714	8,102	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(16)	(716)	(142)	(187)	(349)	(679)	(181)	(1,577)	(225)	
Facilities & Estates	Pay budget	5,057	5,113	5,142	5,070	20,382	1,699		1,708	1,788	1,744	5,239	1,740	1,770	1,780	5,291	1,739	12,268	1,753	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	72	195	82	107	80	269	80	543	78	4.4%
	Agency	145	189	249	154	738	62	3.6%	32	27	37	96	26	29	28	84	33	213	30	1.7%
	Waiting List initiative	0	0	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	66	82	66	213	80	494	71	4.0%
	Other pay	4,406	4,373	4,371	4,499	17,649	1,471	86.5%	1,572	1,609	1,592	4,773	1,546	1,567	1,580	4,693	1,532	10,999	1,571	89.8%
	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	1,720	1,785	1,754	5,259	1,726	12,249	1,750	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(22)	(26)	20	(16)	26	31	13	19	3	
(Including R&I and	Pay budget	6,487	6,496	6,977	7,438	27,398	2,283		2,327	2,532	2,398	7,257	2,382	2,218	2,431	7,030	2,420	16,707	2,387	
(Incl R&I and Support Services)	Bank	179	211	232	223	846	70	3.2%	60	61	92	213	70	71	43	184	84	481	69	3.0%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	116	239	35	44	23	102	37	379	54	2.3%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0	0	0	0	0	0	0	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	3	13	5	9	7	21	5	39	6	0.2%
	Other pay	6,029	5,967	6,201	6,662	24,859	2,072	92.8%	2,190	2,213	2,191	6,594	2,194	1,997	2,283	6,474	2,288	15,356	2,194	94.5%
	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	2,305	2,120	2,356	6,781	2,414	16,255	2,322	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	(5)	197	77	97	75	249	6	452	65	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	30,194	90,462	30,198	30,548	30,319	91,065	30,478	212,005	30,286	
	Bank	2,949	3,244	2,834	3,254	12,281	1,023	3.4%	774	998	1,046	2,818	1,080	1,199	955	3,235	931	6,984	998	3.3%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	961	3,049	1,047	1,078	1,064	3,188	929	7,167	1,024	3.3%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	265	350	276	891	234	197	167	598	117	1,606	229	0.7%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	150	463	146	160	148	454	168	1,085	155	0.5%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,083	28,223	27,876	84,183	27,616	28,078	28,805	84,500	28,737	197,419	28,203	92.1%
	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	30,123	30,712	31,139	91,975	30,882	214,261	30,609	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(115)	(942)	74	(164)	(821)	(911)	(404)	(2,256)	(322)	

NOTE: Other Pay includes all employer's oncosts.

	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 movements	97	(9)	87	-	(160)	(366)	(351)	10	165	28	40	83	99	141	(215)	351
July movements	(20)	(45)	447		(119)	(207)	56	9	91	45	27	103	98	218	(647)	(56)
August Movements		(6)	234		(80)	(118)	30	58	31	42	42	59	37	122	(421)	(30)
September movements	(17)	(9)	(120)		(165)	(105)	(416)	8	24	57	43	131	24	160	(31)	416
September																
Incremental drift		(522)					(522)	37	49	80	159	182	6	9		522
Strategic Scheme Costs						(28)	(28)						18	10		28
Spend to Save						(14)	(14)			3	6			5		14
CQUINs			(1,297)				(1,297)			7	2			17	1,271	1,297
Developments			(228)				(228)					204		24		228
CSIP						(39)	(39)							39		39
EWTD					(143)		(143)	9	30	20	25	54	2	2	1	143
Other	(53)	(7)	(7)			(17)	(84)					37	14	33		84
Month 7 balances	559	2,112	2,727	(683)	1,337	1,875	7,927	3,706	9,470	9,039	9,646	10,490	1,562	2,723	1,231	47,867

2016/17 Sustainability & Transformation Funding – October trajectory performance

In order for the Trust to be eligible for Sustainability & Transformation Funding (STF), first it must deliver the monthly net surplus Control Total excluding STF. Delivery of the Control Total entitles the Trust to 70% of the STF from July onwards.

Net surplus Control Total

The cumulative net surplus Control Total (excluding STF) was achieved for the period to October with an actual cumulative net surplus excluding STF of £2.072m against a Control Total of £1.903m. Please see table one below.

Table one: Net surplus Control Total and performance to date

Control Total	Q1 £m	July £m	August £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m
Planned net surplus	3.858	5.258	6.719	8.135	9.486	10.850	12.084	13.383	14.475	15.900
Less planned STF	(3.250)	(4.333)	(5.416)	(6.500)	(7.583)	(8.666)	(9.750)	(10.833)	(11.916)	(13.000)
Planned net surplus exc STF	**0.608**	**0.925**	**1.303**	**1.635**	**1.903**	**2.184**	**2.334**	**2.550**	**2.559**	**2.900**
Actual reported net surplus	3.871	5.275	6.722	8.170	9.086					
Less STF	(3.250)	(4.279)	(5.308)	(6.337)	(7.014)					
Actual net surplus exc STF	**0.621**	**0.996**	**1.414**	**1.833**	**2.072**					
Control Total delivered / Eligible for STF?	Yes	Yes	Yes	Yes	Yes					

A&E waiting times

The Trust did not achieve the A&E waiting times standard trajectory in October with performance of 82.9% against the in-month trajectory of 93.3%. However, cumulative performance was 88.2% and ahead of the agreed trajectory of 87.2%. Therefore, the Trust was eligible for STF of £0.135m for October.

The Trust is currently forecasting ongoing achievement of the cumulative but not in-month A&E trajectory for November, but predicts failure for December through to March. Failure to achieve the A&E trajectory for the last four months of the financial year would mean a loss of STF of £0.540m. Table two summarises the position.

Table two: A&E waiting times trajectories and performance to date

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Agreed in month trajectory	81.9%	84.4%	85.9%	86.6%	88.4%	92.2%	93.3%	90.0%	89.3%	88.5%	87.4%	91.0%
Actual performance	87.2%	91.7%	89.0%	89.3%	90.0%	87.3%	82.9%					
Agreed cumulative trajectory	81.9%	83.2%	84.1%	84.7%	85.2%	86.2%	87.2%	87.5%	87.7%	87.8%	87.7%	88.1%
Actual - cumulative performance	87.2%	89.5%	89.3%	89.3%	89.5%	89.1%	88.2%					
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/delivered	Yes	Yes	Yes	Yes	Yes	Yes	Yes					
STF due	*£135k*	*£135k*	*£135k*	£135k	£135k	£135k	£135k					

Italics represent notional values relating to the agreement of trajectories only for quarter 1.

Cancer waiting times

The cumulative quarter two performance against the 62-day GP standard was confirmed at 80.1% compared with a trajectory of 82.8% (inclusive of the 1% tolerance). A formal appeal will be submitted for securing funds for the complete quarter due to the number of breaches outside of the control of the Trust, which more than make-up the 2.7% gap in performance. The appeal will be on the basis of the additional breaches of the 62-day standard related to the histopathology reporting delays following the service transfer to North Bristol NHS Trust at the beginning of May, and the likely associated increase in late referrals from North Bristol NHS Trust experienced during quarter two. Current indications are, however, that few appeals are likely to be successful.

Current performance in quarter three is below trajectory. But this is before final validation and adjustments to performance to take account breach reallocations that apply under the new national and local CQUIN rules which came into effect on the 1 October 2016. Access to the £0.165m funds for the quarter will, however, be subject to appeal, as required in order to take account of breach reallocation. The appeal process now places doubt on whether any appeal a trust makes is likely to be successful. For this reason STF for the cancer element for quarter three are no longer assumed. Quarter four is considered a high risk quarter with the achievement of the Cancer standard being unlikely due to higher levels of patient choice and also emergency pressures which often impact to a greater extent in the last quarter of the year than in other quarters. Failure to achieve the Cancer access trajectory for the last five months of the financial year would mean a loss of STF of £0.275m in addition to the £0.165m forfeited to date in July, September and October, a total loss of STF of £0.440m. Table three summarises the position below.

Table three: Cancer waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Agreed in month trajectory	72.7%	73.2%	81.8%	84.7%	81.7%	85.0%	85.2%	85.1%	86.9%	83.6%	85.7%	85.9%
Actual performance	77.2%	70.5%	70.8%	73.3%	84.8%	80.5%	80.6%					
Agreed cumulative trajectory	72.7%	73.0%	76.0%	83.7%	82.3%	82.8%	84.7%	84.6%	85.0%	83.6%	84.7%	85.0%
Actual - cumulative performance	77.2%	73.7%	72.7%	73.3%	80.0%	80.1%	80.6%					
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory agreed/ delivered	Yes	Yes	Yes	No*	Yes	No*	No					
STF due	*£55k*	*£55k*	*£55k*	£0k	£54k	£0k	£0k					

Italics represent notional values relating to the agreement of trajectories only for quarter 1.
** Subject to appeal*
Please note: October figures are still subject to final reporting

Referral to Treatment Time (RTT)

RTT performance in October has been confirmed on final reporting as 91.2%. This takes the cumulative delivery for the year-to-date to 91.6% compared with a trajectory of 92.0% (i.e. the national standard). For quarter three, the forecast remains that the Trust will not achieve the required 92% standard in any month, due to a lack of confidence that sufficient additional activity can be established to reduce the backlog to the level required to support achievement, especially in the context of winter pressures. Recovery plans are expected to support achievement in each month in quarter four. But, this will not be sufficient to earn back the quarter three's STF, due to the scale of performance already lost in quarter two and three, and hence the scale of recovery required to meet the cumulative trajectory.

An appeal will be made to attempt to secure the RTT funding for quarter two, due to the high levels of referrals in the period and the STF rules related to the application of the tolerance where a Trust has submitted aspirational trajectories above the national standard to support the commissioners' plans. However, the STF for the RTT element is no longer being assumed for quarter two, due to the latest information on the appeal process and the low likelihood of success for any trust making an appeal resulting in a loss of STF of £0.270m. Failure to achieve the RTT access trajectory in quarter three would mean a further loss of STF of c£0.405m, a total STF loss of £0.675m for RTT. Table four summarises the position below.

Table four: RTT waiting times trajectories and performance to date

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
National standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Agreed in month trajectory	92.6%	92.6%	92.8%	93.2%	93.2%	93.4%	93.4%	93.4%	92.8%	92.8%	92.8%	93.0%
Actual performance	92.3%	92.6%	92.1%	92.0%	90.5%	90.4%	91.2%					
Agreed cumulative trajectory	92.6%	92.6%	92.7%	92.8%	92.9%	93.0%	93.0%	93.1%	93.0%	93.0%	93.0%	93.0%
Actual - cumulative performance	92.3%	92.5%	92.3%	92.3%	91.9%	91.6%	91.6%					
Tolerance	N/A	N/A	N/A	1%	1%	1%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%
Trajectory / national standard agreed/ delivered	Yes	Yes	Yes	Yes	No*	No*	No*					
STF due	*£135k*	*£135k*	*£135k*	£135k	£0k	£0k	£0k					

Italics represent notional values relating to the agreement of trajectories only for quarter 1.
**Subject to appeal*

Diagnostics

The Diagnostics access trajectory does not attract STF and is not therefore considered here.

Summary

The Trust's Operational Plan Control Total surplus of £15.9m assumed full receipt of the STF at £13.0m of which £2.925m relates to the delivery of the Trust's access performance trajectories. The current assessment of performance against the access standard trajectories indicate a potential loss of funding of £1.655m of the £2.925m available.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Public Trust Board	**Meeting Date**	29 November 2016
Report Title	Taking Further action to reduce Agency spend		
Author	Deborah Tunnell, Head of HR Service Centre		
Executive Lead	Alex Nestor, Acting Director of Workforce and Organisational Development		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff. c.	☐	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.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

Purpose

On 17th October 2016, NHS Improvement wrote to all Trust Chairs, Chief Executives and Finance Directors to lay out actions needed to reduce agency spend, which include promoting transparency, better data, stronger accountability to Boards and additional reporting of high-cost overrides. This paper summarises the expectations on Trusts.

Key issues to note

- The new NHS Improvement reporting requirements
- Progress to date on the delivery of the new requirements
- New levels of scrutiny required by Executives on high cost agency usage
- The Board self-certification checklist

Recommendations

Members are asked to:

- **Endorse** the Board self-certification checklist for submission to NHS Improvement

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☒	Failure to comply with targets, statutory duties and functions.	☐

Corporate Impact Assessment
(please tick any which are impacted on / relevant to this paper)

Quality	☐	Equality	☐	Legal	☐	Workforce	☒

Impact Upon Corporate Risk

N/A

Resource Implications
(please tick any which are impacted on / relevant to this paper)

Finance	☒	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				HR Workforce Management Group Also discussed at Executive Directors

NHS Improvement - Taking further action to reduce agency spending

Despite some positive action and results being seen, agency staff still cost the NHS around £250 million a month; at present the sector is falling short of what is needed.

In order to retain costs within the available resources for the NHS, NHS Improvement need to be assured that Boards, are doing all they can to take control of agency spending.

On 17th October 2017, NHS Improvement wrote to all Trust Chairs, Chief Executives and Finance Directors to lay out actions needed to reduce agency spend, which include promoting transparency, better data, stronger accountability to Boards and additional reporting of high-cost overrides. This paper summarises the expectations on Trusts.

Action	Purpose	Who	When	Comments
1 Submit data: Monthly agency spending broken down by cost centre/service line	To help us and the NHS Improvement Relationship team to better understand our agency usage/spend as at Q2	Finance	One-off return Submit data by 12pm on 24 October 2016	Completed and submitted
2 Submit data: ☐A list of your 20 highest-earning agency staff (anonymised) ☐A list of agency staff that have been employed for more than 6 consecutive months (anonymised)	Focussed action is on paying over the odds for very expensive individuals or relying on the same agency staff members for very long periods.	Resourcing	One-off return Submit data to Agency inbox by 12pm on 31 October 2016 To be embedded into local reporting as part of the suite of other related reports with effect from 1 December 2016	Completed and submitted
3 Board, together with CFO, HR director and Nursing and Medical directors to discuss and complete agency self-certification checklist.	This self-certification checklist is for the Board to be assured that the Trust is taking all appropriate actions on agency spending and to identify additional steps. Actions include establishing governance, accessing accurate and timely data to inform your decisions and using appropriate tools and processes, such as rapid recruitment processes and e-rostering.	Board	One-off return Submit completed checklist by 30 November 2016 Draft response attached in Appendix 1	Currently being completed

4 Chief executives to personally sign off on: ☐All shifts by individuals costing more than £120 per hour. ☐All framework overrides above price cap.	Often going off-framework is indicative of poor planning and agency procurement behaviour resulting in Trusts paying significantly higher prices for agency staff. To ensure that chief executives have full sight of these significant overrides, we are required to have Robert Woolley to personally sign off these over-rides. A full escalation process has been discussed and disseminated through the Senior Leadership Team On 16 November 2016. See Appendix 2	Resourcing	To be embedded into local Trust reporting as part of the suite of other related reports with effect from 23 November 2016 To be formally submitted to NHSI on a weekly basis with effect from January 2017 (There is currently a delay in NHS Improvement's development of the IT system to receive this data)	Embed action in Trust as part of the existing weekly returns on framework, agency caps and worker rate over-rides
5 Trusts will be required to secure approval from NHS Improvement in advance of: ☐Signing new contracts with agency senior managers where the daily rate exceeds £750, including on costs. ☐Extending or varying existing contracts where the daily rate exceeds £750, including on costs or incurring additional expenditure to which they are not already committed.	The NHS often achieves poor value for money from recruiting agency managerial staff. We should be aiming to radically reduce and ideally eliminate reliance on agency managerial staff and use internal NHS solutions. Trusts will need to demonstrate that they first tried to fill the role internally, within their STP footprint or within the NHS.	Divisions	From 31 October 2016 Submit ALL requests to the NHSI Agency inbox This is being incorporated into the new rigour implemented for specialist, non-clinical agency use. Being disseminated through DFM's and HRBP's	Guidance, including template, now published on NHSI website

Promoting transparency and collaboration

Trusts have been asking for more information on agency spending to allow them to benchmark against their peers and work more collaboratively within the region. To support this, from November NHS Improvement will be sharing data on agency expenditure (in relation to ceilings and total workforce costs) for all trusts in the region. The first of the south monthly regional agency performance reports was received on 11 November 2016.

Deborah Tunnell, Head of HR Service Centre - November 2016

	Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
	Governance and accountability		
1	Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	There is a collaborative approach to the management of agency spending between the Chief Nurse, HR Director and Medical Director, in close conjunction with the Finance Director. Key significant risks are raised to the CEO.	With effect from 23/11/2016 all off-framework usage with price cap over-rides, plus shifts costing in excess of £120 ph, will be countersigned by an Executive Director at the point of booking, with a report going to the Chief Executive on a daily basis.
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Yes - both the Chief Nurse and Medical Director have clear objectives to drive a reduction in agency reliance and spend.	
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	Yes - There are Divisional plans which are monitored monthly by Executives (these are called Divisional Performance and Ops reviews). Within these operating plans there are clear targets to reduce agency spend.	The Workforce Director will be offering a clear strategic lead to the current procurement exercise being undertaken for nurse agency supply
4	We are not engaging in any workarounds to the agency rules.	Yes correct - the Trust has from the outset maintained a clear focus on working within the requirements of the agency caps and worker rates laid out by NHS Improvement. Whilst challenging, reporting is transparent and accurately reflects the activity undertaken.	
	High quality timely data		
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	Yes, as above - there are Divisional plans which are monitored monthly by Executives. Within these operating plans there are clear targets to reduce agency spend. Reasons for agency usage is clear and an essential element of the agency booking process. This is reported monthly through the Divisional Performance and Ops reviews where Heads of Nurses are held accountable for all agency bookings which includes reasons. A daily report is also published reflecting the previous day's agency activity, reasons for the bookings and lines of approval. A weekly report of medical agency locum usage is reported to the Medical Director.	Reporting our highest cost and longest serving agency individuals will be embeded into local controls reporting from 1 December 2016
	Clear process for approving agency use		
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	Yes - the Trust has its own Temporary Staffing Bureau which is an in-house service through which all bank and agency worker requirements are booked.	
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	There is a Standard Operating Procedure for requesting and booking temporary staff. Booking agency staff is the last route once other alternatives such as overtime or internal bank cover has been fully explored.	
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	There is a formal escalation process which is followed by those needing an agency worker and the Temporary Staffing Bureau. There is an audit trail against each request and booking made.	With effect from 23/11/2016 all shifts costing in excess of £120 ph, will be countersigned by the COO, Chief Nurse or Medical Director at the point of booking, with a report going to the Chief Executive on a daily basis.
	Actions to reducing demand for agency staffing		
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	There are Divisional plans which are monitored monthly by Executives. Exceptions in spending levels are challenged. The Trust has robust methods of data collation which allows for close srcutiny and transparency of agency usage and spend.	
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	The Trust has a clear action plan in place which is monitored by the Medical Director, Chief Nurse and Director of Workforce. It addresses a range of activities with the aim of encouraging bank work and reducing agency reliance. Actions also include a number of incentives to attract and reward staff.	A medical locum bank will be created within the existing functionality of the Trust's in-house Bank service with effect from April 2017
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	Rostering is undertaken 6 weeks in advance across clinical services	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	The Trust has clear KPIs to monitor recruitment performance and conversion to appoint with tight targets, monitored through divisional Performance and Ops reviews.	The Trusts SLA for time to hire for agenda for change roles of 45 working days from vacancy approval to final offer with start date. We would be interested to learn from Trusts who are achieving a 21 day turnaround time quoted in this question, given the majority of appointees have a minimum 4-week notice period.
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	The Trust has a robust operating planning round each year within each Division where service development and role redesign is considered and accounted for. These are signed off by the Executive team. Innovative recruitment solutions are considered and put in place throughout the year to meet demand.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	As above in Q13	
	Working with your local health economy		
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	See Q16 below	
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	There are quarterly Exec to Exec meetings with the neighbouring acute Trust. Professional leads such as Finance, HR also attend professional network meetings where such issues are discussed.	

Signed by [Date]

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix 2

Escalation and sign-off controls for non-framework agency use and high cost agency shifts

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Escalation and sign-off controls are being implemented for:

1. All off-framework agency usage and above the price cap
2. All agency shifts costing more than £120 per hour

These controls come into effect from Monday 28th November 2016.

1. Off-framework agency usage:

- **Out of hours -** all requests to go off-framework are to be escalated by the on-call manager to the Exec on-call

- **In hours -** all requests to go off-framework are to be initially approved in line with the current escalation process i.e. by the HON, but must now also be countersigned by Carolyn Mills as Chief Nurse or Owen Ainsley as COO.

  The request will come from the TSB who will call or text both Carolyn and Owen at the same time. They will accept the first response back. On the occasion when neither Carolyn nor Owen can respond in 15 minutes, the TSB will escalate sign-off to Peter Russell - Head of Resourcing, or Deborah Tunnell - Head of the HR Service Centre.

- A daily report reflecting the previous days agency usage (inclusive of off-framework) will be sent to Yvonne Quinn each day.

2. All agency shifts costing more than £120 per hour

- **Out of hours -** all requests are to be escalated by the on-call manager to the Exec on-call. *These will be minimal out of hours*

- **In hours -** all requests must first go to the Clinical Chair/Divisional Clinical Director for initial approval in line with the current escalation process, but must now also be countersigned by Sean O'Kelly as Medical Director or Owen Ainsley as COO.

  The request will come from the TSB who will call or text both Sean and Owen at the same time. They will accept the first response back. On the occasion when neither Sean nor Owen can respond in 15 minutes, the TSB will escalate sign-off to Peter Russell or Deborah Tunnell.

- A daily report reflecting the previous days bookings/use of high cost agency locums, will be sent to Yvonne Quinn each day.

There is a possibility that specialist nurses who are in charge on bank holidays through a non-framework agency could cost in excess of £120ph. A hybrid of both scenarios. In this circumstance, the approval process for the **off-framework agency use** should be followed, as described above.

A new weekly report will be produced reflecting the previous week's activity, which will go to Alex Nestor as Director of Workforce & OD for discussion and sign-off with Robert Woolley as Chief Executive. The report has to be sent to NHSI with effect from January 2017, as part of the Trust's existing weekly reporting which reflects all agency cap and worker rate over-rides.

This new escalation process will be regularly reviewed with all the key stakeholders to ensure it is efficient and remains fit for purpose.

Please Note:

- It is expected that the same degree of scrutiny is given by the key staff involved in the agency booking process before it reaches the on-call Exec out of hours and the relevant Exec in hours.
- The only change to the current escalation process to go off-framework is that it needs to be countersigned/challenged by the relevant Exec prior to the TSB placing the booking. This additional escalated sign-off requirement is not changing existing processes in place.
- 99% of off-framework use is with Thornbury Nursing Services, with very occasional use of Prestige and Greenstaff. The latter have a very minimal supply.
- The new guidance will be kept on the on-call managers and patient flow workspaces where the existing escalation processes are held.

Deborah Tunnell – Head of HR Service Centre

November 2016

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Public Trust Board	**Meeting Date**	**29 November 2016**
Report Title	Trust Constitution		
Author	Kate Hanlon, Interim Head of Governance and Membership		
Executive Lead	Pam Wenger, Trust Secretary		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1:We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff. c.	☐	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☒	For Information	☐

Executive Summary
Purpose This paper outlines the changes to the Trust Constitution proposed by the governor Constitution Project Focus Group on 1 September 2016 and agreed by the Council of Governors on 31 October 2016. Key issues to note The changes are noted below. The amendments are shown in the Trust Constitution, which is available in the 'Supporting Information' pack.

I. 8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency if they have exercised these functions continuously for a period of at least 12 months. This category includes (but is not limited to):
— 8.2.2 registered volunteers at the Trust or individuals who work at the Trust on behalf of a voluntary organisation.
Council of Governors AGREED to remove section 8.2.2.

II. *10.1 An individual who has, within the preceding three years, attended any of the Trust's hospitals as either a patient or as the carer of a patient may become or continue as a Member.*
Council of Governors AGREED to remove the words 'within the preceding three years'.

III. *27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election is eligible to vote in that election.*
Council of Governors AGREED the minimum age for voting will be 16 years old.

IV. A carer is someone who provides unpaid help and support to another person who could not cope without their help. This could be due to age, physical or mental illness, disability or addiction.
Council of Governors AGREED to include a definition of carer in the Trust Constitution.

Recommendations

Members are asked to:

- **Receive** and **approve** the updates to the Trust Constitution.

Intended Audience
(please select any which are relevant to this paper)

Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☐

Board Assurance Framework Risk
(please choose any which are impacted on / relevant to this paper)

Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Council of Governors**
				31/10/2016

University Hospitals Bristol NHS Foundation Trust

Constitution

[as at 29 January 2015]

University Hospitals Bristol NHS Foundation Trust Constitution

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TABLE OF CONTENTS

Paragraph

1. **Interpretation and definitions**

1.1 Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the 2006 Act.

1.2 Words importing the masculine gender only shall include the feminine gender, words importing the singular shall import the plural and vice-versa.

1.3 References to statutory provisions shall be construed as references to those provisions as subsequently amended or re-enacted (whether before or after the date of this Agreement) from time to time and shall include any provisions of which they are re-enactments (whether with or without modification).

1.4 The following expressions have the following meanings, unless the context requires otherwise—

"the 2006 Act"	is the National Health Service Act 2006 (as amended by the 2012 Act).
"the 2012 Act"	is the Health and Social Care Act 2012.
"Accounting Officer"	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
"Annual Members Meeting"	means an annual meeting of the Members.
"constitution"	means this constitution and all annexes to it.
"Director"	means a member of the Board of Directors of the Trust.
"Governor"	means a member of the Council of Governors of the Trust.
"health service body"	means an NHS foundation trust or any of the bodies listed in Section 9(4) of the 2006 Act.
"Member"	means a member of the Trust.
"Monitor"	is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.
"voluntary organisation"	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2. **Name**

2.1 The name of the foundation trust is University Hospitals Bristol NHS Foundation Trust (the Trust).

3. **Principal purpose**

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

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health

service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to—

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph, for the purpose of making additional income available in order better to carry on its principal purpose.

4. **Powers**

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

5. **Membership and constituencies**

5.1 The Trust shall have Members, each of whom shall be a Member of one of the following constituencies—

5.1.1 a Public Constituency,

5.1.2 the Staff Constituency, or

5.1.3 the Patients and Carers Constituency

6. **Application for Membership**

6.1 An individual who is eligible to become a Member may do so on application to the Trust or by being invited by the Trust to become a Member of the Staff Constituency in accordance with paragraph 9.

6.2 An individual shall become a Member on the date his name is added to the Trust's register of Members, and shall cease to be a Member on the date is removed from the register of Members.

7. **Public Constituency**

7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a Member.

7.2 Those individuals who live in an area specified for a Public Constituency are referred to collectively as a Public Constituency.

7.3 An individual who ceases to live in any area specified in Annex 1 shall cease to be a Member of any Public Constituency. A Member who moves from one area to another shall become a Member of the Public Constituency for that new area. Members should notify the Trust of any change of address.

7.4 In the case of any doubt, the Trust's decision as to whether or not an individual lives in an area will be final.

7.5 The minimum number of Members for each Public Constituency is specified in Annex 1.

8. **Staff Constituency**

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member provided—

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months, or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as Members of the Staff Constituency if they have exercised these functions continuously for a period of at least 12 months. This category includes (but is not limited to) —

8.2.1 contractors who provide services to the Trust for at least 16 hours per week or 50% of their contracted hours (whichever is the lesser),

8.2.2 ~~registered volunteers at the Trust or individuals who work at the Trust on behalf of a voluntary organisation, and~~

8.2.3 academic staff who have an honorary contract with the Trust and who work at the Trust

8.3 Those individuals who are eligible for membership by reason of this paragraph 8 are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a Staff Class within the Staff Constituency.

8.5 The minimum number of Members in each Staff Class is specified in Annex 2.

9. **Automatic membership by default – staff**

9.1 An individual who is—

9.1.1 Eligible under paragraph 8.1 to become a Member of the Staff Constituency, and

9.1.2 invited by the Trust to become a Member of the Staff Constituency and a Member of the appropriate Staff Class,

shall become a Member as a Member of the Staff Constituency and appropriate Staff Class without an application being made, unless he informs the Trust that he does not wish to do so.

10. **Patients and Carers Constituency**

10.1 An individual who has~~, within the preceding three years,~~ attended any of the Trust's hospitals as either a patient or as the carer of a patient may become or continue as a Member. A carer is someone who provides unpaid help and support to another person who could not cope without their help. This could be due to age, physical or mental illness, disability or addiction.

10.2 Those individuals who are eligible for membership by reason of paragraph 10.1 are referred to collectively as the Patients and Carers Constituency.

~~10.3 An individual who has not attended any of the Trust's hospitals in the preceding three years as a patient or carer may not continue as a Member of the Patients and Carers Constituency.~~

~~10.4~~10.3 The Patients and Carers Constituency shall be divided into three descriptions of individuals who are eligible for membership of the Patients and Carers Constituency. Each description of individuals is specified within Annex 3 and is referred to as a class of the Patients and Carers Constituency.

~~10.5~~10.4 An individual providing care under a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Patients and Carers Constituency.

~~10.6~~10.5 The minimum number of Members in each class of the Patients and Carers Constituency is specified in Annex 3.

~~10.7~~10.6 An applicant for membership who notifies the Trust of his eligibility to be a Member of either a Public Constituency or of the Patients and Carers Constituency, shall become a Member of the appropriate class of the Patients and Carers Constituency unless he has informed the Trust in writing that he wishes instead to become a Member of a Public Constituency.

11. Restriction on membership

11.1 A Member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a Member of any other constituency or class.

11.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a Member of any constituency other than the Staff Constituency.

11.3 An individual shall not be eligible for membership if he—

11.3.1 fails or ceases to fulfil the criteria for membership of any of the constituencies,

11.3.2 was formerly employed by the Trust or its predecessor applicant NHS Trust and was dismissed for gross misconduct,

11.3.3 was formerly employed by the Trust and in the preceding two years was lawfully dismissed other than by reason of redundancy,

11.3.4 has been involved as a perpetrator in a serious incident of violence or abuse in the last five years at any of the Trust's hospitals or against any of the Trust's staff members or patients,

11.3.5 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children & Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974,

11.3.6 does not agree to, or by his actions or conduct shows that he does not (in the reasonable opinion of the Trust), abide by the Trust values as set out in the Trust's Integrated Business Plan or elsewhere,

11.3.7 has been identified as a vexatious complainant by the Trust or other authority or has been excluded from treatment at any of the Trust's hospitals due to unacceptable behaviour,

11.3.8 is deemed, in the reasonable opinion of the Trust, to have acted in a

manner contrary to the interests of the Trust,

11.3.9 is deemed, in the reasonable opinion of the Trust, to have failed to comply in a material way with the values and principles of the National Health Service or the Trust, and/or this constitution, or

11.3.10 is under the age of seven (7) years.

11.4 Members should ensure their own eligibility for membership and inform the Trust if they cease to be eligible.

11.5 A Member shall cease to be a Member if—

11.5.1 he resigns by notice in writing to the Membership Manager,

11.5.2 he dies,

11.5.3 he ceases to be entitled under this constitution to be a Member,

11.5.4 he is expelled under this constitution, or

11.5.5 it appears to the Membership Manager that the Member no longer wishes to be involved in the affairs of the Trust as a Member, and after enquiries made in accordance with a process approved by the Governors, the Member does not establish that he has a continuing wish to be involved in the affairs of the Trust as a Member.

11.6 The Trust shall give any Member at least 14 days' written notice before removing him from Membership under paragraphs 11.5.3, 11.5.4, or 11.5.5. The Trust shall consider any representations made by the Member during that notice period.

12. Annual Members' Meeting

12.1 The Trust shall hold an Annual Members' Meeting no later than 30 September every year. The Annual Members' Meeting shall be open to the public.

12.2 Any Members' meetings other than the Annual Members' Meeting shall be called "Special Members' Meetings".

12.3 Special Members' Meetings shall be open to all Members, Governors and Directors, and to representatives of the Trust's financial auditors. Special Members' Meetings shall not be open to anyone else unless invited by the Trust.

12.4 All Members' meetings are to be convened by the Directors.

12.5 The Directors shall decide where any Members' meeting is to be held and may provide that the same meeting can be conducted in multiple venues.

12.6 The Directors shall set the quorum for any Members' meeting.

12.7 The Trust shall give at least 14 clear days' notice of any Members' meeting—

12.7.1 by notice in writing to all Members (by email where email addresses are held),

12.7.2 by notice prominently displayed at the Trust's main address and at all of the Trust's principal places of business,

12.7.3 by notice on the Trust's website, and

12.7.4 to the Governors and the Directors, and to the Trust's auditors,

stating whether the meeting is an Annual Members' Meeting or a Special

Members' Meeting, giving the time, date and place of the meeting and indicating the business to be dealt with at the meeting.

12.8 The Directors shall present to the Members at the Annual Members' Meeting—

12.8.1 a report on steps taken to secure that (taken as a whole) the actual membership is representative of those eligible for such membership,

12.8.2 the progress of the membership strategy,

12.8.3 any proposed changes to the policy for the composition of the Governors and of the Non-Executive Directors,

12.8.4 the results of the election and appointment of Governors, and

12.8.5 any other reports or documentation it considers necessary or otherwise required by Monitor or the 2006 Act, including the annual accounts, any report of the auditor and the annual report.

12.9 The Chair or in his absence the Deputy Chair shall chair any Members' meetings. If neither the Chair nor the Deputy Chair is present, the Governors present shall elect one of their number to chair the meeting. If there is only one Governor present and willing to act that person shall chair the meeting. If no Governor is present and willing to chair the meeting within fifteen minutes after the notified start time of the meeting, the Members present and entitled to vote shall choose one of their number to chair the meeting.

13. Council of Governors – composition

13.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

13.2 The composition of the Council of Governors is specified in Annex 4.

13.3 The Governors, other than the appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency.

13.4 The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13.5 At all times more than half of the Governors shall be Governors who are elected by Members of the Public Constituency and the Patients and Carers Constituency.

14. Council of Governors – election of Governors

14.1 Elections for elected Governors shall be conducted in accordance with the Model Election Rules.

14.2 The Model Election Rules as published from time to time by the Department of Health form part of this constitution. The Model Election Rules current at the date of the Trust's Authorisation are attached at Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 45 of the constitution (amendment of the constitution).

14.4 An election, if contested, shall be by secret ballot.

14.5 A Member of a Public Constituency or the Patients and Carers Constituency standing for election as Governor must, at the time of his nomination, make a declaration for the purposes of Section 60 of the 2006 Act in the form specified by the Trust, stating the particulars of his qualification to vote as a Member and that

he is not prevented from being a Governor by virtue of any provisions of this constitution.

15. **Council of Governors - tenure**

15.1 An elected Governor may hold office for a period of up to three years.

15.2 An elected Governor shall cease to hold office if he ceases to be a Member of the constituency or class by which he was elected (except that a Public Governor who moves from one Public Constituency to another during his term of office shall continue in office as a Public Governor for the constituency which elected him for the remainder of his term).

15.3 Subject to paragraph 15.7, an elected Governor shall be eligible for re-election at the end of his term.

15.4 An appointed Governor may hold office for a period of up to three years (except for Governors appointed by the Trust's Youth Council who may hold office for a period of up to one year).

15.5 An appointed Governor shall cease to hold office if the appointing organisation withdraws his appointment.

15.6 Subject to paragraph 15.7, an appointed Governor shall be eligible for re-appointment at the end of his term.

15.7 No Governor may serve for more than a total of nine years.

16. **Council of Governors – disqualification and removal**

16.1 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

16.2 A person may not become or continue as a Governor if he—

16.2.1 has been adjudged bankrupt or his estate has been sequestrated and (in either case) has not been discharged,

16.2.2 has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

16.2.3 within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him,

16.2.4 has within the preceding two years been lawfully dismissed otherwise than by reason of redundancy from any paid employment with a Health Service Body,

16.2.5 was formerly employed by the Trust or its predecessor application NHS trust and was dismissed for gross misconduct,

16.2.6 is a person whose term of office as the chair or as a member or director of a Health Service Body has been terminated on the grounds that his continuance in office is no longer in the best interests of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest,

16.2.7 has had his name removed by a direction under Section 154 of the 2006 Act from any list prepared under Part 4 of that Act and has not

subsequently had his name included in such a list,

16.2.8 has failed to make, or has falsely made, any declaration as required to be made under Section 60 of the 2006 Act or has spoken or voted in a meeting on a matter in which he had a direct or indirect pecuniary or non-pecuniary interest and he is judged to have acted so by a majority of of the Council of Governors,

16.2.9 has been removed as a Governor, suspended from office or disqualified from holding office as a Governor by Monitor, or Monitor has exercised any of those powers in relation to him on any other occasion whether in relation to the Trust or some other NHS Foundation Trust,

16.2.10 has received a written warning from the Trust for verbal and/or physical abuse towards Trust staff or patients,

16.2.11 has been placed on the registers of Schedule 1 Offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Act 1933 to 1969 (as amended) and his conviction is not spent under the Rehabilitation of Offenders Act 1974,

16.2.12 is a Member of a Staff Class and any professional registration relevant to his eligibility to be a Member of that Staff Class has been suspended for a continuous period of more than six months,

16.2.13 is incapable by reason of mental disorder, illness or injury in managing and administering his property and/or affairs,

16.2.14 is appointed by an organisation that ceases to exist,

16.2.15 is a member of the UK Parliament,

16.2.16 is a director or a governor of another NHS Foundation Trust,

16.2.17 is a member of a health related local authority overview and scrutiny committee, or

16.2.18 information revealed by a DBS check is such that it would be inappropriate for him to become or continue as a Governor on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

16.3 A Governor who becomes disqualified must notify the Trust as soon as practicable and in any event within 14 days of first becoming aware that he is disqualified.

16.4 If the Trust becomes aware that a Governor is disqualified, the Trust will give him notice that he is disqualified as soon as practicable.

17. Council of Governors: Termination of Tenure

17.1 A Governor's term of office shall be terminated—

17.1.1 by the Governor giving notice in writing to the Trust of his resignation from office at any time during that term of office,

17.1.2 by the giving of a notice under either paragraph 16.3 or 16.4,

17.1.3 by the Council of Governors if he has failed to attend two successive meetings of the Council of Governors unless the Council of Governors is satisfied:

17.1.3.1 the absence was due to reasonable cause, and

17.1.3.2 that the Governor will resume attendance at meetings of the Council of Governors within such period as it considers reasonable.

17.1.4 if the Council of Governors resolves that—

17.1.4.1 his continuing as a Governor would or would be likely to prejudice the ability of the Trust to fulfil its principal purpose or of its purposes under this constitution or otherwise to discharge its duties and functions,

17.1.4.2 his continuing as a Governor would or would be likely to prejudice the Trust's work with other persons or body with whom it is engaged or may be engaged in the provision of goods and services,

17.1.4.3 his continuing as a Governor would or would be likely to adversely affect public confidence in the goods and services provided by the Trust,

17.1.4.4 his continuing as a Governor would or would be likely to otherwise bring the Trust into disrepute or be detrimental to the interest of the Trust,

17.1.4.5 it would not be in the best interests of the Council of Governors for him to continue in office as a Governor,

17.1.4.6 it would not be in the best interests of the Trust for him to continue in office as a Governor,

17.1.4.7 he is a vexatious or persistent litigant or complainant with regard to the Trust's affairs and his continuance in office would not be in the best interests of the Trust,

17.1.4.8 he has failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required him to undertake in his capacity as a Governor,

17.1.4.9 he has in his conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust, and/ or this constitution, or

17.1.4.10 he has committed a material breach of any code of conduct applicable to Governors and/or the Standing Orders for Governors.

17.2 A resolution under paragraph 17.1.4 shall be proposed by the Chair (or in his absence, the Deputy Chair) and considered in a meeting of the Council of Governors convened for that purpose and to pass requires a majority of three quarters of the Governors voting at that meeting.

17.3 If the Chair is minded to propose a resolution under paragraph 17.1.4, the Chair shall first offer the Governor in question the opportunity to have the evidence reviewed by an independent assessor agreeable to that Governor and to the Chair.

17.4 The Standing Orders adopted by the Council of Governors may contain provisions governing its procedure for terminating a Governor's term of office.

17.5 A Governor whose term of office is terminated before it expires shall not be eligible to be a Governor for three years from the date of termination, except by resolution carried by a majority of the Council of Governors voting.

18. **Council of Governors: vacancies**

18.1 If an appointed Governor's term of office is terminated before it expires, the Trust will invite the relevant appointing body to appoint a new Governor to hold office for the remainder of the term of office.

18.2 If an elected Governor's term of office is terminated [more than 90 days before it] before it expires, the Trust will invite the candidate who secured the second highest number of votes in the last election for that office to assume the position for the remainder of the retiring Governor's term, provided that he achieved at least five percent (5%) of the number of votes for that constituency (or class of constituency, as the case may be). If that candidate does not accept, the vacancy will be offered to the candidate who secured the next highest number of votes (provided that he achieved at least five percent (5%) of the number of votes), and so on.

18.3 If no reserve candidate is available or willing to fill the vacancy, and an election is not due to be held within 6 months of the vacancy arising, an election will be held in accordance with the Election Scheme as soon as is reasonably practicable. If an election is due to be held within 6 months, the office will stand vacant until the next scheduled election, unless the vacancy causes the aggregate number of Public Governors and Patient and Carer Governors to be less than half the total membership of the Council of Governors. In that case an election will be held in accordance with the Election Scheme as soon as reasonably practicable.

18.4 No defect in the election or appointment of a Governor or deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

19. **Council of Governors – duties of Governors**

19.1 The general duties of the Council of Governors are—

19.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

19.1.2 to represent the interests of the Members as a whole and the interests of the public.

19.2 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

20. **Council of Governors – meetings of Governors**

20.1 The Chair or, in his absence the Deputy Chair, shall preside at meetings of the Council of Governors.

20.2 Meetings of the Council of Governors shall be open to members of the public, unless members of the public are excluded for special reasons.

20.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting of the Council of Governors.

21. **Council of Governors – standing orders**

21.1 The standing orders for the practice and procedure of the Council of Governors are attached at Annex 6.

22. **Council of Governors – referral to the Panel**

22.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

22.1.1 to act in accordance with its Constitution, or

22.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

22.2 A Governor may refer a question to the Panel only if more than half of the Governors voting approve the referral.

23. **Council of Governors – conflicts of interest of Governors**

23.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the Governors as soon as he becomes aware of it.

23.2 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

24. **Council of Governors – travel expenses**

24.1 The Trust may pay travelling and other expenses to Governors at rates determined by the Trust.

25. **Board of Directors – composition**

25.1 The Trust has a Board of Directors, which comprises both Executive and Non-Executive Directors.

25.2 The Board of Directors comprises—

25.2.1 a Non-Executive Chairman,

25.2.2 up to 8 other Non-Executive Directors (one of whom may be nominated as the Senior Independent Director), and

25.2.3 up to 7 Executive Directors.

25.3 One of the Executive Directors is the Chief Executive.

25.4 The Chief Executive is the Accounting Officer

25.5 One of the Executive Directors is the Finance Director

25.6 One of the Executive Directors is a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)

25.7 One of the Executive Directors is a registered nurse or a registered midwife

25.8 The Board of Directors shall at all times be constituted so that the number of Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

26. **Board of Directors – general duty**

26.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members as a whole and for the public.

27. **Board of Directors – qualification for appointment as a Non-Executive Director**

27.1 A person may be appointed as a Non-Executive Director only if—

27.1.1 he is a Member of a Public Constituency, or

27.1.2 he is a Member of the Patients and Carers Constituency, or

27.1.3 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

27.1.4 he is not disqualified by virtue of paragraph 31 below.

28. **Board of Directors – appointment and removal of the Chair and other Non-Executive Directors**

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair and the other Non-Executive Directors.

28.2 Removal of the Chair or another Non-Executive Director shall require the approval of at least three-quarters of the Council of Governors.

29. **Board of Directors – appointment of the Deputy Chair**

29.1 The Council of Governors at a general meeting shall appoint one of the Non-Executive Directors to be the Deputy Chair.

30. **Board of Directors - appointment and removal of the Chief Executive and other Executive Directors**

30.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

30.2 The appointment of the Chief Executive shall require the approval of the majority of the Council of Governors.

30.3 A committee consisting of the Chief Executive, the Chair and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

31. **Board of Directors – disqualification**

31.1 A person may not become or continue as a Director if he—

31.1.1 has been adjudged bankrupt or his estate has been sequestrated and (in either case) has not been discharged,

31.1.2 has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

31.1.3 within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him,

31.1.4 in the case of a Non-Executive Director, no longer satisfies the relevant requirements for appointment,

31.1.5 is a person whose tenure of office as a Chair or as a member or Director of a Health Service Body has been terminated on the grounds that his

appointment is not in the interests of public service, or for non-disclosure of a pecuniary interest,

31.1.6 has within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a Health Service Body,

31.1.7 information revealed by a DBS check is such that it would be inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute,

31.1.8 in the case of an Executive Director, is no longer employed by the Trust,

31.1.9 has had his name removed by a Direction under section 154 of the 2006 Act from any list prepared under Part 4 of that Act, and has not subsequently had his name included on such a list,

31.1.10 is a member of a patient and public involvement forum,

31.1.11 is a member of a local authority's overview and scrutiny committee,

31.1.12 is the subject of a disqualification order made under the Company Directors' Disqualifications Act 1986,

31.1.13 has failed or refused to undertake any training which the Board of Directors requires all Directors to undertake,

31.1.14 has failed to sign and deliver to the Secretary in the form required by the Board of Directors confirmation that he accepts the Code of Conduct of NHS Managers,

31.1.15 is a partner or spouse of an existing Director,

31.1.16 is an 'unfit person' as defined in the Trust's provider licence (as may be amended from time to time), or

31.1.17 does not meet any other statutory requirement for being a Director of an NHS foundation trust.

32. Board of Directors – meetings

32.1 Meetings of the Board of Directors shall be open to members of the public, unless members of the public are excluded for special reasons.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

33. Board of Directors – standing orders

33.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 7.

34. Board of Directors - conflicts of interest of Directors

34.1 The duties that a Director has by virtue of being a Director include in particular—

34.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

34.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in sub-paragraph 34.1.1 is not infringed if—

34.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

34.2.2 the matter has been authorised in accordance with the constitution.

34.3 The duty referred to in sub-paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In sub-paragraph 34.1.2, "third party" means a person other than—

34.4.1 the Trust, or

34.4.2 a person acting on its behalf.

34.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

34.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

34.9 A Director need not declare an interest—

34.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest,

34.9.2 if, or to the extent that, the Directors are already aware of it, or

34.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered—

34.9.3.1 by a meeting of the Board of Directors, or

34.9.3.2 by a committee of the Directors appointed for the purpose under the constitution.

34.10 The Standing Orders of the Board of Directors shall include provisions about the disclosure of interests and arrangements for a Director with an interest to withdraw from a meeting in relation to the matter in respect of which he has declared an interest.

35. Board of Directors – remuneration and terms of office

35.1 The Council of Governors at a general meeting shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

35.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

36. **Registers**

36.1 The Trust shall have—

36.1.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs,

36.1.2 a register of Governors,

36.1.3 a register of interests of Governors,

36.1.4 a register of Directors, and

36.1.5 a register of interests of Directors.

37. **Registers – inspection and copies**

37.1 The Trust shall make the registers specified in paragraph 366 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of—

37.2.1 any Member of the Public, Patients and Carers Constituency, or

37.2.2 any other Member, if he so requests.

37.3 So far as the registers are required to be made available—

37.3.1 they are to be available for inspection free of charge at all reasonable times, and

37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

38. **Documents available for public inspection**

38.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times—

38.1.1 a copy of the current Constitution,

38.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

38.1.3 a copy of the latest annual report.

38.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times—

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act,

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act,

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act,

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act,

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act,

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act,

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act,

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act,

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a Member, the Trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The Trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor by a majority vote at a general meeting of the Council of Governors.

40. Audit committee

40.1 The Trust shall establish a statutory committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The Trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the Trust's auditor.

41.4 The Trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. **Annual report, forward plans and non-NHS work**

42.1 The Trust shall prepare an annual report and send it to Monitor.

42.2 The Trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

42.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about—

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must—

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the Directors of its determination.

42.7 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, the Trust may implement the proposal only if more than half of the Governors voting approve its implementation.

43. **Presentation of the annual accounts and reports to the Governors and Members**

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors—

43.1.1 the annual accounts,

43.1.2 any report of the auditor on them, and

43.1.3 the annual report.

43.2 The documents shall also be presented to the Members at the Annual Members' Meeting by at least one Director in attendance.

43.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. **Instruments**

44.1 The Trust shall have a seal.

44.2 The seal shall not be affixed except under the authority of the Board of Directors.

45. **Amendment of the Constitution**

45.1 The Trust may make amendments of its Constitution only if—

45.1.1 more than half of the Council of Governors voting approve the amendments, and

45.1.2 more than half of the Directors voting approve the amendments.

45.2 Amendments made under paragraph 45.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

45.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)—

45.3.1 at least one Governor must attend the next Annual Members' Meeting and present the amendment,

45.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment, and

45.3.3 if more than half of the Members voting approve the amendment, the amendment continues to have effect, otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

45.4 Amendments by the Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

46. Mergers etc. and significant transactions

46.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the Council of Governors.

46.2 The Trust may enter into a significant transaction only if more than half of the Council of Governors voting approve entering into the significant transaction.

46.3 Significant transaction is defined as investments, divestments or other transactions comprising more than 25% of the assets, income or capital of the NHS Foundation Trust, in line with Monitor's Risk Assessment Framework.

47. Indemnity

47.1 Governors and Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust and the Trust shall have the power to purchase suitable insurance or make appropriate arrangements with the National Health Service Litigation Authority to cover such costs.

ANNEX 1

THE PUBLIC CONSTITUENCIES

The Public Constituencies	**Area of each Public Constituency (as defined by Local Authority boundaries)**	**Minimum Number of Members**
Bristol	Bristol City Council	2163
North Somerset	North Somerset District Council	1022
South Gloucestershire	South Gloucestershire Council	1331
Rest of England and Wales	Rest of England and Wales	5

The minimum number of members is based on 0.5% of the population in each Public Constituency as reported in the ONS 2012 based sub-national population data:

Rest of England and Wales – fixed value at 5 members

ANNEX 2

THE STAFF CONSTITUENCY

Classes within the Staff Constituency	**Individuals Eligible for Membership of that Staff Class**	**Minimum Number of Members in each Staff Class**
Medical and Dental Staff	Those individuals defined in paragraph 1 below.	628
Nursing and Midwifery Staff	Those individuals defined in paragraph 2 below.	2372
[Other Clinical Healthcare Staff]	Those individuals defined in paragraph 3 below.	1023
[Non-Clinical Healthcare Staff]	Those individuals defined in paragraph 4 below.	1882

The minimum number of members is based on 75% of the headcount the workforce in each Staff Constituency as at December 2014.

1. **Medical and Dental Staff**

1.1 Members of the Staff Constituency who are fully registered persons within the meaning of the Medical Act 1983 or the Dentists Act 1984 and who are otherwise fully authorised and licensed to practise in England and Wales or who are otherwise designated by the Trust from time to time as eligible to be members of this Staff Class for the purposes of this paragraph having regard to the usual definitions applicable at that time for persons carrying on the professions of medical practitioner or dentist.

2. **Nursing and Midwifery Staff**

2.1 Members of the Staff Constituency who are registered under the Nurses, Midwifes and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practise in England and Wales or are otherwise designated by the Trust from time to time as eligible to be Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife and individuals who are health care assistants.

3. **Other Clinical Healthcare Staff**

3.1 Members of the Staff Constituency who do not come within paragraphs 1 or 2 above and are regulated by a regulatory body that falls within the remit of the Professional Standards Authority for Health and Social Care established by the NHS Reform Act 2002 (as amended by the 2012 Act), or who are otherwise designated by the Trust from time to time as eligible Members of this Staff Class for the purposes of this paragraph, having regard to the usual definitions applicable at that time for persons carrying on such professions.

4. **Non-Clinical Staff**

4.1 Members of the Staff Constituency, who do not come within paragraphs 1, 2 or 3 above and are designated by the Trust from time to time as eligible to be a

Member of this Staff Class.

5. **Honorary contract holders**

5.1 Those individuals who are Members of the Staff Constituency pursuant to paragraph 8.2.3 of this constitution (academic staff under an honorary contract with the Trust) shall be members of a Staff Class detailed in paragraphs 1, 2 and 3 above as appropriate.

6. **Continuous Employment**

6.1 For the purposes of paragraph 8.1.2 and 8.2 of this constitution, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust.

7. **Exercise of Functions**

7.1 For the purposes of paragraph 8.2 of this constitution it shall be for the Trust in its absolute discretion to determine whether an individual exercises functions for the purposes of the Trust and whether that individual has done so continuously for a period of at least twelve months.

ANNEX 3

THE PATIENTS AND CARERS CONSTITUENCY

Classes within the Patients and Carers Constituency	**Individuals eligible for Membership of each Class**	**Minimum Number of Members in each Class**
Local Patients	Patients residing in any of the Bristol, North Somerset or South Gloucestershire Public Constituencies	100
Carers of Adult Patients	Carers who provide care to patients who are 16 years of age or over	50
Carers of Child Patients	Carers who provide care to patients who are under 16 years of age	50

ANNEX 4

COMPOSITION OF COUNCIL OF GOVERNORS

	Electing/Appointing Body	**Number of Governors**	**Total**
1.	**Public Constituencies**		
	Bristol	5	
	South Gloucestershire	2	
	North Somerset	2	
	Rest of England and Wales	2	**11**
2.	**Staff Constituency**		
	Medical and Dental Staff Class	1	
	Nursing and Midwifery Staff Class	2	
	Other Clinical Healthcare Staff Class	1	
	Non-Clinical Healthcare Staff Class	2	**6**
3.	**Patients and Carers Constituency**		
	Carers of Adult Patients	2	
	Carers of Child Patients	2	
	Local Patients	6	**10**
4.	**Appointed Governors**		
	Local Authority		
	Bristol City Council	1	
	Universities		
	University of Bristol	1	
	University of West of England	1	
	Partnership Organisations		
	Avon and Wiltshire Mental Health Partnership NHS Trust	1	
	South Western Ambulance Service NHS Foundation Trust	1	

	Joint Union Committee	1	
	Community and Voluntary Sector	1	
	University Hospitals Bristol NHS Foundation Trust Youth Council	2	**9**
	Total Number of Governors		**36**

1. **Appointed Governors**

1.1 Each appointing body shall be entitled to appoint a Governor or Governors (as set out in the table above) in accordance with a process of appointment agreed by it with the Trust. The absence of any such agreed process of appointment shall not prevent an appointing body from appointing it Governor(s).

1.2 If Bristol City Council declines or fails to appoint a Governor within three months of being requested to do so by the Trust, the Trust shall consult North Somerset District Council and South Gloucestershire Council and the Trust shall invite one of those local authorities to appoint a Governor in substitution for Bristol City Council.

1.3 At the end of the term of appointment of that Governor the Trust shall in its absolute discretion decide whether to permit Bristol City Council to appoint a Governor for the next period of office (provided it remains eligible to do so) or to invite the local authority which had appointed a Governor in substitution to do so.

ANNEX 5

THE MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

PART 2: TIMETABLE FOR ELECTION

PART 3: RETURNING OFFICER

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

PART 5: CONTESTED ELECTIONS

Action to be taken before the poll

The poll

PART 12: MISCELLANEOUS

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their

votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which

party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule

13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5

and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following

information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or

elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that

comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual, aged 16 or over, who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been

received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the

text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone

voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules

FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who

are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at

which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be

named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6

STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. INTERPRETATION

1.1 In these Standing Orders, the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning.

2. MEETINGS OF THE COUNCIL OF GOVERNORS

2.1 Calling Meetings

2.1.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website.

2.1.2 The Secretary shall ensure that within the meeting cycle of the Council of Governors, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

2.1.3 If the Chair fails to call a meeting of the Council of Governors after a requisition for that purpose, signed by at least one-third of the whole number of the Council of Governors has been presented to him at Trust Headquarters, such one third or more members of the Council of Governors may forthwith call a meeting.

2.1.4 **Admission of the Public** and the Press– The meetings of the Council of Governors shall be open to members of the public and press unless the Council of Governors decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Council of Governors following the exclusion of members of the public and/or press shall be confidential to the members of the Council of Governors. Governors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

2.1.5 In the event that the public and press are admitted to all or part of a meeting by reason of SO 2.1.4 above, the Chair (or Deputy Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Council of Governors resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

2.1.6 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Council of Governor meetings.

2.1.7 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Council of Governors. Such permission shall be granted only upon resolution of the Trust.

2.1.8 The Council of Governors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

2.1.9 **Chair of Meetings** – The Chair of the Trust, or in his absence, the Deputy Chair, is to preside at meetings of the Council of Governors.

2.1.10 The Deputy-Chair may preside at meetings of the Council of Governors in the following circumstances:

2.1.10.1 When there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chair is not present.

2.1.10.2 On those occasions when the Council of Governors is considering matters relating to Non-Executive Directors and it would be inappropriate for the Chair to preside.

2.1.10.3 When the remuneration, allowance and other terms and conditions of the Chair are being considered.

2.1.10.4 When the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

2.1.10.5 On occasions when the Chair declares a pecuniary interest that prevents him from taking part in the consideration or discussion of a matter before the Council of Governors.

2.1.11 **Setting the Agenda –** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

2.1.12 **Agenda** – A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or Secretary at least three clear business days before Notice of the meeting is given. Requests made less than three days before the Notice is given may be included on the agenda at the discretion of the Chair.

2.1.13 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least ten clear days before the meeting to the Chair or Secretary, who shall insert in the agenda for the meeting all notices so received subject to the Notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without Notice on any business mentioned on the agenda in accordance with SO 2.1.13, subject to the Chair's discretion.

2.1.14 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

2.1.15 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing, be in accordance of SO 2.1.14 and shall bear the signature of the Governor who gives it and also the signature of four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he considers it appropriate.

2.1.16 **Motions** – The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

2.1.17 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

2.1.17.1 An amendment to the motion.

2.1.17.2 The adjournment of the discussion or the meeting.

2.1.17.3 That the meeting proceed to the next business.

2.1.17.4 That the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

2.1.18 **Chair's Ruling** – Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

2.1.19 **Voting** – Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

2.1.20 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

2.1.21 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

2.1.22 If a Governor so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

2.1.23 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

2.1.24 **Minutes** – The Minutes of the proceedings of a matter shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

2.1.25 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

2.1.26 **Suspension of Standing Orders** – Except where this would contravene any statutory provision, or any provision of the Constitution, any one or more of the SO's may be suspended at any meeting provided that at least two thirds of the Council of Governors are present, including one Public Governor, one Staff Governor and one Patients and Carers Governor, and that a majority of those present vote in favour of suspension.

2.1.27 A decision to suspend SO's shall be recorded in the minutes of the meeting.

2.1.28 A separate record of matters discussed during the suspension of SO's shall be made and shall be available to the Governors.

2.1.29 No formal business may be transacted while SO's are suspended.

2.1.30 **Record of Attendance** – the names of the Governors present at the meeting shall be recorded in the minutes.

2.1.31 **Quorum** – A meeting of the Council of Governors shall be quorate and quoracy shall require that there shall be present at the meeting not less than 50% of all Governors and of those not less than 51% shall be Elected Governors (excluding those Governors representing the Staff Constituency).

2.1.32 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

2.1.33 Subject to SO's in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council of Governors and, subject to the overall control of the Chair, to speak to any item under consideration.

3. COMMITTEES

3.1 Except as required by paragraph 9 of this Annex 6, the Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a committee.

4. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

4.1 **Declaration of Interests** – in accordance with the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

4.2 A Governor must declare to the Secretary:

4.2.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

4.2.2 any interests which are relevant and material to the business of the Trust.

4.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these SO's and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within three working days.

4.4 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if he has declared a pecuniary interest, he shall not take part in the consideration or discussion of the matter. The provisions of this paragraph are subject to paragraph 4.5.

4.5 "relevant and material" interests may include but may not be limited to the following:

4.5.1 directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

4.5.2 ownership or part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

4.5.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

4.5.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

4.5.5 any connection with a voluntary or other organisation contracting for or commissioning NHS services;

4.5.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to, lenders or banks;

4.5.7 research funding/grants that may be received by an individual or their department;

4.5.8 interests in pooled funds that are under separate management.

4.6 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

4.7 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

4.7.1 he, or a nominee of his, is a director of a company or other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

4.7.2 he is a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

4.8 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

4.8.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

4.8.1 of an interest in any company, body, or person with which he is connected as mentioned in paragraphs 4.2, 4.5 and 4.7, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

4.9 Where a Governor:

4.9.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

4.9.1 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

4.9.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

4.10 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty disclose his interest.

4.11 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these SO's to be also an interest of the other.

4.12 If Governors have any doubt about the relevance of an interest, this should be discussed with the Trust Secretary.

4.13 **Register of Interests** - the Trust Secretary shall record any declarations of interest made in a Register of Interests kept by him in accordance with paragraph 36 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

4.14 The Register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register. If the person requesting a copy or extract is not a member of the Trust then a reasonable charge may be made for doing so.

5. STANDARDS OF BUSINESS CONDUCT

5.1 **Policy –** in relation to their conduct as a Governor of the Trust, each Governor must comply with the Code of Conduct for Governors. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

5.2 **Interest of Governors in Contracts** – if it comes to the knowledge of a Governor that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Secretary of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

5.3 A Governor shall not solicit for any person any appointment in the Trust.

6. REMUNERATION

6.1 Governors are not to receive remuneration.

7. PAYMENT OF EXPENSES TO GOVERNORS

7.1 The Trust will pay travelling expenses to Governors at the prevalent NHS Public Transport rate for attendance at General Meetings of the Governors, or any other business authorised by the Trust Secretary as being under the auspices of the Council of Governors.

7.2 Expenses will be authorised and reimbursed through the Trust Secretary's office on receipt of a completed and signed expenses form provided by the Trust Secretary.

7.3 A summary of expenses paid to Governors will be published in the Trust's Annual Report.

8. MISCELLANEOUS

8.1 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors and any requirements for amendments must be directed to the joint meeting with the Board of Directors.

8.2 **Deputy-Chair** – In relation to any matter concerning the Council of Governors or a Governor outside a meeting of the Council of Governors, which arises the Deputy-Chair may exercise such power as the Chair would have in those circumstances.

8.3 **Notice** – Any written notice required by these SO's shall be deemed to have been given on the day the notice was sent to the recipient.

8.4 **Confidentiality** – A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

9. COUNCIL OF GOVERNORS : NOMINATIONS AND APPOINTMENTS COMMITTEE

9.1 The Chair and other Non-Executive directors shall be appointed following a process of open competition conducted in accordance with a policy to be agreed by the Council of Governors.

9.2 The Council of Governors shall establish a committee of its members to be called the Nominations and Appointments Committee ("the Committee") to discharge those functions in relation to the selection of the Chair and Non-Executive Directors described in Terms of Reference to be approved by the Council of Governors.

ANNEX 7
STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

1. INTERPRETATIONS AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2 All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3 For convenience, and unless the context otherwise requires, the terms and expressions contained within the Interpretations and Definitions section of the Constitution at page 4 are incorporated and are deemed to have been repeated here verbatim for the purposes of interpreting words contained in this Annex 8 and in addition:

"AUDIT COMMITTEE" means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework.

"COMMITTEE" means a committee or sub-committee appointed by the Trust.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Trust to sit on or to chair specific committees.

"CONTRACTING AND PROCURING" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"FUNDS HELD ON TRUST" means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 6, paragraph 8 of the 2006 Act. Such funds may or may not be charitable.

"COMMISSIONING" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"NOMINATED OFFICER" means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and standing financial instructions.

"OFFICER" means an employee of the Trust or any other person holding a paid appointment or office with the Trust.

"SFIs" means standing financial instructions.

"SOs" means Standing Orders.

2. THE BOARD

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3 The power of the Trust shall be exercised in public or private session as provided for in SO 3.

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Schedule of Matters reserved to the Board and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Deputy Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

3.3 The Board of Directors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

3.4 **Observers at Board Meetings** - The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committee. Such permission shall be granted only upon resolution of the Trust.

3.6 **Calling of Meetings** – Ordinary meetings of the Board shall be held at such times and places as the Board determines.

3.7 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.8 **Notice of Meetings** – Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least three clear days before the meeting.

3.9 Want of service of the notice on any Director shall not affect the validity of a meeting.

3.10 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.21.

3.11 Agendas will normally be sent to members of the Board five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be

despatched no later than five clear days before the meeting, save in emergency. Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served one day after posting.

3.12 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least five clear days before the meeting.

3.13 **Setting the Agenda** – The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

3.14 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least twelve clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than twelve days before a meeting may be included on the agenda at the discretion of the Chair.

3.15 **Petitions** - Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.16 **Chair of Meeting** – At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Deputy-Chair, if there is one and he/she is present, shall preside. If the Chair and Deputy-Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.17 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy-Chair, if present, shall preside. If the Chair and Deputy-Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

3.18 **Notices of Motion** – A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least twelve clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chief Executive shall insert in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. Subject to SO 3.21.8, this paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

3.19 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.20 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if he/she considers it appropriate. This Standing Order 3.19 shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.21 **Motions** - A motion may be proposed by the Chair or any Director present at the meeting. Such motion shall be seconded by another Director. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Emergency Motions

3.21.1 Subject to the agreement of the Chair and SO 3.22 below, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda (by reason of SO 3.6 and SO 3.9), up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.22 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

3.22.1 an amendment to the motion;

3.22.2 the adjournment of the discussion or the meeting;

3.22.3 that the meeting proceed to the next business; (*)

3.22.4 the appointment of an ad hoc committee to deal with a specific item of business;

3.22.5 that the motion be now put; (*)

3.22.6 that a Director be not further heard; (*)

3.22.7 that the public be excluded pursuant to SO 3.1;

3.23 *in the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

3.24 no amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved;

3.25 the Chair may (at his/her discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.16, other than a motion relating to:

(a) the reception of a report;

(b) consideration of any item of business before the Trust Board;

(c) the accuracy of minutes;

(d) that the Board proceed to next business;

(e) that the Board adjourn;

(f) that the question be now put.

3.26 **Chair's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matter shall be final.

3.27 **Voting** - Save as provided in SO 3.32 every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.28 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.29 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.30 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.31 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.32 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.33 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.34 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.35 Minutes shall be circulated in accordance with Director' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.36 **Joint Directors** – Where the Office of a Director is shared jointly by more than one person:

3.36.1 either or both of those persons may attend or take part in meetings of the Board:

3.36.2 if both are present at a meeting they should cast one vote if they agree:

3.36.3 in the case of disagreements no vote should be cast:

3.36.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO 3.38 (Quorum).

3.37 **Suspension of Standing Orders** – Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present vote in favour of suspension.

3.38 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.39 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.40 No formal business may be transacted while Standing Orders are suspended.

3.41 The Audit and Assurance Committee shall review every decision to suspend Standing Orders.

3.42 **Record of Attendance** – The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

3.43 **Quorum** – No business shall be transacted at a meeting unless at least one half of the whole number of the voting Chair and Directors appointed are present (including at least two Non-Executive Director and one Executive Director).

3.44 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.45 If the Chair or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Nominations Committee).

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders (Standing Order 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain an accountability to the Trust.

4.6 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the

Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or Monitor requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by the Monitor), the Trust may appoint committees of the Trust, or together with one or more Health Authorities or other Trusts, appoint joint committees, consisting wholly or partly of the Chair and members of the Trust or other health service bodies or wholly of persons who are not members of the Trust or other health service bodies in question.

5.2 A committee or joint committee appointed under SO 5.1 may, subject to such directions as may be given by the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

5.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute, or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.6 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.8 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.9 The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests** - The Constitution, the 2006 Act and the Code of Conduct and Accountability requires Board Directors to declare interests which are relevant and material to the NHS board of which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);

6.2.2 ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

6.2.3 majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

6.2.4 a position of trust in a charity or voluntary organisation in the field of health and social care;

6.2.5 any connection with a voluntary or other organisation contracting for NHS services;

6.2.6 any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;

6.2.7 interests in pooled funds that are under separate management;

6.2.8 research funding/grants that may be received by an individual or their department;

6.2.9 any other commercial interest in the decision before the meeting.

6.3 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

6.4 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 There is no requirement in the Code of Conduct and Accountability for the interests of Board Directors' spouses or partners to be declared. However SO 7 requires that the interest of Directors' spouses, if living together, in contracts should be declared. Therefore

the interests of Board Directors' spouses and cohabiting partners should also be regarded as relevant.

6.7 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests** - The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.9 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.10 The Register will be available to the public in accordance with paragraph 36 and 37 of the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.11 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their respective Directors for clarification.

7 DISABILITY OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Board may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 7.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

7.4.1 he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

7.4.2 he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

7.4.3 and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

7.5.1 of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

7.5.2 of an interest in any company, body or person with which he is connected as mentioned in SO 7.4 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chair or a Director has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

7.7 This SO 7 applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

8 STANDARDS OF BUSINESS CONDUCT POLICY

8.1 Staff should comply with the national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”. This section of Standing Orders should be read in conjunction with this document.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

8.4 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

8.5 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 8 shall be included in application forms or otherwise brought to the attention of candidates.

8.6 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 8 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.7 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.8 **Relatives of Directors or Officers** – Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

8.9 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

8.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8.11 Where the relationship to a Director of the Trust is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

9 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

9.2 **Sealing of Documents** – The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors, one Director and the Secretary or two senior managers (not being from the originating department) duly authorised by the Chief Executive and shall be attested by them.

9.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an Officer nominated by him/her who shall not be within the originating directorate).

9.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

10 SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

11 MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** – It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are

notified of and understand their responsibilities within Standing Orders and standing financial instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate in Standing Orders.

11.2 **Documents having the standing of Standing Orders** – standing financial instructions (including provisions as to tendering and contract procedures, disposals and in-house services), Schedule of Matters reserved to the Board and Scheme of Delegation, the Policy on the Register of Interests and Hospitality and the Staff Disciplinary and Appeals Procedures document shall be read in conjunction with the Standing Orders. The Board may also, from time to time, agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by the Trust. The decision to approve such policies and procedures shall be recorded in an appropriate Trust Board minute to be read in conjunction with these Standing Orders.

11.3 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Board and any requirements for amendments must be directed to the joint meeting with the Council of Governors unless paragraph 8.3.1 of Annex 9 applies. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

11.4 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using appropriate powers under the 2006 Act and shall comply with procedures laid down by the Finance Director which shall be in accordance with this Act.

ANNEX 8
COUNCIL OF GOVERNORS CODE OF CONDUCT

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

1. Introduction

1.1 As defined by legislation, the Trust's Council of Governors have a formal role in the governance of the Trust, working with the Board of Directors to promote the success of the organisation for its members and the public. To support the proper discharge of the Council of Governors' statutory duties and to promote the success of the relationship between the Council of Governors and the Board of Directors, it is essential that Governors adopt high standards of personal conduct. Recognising this, this document sets out the Council's expectations for the way in which Governors will conduct themselves in all aspects of their role within the Trust.

2. Framework for Council of Governors

2.1 The Trust operates within a legal, regulatory and governance framework which includes the NHS Act 2006, the Health and Social Care Act 2012, the Foundation Trust Code of Governance and the Trust's Constitution. The Constitution defines the composition of the Council of Governors and the arrangements for appointing (and, where necessary, removing) Governors. The Constitution's annexes include the Standing Orders for the Council of Governors and Board of Directors.

2.2 The regulatory and governance framework is supplemented by the Terms of Reference for the Council of Governors, the Role Description for Governors and this Code of Conduct. This Code of Conduct, the Terms of Reference and the Role Description are subject to the Constitution; nothing within them shall take precedence over or in any way amend the Constitution or any legal or regulatory requirements. This Code of Conduct is to be read in the context of that legal and regulatory framework.

3. Role of the Council of Governors

3.1 The role of the Council of Governors is defined in law and in Monitor's regulatory and governance framework. Although the role definition is not repeated here it is important as context for this Code of Conduct to recognise that good governance in the Trust depends upon active and constructive engagement between the Board of Directors and the Council of Governors. Adopting this approach will ensure that the Council of Governors is able to discharge its statutory duties, particularly in relation to:

3.1.1 Holding the Non-Executive Directors individually and collectively to account for the performance of the Board; and

3.1.2 Representing the interests of the members as a whole and of the public

4. Board of Directors/Council of Governors Engagement

4.1 The Constitution and supporting guidance commit the Board of Directors and the Council of Governors (as a whole and Governors individually) to engaging proactively and constructively with the Board of Directors, acting through the Chairman, Senior Independent Director and the Lead Governor where appropriate according to their roles.

4.2 The Council of Governors will work with the Board of Directors for the best interests of the Trust as a whole, taking into account all relevant advice and information presented to, or requested by, the Council of Governors. The Council of Governors will not unduly delay responses to proposals or other reports from the Board of Directors, acting proactively to

agree with the Board of Directors the information which the Council of Governors will need in order properly to discharge its statutory duties.

5. Conduct of Governors

5.1 This section of the Code sets out the conduct which all Governors agree to abide by. These commitments are in addition to compliance with Monitor's requirements, the Code of Governance, the Constitution, and Terms of Reference for the Council of Governors and Role Description for Governors.

5.1.1 **Personal Conduct**

Governors agree that they will:

a) Act in the best interests of patients and the Trust as a whole in the delivery of services within relevant financial and operational parameters, seeking at all times to properly discharge their statutory duties;
b) Comply at all times with legal and regulatory requirements and with the Constitution, Standing Orders, relevant Terms of Reference, Role Descriptions, policies and guidance;
c) Be honest and act with integrity and probity at all times;
d) Respect and treat with dignity and fairness, the public; patients; relatives; carers; NHS staff and partners in other agencies;
e) Respect and value all Governors and Directors as colleagues;
f) Not seek to profit from their position as a Governor or in any way use their position to gain advantage for any person;
g) Accept responsibility for their actions and generally take seriously the responsibilities which are commensurate with the decision-making rights assigned to the Council of Governors through the legal and regulatory framework;
h) Ensure that the interests of the members as a whole and the public are represented and upheld in decision making such that in accordance with the requirements of the Constitution and relevant policies, those decisions are not influenced by gifts or inducements or any interests outside the Trust;
i) Not be influenced in any way and not represent any outside interests which they may hold, including any membership of trade unions or political organisations;
j) Ensure that no person is discriminated against on grounds of religion or belief; ethnic origin; gender; marital status; age; disability; sexual orientation or socio-economic status;
k) Show their commitment to team working by working constructively with their fellow Governors and the Board of Directors as well as with their colleagues in the NHS and the wider community;
l) Not make, permit or knowingly allow to be made, any untrue; misleading or misrepresentative statement either relating to their own role or to the functions or business of the Trust;
m) At all times, uphold the values and core principles of the NHS and the Trust as set out in its Constitution;
n) Conduct themselves in a manner which reflects positively on the Trust and not in any manner which could be regarded as bringing it into disrepute;
o) Seek to ensure that the membership of the constituency from which they are elected/their appointing organisation is both properly informed and represented
p) At all times, uphold the seven principles of public life as set out by the Committee on Standards in Public Life (also known as the Nolan Principles) as below:
    (i) Selflessness: Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves; their family or friends or other interested parties.
    (ii) Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
    (iii) Objectivity: In carrying out public business, including making public

appointments; awarding contracts or recommending individuals for awards or benefits, holders of public office should make choices on merit.

(iv) Accountability: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

(v) Openness: Holders of public office should be as open as possible about all the decision and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

(vi) Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

(vii) Leadership: Holders of public office shall promote and support these principles by leadership and example.

q) seek advice from the Chairman or the Trust Secretary on matters relating the Constitution, governance requirements or conduct, and have regard to the advice given to them.

5.1.2 **Confidentiality**

Governors agree that they will:

r) Respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors, except where information is made available in the public domain.

s) Understand, endorse and promote the Trust's Confidentiality and Data Protection Policy in every aspect of their work. A copy of this policy will be provided to each Governor and training will be provided where necessary.

t) Make no public statements on behalf of the Trust or communicate in any way with the media without the prior consent of the Chairman or a designated officer from the Trust's Communications Department.

5.1.3 **Declaration of Interests**

Governors agree that:

u) It is essential for good corporate governance and to maintain public confidence in the Trust that all decision making is robust and transparent. To support this, the Constitution and the Trust's Policy on Declaration of Interests set out requirements for Governors to declare relevant interests (as defined in the Constitution).

v) Governors will declare interests on request from the Trust Secretary or, as required by the Constitution, whenever they become aware of a potential conflict of interest in respect of a matter being considered by the Council of Governors. Governors should seek advice from the Trust Secretary or the Chairman where they are unsure as to whether an interest needs to be declared. Declared interests will be included in a Register of Interests, which will be published

6. Participation in Meetings and in Training and Development

6.1 The Council of Governors will hold a number of meetings per year, the number to be determined by the Chairman. The schedule for these meetings and for other activities will be proposed by the Trust Secretary and is subject to approval by the Council of Governors.

6.2 It is expected that Governors will attend meetings of the Council of Governors and of any committees or working groups (including Project Working Focus Groups) to which they are

appointed but it is accepted that there will be occasions on which Governors cannot attend, in which case they will give apologies for absence.

6.3 The Constitution provides for the Council of Governors to remove any Governor from office where he/she fails to attend two consecutive Council of Governor meetings and where the Council is not satisfied that the absence was due to a reasonable cause and that the attendance record will be rectified.

6.4 The Board of Directors has a statutory duty to take steps to ensure that the Governors are equipped with the skills and knowledge they need to discharge their responsibilities appropriately. A programme of training and development will be agreed with the Council of Governors and it is expected that Governors will participate in such activities unless, in reasonable circumstances, this is not possible.

7. Upholding this Code of Conduct

7.1 Following approval of this Code of Conduct by the Council of Governors, individual Governors agree to comply with all of its content.

7.2 Where possible or appropriate, any concerns about the conduct or performance of a Governor will be addressed under the leadership of the Chairman through training, development or other means which are considered appropriate. Where such concerns exist the Chairman will write to the Governor concerned to set out the concerns and the action agreed to rectify or otherwise address them.

7.3 The Constitution provides for the circumstances in which a Governor can be removed from office, including where any Governor fails to comply with this Code of Conduct. It is for the Chairman to propose removal from office if this is necessary after all other course of action, including training and development where relevant, have been exhausted. The Constitution provides for an independent review of evidence associated with such a proposal, reflecting the Foundation Trust Code of Governance. As required by the Constitution, it is for the Council of Governors to determine (in accordance with rules set out in the Constitution) whether any Governor should be removed from office following a proposal from the Chairman and an independent review if one is commissioned.

Approved by the Council of Governors on 29th January 2015

To be reviewed not later than January 2017

ANNEX 9
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

CODE OF CONDUCT FOR GOVERNORS

DECLARATION OF ACCEPTANCE

I confirm that I have received, read and understood the Code of Conduct for Governors (the Code).

I further confirm that I will comply with the provisions of the Code.

……
Signature of Governor

……
Name of Governor

……
……
……
……
……
Address for Governor

……
Date of signature

Please return the completed form to:

The Trust Secretariat
Trust Headquarters
University Hospitals Bristol NHS Foundation Trust

Cover report to the Public Trust Board meeting to be held on 29 November 2016 at 11.00 am -1.00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Public Trust Board	**Meeting Date**	**29 November 2016**
Report Title	Governors' Log of Communication		
Author	Kate Hanlon, Interim Head of Governance and Membership		
Executive Lead	Pam Wenger, Trust Secretary		
Freedom of Information Status		Open	

Strategic Priorities (please chose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	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.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

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
Members are asked to: • **Receive** the report.

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☒	Staff	☐	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to act on feedback from patients, staff and our public.	☐	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	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.	☐
Failure to maintain financial sustainability.	☐	Failure to comply with targets, statutory duties and functions.	☒

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

ID **Governor Name**

169 **Mo Schiller** ***Theme:*** Direct access ***Source:*** Trust Board Meeting

Query **14/11/2016**

At the October Board meeting, we heard a patient story which suggested that direct access to a service (in this case the rheumatology service), rather than regular scheduled outpatient appointments, appears to be beneficial for the patient in terms of managing a chronic illness. Clearly access via a specialist nurse team is paramount to facilitate this service. Does the Trust have plans to expand direct access to other areas, in preference to three/six/12 monthly outpatient appointments, for patients who would prefer this option?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

168 **Mo Schiller** ***Theme:*** Bristol Eye Hospital ***Source:*** Governor Direct

Query **14/11/2016**

I understand that when a patient is referred to Bristol Eye Hospital via Choose and Book it takes at least six weeks for Bristol Eye Hospital to notify the patient about their appointment date. Why is this the case, and at what point does the NHS 18-week waiting time start?

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
167	Pauline Beddoes	***Theme:*** Radiotherapy	***Source:*** From Constituency/ Members

Query **01/11/2016**

During a course of radiotherapy, relationships are formed between both staff and patients. Is there any ongoing face-to-face support available to patients on completion of a radiotherapy course? Phone calls are often not enough, it is the interaction between people which is important and appears to be lacking.

Division: Specialised Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **08/11/2016**

At the end of treatment, patients are given details of how to access support by telephone. In addition, they are given an appointment for a follow up but that may be several weeks hence.

If a patient telephones and he/she and the radiographer they speak to feels it would be beneficial for them to come into the department then that can be arranged. Usually, that would be for the treatment of any acute side effects or to provide support to patients with psychosocial needs in the immediate couple of weeks after treatment. The latter needs may be better met by the excellent staff in the BHOC Patient Information Centre and who are there to support patients at any point during their journey. The team in radiotherapy work collaboratively with the patient's own GP and community team so it is sometimes appropriate to involve their help and support too.

The needs of patients after treatment are very individual so the telephone is the first point of call for patients and they can discuss the best help and support for them at that stage.

Status: *Awaiting Governor Response*

ID	Governor Name		
166	Anne Skinner	***Theme:*** Nursing staff	***Source:*** Governor Direct

Query **13/10/2016**

Following up from log query no. 62 (relating to arrangements for appropriately qualified cover to be available on wards at night to ensure nursing staff can take their meal breaks) it is good to hear that nursing staff are encouraged and expected to take their breaks. However, what measures are in place to ensure that they actually do take proper breaks?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **03/11/2016**

Each ward has a designated nurse in charge of the night shift one of whose roles is to coordinate the times of breaks overnight to ensure that everyone can take a break and where required organise specific one to one relief cover for high care/high dependency patients. There is a responsibility on the individual nurses/nursing assistants to then take their breaks at the time allocated.

Status: *Awaiting Governor Response*

165	Anne Skinner	***Theme:*** CSSD	***Source:*** Chairman's Counsel

Query **13/10/2016**

On a visit in August 2016 to the Centralised Sterile Services Department, governors were concerned to see staff working in uncomfortable conditions due to a breakdown in the cooling system. Can you explain why this issue is still ongoing and assure governors and the staff within the department when the cooling system will be fixed?"

Division: Trust Services ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
164	Malcolm Watson	***Theme:*** Processes in divisions for early identification of issues	***Source:*** Project Focus Group

Query **06/10/2016**

In a recent Quality Focus Group meeting, the group received a presentation from Xanthe Whittaker to explain the data in the Quality & Performance reports. While the data in these reports represent aggregated data, I am interested what happens when the 'lower level' data are disaggregated and demonstrate 'aspects that may be falling down'. What processes are in place to identify early identification of issues? What processes are followed within divisions when issues are identified and what actions are taken as a result?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 06/10/2016

Response

For each of the Trust level scorecards that are presented in the Quality & Performance Report there is an equivalent Divisional version. There are also 'directorate' specific versions of the Scorecards, such as Children's Services, Oncology and Cardiac. The scorecards are used by Divisions to understand and improve their performance.

Like the Trust-level scorecards, Divisions use these scorecards to report their performance each month to their Divisional Boards. Divisions also use these scorecards at their monthly and quarterly Exec-led review meetings, at which there are detailed discussions around specialties/areas/sites that are failing the performance standards.

To complement each of the indicators in the Trust and Divisional-level scorecards we have set up a Key Performance Indicator (KPI) report. This provides a detailed breakdown of the performance against that indicator, at a Trust, Division, specialty/site and/or ward level. These are used by corporate teams and Divisions to delve deeper into the data.

We also have a range of Performance Books, which provide a ward or unit level view of performance against a range of indicators (Access, Quality and Workforce) for a given ward or unit each month. Many wards use their Performance Books to understand what issues they have at a local level and importantly, to understand the potential relationship between different indiactors (such as workforce indicators and quality indicators). The Performance Books were shared with the CQC at the time of the last inspection and were positively noted in the final published report.

In addition to the above we have a range of bespoke reports, which provide more granular detail of performance. How these are used varies dependent upon the area of performance. But as an example, there is a weekly report that is produced on Referral to Treatment Times (RTT) which gives a breakdown of the number of patients waiting over 18 weeks in every specialty across the Trust. This is used by Divisions to understand whether they need to try to establish additional capacity to treat more patients. It is also used by the corporate team to understand how backlogs are changing across time, and what risk that poses to the achievement of the national standard.

ID **Governor Name**

As is the case for many of the Trust's KPIs, there is a steering group which oversees performance against this indicator. The RTT Steering Group meets monthly and uses both weekly and monthly specialty/Divisional level RTT data to understand and improve performance. From this specialty-level information action plans are developed as appropriate, such as the one currently in use as part of a weekly escalation process to try to restore RTT performance back to the national 92% standard as quickly as possible. This is just one example of how more granular data is made available and used. Similar processes exist for a wide range of the Trust's KPIs.

Status: *Awaiting Governor Response*

ID	Governor Name		
163	Clive Hamilton	***Theme:*** Risk Management Policy and guidance	***Source:*** Governor Direct

Query **14/09/2016**

Page 386 of the July 2016 Board report sets out some of the duties, roles and responsibilities of those involved in the risk management process as follows:

"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."

Firstly, is there a need to define the Ward and Departmental Leads responsibilities more directly?

i.e. "...Risk Assessments are completed and that the resulting control measures are implemented within the agreed time frame and communicated to all staff responsible for implementation."

and

"...Where the Ward Manager or Departmental Lead is unable to ensure suitable and sufficient control measures are implemented, the risk, control measures and time frame target must be escalated to the next in line of supervision and documented to that effect."

Secondly, one of the findings of the Review of Cardiac Services at the Bristol Children's hospital was the inadequate escalation of risks to higher levels of management for mitigation, especially in relation to safe staffing levels on Ward 32.

Are we assured that the current Risk Management policy and guidance is now in place to reduce the likelihood of inadequate risk control escalation procedures?

Division: Trust Services ***Executive Lead:*** *Trust Secretary* ***Response requested:***

Response **25/10/2016**

Thank you for the comments which are helpful. We hope that the recent Governor Development Seminar on risk management provided governors with additional context and assurances in relation to the approach to Risk Management.

The specific responses to your questions are below:

ID **Governor Name**

The roles and responsibilities section of the policies was reviewed following some helpful comments received at Trust Board meeting where the policy was approved. A minor amendment was subsequently made to section 6.14 to strengthen the wording following these comments. Whilst we could see the sense in the challenge we did not identify the need for any further amendment at this point as the process of risk escalation is laid out clearly in section 10.4 and the responsibilities of staff are implicit at this point.

Further practical guidance is given to members of staff with risk management responsibilities during training and ongoing support is provided by the central risk management team.

There have been significant improvements in the way in that the risk management process is monitored following the implementation of a new system that has brought a greater level of transparency at all levels. and escalated and this has been noted by the Board. The process for the escalation of risks is considered monthly by the Senior Leadership Team who receive a detailed report of risks requiring escalation and also an oversight of significant risk that are being managed at a divisional level. On a rolling annual basis divisions are required to provide a report to the Risk Management Group on their divisional risks and reporting processes. The Audit Committee received a copy of the minutes of the Risk Management Group which provides the assurances through to the Board on the implementation of the policy. Furthermore, significant work has been undertaken to align the Corporate Risk Register with the Board Assurance Framework.

Status: *Closed*
