University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for the Meeting of the Trust Board of Directors held in Public
To be held on Tuesday 28 June 2016 at 3:00pm
in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item	*Sponsor*	*Page No*
1. Chairman's Introduction and Apologies To note apologies for absence received	Chairman	
2. Patient Story To receive the Patient Story for review	Chief Nurse	3
3. Declarations of Interest To declare any conflicts of interest arising from items on the agenda	Chairman	
4. Minutes from previous meeting To approve the Minutes of the Board of Directors Meeting held in public on 25 May 2016	Chairman	9
5. Matters Arising (Action log) To review the status of actions agreed	Chairman	22
6. Chief Executive's Report To receive the report to note	Chief Executive	23
Delivering Best Care and Improving Patient Flow		
7. Quality and Performance Report To receive and consider the report for assurance: a) Performance Overview b) Board Review – Quality, Workforce, Access	Chief Operating Officer/Deputy CEO	27
8. Quality and Outcomes Committee Chair's report To receive the report for assurance	Quality & Outcomes Committee Chair	To be tabled
9. Terms of Reference for Quality and Outcomes Committee To receive the terms of reference for approval	Chair of Quality & Outcomes Committee	84
10. Strategic Planning and Implementation Framework 2016/17 To receive the report for information	Director of Strategy & Transformation	94
11. Complaints and Patient Experience Quarterly Reports To receive the report for assurance	Chief Nurse	106
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12. Finance Report To receive the report for assurance	Director of Finance & Information	164
13. Finance Committee Chair's Report To receive the report for assurance	Finance Committee Chair	To follow
Compliance, Regulation and Governance		
14. Monitor Q4 Risk Assessment Framework Feedback To receive the feedback to note	Chief Executive	200
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16. Register of Seals To receive the Register to note	Chief Executive	214
Information		
17. West of England Academic Health Science Network Board Report June 2016 To receive the report for information	Chief Executive	216
18. Audit Committee Chair's Report To receive the report for assurance	Audit Committee Chair	220
19. Governors' Log of Communications To receive the Governors' log to note	Chairman	239
20. Any Other Business To consider any other relevant matters not on the Agenda	Chairman	
Date of Next Meeting of the Board of Directors held in public: Thursday 28 July 2016, 11:00 – 13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU		

Cover report to the Board of Directors meeting held in public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
02. Patient Story									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Author:** Tony Watkin, Patient and Public Involvement Lead									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

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

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

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

Patient Story Summary

This story charts the experience of a patient who attended the Bristol Heart Institute in December 2015 for a routine heart valve operation. It clearly highlights the importance of listening to carers and responding in a timely manner to the needs of a deteriorating patient.

In summary, the patients operation was initially cancelled and re-scheduled to proceed the following day. The operation appeared to have been successful and the patient was moved to the Cardiac Intensive Care Unit (CICU). There were no concerns and the patient's daughter had only praise for the care they provided. However, once on ward C708 she had felt that her mother did not receive the clinical care that she needed.

Subsequent to the operation, the patient's daughter contacted the Trust to raise a number of issues and concerns she had in relation to her mother's care and specifically how ward staff had managed her mother's deteriorating condition. The concerns are detailed in the attached letter and in summary are:

- A concern the patient returned to Ward C708 too early.
- Whilst on Ward C708 no-one seemed to notice the patient wasn't drinking a lot and that something was wrong.
- The use of a water jug with a red lid to facilitate fluid intake.
- The importance of accurately recording a patient's temperature.

These issues and concerns have now been addressed by way of the Trust's complaints process and resolution meeting with the following actions put in place:

- A review of fluid charts trust wide to include a requirement to continue a fluid chart for 48 hours post critical care discharge.
- All patients on a food intake chart on C708 will have fluid balance maintained.

- Ensure all staff in Cardiac Surgery utilise the use of a red drinking jug and glass for patients who have been recognised as having a poor oral intake.
- Early Warning Score and Sepsis escalation training to be undertaken by all members of staff on C708.
- Division to undertake a systematic review including review of observations, fluid charts and bloods as a minimum standard for patients undergoing cardiac surgery
- All cardiac surgery medical team doctors to undertake Early Warning Scoring (EWS) and Escalation training.
- Locum doctors to be made aware of the EWS escalation policy as part of departmental induction.
- Review of staffing arrangements which sees nurse practitioners transition to a 7 day service including bank holidays. This includes a resident registrar on site 24 hours per day.

In addition, the daughter was willing to share her mother's experiences more widely in the Trust to ensure learning was shared across the organisation. The patient was discharged home after a 4½ month stay in hospital.

Recommendations

To receive the patient story, and note the context from which it was generated.

Impact Upon Board Assurance Framework

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

Impact Upon Corporate Risk

None

Implications (Regulatory/Legal)							
Learning from feedback supports compliance with CQC's fundamental standards – regulation 9, person centred care; regulation 10, dignity and respect; regulation 12, safe and appropriate treatment; regulation 17, good governance.							
Equality & Patient Impact							
None							
Resource Implications							
Finance				Information Management & Technology			
Human Resources				Buildings			
Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓
Date the paper was presented to previous Committees							
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**		

[redacted]

[redacted]

16th Feb.

For the attention of Sarah Chalkley.

[redacted]

My Mother came into hospital on [redacted] Dec 2015 and was due to have a heart valve replacement operation on the Weds, this was cancelled due to lack of after care staff. The operation took place [redacted] on Thursday [redacted].

She spent time in CICU & CHDU after the operation before being moved back to ward 708 [redacted]. My Father and I visted on a daily basis and we kept being informed that mum wasn't drinking a lot of water and could we encourge her, also she wasn't eating a lot even though we were bringing in food that she liked.

On [redacted] when I visited on the evening I spoke to a nurse about putting a line in as mum wasn't taking enough liquid, she was also very sleepy The nurse replied to me "I have to speak to a Doctor and the is only

one on duty" As I had raised this and mentioned it to the nurse I assumed she would pass on this concern to the Doctor.

On [redacted] I visited mum, again on the evening. When I arrived she was sat in the chair next to her bed, a blanket was over her legs & tummy. The window was open and the fan on, she was very cold to touch, she was asleep but then woke up. Mum told me she wanted to get back into bed, I had to press the button as mum had no access to the button, it was on the bed out of her reach. Colin came over to help her back on the bed and noticed [redacted] she was cold, another nurse came to take mum's blood pressure, temp etc. They took the temperture twice as one said 34° the other 35°. The nurse said "We will take the 35°" At this point mum felt very very cold. I mentioned this to the night nurse and she said she would keep an eye on mum overnight

On Tuesday morning I had a call to say that mum had been rushed back to CICU with dhyration and Kidney failure.

I feel the following questions need to be addressed

① Was mum returned to Ward 708 too early?

② Why did no-one notice she wasn't drinking a lot?

③ Should she have had a water jug with a red Lid? and do something about it.

④ Why was it, it took to the Tues morning when there are more Doctors on duty, after the bank holiday that people noticed something was wrong and she was rushed back to CICU.

⑤ If mum's temperture dropped to 34° on the Monday evening, why was this not recorded, the night nurse did not appear to know it had dropped that low.

I am happy to attend a meeting with you to disscuss the above.

On the plus side I would like to take this opportunity to praise all of the staff that have looked after mum in both CICU and CHOU. The care has been outstanding, all the staff have been friendly and caring towards my mum and immediate family.

I look forward to hearing from you in the near future.

Yours sincerally

[redacted]

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of the Meeting of the Trust Board of Directors held in Public on Wednesday 25 May 2016 at 11.00am, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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

Present or in attendance:
Alex Nestor, Deputy Director of Workforce and Organisational Development
Mo Schiller, Public Governor
Angelo Micciche, Patient Governor
Carole Tookey, Head of Nursing, Division of Medicine
Clive Hamilton, Public Governor
Flo Jordan, Staff Governor
Bob Bennet, Public Governor
Fiona Reid, Head of Communications
Jo Witherstone, Senior Nurse for Quality [item 3 only]
David McClay, member of the public
Sid Ryan, Journalist, Bristol Cable (Observer)
Pam Wenger, Trust Secretary
Rachel Smith, Corporate Governance Administrator

25/05/16 Chairman's Introduction and Apologies
John Savage, Chairman, welcomed everyone to the meeting. Apologies for absence were received from Sue Donaldson, Director of Workforce and Organisational Development.

26/05/16 Declarations of Interest
In accordance with Trust Standing Orders, all Board members present were required to declare any conflicts of interest with items on the meeting agenda. There were no new declarations made.

27/05/16 Trust Film: "We Are Proud To Care"
Jo Witherstone, Senior Nurse for Quality, introduced the film which had been the culmination of two years' work from the Compassion and Care group, and had been supported by charitable funds from Above and Beyond. Staff were commended on their involvement in the project, which brought to life the Trust's values.

The film showcased the Trust, its services and facilities, and the staff in their daily working lives, providing care and compassion to patients and their families and enabled staff to reflect on the work they do within the Trust. The film had been incorporated into the corporate induction programme, and shown for the first time to new employees this week. Following its launch on Nurses Day on 12 May, there were a number of opportunities for new and existing staff to watch the film, which included Divisional Board meetings, staff meetings and via Connect. The film had also been made available through a number of social media outlets and to date, the film had been viewed over 45,000 times through social media. Over 1,200 comments had been received in response to the film, one example of which stated "I am very proud to work in such a great place, with inspirational people doing an amazing thing every day". It was:

RESOLVED:
- **That the Board receive the Trust film "We Are Proud To Care" film for information**

28/05/16 Minutes from previous meeting
The Board considered the minutes of the meeting held in public on 28 April 2016. It was:

RESOLVED:
- **That the minutes of the meeting held on 28 April 2016 be agreed as an accurate record of proceedings**

29/05/16 Matters Arising
Outstanding and completed actions were noted by the Board.

30/05/16 Chief Executive's Report
The Board received a written report of the main business conducted by the Senior Leadership Team in May 2016.

Robert Woolley highlighted the recent announcement of a potential solution to the protracted junior doctor contract dispute. Trainee members of the British Medical Association (BMA) would be invited to vote in a ballot in response to the agreement that had been reached between the BMA, the Secretary of State and NHS Employers. The Senior Leadership Team (SLT) would continue to provide support for the juniors doctors through the latter phase of the process and communication mechanisms remained in place between SLT and junior doctor representatives.

The Board noted the continued challenged faced by the National Health Service and the announcement from NHS Improvement which advised of a net deficit of £2.45bn for the provider sector at the end of 2015/16. The reasons for the deficit, as previously discussed, included increased agency staff usage, levels of fines exerted on providers, the impact of delayed transfers of care, and the difficulty in identifying savings year on year. The Kings Fund had produced a similar report which acknowledged the difficulty in overstating the challenges that would be faced in 2016/17. It was, however, positive to note that the Trust had commenced 2016/17 in a relatively good position.

Robert Woolley advised the Board that the Community Child Health Partnership had submitted its response to the 'Invitation to Submit a Detailed Proposal' (ISDP) and it was noted that the consortium had been the sole bidder in the tender process.

The consortium would be required to provide further information to the Clinical Commissioning Groups in June and progress reports would be provided for the Board in due course.

Robert Woolley highlighted the very successful Nurses Day held on 12 May, during which the "We Are Proud To Care" film had been launched and very well received.

The Board noted that the report into the Independent Review of Children's Cardiac Services would be published on 30 June. Activities were in development to support the staff involved and to prepare the Trust's response to the report. It was:

RESOLVED:
- **That the Board receive the report from the Chief Executive to note**

31/05/16 Quality and Performance Report

Overall Performance

Deborah Lee advised the Board of the sustained levels of good performance and the continued improvements against a wide range of indicators. The junior doctor industrial action had affected the Referral to Treatment Times (RTT) but this had been mitigated by the headroom that had been generated in previous months as the Trust had exceeded its performance trajectory. It was positive to note that the 92% national standard had been achieved for a fourth consecutive month. It was unfortunate that the industrial action had impacted the Diagnostics 6 week wait standard as a significant number of endoscopy lists had been cancelled. The Trust did not achieve the 99% standard in April but it was anticipated that performance against this standard would be recovered by July 2016.

Operational pressures had begun to ease, with the lowest reported number of last-minute cancellations for elective surgery since December 2015. A 7% increase in demand in the Emergency Department (ED) had been reported in comparison to the same period in 2015 but a 5% improvement in ED performance against the national standard from March was noted. Nationally, the Trust's previously reported position of 87th out of 127 Trusts nationally had improved and the Trust was now in the top quartile for ED performance. The improved performance was important for both patients and the organisation.

The Trust had also reported a sustained positive picture in terms of the quality metrics. The quality dashboard had been revised to include additional metrics which demonstrated continued and strong performance against the quality Key Performance Indicators (KPIs). It also demonstrated that the changes made over the last year had been embedded and were delivered through normal daily routines.

The Board's attention was drawn to the improvements in VTE assessment, which had previously been highlighted as an area of concern. Deborah Lee assured the Board that the data issues had been resolved and performance had been restored in line with the planned trajectory.

With regard to workforce, it had been positive to note that the sustained efforts had started to come to fruition. Deborah Lee highlighted a reduction in vacancy rates for a second consecutive month in some Divisions, including Women's and Children's who had reported a 1.5% vacancy rate, which was very positive.

Sickness had also reduced in the month, and had been better than anticipated for the time of year. Significant work had been undertaken around strategic retention and engagement to understand why staff chose to work elsewhere and improve further the current amber rating for turnover.

In response to a query from Julian Dennis, Deborah Lee reported a more positive picture with regard to delayed discharges and that the number of patients awaiting discharge had stabilised between 50-55 from its peak of close to 90 in the winter. The beds that had been lost in Clevedon Hospital, due to the ward refurbishment, remained closed but it was positive to note that a large nursing home would be opening in Bristol in the summer, which would include a significant number of beds for patients with dementia or other forms of cognitive impairment. The developments in community care felt positive, with continued close collaboration and traction between partners, due in part to the ongoing work around the Sustainability and Transformation Plan.

Lisa Gardner referred to the Deteriorating Patient Early Warning Scores and queried the lengthy timescale of the improvement trajectory. Carolyn Mills advised the trajectory had been aligned to the Trust's Patient Safety Improvement Programme for Early Warning Scores and did not reflect the specific timescale for the individual actions. The Patient Safety Improvement Board provided updates for the Quality and Outcomes Committee on a quarterly basis.

In response to a query from Emma Woollett, Alison Ryan advised that the impact of the transition from the Early Warning Score (EWS) to the National Early Warning Score (NEWS) had been cited in a number of Serious Incidents reviewed by the Quality and Outcomes Committee (QOC). The Committee had acknowledged that the implementation of NEWS and the subsequent audit would take significant time to embed into practice but had been assured that this was a key area of focus for the Patient Safety Improvement Board. Deborah Lee advised that when reviewing Serious Incidents, QOC closely scrutinised the reports to identify if any systematic issues had contributed to the incident but had found none.

John Moore referred to the delayed discharges and queried whether the relationship with North Somerset Council was as successful as that with Bristol City Council. Deborah Lee advised that for North Somerset Council, 80% of their social care patients were within the Weston area and acknowledged that whilst the established social care team in Weston did outreach to Bristol, the level of interaction was not at the same level as with Bristol City Council. It was acknowledged that this would not change unless the service in Weston was resourced differently than at present.

Jill Youds expressed a concern with regard to the 14% of Outpatient Department (OPD) appointments cancelled in April. Deborah Lee shared Jill's concern and referred to previous discussions around the pressures on the OPD administrative team. Deborah further explained that a proportion of cancellations had been attributable to patients whose appointment had been cancelled and brought forward in order to expedite their care. The largest number of re-booked patients had been referred by their GP via the partial booking system, whereby the electronic booking system generated an appointment which patients were invited to change if it was not suitable. It had been acknowledged in previous discussions that the electronic booking system and methods of booking appointments could be improved further. The Board noted that the OPD Improvement Programme maintained a focus on this indicator and Deborah Lee advised that an update with regards

to the improvements in OPD would be provided to the Quality and Outcomes Committee in June.

John Moore queried what proportion of cancellations had been due to capacity and / or logistical issues and Deborah Lee advised that approximately 50% of cancellations were attributed to this. Deborah reiterated that those patients whose initial appointment had to be re-arranged were reported as a cancellation but this could be eliminated by improving the method by which first appointments were made.

Mo Schiller highlighted continued issues with regard to the OPD Co-ordinator telephones, in that patients do not always get to the telephone in time to speak with the co-ordinator to re-arrange an appointment and on returning the call, patients were required to leave a voicemail. Deborah Lee advised she would look in to the concerns raised and would respond through the Governors Log.

In response to a query from Emma Woollett, Sean O'Kelly confirmed there was a continued focus to admit patients directly to the stroke ward and ensure they received the majority of their treatment on that ward. It was noted that on occasion, patients presented with symptoms that did not indicate a stroke and a diagnosis was not always apparent on admission. With regard to imaging of stroke patients, Sean further advised that patients who presented in the ED with a suspected stroke underwent a CT scan attached to the ED as soon as possible. The continued focus on stroke care was actively reviewed and discussed with the Divisions.

Lisa Gardner queried whether the outcomes of UH Bristol stroke patients were comparable to those in other Trusts and Sean O'Kelly advised they were very similar. The local Stroke Network indicated that outcomes for UH Bristol were as good as, or exceeded, other hospitals but was not able to confirm the figures.

Deborah Lee suggested that the Board may benefit from receiving comparative performance figures for the indicators, in addition to further work ongoing to correlate outcomes to current performance levels. It was agreed this would be included within the next exception report for the Quality and Outcomes Committee to review.

In response to a query from Lisa Gardner with regard to cleanliness, Deborah Lee advised that the issue around cleaning raised at the last Board meeting had been included within the Governors' Log and was under investigation. It was noted that a number of the issues within the cleanliness report related to cracked ceiling tiles and until the entire programme of work around cracked ceiling tiles had been completed, the score would remain at zero. Carolyn Mills advised that she had responded to the query on the Governors Log and that the issues related to high level dusting of pendants , the cleaning of which was currently the responsibility of external contractors. The contractors did attend to undertake the cleaning but could not always access the location to be cleaned and as a result, the areas would not be cleaned until the next time they were scheduled to visit. Consequently, the Facilities team had implemented a separate Standing Operating Procedure which would take responsibility for cleaning those areas as an internal team of cleaners would be available more regularly. Carolyn assured the Board with regard to the levels of cleaning and the processes in place to monitor delivery against cleaning KPIs and the processes of escalation should any area receive two consecutive red or amber ratings.

Lisa Gardner noted the decline in the nutrition scores and Carolyn Mills advised that a review had been undertaken to understand the decrease in scores. Patients all undergo

an initial nutrition assessment which was then to be followed by a 72-hour assessment and the review highlighted improvements were required on the initial assessment. Helen Morgan, Deputy Chief Nurse, was leading this piece of work. It was:

RESOLVED:

- **That the Board receive the Quality and Performance Report for assurance**
- **That the Quality and Outcomes Committee would receive a briefing on comparative performance for the stroke indicator set**

32/05/16 Quality and Outcomes Committee Chair's Report

Alison Ryan presented the report for members of the Board on the business of the Quality and Outcomes Committee (QOC) meeting held on 24 May 2016.

The Quality and Outcomes Committee receives assurance and evidence from a number of sources including Serious Incident and Root Cause Analysis reports, the Quality and Performance Report and various surveys. Should an issue or incident cause concern, further assurance would be sought and at the meeting on 24 May, the Committee received a presentation from the Division of Surgery Head and Neck which provided an update on a Serious Incident which had caused concern to the Committee at their meeting in March. The presentation provided the Committee with the opportunity to discuss any further issues, whether the Division required further support and whether it had been an isolated incident or was a wider issue throughout the Trust.

The Serious Incident and Root Cause Analysis process provided insights of issues within Divisions and Committee members spent considerable time examining whether they had a clear view and sight of incidents that had occurred.

The Committee had also discussed issues around the Early Warning Scores and the deteriorating patient, last minute cancellations and also the configuration of ITU beds, which remained a key area of focus for the Committee.

RTT remained a focus and Committee members noted the successes in managing the backlog of patients. Alison Ryan reassured the Board that the Committee would closely monitor the slightest change to the position and noted that the total number of ongoing pathways was increasing and this was a marker that performance could deteriorate in the coming months if action to address this was not taken. Deborah Lee confirmed that work was underway to understand the reasons for the increase and to develop remedial plans to address the increase

In response to a query from John Moore around Serious Incident reporting, Carolyn Mills advised that in April, only three Serious Incidents had been reported and following the timely identification of an incident as a Serious Incident, the form had been misplaced in the Executive PA office and subsequently, the 48-hour reporting deadline had been breached. A second separate Serious Incident breached the 72-hour reporting deadline due to the absence of a member of staff on Annual Leave. This had resulted in a 67% compliance rate for both reporting standards. Carolyn Mills had met with the Clinical Commissioning Group to discuss the contract quality performance notice which had previously been issued, and the CCG advised that the Trust was required to acknowledge the variance that small numbers brought into the compliance figures. It was:

RESOLVED:

- **That the Board receive the Quality and Outcomes Committee Chair's Report for assurance**

33/05/16 Quarterly Workforce Report

Alex Nestor introduced the report which included updates on key programmes related to the workforce strategy and the impact this had had on the Key Performance Indicators (KPIs) and year-end performance to date. The reports described Divisional successes, challenges and priorities and provided assurance with regard to the future priorities for focus from April onwards, which had been agreed as part of the Operating Planning process with the Divisions. Key areas of focus included staff retention, management of short-term and long-term sickness absence and agency usage.

In response to a query from Julian Dennis, Alex Nestor confirmed that the Trust had a Service Level Agreement in place with Avon Partnership NHS Occupational Health Services to provide counselling services for staff. It was noted that the service received nearly 300 referrals from staff in 2015/16 which demonstrated staff were aware of the service and how to access it.

Jill Youds welcomed the report and acknowledged the work already undertaken, in addition to the need for the momentum required to make the required step changes. Jill queried whether Divisional teams had been aligned to the plans and whether the workforce priorities identified within the report had been included as a key objective for the Divisions. Robert Woolley advised that in his quarterly senior leaders briefing on 24 May, Alex had presented the workforce priorities as this was a key part of Divisional performance and the quarterly Divisional review process. The operating plans had built on the Divisional assessments of the required workforce capacity and the workforce issues highlighted within their delivery plans. The Strategic Senior Leadership Team meetings were regularly used as a forum to discuss the workforce priorities and this would continue.

In response to a further query from Jill Youds, Robert Woolley was confident that the corporate workforce strategy fully supported the Divisions and their requirements. Robert advised that there was a range of ways in which the central workforce team linked with the Divisional HR Business Partners, the Divisional Directors and the Clinical Chairs to ensure the relationships were as effective and productive as they could be.

Deborah Lee highlighted the challenge around maintaining the correct balance between a strong personnel function for the Divisions with the more strategic approach which would resolve or diminish the various workforce pressures they faced. A key issue to resolve related to the distinction between the role of the HR Business Partner and the role of Divisional line managers and general managers to support HR issues, and how the HR Business Partners provided appropriate support to the Divisions. It was acknowledged that further work was required in this area and this had been a key message at the quarterly Senior Leaders briefing.

John Moore referred to page 48 of the Quality and Performance Report and queried the red rating for agency usage, whilst the Trust reported 0.1% over funded establishment. Robert Woolley advised that there were a range of operational reasons which affected the reported figure, including specialised nursing requirements, 1:1 nursing, additional mental

health nursing, skill mix and rostering controls. Efficient workforce deployment, the pressures of demand and the variety of casemix also affected the workforce requirements.

Paul Mapson advised that for future reports, the issues related to extra capacity and specialised nursing would be separated from controllable factors i.e. rostering, in order to provide a clearer picture. This level of detail was discussed at Divisional level and it was agreed this would also be helpful for the Board.

Lisa Gardner advised this had been discussed at the Finance Committee meeting on 23 May and Deborah Lee advised of a pilot scheme due to commence on a small number of wards in May which would greatly contribute to controls in this area. Carolyn Mills advised that sickness also affected the operating plans as the Trust was effectively funding staff twice for the same ward. A further pilot was under consideration which would allocate a RAG rating for staffing levels on each shift to demonstrate appropriate staffing levels on the wards and avoid the use of agency staff where possible. The impact of the initiative and the criteria for the ratings was to be debated further and it was entirely appropriate to ensure a cautious first approach due to the potential impact on safety. There was evidence that this was already undertaken to a degree on the wards.

John Moore queried whether the funded established reflected the aspiration for the operational need, taking into account sickness, leave absence and vacancies etc. Deborah Lee commented that there was evidence which demonstrated sufficient levels of staffing required to cover the average absences through sickness, annual leave etc. There was also an element around more effective rostering and she advised the Board that the Trust was in the process of procuring a new rostering system, which would be a key tool in improved rostering.

Julian Dennis acknowledged the interesting and useful report but suggested it would be enhanced by the inclusion of timescales for when the new initiatives would commence.

Clive Hamilton referred to the film presented to the Board at the beginning of the meeting and the strong sense of vocation it portrayed. At the last Quality Focus Group, the Governors thought it important to look at motivation and the ability of staff to deliver the quality of care that was required. Clive requested, on behalf of the Quality Focus Group, that the Board developed this further. Robert Woolley acknowledged Clive's comments, which were at the heart of the workforce agenda and which had formed part of the discussion with the Divisional leaders at the quarterly briefing held on 24 May. It was:

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

34/05/16 Strategic Workforce Retention

Alex Nestor introduced the Strategic Workforce Retention report which summarised the discussions held at the Board Seminar on 13 May 2016. The paper also demonstrated how a number of the work programmes would be accelerated. The next steps proposed the co-design of a detailed plan with input from key stakeholders, including the Strategic Leadership Team and the Partnership Forum, for further discussion at an extraordinary Board Seminar on 24 June. It was:

RESOLVED:

- **That the Board approve the recommendations in relation to the Strategic Workforce Retention work programmes**

35/05/16 Finance Report

Paul Mapson introduced the report which detailed the financial position at the end of April 2016 with a month-end surplus position of £0.226m (before technical items) for the first month of the financial year. The 2016/17 financial plan, which included the receipt of £13m sustainability funding, was to deliver a surplus of £14.2m before technical items.

The Board noted that the £13m sustainability funding had not yet been confirmed. Early indications for month one indicated an adverse position for nursing and whilst improvements had been made, they were not sufficient to achieve the plan. The Board also noted the unexpected low level of activity income, predominantly in Women's and Children's. An improvement in the run rate had also been expected.

The Board noted that contract negotiations with NHS England continued, and a small number of major items were still to be agreed.

The Trust reported a healthy position in relation to cash balance, capital and debtors and no adverse adjustments had been required from the last financial year into the new financial year. It was:

RESOLVED:

- **That the Board receive the Finance Report for assurance**

36/05/16 Finance Committee Chair's Report

Lisa Gardner introduced the report of the business discussed at the meeting of the Finance Committee on 23 May 2016.

The month one position had been discussed with the expectation that month two would provide more clarity. Activity levels had also been discussed.

Carolyn Mills had presented the Quarterly Workforce report to the Committee on behalf of Sue Donaldson and the Committee had discussed agency controls and the immense work underway to improve the control issues. It had been noted that the supply of agency nursing had not been an issue, but that the cost was the main factor. Discussions continued with NHS Improvement with regard to the difficulties faced by the Trust and the behaviours of certain agencies who continued to operate outside the capped rates.

The Committee had received a presentation on the action plans which had been developed as a result of the Carter Report. The recently released model hospital portal would give access to benchmarking comparisons but it was noted this was still in its infancy. The action plans that had been allocated to Executive Leads had also been reviewed by the Committee and details with regard to timescales were awaited.

The Committee had discussed the role of the Transformation team and the support they would provide for the Divisions.

With regard to savings, a projection of 82% had been discussed and the difficult but positive position was noted, particularly within Surgery Head and Neck. Representatives from Surgery Head and Neck would also be attending the Finance Committee meeting in June to discuss their plans for the coming year.

The Committee had discussed and approved the Annual Accounts for 2015/16, which would be presented to the Private Board which was scheduled to meet after the Public Board.

The Committee had approved the revised Capital Investment Policy.

Clive Hamilton queried how fines were levied around non-performance. Paul Mapson advised that if the Trust received sustainability funding, NHS Improvement would not issue fines for non-achievement of core targets (A&E, RTT) but the Trust may be fined for non-achievement of non-core targets e.g. 28 day re-admissions. Further clarity was awaited but the assumption should be made that if formal targets were not met, fines would be issued. It was unsatisfactory that the Trust was still not fully aware of the terms on which it was to set its plan and it was noted this was a national problem. It was:

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

37/05/16 Capital Investment Policy
Paul Mapson introduced the revised Capital Investment Policy which had been discussed and approved by Finance Committee on 23 May.

Robert Woolley highlighted to the Board that the criteria for assessing non-financial evaluation of major medical and operational capital investments at Annex Two of the report was scheduled for review later in the year. It was:

RESOLVED:
- **That the Board approve the Capital Investment Policy**

38/05/16 Board of Directors Code of Conduct Declaration (including Fit and Proper Person Test declaration)
Pam Wenger introduced the report, which was part of the annual requirement for the Board of Directors to complete. The Board was reassured that declarations had been received for all Board members. It was:

RESOLVED:
- **That the Board receive the Board of Directors Code of Conduct Declaration for information**

39/05/16 Audit Committee Chair's Report
John Moore introduced the report of the business discussed at the meeting of the Audit Committee on 24 May 2016. The Committee met to review the Annual Report and Accounts, all of which were recommended to the Private Board for approval.

The Internal Auditors had reviewed the current management processes with regard to fire training compliance and a plan had been developed in order to meet the new national standards of compliance.

With regard to the Annual Report 2015/16, the Annual Accounts and the Quality Report were both unqualified by the External Auditors. The data metric for RTT was qualified and it was noted that a number of Trusts in England continued to have this metric qualified and some Trusts had revised their procedures in order for the metric to be unqualified. UH Bristol was in the process of establishing an improved IT system in order to achieve the national standard for the RTT metric. The Audit Committee had been assured of the action plan in place for this.

Deborah Lee confirmed that the Trust would be compliant against the new national standards for fire training by December. Deborah also advised that the RTT metric was linked to the Medway upgrade, for which a timeline had not yet been agreed.

In response to a query from David Armstrong, John Moore advised that the audit programme was predominantly determined by the External Auditors and that the majority of the audits were obligatory. The External Auditors also audited the Quality Report but this was not audited to the same level of detail that was applied to the Annual Accounts. A number of metrics were selected at a national level for audit, and the Governors also selected certain metrics for audit. With regard to Internal Audit, the team worked with the Executive Director to agree the areas to be audited. The audit programme covered a five year timeframe to ensure items / areas were not missed or omitted and audited regularly. A degree of flexibility was also built into the plan should subsequent areas for audit arise. The Clinical Audit Team also categorised areas for audit into three priorities; level one was obligatory and usually set at a national level.

Paul Mapson advised that the Risk Register was also a significant driver for areas to be audited and risk-based audits were also selected.

Alison Ryan advised that the Quality and Outcomes Committee also identified separate issues for inclusion in the audit programme. Alison was a member of the Audit Committee and provided the link between the two Committees.

John Moore highlighted that the most significant risk was the tight timescale in which the auditors were expected to deliver the audit report.

John Moore further advised that the External Auditor had commented that the Trust's systems and processes were very robust but had selected areas where control measures could be improved i.e. goods received by invoice. It was acknowledged that the Trust had a clean accounting system, and produced very thorough accounts.

John Savage thanked Paul Mapson and his team for the accounts they had produced. It was:

RESOLVED:

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

40/05/16 Governors' Log of Communications
The report provided the Trust Board with an update on governors' questions and responses from Executive Directors. It was:

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

41/05/16 Any Other Business

a. Self-certification Against Board Statements
Robert Woolley introduced the report which detailed the annual requirement which was in line with the annual reporting process. The Trust was required to certify to NHS Improvement that it complied with General Condition number 6 of the provider licence. The certification confirmed that the Trust had processes and systems in place to identify risks and mitigation; that systems were in place to comply with the provider licence, including the NHS Constitution; and that the Trust met the criteria for holding the licence. Robert Woolley confirmed the Trust was registered with the Care Quality Commission and the Board had noted at agenda item 14 that it complied with the NHS Improvement Fit and Proper Person Test. Robert recommended the Board to agree that the Trust could certify to NHS Improvement by the end of the month that it complied with General Condition number 6. It was:

RESOLVED:
- **That the Board approve the self-certification in relation to General Condition 6 of the NHS Improvement licence**

b. Governors
John Savage formally thanked those Governors who were standing down from their role and would formally write to each of them, to thank them on behalf of the Trust. John thanked and encouraged those Governors continuing in their role to continue to work with the Board to make improvements.

c. Deborah Lee, Chief Operating Officer/ Deputy Chief Executive
John Savage formally recorded the Board's gratitude for the contribution made by Deborah Lee. Deborah had shown an outstanding energy and commitment to the Trust and John, on behalf of the Board, expressed his very best wishes for her new role as Chief Executive at Gloucestershire Hospitals NHS Foundation Trust. Clive Hamilton and Mo Schiller seconded John's comments and thanked Deborah for the help and support she had provided to the Governors.

d. Communication for Governors and Staff
David Armstrong referred to the discussion at the Non-Executive Director and Governors meeting on 24 May and the suggestion to produce a brief for new and existing Governors and staff which detailed the various relationships with the Trust's health community partners. John Savage welcomed the suggestion and Guy Orpen offered to assist in its production

Meeting close and Data and Time of Next Meeting
There being no other business, the Chair declared the meeting closed at 12.30pm. The next meeting of the Trust Board of Directors will take place on Tuesday 28 June 2016,

3:00pm – 5:00pm, in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Trust Board of Directors meeting held in Public 25 May 2016
Action tracker

Outstanding actions following meeting held 25 May 2016					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	**31/05/16**	QOC to receive a briefing showing comparative performance figures for the stroke indicator set.	Medical Director	July 2016	Added to the agenda plan for QoC July 2016.
2.	**181/02/16**	The Board to receive an update on the major strategic schemes for consideration and prioritisation.	Director of Strategy & Transformation	Autumn 2016	The process to refresh the Trust strategy and associated major strategic developments is commencing and will be discussed at Board seminar on 24 June
Completed actions following meeting held 25 May 2016					

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

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

Executive Summary

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

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

Recommendations

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

Impact Upon Board Assurance Framework

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

Impact Upon Corporate Risk

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

Implications (Regulatory/Legal)

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

Equality & Patient Impact

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

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – JUNE 2016

1. INTRODUCTION

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

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

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

3. STRATEGY AND BUSINESS PLANNING

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

The group **noted** an update on the CQUIN program and associated risks.

The group noted and **agreed** the proposed process for the prioritisation and allocation of strategic capital.

The group received an update on the work being undertaken around strategic retention and **agreed** next steps.

The group **agreed** to further discussions with the University West of England around offering placements for Associate Physician students.

The group **agreed** to proceed to consultation with the Local Negotiating Committee on the proposed standardised sessional payments for additional work by junior doctors and dentists in the Trust. The group **noted** the impact and risks around the revised payments for additional hours worked by consultant staff in a number of specialties that had recently been implemented and agreed that a formal impact assessment should be undertaken.

The group **noted** an update on the Integrated Sexual Health Services tender, noting the risks, issues and next steps.

4. RISK, FINANCE AND GOVERNANCE

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

The group received and **noted** the Quarter 4 Complaints and Patient Experience Reports for ongoing submission to the Quality and Outcomes Committee and Trust Board.

The group **approved** the Trust Services Divisional Board Terms of Reference.

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

The group **received** one high impact Internal Audit Report in relation to Fire Safety, one medium impact in relation to Infection Control and four low impact in relation to Waiting List Initiatives, Financial Reporting, Payroll and Information Governance Toolkit.

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
June 2016

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
07. Quality and Performance Report

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

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

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

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

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

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

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

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

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Quality & Performance Report

June 2016

Executive Summary

The initial signs of recovery against a range of access standards seen in April, continued into May, following the easing of emergency pressures. Continued improvements were seen for flow related measures, including A&E 4-hour performance and cancelled operations. Despite May being another short month in terms of number of usual working days, the number of patients waiting over 18 weeks from Referral to Treatment (RTT) decreased slightly, with the 92% national standard and stretch target of 92.6% being achieved at month-end. Other noteworthy successes for the month are detailed on the Overview page of this report, alongside the priorities, risks and threats for the coming months.

Although there was an easing of the pressures on the Trust's emergency services this month, the number of patients arriving and being admitted via our Emergency Departments was still 3% above the same period last year. However, the number of ambulance arriving returned to last year's levels, and there was a sharp seasonal decrease in the percentage of patients admitted aged 75 years and over. As a consequence, bed occupancy within the BRI dropped back to more normal levels, from the all-year highs reported for the past three months. The reduction in bed occupancy has resulted in a number of improvements in flow metrics, including a further reduction from last month in the number of operations cancelled at last minute for non clinical reasons, and a significant reduction in the number of days patients spent in the month outlying from their planned specialty ward. There has been a rise in the number of patients on the outpatient waiting list, despite new outpatient attendance levels being higher than the seasonal norm. For the quarter to date, referrals into outpatients are up by 7% overall, relative to the same period last year, with an 8% increase in GP/GDP referrals. This has resulted in an increase in the total number of patients with ongoing RTT pathways, and poses a risk to continued achievement of the 92% RTT national standard if this heightened level of demand cannot be met to avoid patients breaching the 18 week standard. The 99% national standard for the percentage of patients waiting under 6 weeks for a diagnostic test continues to be failed as forecast, due to the high number of endoscopy lists lost as a result of the junior doctor industrial action and the repeated failure to recruit a locum endoscopist. The Trust continues to flag these system risks to NHS Improvement and escalate issues to commissioners to engage primary care and partner organisations in mitigations to manage demand.

Overall performance against both the range of quality indicators that sit within the Trust's Summary scorecard, but also the wider range of quality metrics we report in our Safe, Caring & Effective Scorecard, has remained strong. Notable this month is the improvements made in the timeliness of reporting and investigation of Serious Incidents, achievement of the Green threshold for the National Early Warning Scores (NEWS) acted upon for deteriorating patients, along with sustained good performance for a number of other indicators of good patient safety, including Non-purposeful omitted doses of listed critical medication, Safety Thermometer measures of Harm Free Care and the rate of inpatient falls and pressure ulcers per 1,000 bed-days.

Whilst system pressures have eased to a certain extent, they continue to provide context to the current workforce challenges, especially bank and agency spend and considerable focus is being placed on the reasons and necessity for each band and agency shift. There remains a strong internal focus on recruitment and retention of staff, in order to stay responsive to rising demand, with our vacancy rates being green rated for a third consecutive month. We also continue to work in partnership with other organisations within the community to mitigate these system risks, and improve the responsiveness of the Trust's services.

Performance Overview

External views of the Trust

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

Care Quality Commission

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites

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

NHS Choices

Website

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

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

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

NHS Improvement Risk Assessment Framework

For the quarter to date the Trust is not achieving six of the standards in the NHS Improvement 2016/17 Risk Assessment Framework, as shown in the table below. One of these six standards (i.e. 31-day subsequent drug therapy) is no longer forecast to be achieved for the quarter as a whole due to the breaches being outside of the control of the Trust. Achievement of the 31-day first definite and 31-day subsequent surgery cancer waiting times standards is on track for the month of June, but will not be sufficient to recover performance for the quarter as a whole.

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

NHS Improvement Risk Assessment Framework - dashboard

Number	Target	Weighting	Target threshold	Reported Year To Date	Risk Assessment Framework					Q1 Forecast	Notes	Q1 Forecast Risk Assessment Risk rating
					Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16*	Q1 16/17*			
1	Infection Control - C.Diff Infections Against Trajectory	1.0	< or = trajectory	TBC**	✓	✓	✓	✓	TBC**	✓	Limit to the end of Q4 = 45 cases	Achieved
2a	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	1.0	98%	96.5%	✓	✓	✓	✓	97.6%	✖	31-day subs surgery/first will not be met due emergency pressues/lack of critical care beds in Q4; 31-day drug at risk due to breaches outside of the Trust's control.	Not achieved
2b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)		94%	76.2%	✓	✓	✓	✓	85.7%	✖		
2c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)		94%	97.9%	✓	✓	✓	✓	98.4%	✓		
3a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	1.0	85%	76.4%	✖	✖	✖	✖	75.5%	✖	62-day GP standard also lower than expected due to critical care bed issue and histopathology delays.	Not achieved
3b	Cancer 62 Day Referral To Treatment (Screenings)		90%	41.7%	✖	✖	✖	✖	39.3%	✖		
4	Referral to treatment time for incomplete pathways < 18 weeks	1.0	92%	92.5%	Not achieved	Not achieved	Not achieved	Achieved	92.5%	✓		Achieved
5	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	1.0	96%	91.3%	✓	✓	✓	✓	93.5%	✖	See 31-day subs surgery note.	Not achieved
6a	Cancer - Urgent Referrals Seen In Under 2 Weeks	1.0	93%	94.3%	✓	✓	✓	✓	94.6%	✓		Achieved
6b	Cancer - Symptomatic Breast in Under 2 Weeks		93%	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		
7	A&E Total time in A&E 4 hours	1.0	95%	89.5%	✖	✖	✖	✖	89.5%	✖		Not achieved
8	Self certification against healthcare for patients with learning disabilities (year-end compliance)	1.0	Agreed standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met	Standards met		Achieved
	CQC standards or over-rides applied	Varies	Agreed standards met	None in effect	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable		Achieved
				Risk Rating	GREEN	GREEN	GREEN	To be confirmed	To be confirmed	Triggers further investigation		

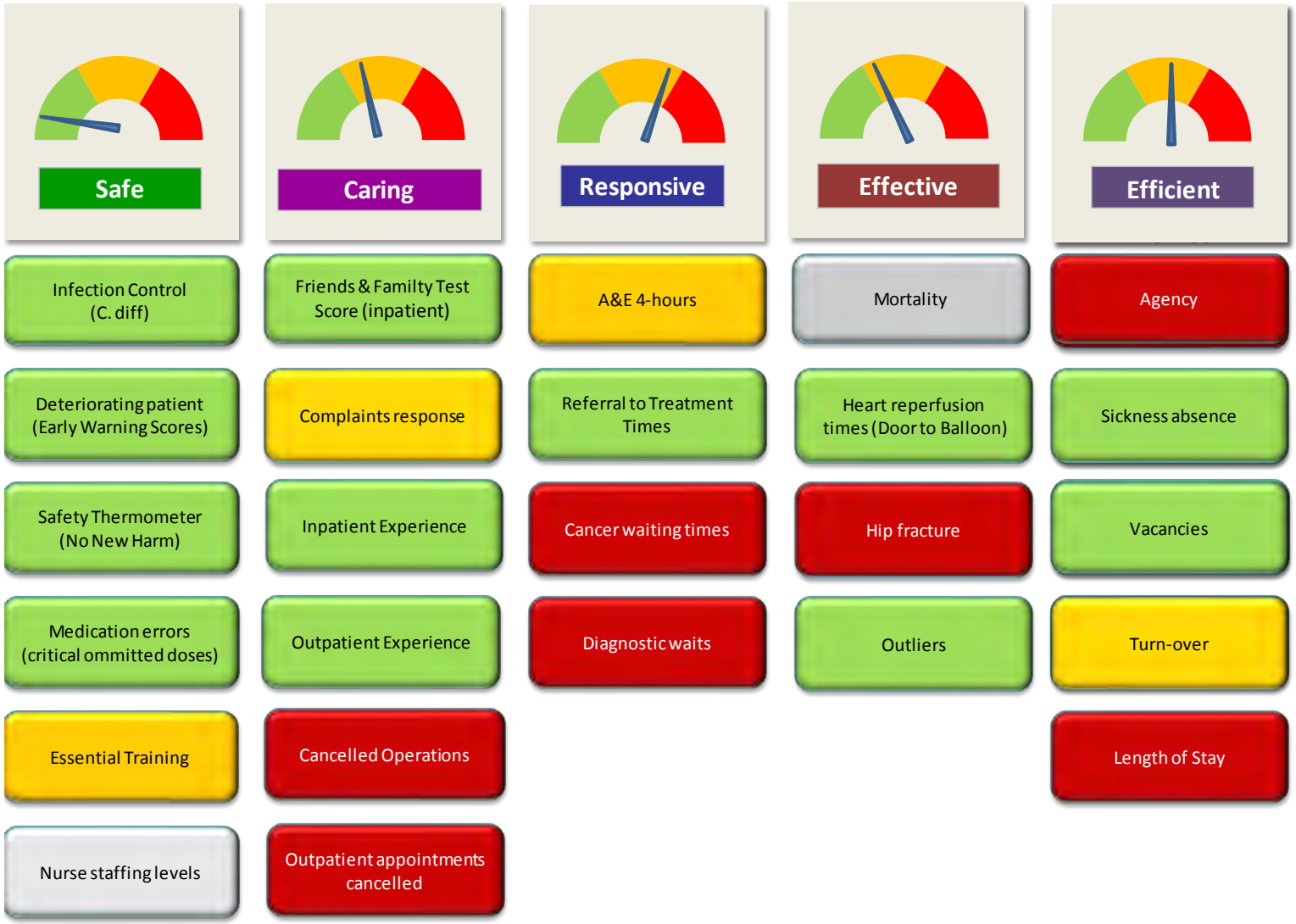
Please note: If the same indicator is failed in three consecutive quarters, a trust will be put into escalation and Monitor will investigate the issue to identify whether there are any governance concerns. For A&E 4-hours, escalation will occur if the target is failed in two quarters in a twelve-month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

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

4.0
To be confirmed (see narrative)

Summary Scorecard

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



Key changes in indicators in the period:

GREEN to AMBER:

- Essential Training

RED to GREEN

- Deteriorating patient
- Outliers

AMBER to GREEN

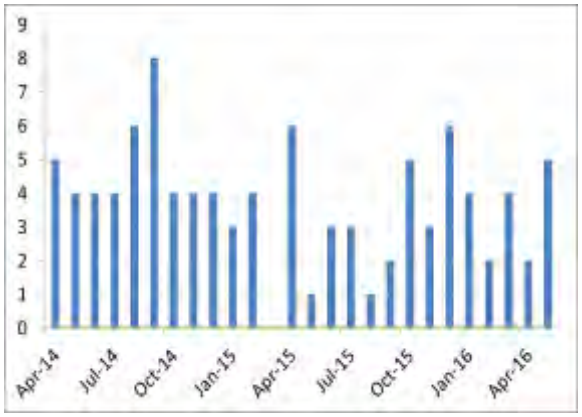
- Sickness

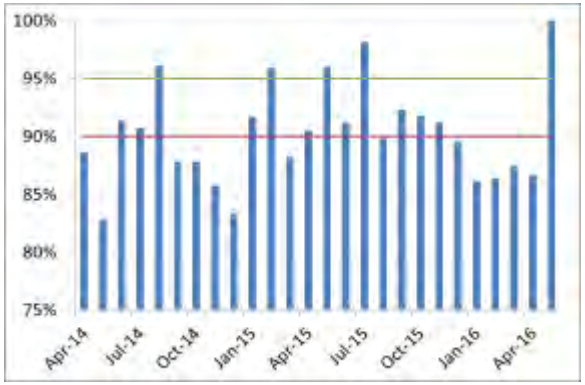
Mortality – un-rated this month (see SHMI report)

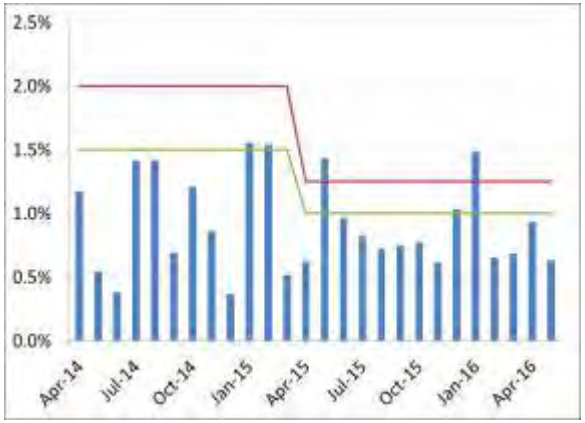
Overview

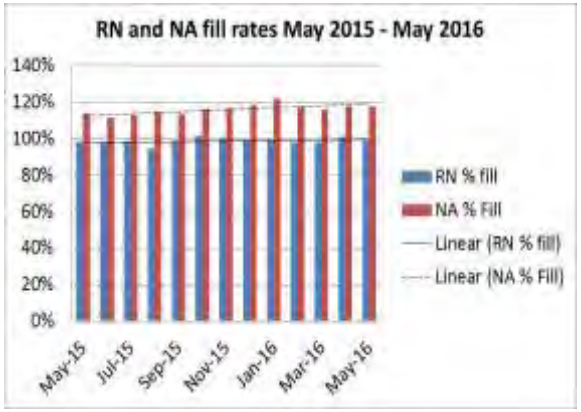
The following summarises the key successes in May 2016, along with the priorities, opportunities, risks and threats to achievement of the quality, access and workforce standards in quarter 1 2016/17.

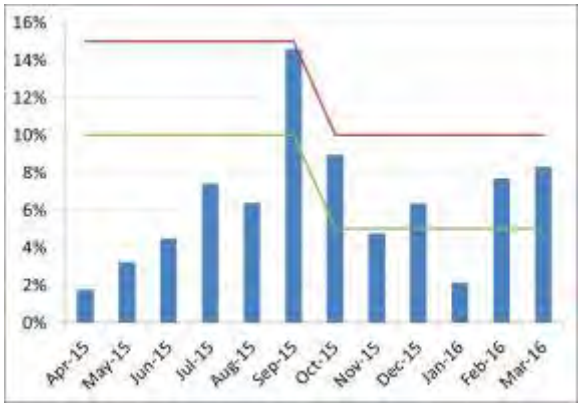
Successes	Priorities
• Significant improvement in early warning scores acted upon to 100% in May from 87% in April; • Improvement in serious incident reporting timescales to 100%; • Significant reduction in outlier bed days which is reflective of improved patient flow across the hospitals and some reduction in level of demand; • Sickness absence achieved the GREEN thresholds this month with four out of seven divisions meeting their monthly targets; • Achievement of the RTT national standard and performance trajectory; • Further reduction in the level of last-minute cancelled operations.	• Improve performance in treating patients with fractured neck of femur; • There is a continued focus on the reduction of staff turnover and sickness absence with the development of action plans to support the achievement of the 2016/17 KPIs; • Delivery of planned Referral to Treatment (RTT) clock stop activity in June in order to continue to achieve the national RTT standard; • Recovery of cancer 31-day first definitive and subsequent surgery standards for June, following critical care-bed related cancellations of surgery in quarter 4 2015/16; • Implement a recovery plan for restoring performance against the 6-week wait diagnostic standard by the end of July if possible.
Opportunities	**Risks & Threats**
• UH Bristol has been awarded The Workplace Wellbeing Charter achieving "Excellence" in Health and Safety, and "Achievement" in Leadership, Attendance Management, Mental Health and Physical Activity. Our opportunity is to reach the "achievement" level in Smoking and Tobacco, Healthy Eating, Alcohol and Substance Misuse.	• Due to the described change in calculating the percentage of dissatisfied complainants, it is likely this will increase in subsequent months beyond levels reported in 2015/16; • Falls with harm increased in May 2016 (4 falls with harm), although the overall number of falls is sustaining previous improvement. This Trust-wide risk has been re-assessed and entered on the Trust Services Division Risk Register; • Changes in the requirements to achieve compliance in Information Governance and Fire Safety means levels have reduced levels of compliance. A recovery trajectory is being developed; • The rise in the outpatient waiting list due to an increase in outpatient referrals, may put at risk future achievement of the RTT incomplete pathways standard, unless capacity can be flexed to meet the heightened level of demand; • Delays in histopathology reporting, following centralisation of the service at North Bristol Trust, is impacting on performance against the cancer waiting times standards in June.

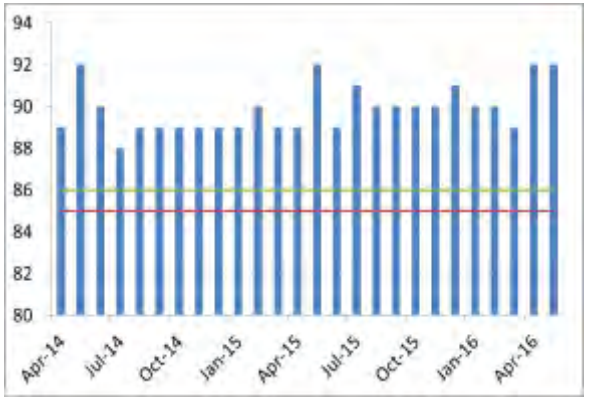
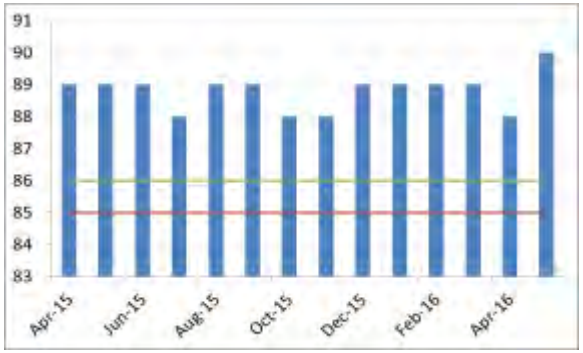
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Infection control
The number of hospital-apportioned cases of Clostridium difficile infections. The Trust limit for 2016/17 is 45 avoidable cases of clostridium difficile (the same as 2015/16).</td>
<td>There were five cases of Clostridium difficile (C. diff) attributed to the Trust in May. Two cases were in the Division of Medicine, one case for the Division of Surgery Head & Neck and two cases for the Division of Specialised Services.
<table>
<tr><th></th><th>C. difficile</th></tr>
<tr><td>Medicine</td><td>2</td></tr>
<tr><td>Surgery</td><td>1</td></tr>
<tr><td>Specialised Services</td><td>2</td></tr>
<tr><td>Women’s & Children’s</td><td>0</td></tr>
</table>
</td>
<td>Total number of C. diff cases
 

A total of 7 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 two cases attributable to the Trust in April were assessed as unavoidable. The cases in May have yet to be assessed by the Clinical Commissioning Group. The outcome of these cases will be reported in June.
There have been no MRSA bacteraemia cases attributed to the Trust to date since August 2015.</td>
</tr>
<tr>
<td>Deteriorating patient
Early warning scores acted upon in accordance with the escalation protocol (excluding paediatrics). This is an area of focus for our Sign up to Safety Patient Safety Improvement Programme. Our three year goal is sustained improvement above 95%.</td>
<td>Performance is May was 100% against a three year improvement goal of 95%. This is an improvement from April (87%).</td>
<td>Deteriorating patient: percentage of early warning scores acted upon
 
</td>
<td>As reported last month, actions being taken to make improvements have involve training staff in various aspects of deteriorating patient management and testing new improvement ideas. This will help to realise sustained improvement in performance and to support staff that are new to the Trust.</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 May 2016, the percentage of patients with no new harms was 98.7 %, against an upper quartile target of 98.26% (GREEN threshold) of the NHS England Patient Safety peer group of trusts.	**The percentage of patients surveyed showing No New Harm each month** 	The May 2016 Safety Thermometer point prevalence audit showed five new catheter associated urinary tract infections, zero falls with harm, two new pressure ulcers and three incidences of 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 May 2016, 0.63% of critical medications were omitted. This is a decrease on the previous month's figure of 0.93%, and below the target 1% on average for the calendar year to date (0.88%). The 0.63% for May relates to 8 patients who had a non-purposeful missed / omitted dose of the listed critical medication in the 3 days prior to prescription review in the month, from a review of 1265 patients. Three wards had two omitted doses each and the other two were on different wards.	**Percentage of omitted doses of listed critical medicines** 	Reasons for omissions were as follows: for four patients the drug was not on ward at the time, for one patient the dose was unintentionally omitted, for one patient the drug was given but not signed for, one dose was prescribed but administered later than stated and for one patient the reason is unknown. Actions being taken are described in the actions section (Action 1)

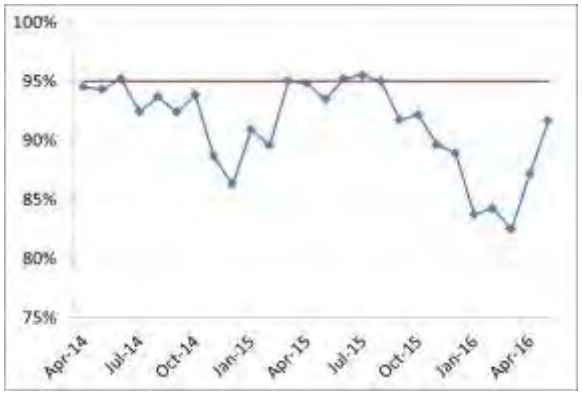
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%</td>
<td>Achievement of the Green threshold for this indicator now depends on all five of the new categories of Essential Training achieving a 90% standard. The compliance with the new reporting categories is provided below.
<table>
<tr><th>May 2016</th><th>Trust level</th></tr>
<tr><td>Total</td><td>85%</td></tr>
<tr><td>Three Yearly (14 topics)</td><td>88%</td></tr>
<tr><td>Annual (Fire & IG)</td><td>56%</td></tr>
<tr><td>Induction</td><td>96%</td></tr>
<tr><td>Resuscitation</td><td>78%</td></tr>
<tr><td>Safeguarding</td><td>88%</td></tr>
</table>
Overall compliance is 85% (excluding Child Protection Level 3).</td>
<td>This represents a new and more comprehensive way of reporting, and is not comparable with previous parameters for reporting. Future reports will include a graph to show progress for each category.</td>
<td>Reporting has changed this month to include a wider range of Essential Training than Core topics previously covered. Full details including a divisional breakdown are provided in the Appendix 2.
Action plan 2 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 May the Trust had rostered 221,886 expected nursing hours, with the number of actual hours worked of 230,712.
This gave a fill rate of 104%
<table>
<tr><th>Division</th><th>Actual Hours</th><th>Expected Hours</th><th>Difference</th></tr>
<tr><td>Medicine</td><td>66,884</td><td>62,017</td><td>+4,867</td></tr>
<tr><td>Specialised Services</td><td>40,395</td><td>40,064</td><td>+331</td></tr>
<tr><td>Surgery Head & Neck</td><td>44,333</td><td>42,542</td><td>+1,791</td></tr>
<tr><td>Women’s & Children’s</td><td>72,885</td><td>72,301</td><td>+584</td></tr>
<tr><td>Trust - overall</td><td>230,712</td><td>221,886</td><td>+8,826</td></tr>
</table></td>
<td>The percentage overall staffing fill rate by month
 
</td>
<td>Overall for the month of May 2016, the Trust had 100% cover for Registered Nurses (RNs) on days and 97% RN cover for nights. The unregistered level of 114% for days and 123% for nights reflects the activity in May. This was due primarily to Nursing Assistant (NA) specialist assignments to safely care for confused or mentally unwell patients in both adults and children. (Action 3).</td>
</tr>
</table>

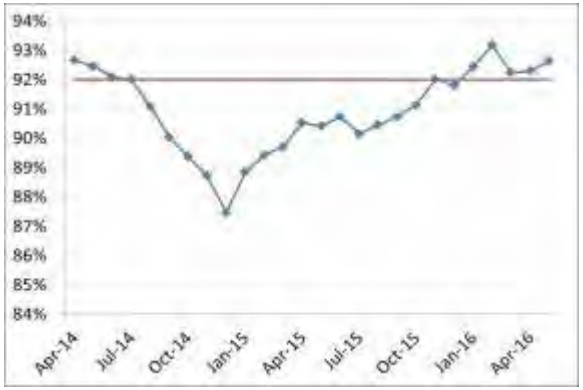
Description	Current Performance	Trend	Comments
Friends & Family Test inpatient score is a measure of how many patients said they were 'very likely' to recommend a friend or family to come to the Trust if they needed similar treatment. The scores are calculated as per the national definition, and summarised at Division and individual ward level.	Performance for May 2016 was 95.8%. This metric combines Friends and Family Test scores from inpatient and day-case areas of the Trust, for both adult and paediatric services. Division and hospital-level data is provided to the Trust Board on a quarterly basis and will be provided at the end of quarter 1.	**Inpatient Friends & Family scores each month** 	The scores for UH Bristol are in line with national norms. A very high proportion of the Trust's patients would recommend the care that they receive to their friends and family. These results are shared with ward staff and are displayed publically on the wards. Division and hospital-level data is provided to the Trust Board and is explored within the Quarterly Patient Experience report.
Dissatisfied Complainants. By October 2015 we are aiming for less than 5% of complainants to report that they are dissatisfied with our response to their complaint by the end of the month following the month in which their complaint response was sent.	There is no available data yet for April 2016. Our initial assumption was that most complainants who were dissatisfied with their response would come back to us by the end of the month following that in which they received their response. An audit recently conducted for 2015/16 to check our initial assumption revealed that only about 50% of dissatisfied complainants were coming back within this time frame, and the remainder were coming back within two months following the month in which they received their response. Therefore we will report this indicator two months in arrears for 2016/17. The data for responses sent in April 2016 will be available in July and is likely to show an increase from figures reported in 2015/16 for this reason.	**Percentage of compliantaints dissatisfied with the complaint response each month** 	Our performance for 2015/16 was 6.15%. Informal benchmarking with other NHS Trusts suggests that rates of dissatisfied complainants are typically in the range of 8% to 10%. Actions continue as previously reported to the Board (Action 4).

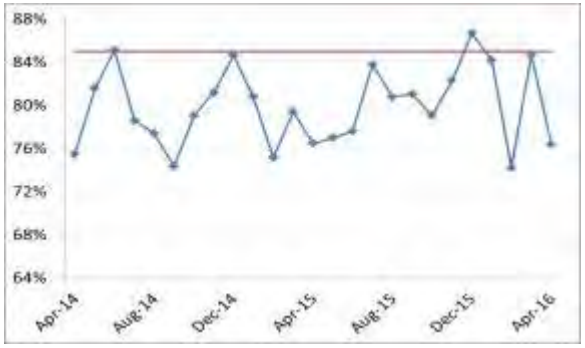
Description	Current Performance	Trend	Comments
Inpatient experience tracker comprises five questions from the monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via analysis and focus groups.	For the month of April and May 2016, the score was 92 out of a possible score of 100. Divisional scores are broken down at the end of each quarter as numbers of responses each month are not sufficient for a monthly divisional breakdown to be meaningful. Q 3 / Q4 Trust: 90 / 90 Division of Medicine: 86 / 86 Division of Surgery, Head & Neck: 92 / 92 Division of Specialised Services: 91 / 91 Women's & Children's (Bristol Royal Hospital for Children): 91 / 91 Women's & Children's Division (Postnatal wards): 90 / 90	**Inpatient patient experience scores (maximum score 100) each month** 	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.
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.	The scores for the Trust as whole were 88 in April 2016 and 90 in May 2016 (out of score of 100). Quarter 4 2015/2016 / May 2016 Trust: 89 / 90 Medicine: 87 Specialised Services: 88 Surgery, Head & Neck: 88 Women's & Children's (Bristol Royal Hospital for Children): 86 Diagnostics & Therapies: 94 Scores are out of 100.	**Outpatient Experience Scores (maximum score 100) each month** 	UH Bristol performs in line with national norms in terms of patient-reported experience. This metric would turn red if outpatient experience at UH Bristol began to deteriorate to a statistically significant degree – alerting the Trust Board and senior management that remedial action was required. In the year to date the Trust score remains green. Divisional scores are examined in detail in the Trust's Quarterly Patient Experience Report.

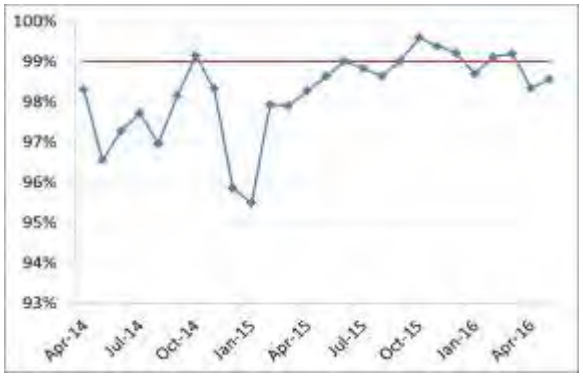
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Last Minute Cancellation is a measure of the percentage of operations cancelled at last minute for non-clinical reasons. The national standard is for less than 0.8% of operations to be cancelled at last minute for reasons unrelated to clinical management of the patient.</td>
<td>In May the Trust cancelled 59 (0.96% of) operations at last-minute for non-clinical reasons. The reasons for the cancellations are shown below:
<table>
<tr><th>Cancellation reason</th><th></th></tr>
<tr><td>Emergency patient prioritised</td><td>16 (27%)</td></tr>
<tr><td>No ward bed available</td><td>15 (25%)</td></tr>
<tr><td>Clinically complicated case</td><td>6 (10%)</td></tr>
<tr><td>No theatre staff</td><td>6 (10%)</td></tr>
<tr><td>Other causes (8 different breach reasons - no themes)</td><td>16 (27%)</td></tr>
</table>
Two patients cancelled in April were readmitted outside of 28 days due to emergency pressures and other patients taking priority. This equates to 96.8% of cancellations being readmitted within 28 days, which is above trajectory and the former national standard of 95%.</td>
<td>Percentage of operations cancelled at last-minute
 

National 0.8% standard is currently forecast to be achieved again in June.</td>
<td>Although emergency pressures eased slightly within the period, cancellations due to emergency pressures still accounted for almost 60% of all cancellations of routine operations in the period. An action plan to reduce elective cancellations continues to be implemented (Actions 5A and 5B). However, please also see actions detailed under A&E 4 hours (7A to 7C) and outlier bed-days (12A to 12D).</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 May 12.4% of outpatient appointments were cancelled by the hospital, which is a 1.6% reduction on the previous month. Unlike the previous five months, May was not impacted by cancellations arising from the junior doctor industrial action.
The patient administration system has a large number of different reasons for cancellation which can be selected by users. This creates confusion and impacts on the consistency of reporting of causes of cancellation. For this reason, a review of cancellations reasons is underway, and will be completed in time for the next Quality & Performance report.</td>
<td>Percentage of outpatient appointments cancelled by the hospital
 
</td>
<td>Ensuring outpatient capacity is effectively managed on a day-to-day basis is a core part of the improvement work overseen by the Outpatients Steering Group. The improvement plan for this key performance indicator has now been refreshed, prioritising those actions that are likely to reduce the current underlying rate of cancellation by the hospital (Actions 6A to 6F).</td>
</tr>
</table>

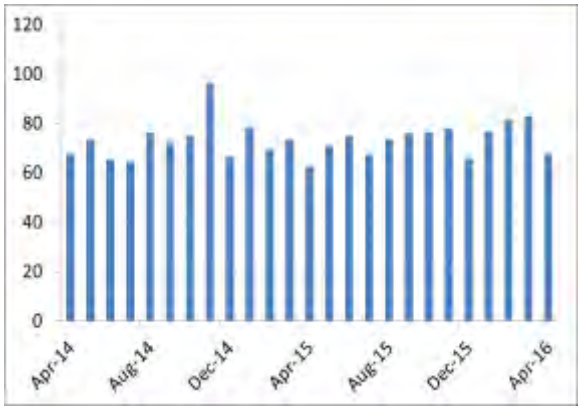
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>A&E Maximum 4-hour wait is measured as the percentage of patients that are discharged, admitted or transferred within four hours of arrival in one of the Trust's three Emergency Departments (EDs). The national standard is 95%.</td>
<td>The 95% national standard was not achieved in May. However, performance improved to 91.7% from 87.2% in April, meeting the recovery trajectory of 84.4%. Performance and activity levels for the BRI and BCH Emergency Departments are shown below.
<table>
<tr><th>BRI</th><th>May 2015</th><th>Apr 2016</th><th>May 2016</th></tr>
<tr><td>Attendances</td><td>5508</td><td>5594</td><td>5834</td></tr>
<tr><td>Emergency Admissions</td><td>1791</td><td>1875</td><td>1842</td></tr>
<tr><td>Patients managed < 4 hours</td><td>5101
92.6%</td><td>4464
79.8%</td><td>5118
87.7%</td></tr>
<tr><th>BCH</th><th>May 2015</th><th>Apr 2016</th><th>May 2016</th></tr>
<tr><td>Attendances</td><td>3354</td><td>3036</td><td>3475</td></tr>
<tr><td>Emergency Admissions</td><td>803</td><td>753</td><td>830</td></tr>
<tr><td>Patients managed < 4 hours</td><td>3073
91.6%</td><td>2824
93.0%</td><td>3261
93.8%</td></tr>
</table>
</td>
<td>Performance of patients waiting under 4 hours in the Emergency Departments
 

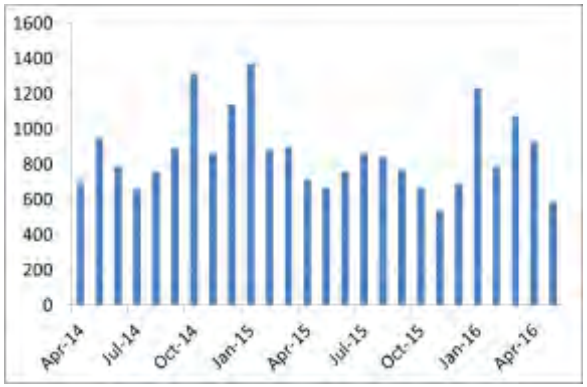
Trajectory target of 85.9% for June forecast to be met.</td>
<td>Overall levels of emergency admissions were 3% higher in May than in the same period in 2015. The level of ambulance arrivals has returned to seasonal norms, which suggests patient acuity has reduced. The number of patients on the Green to Go (delayed discharge) list decreased from 67 at the end of April, to 58 at the end of May, which led to a reduction in bed occupancy and consequent improvement in flow. Actions continue to be taken to manage demand and to reduce delayed discharges (Actions 7A to 7C).</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>Both the 92% national standard and the trajectory target were achieved at the end of May, with the Trust reporting 92.6% of patients waiting less than 18 weeks at month-end. The overall number of patients waiting over 18 weeks reduced for the admitted but not the non-admitted pathways (see Appendix 3).
The number of patients waiting over 40 weeks RTT at month-end decreased in May from the April position, against the trajectory of zero.
<table>
<tr><th></th><th>Mar</th><th>Apr</th><th>May</th></tr>
<tr><td>Numbers waiting > 40 weeks RTT</td><td>26</td><td>24</td><td>22</td></tr>
<tr><td>Numbers waiting > 52 weeks RTT</td><td>0</td><td>0</td><td>0</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 18 weeks RTT by month
 
</td>
<td>There was a small reduction in the overall number of patients waiting over 18 weeks, despite this being a month with fewer normal working days as a result of the two bank holidays. Delivery of the RTT over 18-week trajectories is monitored weekly, with any significant variances from plan escalated to Divisional Director level. The weekly RTT Operational Group continues to oversee the management of waiting lists and booking of longest waiting patients (Action 8).</td>
</tr>
</table>

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Cancer Waiting Times are measured through eight national standards. These cover a 2-week wait to see a specialist, a 31 day wait from diagnosis to treatment, and a 62-day wait from referral to treatment. There are different standards for different types of referrals, and first and subsequent treatments.</td>
<td>The Trust reported performance of 76.4% against the 85% 62-day GP standard in April. This is above the agreed performance trajectory for the month of 72.7%. Performance against the 90% 62-day screening standard was 41.7%. The main reasons for failure to achieve the 85% national 62-day GP standard are shown below.
<table>
<tr><th>Breach reason</th><th>April 16</th></tr>
<tr><td>Late referral by/delays at other provider</td><td>8.5</td></tr>
<tr><td>Medical deferral/clinical complexity</td><td>3.5</td></tr>
<tr><td>Delayed radiology or admitted diagnostic</td><td>3.5</td></tr>
<tr><td>No critical care bed / industrial action</td><td>3.0</td></tr>
<tr><td>Outpatient appointment delay</td><td>1.0</td></tr>
<tr><td>TOTAL</td><td>19.5</td></tr>
</table>
</td>
<td>Percentage of patients treated within 62 days of GP referral
 

There were 3.5 x 62-day screening pathway breaches out of 6 patients treated. The breach reasons were patient choice (1.5), delayed diagnostic (1) and delayed surgical outpatient appointment (1).</td>
<td>Performance was better than the trajectory, which took account of expected breaches due to the recent pressure on critical care beds, but also the usual seasonal high level of late referrals from other providers. The 85% standard was achieved for internally managed pathways. Ideal timescale pathway review meetings are nearing completion (Action 9). Timescales for tertiary referral has been included in a CQUIN for 2016/17. The above areas of focus are part of the action plan signed-off by the Board.</td>
</tr>
<tr>
<td>Diagnostic waits – diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.</td>
<td>The 99% national standard was not achieved at the end of May, with reported performance 98.6%. The number and percentage of over 6-week waiters at month-end, is shown in the table below:
<table>
<tr><th>Diagnostic test</th><th>Mar</th><th>Apr</th><th>May</th></tr>
<tr><td>MRI</td><td>19</td><td>13</td><td>13</td></tr>
<tr><td>Ultrasound</td><td>2</td><td>19</td><td>20</td></tr>
<tr><td>Sleep</td><td>0</td><td>3</td><td>24</td></tr>
<tr><td>Endoscopies</td><td>38</td><td>83</td><td>59</td></tr>
<tr><td>Other</td><td>2</td><td>9</td><td>6</td></tr>
<tr><td>TOTAL</td><td>61</td><td>127</td><td>122</td></tr>
<tr><td>Percentage</td><td>99.2%</td><td>98.3%</td><td>98.6%</td></tr>
<tr><td>Trajectory</td><td>99.3%</td><td>99.0%</td><td>99.0%</td></tr>
</table>
</td>
<td>Percentage of patients waiting under 6 weeks at month-end
 

Achievement of the 99% standard is at risk for the end of June, with potential, although not certain, recovery for the end of July.</td>
<td>This standard was failed mainly due to a shortfall of adult endoscopy capacity following the failure to recruit to a locum endoscopy post and high levels of cancellations due to junior doctor industrial action, with 260 slots being lost for the latter reason. Changes to DVLA requirements have also impacted on the waiting times for sleep studies, with a backlog forecast for the end of June. A recovery plan is being enacted. (Action 10A and 10B).</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Summary Hospital Mortality Indicator (in hospital deaths) is the ratio of the actual number of patients who died in hospital and the number that were 'expected' to die, calculated from the patient case-mix, age, gender, type of admission and other factors.	Summary Hospital Mortality Indicator (SHMI) for March 2016 was 67.6. This indicator has been rebased against the 2015 SHMI baseline as occurs from time to time to reflect improving mortality across all providers. The impact of rebasing is that all providers' SHMI increases. The RAG rating for this indicator has been suspended pending further discussion to refine the accuracy of reporting this indicator to take into account the in-year effect of relative improvement across all trusts. The Quality Intelligence Group continues to conduct assurance reviews of any specialties that have an adverse SHMI score in a given quarter. No patterns of causes for concern have been identified.	**Summary Hospital Mortality Indicator (SHMI) for in hospital deaths each month** 	This is a high level indicator of the effectiveness of the care and treatment we provide. The latest available national SHMI, September 2015, (which includes deaths occurring within 30 day of hospital admission) for our Trust is 97.8 with lower confidence limit of 90 and an upper confidence limit of 111. Our performance continues to indicate that fewer patients died in our hospitals than would have been expected given their specific risk factors.
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 April (latest data), all 37 patients (100%) were treated within 90 minutes of arrival in the hospital. Performance for March, which was not reported in time for the last Quality & Performance Report, was 85.2%, but with performance for the year as a whole remaining well above the 90% standard at 93.0%.	**Percentage of patients with a Door to Balloon Time < 90 minutes by month** 	Routine monthly analysis of the causes of delays in patients being treated within 90 minutes continues.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Fracture neck of femur Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. For details of the eight elements, please see Appendix 1.</td>
<td>In May 2016 we achieved 59.3% (16/27 patients) overall performance in Best Practice Tariff (BPT), against the national standard of 90%. The time to theatre within 36 hours performance was 74.1% (20/27 patients) and the review by an Ortho-geriatrician within 72 hours was 81.5% (22/27 patients).
<table>
<tr><th>Reason for not going to theatre within 36 hours</th><th>Number</th></tr>
<tr><td>Lack of theatre capacity</td><td>5 patients - 3 due to an increase in a week in the number of admissions with a hip fracture (11 admitted – weekly average 6)</td></tr>
<tr><td>A specialist surgeon required</td><td>2 breaches due to the patients needing total hip replacements requiring a specialist surgeon.</td></tr>
</table>
</td>
<td>Percentage of patients with fracture neck of femur whose care met best practice tariff standards.
 
</td>
<td>The percentage of patients going to theatre within the 36 hours has reduced due to a lack of theatre capacity. There has also been a significant level of long-term sickness within the ortho-geriatrician team. This has been partly covered with locums, but cover has not been consistent. Work is ongoing between Medicine and Surgery, Head & Neck, to establish a future service model across T&O, and to ensure that consistent, sustainable cover is provided (Actions 11A to 11E)</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 May 2016 there were 587 outlier bed-days against a target of 815. This is an improvement from April of 343 outlier bed-days.
<table>
<tr><th>Outlier bed-days</th><th>May2016</th></tr>
<tr><td>Medicine</td><td>336</td></tr>
<tr><td>Surgery, Head & Neck</td><td>164</td></tr>
<tr><td>Specialised Services</td><td>85</td></tr>
<tr><td>Women's & Children's Division</td><td>2</td></tr>
<tr><td>Other</td><td>0</td></tr>
<tr><td>Total</td><td>587</td></tr>
</table>
The change is largely within the Division of Medicine which had almost half the number of outlier bed-days than in the previous month, with a smaller improvement in Surgery, Head & Neck.</td>
<td>Number of days patients spent outlying from their specialty wards
 
</td>
<td>Performance against this indicator is reflective of improved patient flow across the hospitals and some reduction in level of demand.
Ongoing actions are shown in the action plan section of this report. (Actions 12A to 12D).</td>
</tr>
</table>

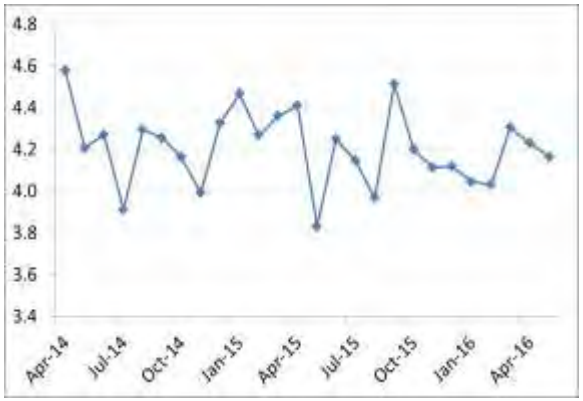
Description	Current Performance	Trend	Comments
Agency usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2015/16. The red threshold is 10% over the monthly target.	Agency usage reduced by 24.1 FTE overall, reducing from 1.9% to 1.6% of total staffing, and nursing agency usage was 25.1 FTE lower than last month. There were reductions in all clinical divisions except Women's & Children's and Surgery Head & Neck. Three Divisions achieved their monthly Green threshold.	**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 13). A summary of the NHS Improvement submission in relation to compliance with the newly established 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 Trust-wide achieved the Green threshold, reducing to 3.8% (against the Trust target of 3.9%), meeting the divisional targets in four out of seven Divisions.	**Sickness absence as a percentage of full time equivalents by month**	Action 14 describes the ongoing programme of work to address sickness absence.

May 2016	FTE	Actual	Target
UH Bristol	**131.9**	**1.6%**	**1.2%**
Diagnostics & Therapies	0.9	0.1%	0.6%
Medicine	25.5	2.1%	2.2%
Specialised Services	21.7	2.3%	1.8%
Surgery, Head & Neck	34.0	1.9%	0.6%
Women's & Children's	21.0	1.1%	0.7%
Trust Services	19.7	2.8%	1.9%
Facilities & Estates	9.2	1.1%	1.4%

May 2016	Actual	Target
UH Bristol	**3.8%**	**3.9%**
Diagnostics & Therapies	2.4%	2.8%
Medicine	3.7%	4.9%
Specialised Services	3.4%	3.5%
Surgery, Head & Neck	3.8%	3.7%
Women's & Children's	4.0%	3.5%
Trust Services	3.0%	3.4%
Facilities & Estates	6.1%	6.0%

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.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Comments</th></tr>
<tr>
<td>Vacancies - vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.</td>
<td>Vacancies increased from 3.8% (305.8 FTE), which was the lowest recorded vacancy since April 2014, to 4.7% (380 FTE), below the target of 5%. Nursing vacancies increased by a total of 35.8 FTE, spread across all Divisions.
<table>
<tr><th>May 2016</th><th>Rate</th></tr>
<tr><td>UH Bristol</td><td>4.7%</td></tr>
<tr><td>Diagnostics & Therapies</td><td>4.3%</td></tr>
<tr><td>Medicine</td><td>6.7%</td></tr>
<tr><td>Specialised Services</td><td>6.6%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>3.9%</td></tr>
<tr><td>Women's & Children's</td><td>2.2%</td></tr>
<tr><td>Trust Services</td><td>8.1%</td></tr>
<tr><td>Facilities & Estates</td><td>4.2%</td></tr>
</table>
</td>
<td>Vacancies rate by month
 
</td>
<td>The programme of recruitment activities is summarised in Action 15. We are closely monitoring specialist nursing and theatre vacancies.
Appendix 2 provides details of nursing vacancies in Heygroves Theatres, Ward D703, and Coronary Intensive Care Unit, where additional investment is in place to support recruitment and retention.</td>
</tr>
<tr>
<td>Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 11.5% by the end of 2015/16. The red threshold is 10% above monthly trajectory.</td>
<td>Turnover reduced from the refreshed April figure of 13.6% to 13.3% in May. Divisional targets were achieved in two out of seven Divisions.
<table>
<tr><th>May 2016</th><th>Actual</th><th>Target</th></tr>
<tr><td>UH Bristol</td><td>13.3%</td><td>13.2%</td></tr>
<tr><td>Diagnostics & Therap.</td><td>13.4%</td><td>12.8%</td></tr>
<tr><td>Medicine</td><td>14.9%</td><td>14.2%</td></tr>
<tr><td>Specialised Services</td><td>13.4%</td><td>14.0%</td></tr>
<tr><td>Surgery, Head & Neck</td><td>13.8%</td><td>13.9%</td></tr>
<tr><td>Women's & Children's</td><td>11.0%</td><td>10.8%</td></tr>
<tr><td>Trust Services</td><td>16.3%</td><td>15.4%</td></tr>
<tr><td>Facilities & Estates</td><td>13.0%</td><td>13.9%</td></tr>
</table>
</td>
<td>Staff turnover rate by month
 
</td>
<td>Programmes to support staff recruitment remain a key priority for the Divisions and the Trust (Action 16).
Increased turnover is due in part to increased retirements which have doubled compared with the previous April.</td>
</tr>
</table>

Description	Current Performance	Trend	Comments
Length of Stay (LOS) measures the number of days inpatients on average spent in hospital. This measure excludes day-cases. LOS is measured at the point at which patients are discharged from hospital.	In May the average length of stay for inpatients was 4.16 days, a further 0.07 day decrease on the previous month. Length of Stay remains above plan, and for this reason is RED rated. At the end of April the number of Green to Go delayed discharges was lower than the same period last year (58 versus 74), but remains above the jointly agreed planning assumption of 30 patients. In May the percentage of over 14 days stay patients discharged was lower than in the previous two months. This suggests the decrease in Length of Stay this month was in part due to fewer long stay patients being discharged in the period.	**Average length of stay (days)** 	Work to reduce delayed discharges and over 14 days stays continues as part of the emergency access community-wide resilience plan and additional exceptional actions being taken (Actions 12A to 12D).

Improvement Plan

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Safe					
Non-purposeful omitted doses of critical medication	1	Feedback detailed results to Heads of Nursing to follow up the eight omitted doses this month.	June 2016	Ensuring detailed focus is maintained to avoid omitted doses	Maintain current improvement and sustain performance below 1%
Essential Training	2	Continue to drive compliance including increasing e-learning.	Ongoing	Oversight by Workforce and OD Group via the Essential Training Steering Group	From July, trajectories will be monitored at a divisional level at monthly performance and Operations meetings.
		Detailed plans focus on improving the compliance of Safeguarding Resuscitation, Information Governance and Fire Safety.	Ongoing	Oversight of safeguarding training compliance by Safeguarding Board	
		Compliance reports have been produced which separate Fire and Information Governance (IG), enabling Divisions to proactively track those who are non-compliant. Detailed communications will be sent out across the organisation to enable staff to identify the appropriate training for them to achieve compliance.	June 2016	Oversight by Workforce and OD Group via the Essential Training Steering Group / Service Delivery Group	
		Trajectories will be produced for Divisions to achieve compliance against Fire and IG and these will be signed off by the Service	July 2016	Service Delivery Group/monthly and quarterly Divisional Performance Reviews.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Delivery Group by July.			
Monthly Staffing levels	3	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	4	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.	Achieve and maintain a green RAG rating for this indicator.
Last minute cancelled operations	5A	Continued focus on recruitment and retention of staff to enable all adult BRI ITU beds to be kept open, at all times. Training package developed to support staff retention. Staff recruited but now in pipeline before starting. Development and implementation of a strategy for managing ITU/HDU beds across general adult and cardiac units, to improve ability to manage peaks in demand.	Ongoing To be confirmed – expected to be by quarter 4, when virtual ward up to full impact, relieving ward bed pressures	Monthly Divisional Review Meetings; Relevant Steering Group to be confirmed, but likely to be Cancer Steering Group, due to the recent impact on cancer	Improvement to be evidenced by a reduction in cancellations in Q1. Achievement of quality objective on a quarterly basis.
	5B	Specialty specific actions to reduce the likelihood of cancellations.	Ongoing	Monthly review of plan with Divisions by Associate Director	As above.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
				of Operations.	
Outpatient appointments cancelled by hospital	6A	Review and revise cancellation reasons available on Medway to improve consistency of reporting and improve the Trust's understanding of the root cause of cancellations.	End of July	Changes approved through Change Board and Medway revised.	See action 6C
	6B	Produce summary analysis of first month's use of the new cancellation codes, and test the reasonableness of the target thresholds currently set. This analysis will include a break-down of the reasons for cancellation, and the percentage of cancellations that relate to patients being able to book on the national Electronic Referral Service, beyond the period of notification for annual leave.	End August	Report provided for Outpatient Steering Group;	Outpatient Steering Group to identify any new actions arising from this analysis, which may alter performance trajectory.
	6C	Select six highest hospital cancellation specialities and investigate reasons for cancellations with frontline staff and Performance & Operations Managers. Share learning with all over specialities via the Outpatient Steering Group.	End of September	Report provided for Outpatient Steering Group	Amber threshold expected to be achieved by the end of October.
	6D	Send Trust Annual Leave Policy to all General Managers and ask them to confirm that the policy is being	End of June	Confirmation to go back to the Outpatient Steering Group in July	See action 6C

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		adhered to within their specialities.			
	6E	Using the new cancellations codes set-up on Medway, confirm that no leave is being agreed within six weeks (or timescale locally agreed).	End of September	Report provided for Outpatient Steering Group	See action 6C

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Responsive					
A&E 4-hours	7A	Commissioner-led task and finish group established in January, to understand drivers of increase in paediatric emergency demand and to identify possible demand management solutions.	Ongoing	Urgent Care Board	Achievement of recovery trajectory in Quarter 1 (achieved in each month to date).
	7B	Delivery of internal elements of the community-wide resilience plan.	Ongoing	Emergency Access Steering Group	Achievement of recovery trajectory in Quarter 1 (achieved in each month to date).
	7C	Working with partners to continue to mitigate any impact of recommissioning of domiciliary care packages providers and bed closures in other acute trusts See also actions 12A to 12D relating to delayed discharges and flow.	Ongoing	Urgent Care Board	Achievement of recovery trajectory in Quarter 1 (achieved in each month to date).
Referral to Treatment Time (RTT)	8	Weekly monitoring of reduction in RTT over 18 week backlogs against trajectory. Continued weekly review of management of longest waiting patients through RTT Operations Group	Ongoing	Oversight by RTT Steering Group; routine in-month escalation and discussion at monthly Divisional Review meetings.	Achievement of the RTT Incomplete/Ongoing pathways standard (remains on track for end of June).
Cancer waiting times	9A	Implementation of Cancer Performance Improvement Plan, including ideal timescale pathways,	Ongoing	Oversight of implementation by Cancer Performance Improvement Group, with	Achieve monthly recovery trajectory submitted for

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		and reduced waits for 2-week wait appointments (copy of plan provided to the Quality & Outcomes Committee as a separate paper in August; and Trust Board in September)		escalation to Cancer Steering Group.	2016/17
	9B	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.	Further information from NBT on recovery trajectory awaited.
Diagnostic waits	10A	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.	Possible recovery of 99% standard by end of July, although this is at risk if additional waiting list initiatives cannot be run to address existing backlog.
	10B	GP with Specialist Interest undertaking additional Sleep Studies outpatient sessions (late June to September), to help address the bulge in demand; additional waiting list sessions also being undertaken.	Ongoing	Weekly monitoring by Associate Director of Performance, with escalation to month Divisional Review meetings as required.	As above

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Effective					
Fracture neck of femur Best Practice Tariff (BPT)	11A	Live flow tracker in situ across Division from June to increase visibility and support escalation standards.	Ready to trial in February with full implementation in June 2016 (deadline revised again from April 2016 to June 2016)	Inclusion of three new fields to include all trauma patients waiting without a plan, all fractured Neck of Femur (NOF) patients waiting, and all fractured NOF patients over 24 hours. IM&T needs to build a new system in order to be able to retrieve this information into the live tracker. Ongoing project in IM&T.	Improve in overall fractured neck of femur pathway
	11B	The Trust has commissioned the British Orthopaedic Association to conduct an external review of outcomes for fractured neck of femur patients.	We expect to receive the formal report sometime in June.	Report of external review	Monitored by Clinical Effectiveness Group/Quality Intelligence Group.
	11C	Review and prioritise/action the recommendations of the British Orthopaedic Association Fractured Neck of Femur mortality review (review took place 10/11 May 2016 – awaiting report due within 3 weeks). Assess potential causes and mitigating actions for increased Fractured Neck of Femur mortality	30 June 2016	Identifiable actions to take to improve the #NOF service for patients which is likely to lead to improved Best Practice Tariff performance	Awaiting report – due June 2016.

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
	11D	Develop 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.	30 June 2016	Successful funding bid and subsequent recruitment to post.	Improvement in Best Practice Tariff indicators.
	11E	Develop and submit case for specialist acute fracture nurse support (Band 6 permanent).	30 June 2016	Successful funding bid and subsequent recruitment to post.	Improvement in Best Practice Tariff indicators.
Outlier bed-days	12A	Reduce demand on beds to support optimal occupancy. Range of initiatives in place to reduce demand for acute services. Limited impact to and further significant initiative now being pursued – community virtual ward.	Ongoing Working to Q4	Oversight in fortnightly Urgent Care Working Group Urgent Care Working Group and System Resilience Group	Maintain modelled occupancy of 90% Plans for commencement of virtual ward project from late June
	12B	Weekly Patient Progress meeting continues to expedite early discharge with support of our partners. Divisions reviewing long stay patients	Ongoing	Monitoring of Green to go list and new reporting of DTOC	Green to Go trajectory or no more than 30 patients
	12C	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	Ongoing	Oversight in Ward Processes Project Group	Linked to increased and timely use of discharge lounge

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		transfer.			
	12D	'Plans for the Weekend' event took place to increase number of weekend discharges	Learning now being shared	Review work streams at new Operating Model Transformation Project Group	To increase number of weekend discharges and support reduction in length of stay

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
Efficient					
Agency Usage	13	Sickness absence, vacancies and turnover are key to managing agency usage (see section 14, 15 and 16). Corporate actions to directly target agency expenditure are detailed below:		Oversight by Savings Board (Nursing Agency) and Medical Efficiencies Group (Medical Agency)	Trust-wide agency and locum ceiling set for 2016/17 of £12.8m, i.e., 35% reduction on 2015/16. Operating plans for 2016/17 set out how this will be achieved. Performance will be closely monitored through Divisional reviews.
		Effective rostering: To reduce "lost time" - currently above funded establishment - ensuring annual leave, study leave, and sickness is planned and monitored appropriately. Actions include:			
		• Planning rosters six weeks in advance	Monitoring ongoing		
		• Roll out of e-rostering to outpatient areas	In progress, complete end of June 2016.		
		• Procurement of new rostering system with integrated acuity and dependency system to enable staff to be moved to areas of greatest need	Tenders close June 2016. Pilot new system November 2016, go live April 2017		
		• Pending the new rostering system, a staffing dashboard is on trial to provide a cross trust overview of inpatient staffing	Staffing dashboard went live end of May 2016		

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

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		marketing to develop an increased pool of bank nurses			
		Agency Caps: • Executive working group set up to review compliance with Monitor caps for maximum rates and develop strategies to reduce reliance on agency workers, e.g. enhancing bank provision and to challenge Agency behaviours.	Ongoing		
Sickness Absence	14	**A dedicated lead**: To develop a sickness absence management plan to: • Review current strategies and develop impact assessment measures • Make further recommendations, supported by an action plan. Current actions include:	Action plan to Executive Directors on 29th June /Senior Leadership Team 20th July	Oversight by Workforce and Organisational Development (OD) Group via the Staff Health and Well Being Sub Group	A KPI for 2016/17 of 3.9% has been set through the operating planning process.
		Pilot of self-certification for absences of 1-3 days: Targets the 11% of sickness which is for 3 days or less, and ensuring timely return to work interviews are undertaken.	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Supporting Attendance Policy: • Audit to ensure policy is fit for purpose and consistently implemented. • Full review of policy including simplifying content/ structure, sign posting and tools to assess attendance	Full audit report findings currently awaited July - September 2016		
		Training for managers: Ensure training meets the needs of managers and achieves improved competence/confidence.	Underway and review Q1		
		Resource allocation: Ensuring that the Employee Services resource is focussed appropriately and targeted at areas of greatest need.	Ongoing		
		Pilot Supporting Attendance Surgeries: To review attendance issues and support managers to expedite cases where possible.	June – August 2016		
		Bespoke Stress and Wellbeing Workshops: Further sessions throughout Q1 after their success in 2015	Q1		
		Musculo-skeletal: As a significant cause of absence, targeted actions include: • Continued interventions by	Ongoing		

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Occupational Health Musculo-skeletal services, Physio direct, and Manual Handling Team • Review of Occupational Health Physiotherapy pathway to improve the focus on prevention and keeping staff at work.			
		Staff Health and Well Being: Annual action plan, including the following: • Free on site health checks over the next 2 years - target of reaching 2000 staff • Launch of "Step into Health" 12 week physical activity/lifestyle programme – currently 46 applicants	In place January to June 2016		
		CQUIN: Actions to achieve a new CQUIN are being developed, focussed on improving health and wellbeing and reducing musculo-skeletal, flu and mental health related absence.	April 2017	CQUIN short term working group	
Vacancies	15	Recruitment action plan includes the following activities. **Marketing and advertising:** • Divisional operating plans identify recruitment requirements for 2016/17 and performance against these will be monitored in Divisional	Review quarterly	Workforce and OD Group /Recruitment Sub Group.	Detailed trajectories are in place for key recruitment hotspots, including theatres; critical care, haematology and ancillary staff

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Performance and Operations Meetings.		Divisional Performance and Operational Reviews	
		• Marketing activity plans to be tailored to support demand, focusing on hard to fill posts including nursing and midwifery. A planned schedule of activities will be developed.	Schedule developed end of June 2016		
		Service level agreements and KPIs for recruitment have been developed to measure performance and support improvement. The agreed KPI target of 45 days for time to recruit will be tracked through divisional reviews against an improvement trajectory.	Reviewed quarterly		
		Business cases have been agreed for recruitment and retention initiatives in specialist areas - Heygroves Theatres, Ward D703 and CICU as an alternative to targeted overseas campaigns. Trajectories are shown in appendix 3.	Reviewed monthly		
Turnover	16	Key corporate and divisional actions include the following:			The KPI target for 2016/17 has been set at 12.1%.

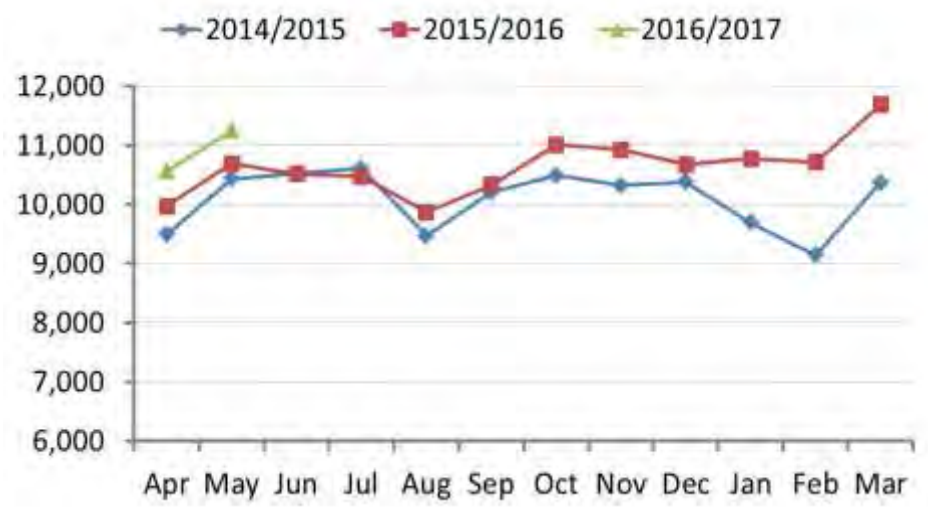
Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		Complete review of appraisal: To improve their quality and application, in response to feedback from the staff survey 2014, including: • Revised policy, in conjunction with staff side; • E-Appraisal working with our Learning and Development portal supplier; • Engaging staff through feedback sessions (105 staff).	September 2016	Workforce and OD Group	
		Targeted leadership and management development programme: Includes Healthcare Leadership Model training and Learning and Leading Together - target of 800 managers trained annually was met for 2015.	Second cohort of Leadership for Supervisors commences July 2016		
		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.	July 2016 (Diagnostic and Therapies pilot Divisional Board)	Transformation Board	
		Staff experience workshops: Divisions have incorporated actions with detailed milestones	November 2015 - March 2017.	Divisional Boards/ Senior Leadership Team/Workforce and OD Group.	

Domain	Action number	Action	Timescale	Assurance	Improvement trajectory
		into their operating plans.			
		Training and Development Investment: £200k for divisional hot spots including ITU, Heygroves and Care of the Elderly to provide innovative training and development. Return on Investment report due June 2016.	September 2015 – end June 2016	Senior Leadership Team/Workforce and OD Group /Divisional Boards	
		Family and Friends Test: This survey has just two questions "Would you recommend UHB as a place to receive treatment" and "Would you recommend UH Bristol as a place to work" providing a pulse check against the annual staff survey, distributed to all staff (previously undertaken one division at a time, now Trust wide). Communications to increase returns in Newsbeat.	Results due end July 2016	Workforce and OD Group	
		Transformational Engagement and retention: A short life working group established to develop high impact projects to improve staff experience and improve retention in response to 2015 Staff Survey. The Group has drafted plans for workshops to be held during the summer across the trust to identify and develop expected behaviours of our leaders.	Senior Leadership Seminar 22nd June, Board Seminar 24th June Workshops summer 2016	Senior Leadership Team/Board	

Operational context

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

Emergency Department (ED) attendances

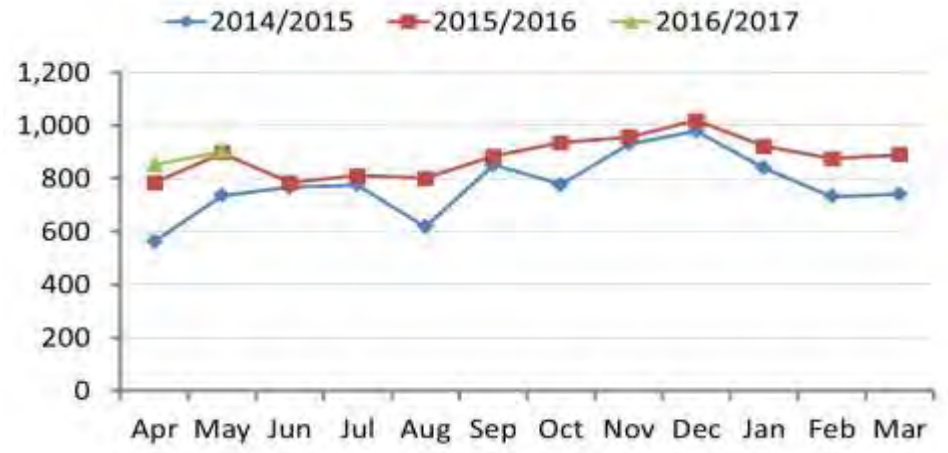


Summary points:

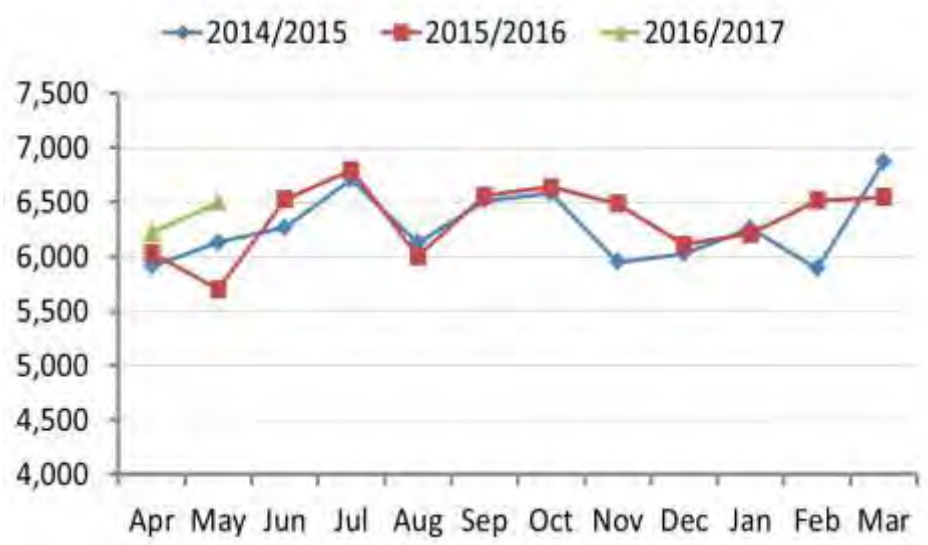
- Emergency activity remains high across all sites, with levels of ED attendances and emergency admissions above the same period last year at the BRI and BCH (see the A&E 4-hour report);
- The number of elective admissions rose sharply, and was higher than the same period last year; as will be seen from the Assurance section, the number on the elective waiting list has stayed at a similar level to last month, suggesting the higher level of activity has off-set what would have otherwise been a seasonal growth in the total waiting list;
- The number of new outpatient appointments is higher than the same period last year, but lower than the levels seen in most recent months due to fewer working days in the month; however, the outpatient waiting list has increased to a greater extent than would be expected, which is due to a 7% increase in outpatient referrals for the quarter to date compared with the same period last year.

Emergency admissions (BRI)

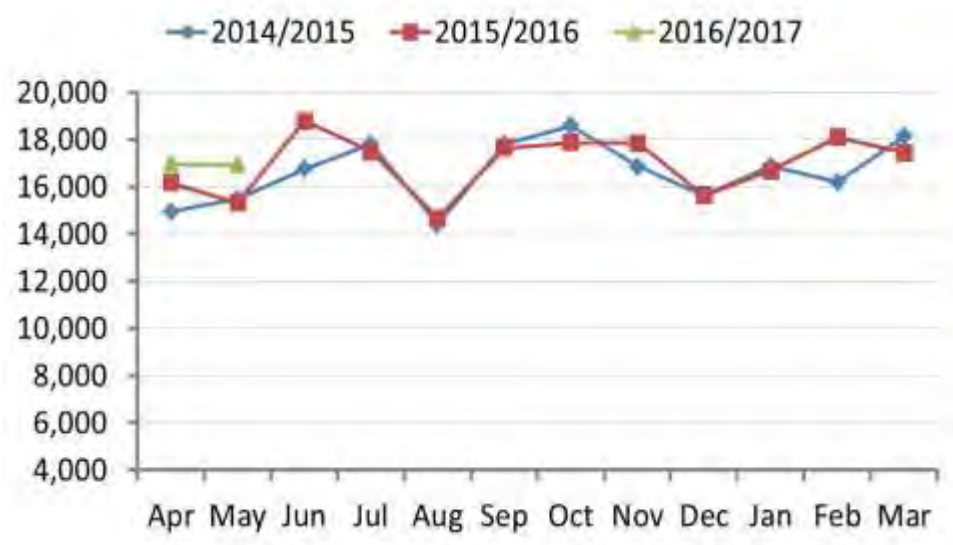
Emergency admissions (BCH)



Elective admissions



New outpatient attendances



Assurance and Leading Indicators

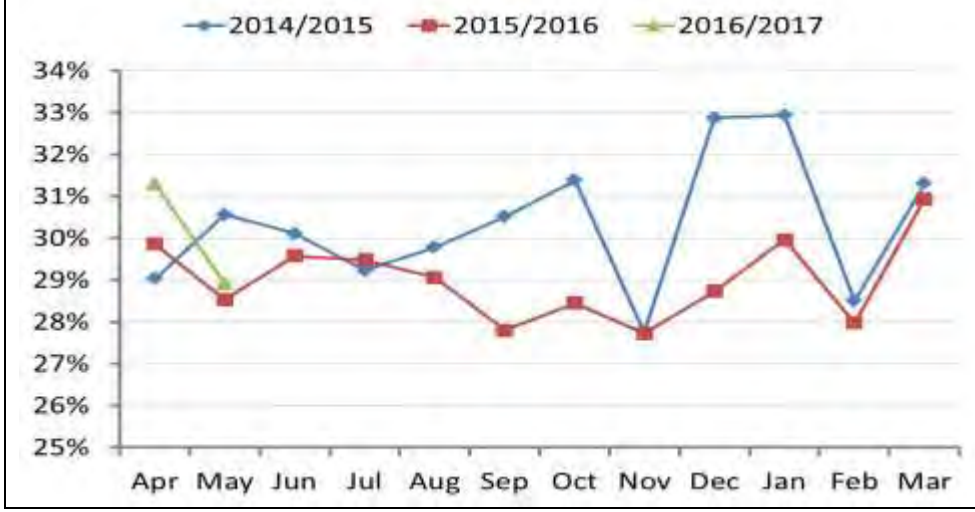
This section of the report looks at set of assurance and 'leading' indicators, which help to identify future risks and threats to achievement of standards.

Percentage ED attendances resulting in admission

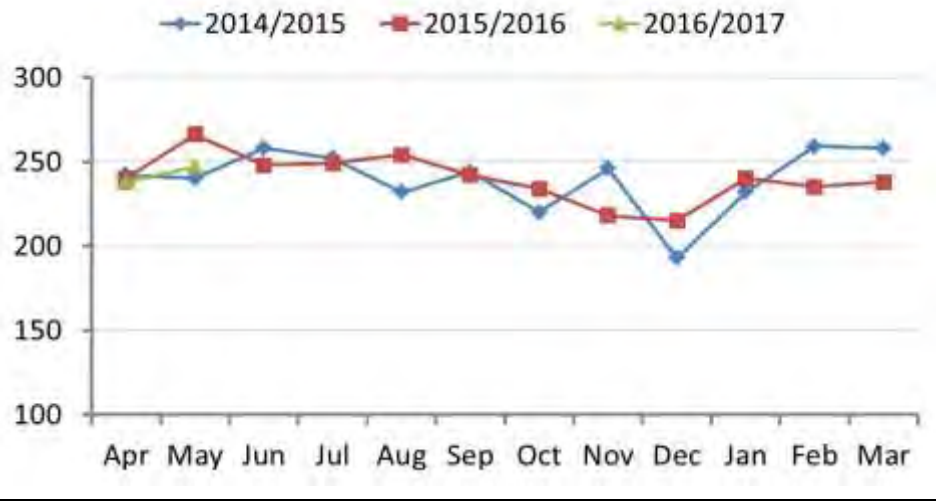
Summary points:

- The percentage of patients arriving in our Emergency Departments and converting to an admission was below the seasonal norm in May; however, the percentage of patients admitted aged 75 years and over has reduced significantly, in line with the pattern seen last year;
- The number of delayed discharges has decreased but the number of over 14 days stays has risen slightly; BRI bed occupancy has, however, reduced from its all-year high, which has resulted in an improvement in patient flow and 4-hour performance;
- The number of patients on the elective waiting list has stayed at a similar level to last month, despite a sharp (but seasonally normal) rise in elective admissions; consistent with this, the number of patients on admitted pathways waiting over 18 weeks RTT has also stayed as a similar level (see Appendix 3);
- Numbers of patients referred by their GP with a suspected cancer has stayed at the seasonal norm.

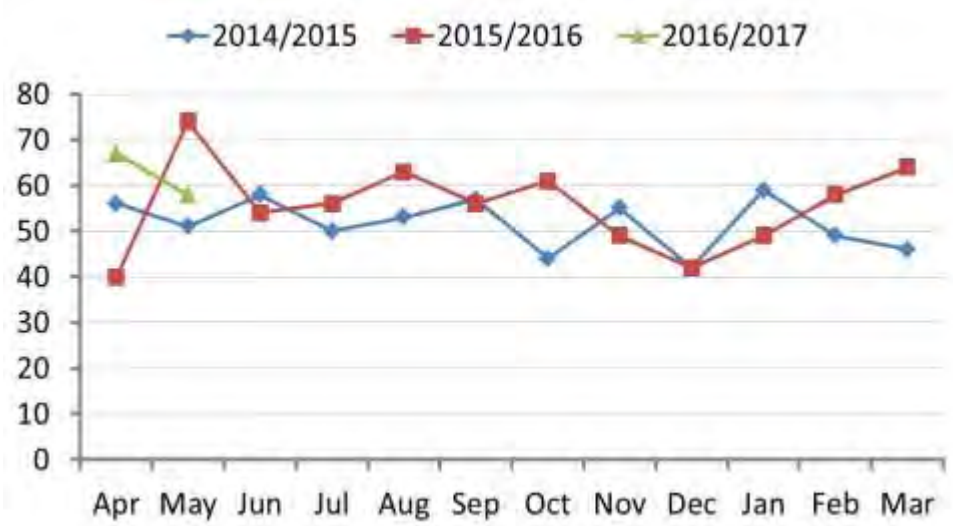
Percentage of Emergency BRI spells patients aged 75 years and over



Over 14 day stays

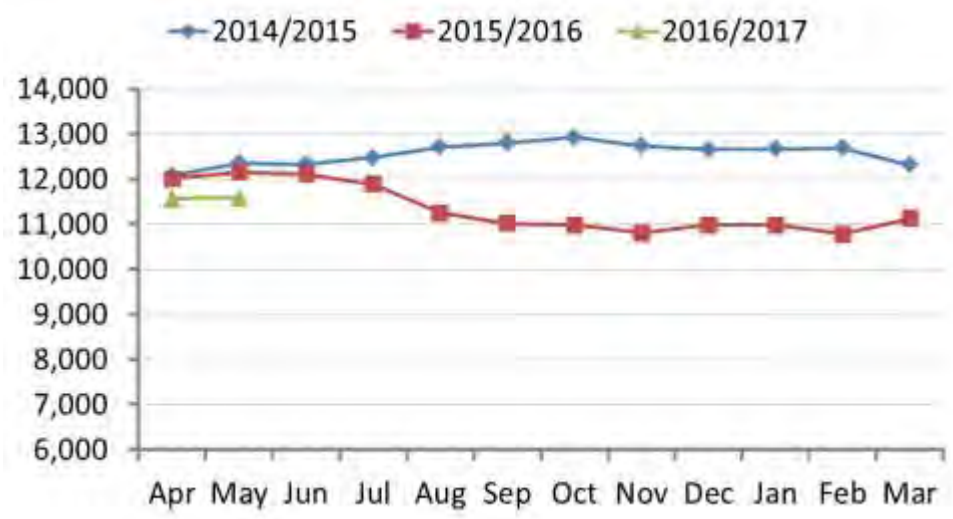


Delayed discharges (Green to Go)

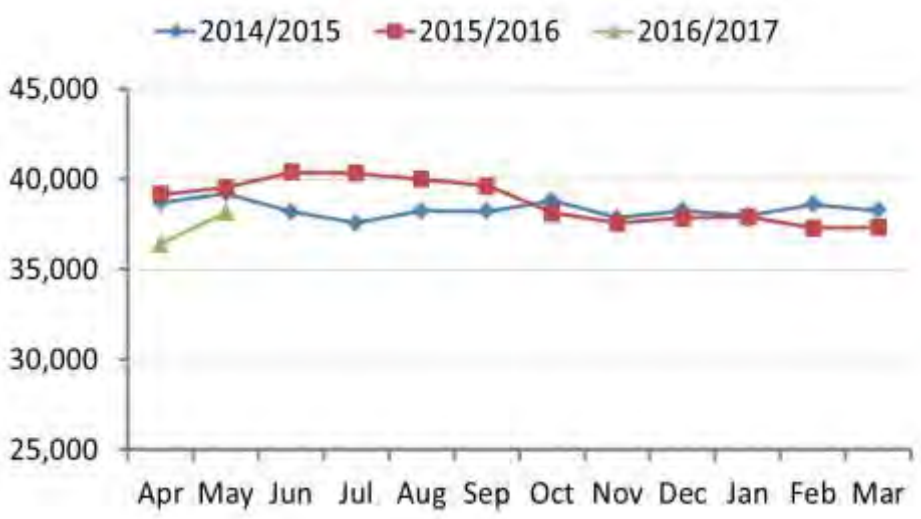


BRI Bed Occupancy

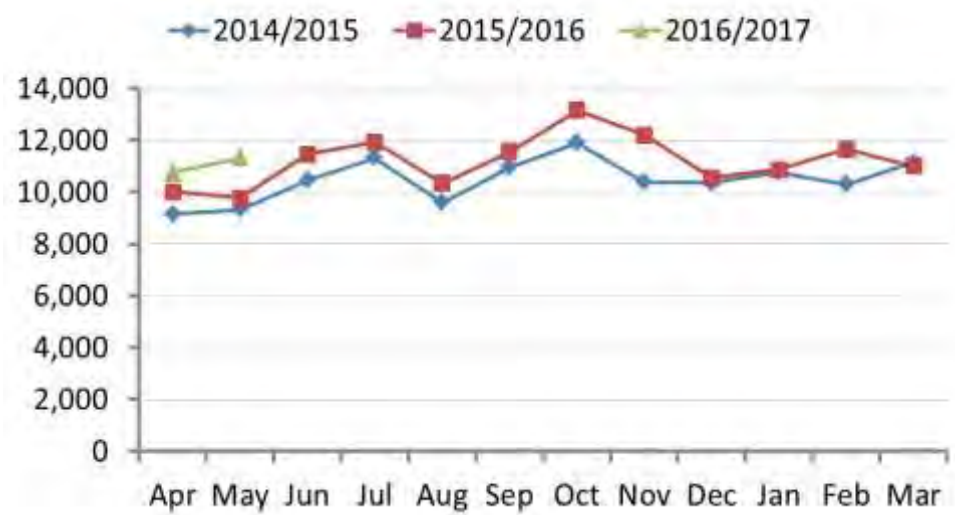
Elective waiting list size



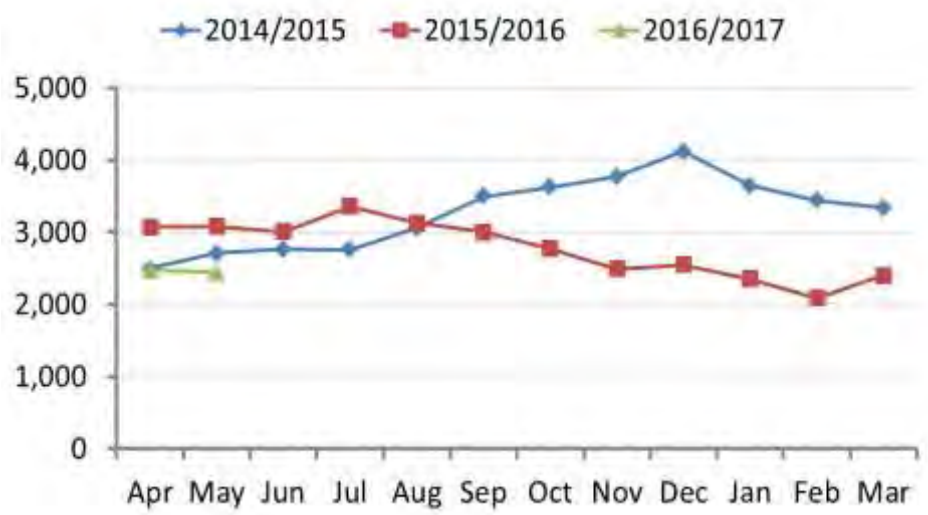
Outpatient waiting list size



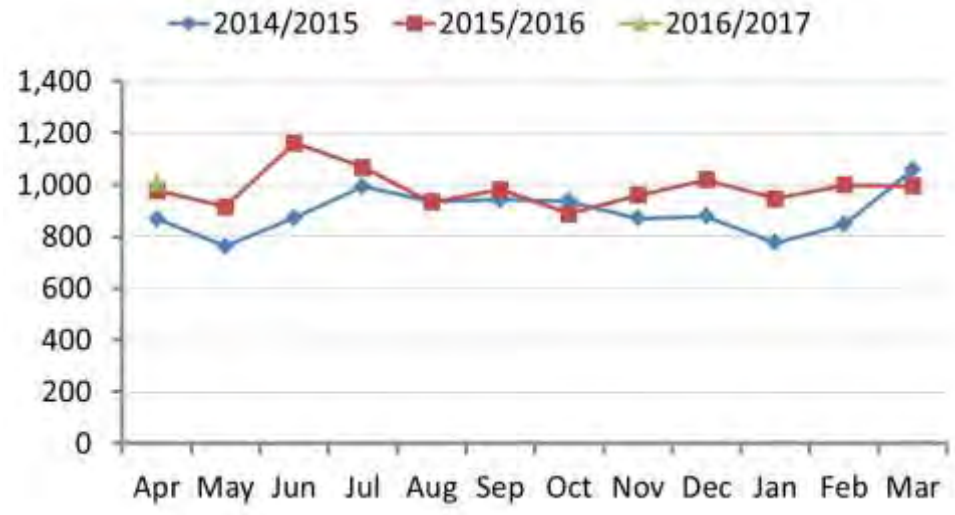
Number of RTT pathways stopped (i.e. treatments)



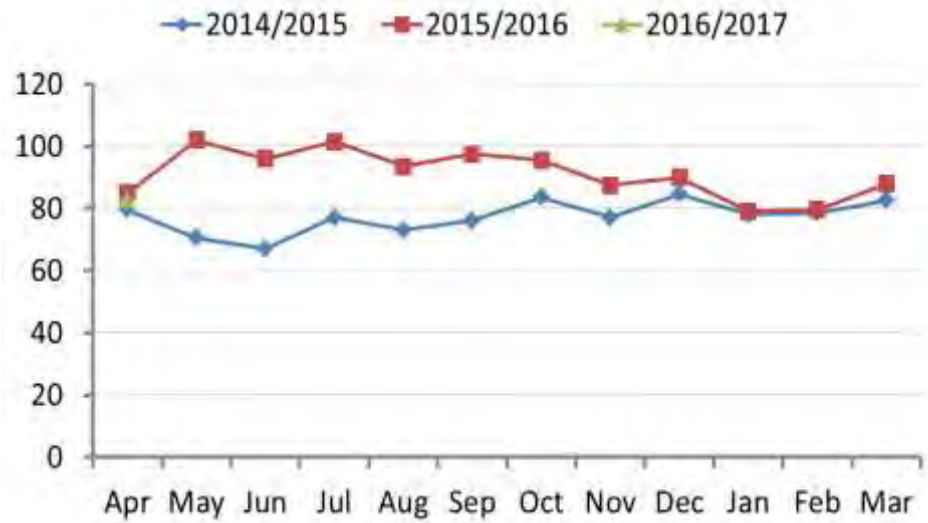
Number of RTT pathways over 18 weeks



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	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Patient Safety																				
Infections	DA01a	MRSA Bloodstream Cases - Cumulative Totals	-	-	2	2	3	3	3	3	3	3	3	3	0	0	-	-	-	-
	DA01	MRSA Bloodstream Cases - Monthly Totals	3	0	1	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
	DA03	C.Diff Cases - Monthly Totals	40	7	3	3	1	2	5	3	6	4	2	4	2	5	6	14	10	7
	DA02	MSSA Cases - Monthly Totals	26	5	4	2	3	2	3	2	2	2	1	0	2	3	7	7	3	5
C.Diff "Avoidables"	DA03c	C.Diff Avoidable Cases - Cumulative Totals	-	-	3	4	5	5	7	7	9	12	14	17	-	-	-	-	-	-
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.3%	96.9%	97.6%	97.7%	97.7%	97.9%	95.8%	98.1%	98.1%	96.4%	97.7%	96.8%	96.6%	97.2%	97.8%	97.3%	97%	96.9%
	DB02	Antibiotic Compliance	87.6%	84.8%	88.9%	88.3%	86.1%	82.3%	85.7%	86%	90.6%	86.5%	88.2%	86.1%	84.4%	85.3%	85.7%	87.2%	86.9%	84.8%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	93%	95%	93%	93%	94%	94%	94%	95%	94%	98%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	97%	96%	97%	96%	97%	97%	97%	98%	98%	96%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	94%	93%	94%	95%	95%	95%	95%	96%	95%	90%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	69	11	4	3	8	4	4	9	5	6	4	10	3	8	15	18	20	11
	S02a	Number of Confirmed Serious Incidents	49	-	3	3	8	1	4	8	4	5	3	-	-	-	12	16	8	-
	S02b	Number of Serious Incidents Still Open	11	11	1	0	0	1	0	1	1	1	1	5	3	8	1	2	7	11
	S03	Serious Incidents Reported Within 48 Hours	84.1%	90.9%	25%	100%	62.5%	100%	100%	44.4%	100%	100%	100%	100%	66.7%	100%	80%	72.2%	100%	90.9%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	-	90.9%	-	-	-	-	-	-	-	-	-	-	66.7%	100%	-	-	-	90.9%
	S04	Percentage of Serious Incident Investigations Completed Within Timescale	74.1%	100%	66.7%	100%	100%	75%	85.7%	66.7%	60%	60%	63.6%	100%	100%	100%	87.5%	72.2%	66.7%	100%
Never Events	S01	Total Never Events	3	0	0	0	1	0	0	1	1	0	0	0	0	0	1	2	0	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	13787	1145	1216	1023	1109	1143	1142	1149	1167	1190	1196	1226	1145	-	3275	3458	3612	1145
	S06b	Patient Safety Incidents Per 1000 Beddays	44.72	44.93	47.66	39.35	42.91	45.47	43.98	45.34	46.17	44.59	48.19	46.64	44.93	-	42.55	45.15	46.43	44.93
	S07	Number of Patient Safety Incidents - Severe Harm	97	2	5	9	13	8	13	8	15	5	6	3	2	-	30	36	14	2
Patient Falls	AB01	Falls Per 1,000 Beddays	3.94	4.08	3.84	4.08	4.6	3.9	3.54	3.79	4.15	3.56	3.59	4.15	4.24	3.93	4.2	3.83	3.77	4.08
	AB06a	Total Number of Patient Falls Resulting in Harm	30	5	0	2	1	1	4	3	5	2	3	5	1	4	4	12	10	5
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.221	0.214	0.314	0.231	0.232	0.318	0.193	0.079	0.158	0.15	0.242	0.114	0.275	0.154	0.26	0.144	0.167	0.214
	DE02	Pressure Ulcers - Grade 2	61	10	7	5	4	7	4	2	4	3	6	3	7	3	16	10	12	10
	DE03	Pressure Ulcers - Grade 3	7	1	1	1	2	1	1	0	0	1	0	0	0	1	4	1	1	1
	DE04	Pressure Ulcers - Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.2%	99.2%	99.1%	99.4%	99.3%	99%	98.4%	98.1%	97.4%	97.1%	95.6%	96.9%	99.3%	99.1%	99.2%	98%	96.5%	99.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	94.6%	95.4%	94.3%	96.6%	95.2%	95.1%	94%	93.5%	94%	93.6%	96%	94.5%	94.8%	96.3%	95.7%	93.9%	94.7%	95.4%
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	90.4%	89.4%	92.3%	90.7%	86.6%	86.5%	91.5%	91.6%	93.2%	90.4%	89.9%	91.4%	83.6%	94%	87.9%	92.1%	90.6%	89.4%
Safety	Y01	WHO Surgical Checklist Compliance	99.9%	99.8%	100%	100%	100%	100%	100%	99.8%	100%	99.9%	99.9%	100%	99.8%	99.9%	100%	99.9%	99.9%	99.8%

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Quarterly Totals 15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Patient Safety																				
Medicines	WA01	Medication Incidents Resulting in Harm	0.8%	0%	0%	1.32%	0.79%	1.75%	0%	1.39%	1.2%	1.28%	0.42%	0.41%	0%	-	1.34%	0.91%	0.7%	0%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.87%	0.8%	0.96%	0.83%	0.73%	0.75%	0.78%	0.62%	1.03%	1.49%	0.66%	0.69%	0.93%	0.63%	0.77%	0.8%	0.92%	0.8%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.1%	97.4%	98.2%	97.4%	96.4%	96.2%	97.3%	95.9%	97.9%	97.2%	96.7%	97.3%	97.1%	97.7%	96.7%	97.1%	97.1%	97.4%
	AK04	Safety Thermometer - No New Harms	98.6%	98.8%	98.6%	98.6%	98%	98%	98.9%	97.9%	99.1%	98.8%	98.9%	99.4%	98.9%	98.7%	98.2%	98.6%	99%	98.8%
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	90%	93%	91%	98%	90%	92%	92%	91%	90%	86%	86%	88%	87%	100%	94%	91%	86%	93%
Out of Hours	TD05	Out of Hours Departures	10.7%	7.8%	11.5%	10.4%	11%	11.4%	13%	11.1%	9.6%	11%	9.6%	9.6%	8.1%	7.5%	10.9%	11.2%	10.1%	7.8%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	20.3%	22.6%	18.6%	19.7%	17.9%	19.8%	19.1%	19.2%	22.1%	21.9%	22.3%	23.3%	23%	22.3%	19.2%	20.2%	22.5%	22.6%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	10444	1923	784	864	741	845	856	836	1002	911	926	990	971	952	2450	2694	2827	1923
Staffing Levels	RP01	Staffing Fill Rate - Combined	103.1%	104.3%	101.8%	102.8%	100.5%	103.1%	105.8%	104.8%	104.8%	105.9%	103.2%	103.1%	104.7%	104%	102.1%	105.1%	104.1%	104.3%
Clinical Effectiveness																				
Mortality	X02	Hospital Standardised Mortality Ratio (HSMR) - 2009/10 Baseline	87.4	-	92.5	89.7	87.2	89.1	96.5	94.4	75.8	97.1	80.1	-	-	-	88.7	88.5	89.7	-
	X05	Summary Hospital Mortality Indicator (SHMI 2013 Baseline) - In Hospital Deat	64.8	59.3	66	58.4	65	66.6	66.6	68.3	58	67.1	71.6	73.5	59.3	-	63.3	64	70.7	59.3
	X09	Summary Hospital Mortality Indicator (2015 Baseline) - In Hospital Deaths	73.8	67.6	74.9	67.2	73.5	75.8	76.4	78	65.8	76.5	81.6	82.9	67.6	-	72.1	73	80.4	67.6
	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	97.3	-	96.8	-	-	97.8	-	-	-	-	-	-	-	-	97.8	-	-	-
Readmissions	C01	Emergency Readmissions Percentage	2.74%	1.74%	2.69%	2.74%	2.89%	2.77%	2.83%	2.82%	2.87%	2.67%	2.66%	1.5%	1.74%	-	2.8%	2.84%	2.27%	1.74%
Maternity	G04	Percentage of Spontaneous Vaginal Deliveries	62.1%	63.6%	64.1%	57.3%	62.5%	62.4%	61.3%	63.9%	63.4%	62.7%	60.1%	62.5%	66.6%	60.9%	60.7%	62.9%	61.8%	63.6%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	75.9%	80.4%	66.7%	76%	81.5%	85.7%	80.8%	76.5%	66.7%	76%	78.6%	80%	87.5%	74.1%	81.3%	74%	78.2%	80.4%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	82.5%	82.4%	91.7%	80%	85.2%	78.6%	92.3%	94.1%	86.7%	80%	78.6%	84%	83.3%	81.5%	81.3%	90.4%	80.8%	82.4%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	63.5%	64.7%	66.7%	60%	70.4%	64.3%	73.1%	70.6%	60%	60%	64.3%	68%	70.8%	59.3%	65%	67.1%	64.1%	64.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	55.8	46.7	40.2	39.4	42.4	44.4	44.8	50.2	47.5	40.5	35.8	61.4	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	61.5%	69.2%	56.1%	43.8%	67.4%	62.2%	57.5%	59.5%	56.8%	62.5%	77.4%	60.6%	69.2%	-	59.2%	57.9%	66.1%	69.2%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	93.5%	88.5%	97.6%	93.8%	95.3%	93.3%	90.2%	91.9%	91.9%	91.7%	96.8%	84.8%	88.5%	-	94.2%	91.3%	91.1%	88.5%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	66.4%	64.3%	30.8%	58.8%	100%	75%	54.5%	62.5%	47.1%	71.4%	80%	80%	58.3%	68.8%	73.5%	52.8%	77.3%	64.3%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	91.6%	95.1%	82.7%	83.3%	92.5%	91.1%	97.6%	97.2%	95%	93.4%	94.7%	96.7%	94.5%	95.8%	88.8%	96.6%	94.9%	95.1%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	95.8%	97.2%	92.8%	90%	92.3%	93.2%	98.4%	96.9%	98.4%	95.7%	96.3%	96.8%	96.8%	97.8%	91.8%	97.9%	96.2%	97.2%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.3%	96.4%	92.9%	80%	100%	88.9%	100%	83.3%	100%	100%	100%	100%	95.2%	100%	88.9%	91.3%	100%	96.4%
	AC04	Percentage of Dementia Carers Feeling Supported	88.3%	75%	93.3%	92.3%	76.9%	70%	100%	72.7%	72.7%	-	93.8%	100%	75%	-	80.6%	84.2%	96.2%	75%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9588	1517	755	858	839	768	666	537	692	1231	788	1072	930	587	2465	1895	3091	1517

SAFE, CARING & EFFECTIVE (continued)

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Quarterly Totals 15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	89	91	90	90	90	90	91	90	90	89	92	92	90	90	90	92
	P01g	Patient Survey - Kindness and Understanding	-	-	93	93	95	94	94	95	94	95	94	93	96	96	94	94	94	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	89	88	89	89	88	88	89	89	89	89	88	90	89	88	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	19.2%	38.9%	16.2%	20.5%	10.4%	19.8%	19.3%	20.4%	20.6%	21.9%	22%	26.3%	35.2%	42.4%	17.1%	20.1%	22.7%	38.9%
	P03b	Friends and Family Test ED Coverage	13%	14.1%	7%	12.3%	14.7%	17.8%	15.9%	16.4%	13.9%	15.8%	16.7%	12.3%	14.8%	13.5%	14.9%	15.4%	14.9%	14.1%
	P03c	Friends and Family Test MAT Coverage	22.7%	21.2%	20.1%	22.1%	18.3%	14.6%	25.3%	20.2%	20.3%	15.7%	24%	33.7%	16.2%	26.3%	18.5%	21.8%	24.3%	21.2%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	96.3%	96.3%	96.3%	97.2%	97.2%	96.2%	96.2%	96.5%	95.6%	96.7%	96.1%	95.9%	97.1%	95.8%	96.8%	96.1%	96.2%	96.3%
	P04b	Friends and Family Test Score - ED	75.4%	79.2%	70.4%	78.1%	77.3%	76.6%	72.2%	76.2%	80%	77.7%	73.7%	71.5%	80.2%	78.1%	77.2%	75.9%	74.4%	79.2%
	P04c	Friends and Family Test Score - Maternity	96.6%	98%	97.8%	98.7%	97.1%	96.3%	98.2%	96.9%	97.7%	94.9%	97.6%	95.8%	96.6%	98.9%	97.6%	97.6%	96.2%	98%
Patient Complaints	T01	Number of Patient Complaints	1941	322	154	207	168	185	182	148	116	143	183	150	176	146	560	446	476	322
	T01a	Patient Complaints as a Proportion of Activity	0.252%	0.244%	0.231%	0.315%	0.302%	0.279%	0.267%	0.219%	0.19%	0.225%	0.268%	0.221%	0.272%	0.218%	0.298%	0.227%	0.238%	0.244%
	T03a	Complaints Responded To Within Trust Timeframe	75.2%	77.2%	82.1%	87%	80.9%	83.3%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%	81.6%	73.1%	83.9%	56.5%	74.6%	77.2%
	T03b	Complaints Responded To Within Divisional Timeframe	91.3%	90.1%	94%	98.1%	93.6%	95.8%	80.4%	81%	90.5%	91.5%	84.6%	100%	87.8%	92.3%	96%	84.5%	91.8%	90.1%
	T04c	Percentage of Responses where Complainant is Dissatisfied	6.15%	-	4.48%	7.41%	6.38%	14.58%	8.93%	4.76%	6.35%	2.13%	7.69%	8.33%	-	-	9.4%	6.83%	5.74%	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.03%	1.02%	1.17%	1.04%	0.46%	0.83%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.78%	0.73%	1.42%	1.02%
	F01a	Number of Last Minute Cancelled Operations	713	122	70	62	25	50	40	51	39	68	71	108	63	59	137	130	247	122

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Quarterly Totals 15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	92%	91.3%	92.5%	90.7%	90.2%	90.5%	90.7%	91.1%	92%	91.8%	92.4%	93.2%	92.2%	92.3%	92.6%	90.4%	91.6%	92.6%	92.5%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3010	3357	3128	3004	2772	2491	2544	2349	2083	2397	2480	2442	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	8	0	0	0	0	1	0	0	0	2	0	0	0	0	1	0	2	0
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	471	46	38	45	38	28	25	22	15	15	14	26	24	22	111	62	55	46
	A09	Referral To Treatment Ongoing Pathways 35+ Weeks	-	-	1738	160	200	188	172	118	96	81	86	75	68	77	80	80	478	263	220	160
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	95.9%	94.3%	95.3%	97.3%	95.4%	96.8%	97.5%	95.8%	94.8%	93.7%	98%	96.6%	94.3%	-	96.5%	96%	96.1%	94.3%
	tbc	Cancer Stretch Target - 7 Day Wait for Urgent Referrals																				
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	97.5%	91.3%	95.3%	96.7%	96.7%	97.3%	98.7%	98.6%	97.8%	98.5%	97%	97.7%	91.3%	-	96.9%	98.4%	97.8%	91.3%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.9%	96.5%	100%	99.1%	98.1%	98.6%	99.1%	100%	98.9%	96.1%	100%	99%	96.5%	-	98.6%	99.3%	98.3%	96.5%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	96.8%	76.2%	97.9%	89.1%	100%	97.6%	97.9%	100%	98%	97.6%	97.9%	95%	76.2%	-	95.6%	98.5%	96.9%	76.2%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	97.1%	97.9%	94.7%	96.1%	98.4%	96%	96.1%	97.6%	97.4%	97.9%	96.7%	98.6%	97.9%	-	96.8%	97%	97.8%	97.9%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	80.6%	76.4%	77.6%	83.7%	80.7%	81%	79.1%	82.3%	86.7%	84.2%	74.2%	84.7%	76.4%	-	81.9%	82.6%	81.1%	76.4%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	68.6%	41.7%	62.5%	76.9%	70%	85.7%	14.3%	71.4%	50%	50%	60%	70%	41.7%	-	78.4%	51.9%	64.6%	41.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	91.1%	75.9%	76.9%	80.8%	86.7%	91.2%	93.6%	92.7%	100%	81%	92.9%	100%	75.9%	-	87.6%	95.7%	92.1%	75.9%
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.03%	1.02%	1.17%	1.04%	0.46%	0.83%	0.64%	0.86%	0.7%	1.2%	1.21%	1.84%	1.08%	0.96%	0.78%	0.73%	1.42%	1.02%
	F01a	Number of Last Minute Cancelled Operations	-	-	713	122	70	62	25	50	40	51	39	68	71	108	63	59	137	130	247	122
	F02c	Number of LMCs Not Re-admitted Within 28 Days	8	8	76	25	12	7	4	2	5	3	2	1	6	12	23	2	13	10	19	25
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.28%	1.59%	1.12%	1.32%	0.65%	0.74%	1.17%	1.67%	1.18%	1.86%	1.36%	1.68%	1.35%	1.82%	0.91%	1.34%	1.63%	1.59%
	F07a	Number of Admissions Cancelled Day Before	-	-	887	191	67	79	35	45	73	99	66	105	80	99	79	112	159	238	284	191
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	75.4%	83.8%	86.4%	73.2%	76%	76%	75.7%	78%	81.8%	75%	59.4%	63%	83.8%	-	74.7%	78.7%	66.7%	83.8%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.3%	100%	90.9%	92.7%	100%	92%	89.2%	95.1%	95.5%	92.5%	93.8%	85.2%	100%	-	94.5%	93.4%	90.9%	100%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.97%	98.45%	99%	98.83%	98.63%	99.01%	99.59%	99.37%	99.2%	98.69%	99.11%	99.2%	98.34%	98.55%	98.83%	99.39%	99.01%	98.45%
Outpatients	R03	Outpatient Hospital Cancellation Rate	6%	10.7%	11.9%	13.2%	11.4%	11.6%	12.7%	12%	11%	10.6%	13%	12.3%	11.8%	13.1%	14%	12.4%	12.1%	11.5%	12.4%	13.2%
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	-	-	51	41	59	48	54	41	30	19	33	31	34	23	-	-	-	-
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	-	-	6	19	11	11	12	10	4	5	5	10	3	6	-	-	-	-
Green To Go List	AQ01	Numbers on the Green to Go List (Acute)	-	-	-	-	48	37	52	45	50	39	33	42	49	48	59	48	-	-	-	-
	AQ02	Numbers on the Green to Go List (Non-Acute)	-	-	-	-	6	19	11	11	11	10	9	7	9	16	8	10	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.16	4.2	4.25	4.15	3.97	4.51	4.2	4.11	4.12	4.04	4.03	4.3	4.23	4.16	4.21	4.14	4.13	4.2

RESPONSIVE (continued)

Topic	ID	Title	Annual Target		Annual		Monthly Totals												Quarterly Totals			
			Green	Red	15/16	16/17 YTD	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	95%	90.43%	89.48%	95.2%	95.51%	94.95%	91.69%	92.16%	89.6%	88.89%	83.76%	84.23%	82.49%	87.17%	91.66%	94.04%	90.23%	83.47%	89.48%
	B07a	BRI ED Total Time in Department - Under 4 Hours	95%	95%	87.4%	83.85%	94.15%	93.78%	93.44%	87.75%	89.34%	89.43%	86.83%	75.72%	79.13%	75.11%	79.8%	87.73%	91.71%	88.55%	76.61%	83.85%
	BB03	BCH ED - Percentage Within 4 Hours	98%	95%	90.56%	93.46%	94.93%	96.02%	94.97%	93.81%	93.12%	84.97%	86.7%	89.12%	84.67%	85.59%	93.02%	93.84%	94.9%	88.18%	86.39%	93.46%
	BB04	BEH ED - Percentage Within 4 Hours	99.7%	99.5%	99.48%	99.43%	98.63%	99.84%	99.61%	99.77%	99.23%	99.83%	99.71%	99.83%	99.6%	98.94%	99.33%	99.54%	99.74%	99.59%	99.44%	99.43%
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	12	1	0	0	0	0	0	0	0	6	0	6	0	1	0	0	12	1
							Note:Nine were declared in March on Monthly SitReps to Dept. of Health. Subsequently revised to six.															
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	99%	97.2%	99.9%	100%	99.6%	96.7%	98.4%	99.6%	99%	98.8%	99.3%	97.5%	96.2%	98.2%	98.8%	99%	98.5%	97.2%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	93%	93.8%	92.3%	93.4%	91.6%	92.8%	93.2%	94.1%	93.8%	92.7%	92.9%	94.1%	93.3%	94.2%	92.6%	93.7%	93.2%	93.8%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.8%	53.4%	53.9%	57.5%	60.4%	53.2%	52.8%	49.8%	53.1%	52.6%	45.3%	45.8%	55.2%	51.7%	57%	51.9%	47.8%	53.4%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	98.9%	98.9%	98.5%	99.1%	99.2%	98.7%	98.8%	99%	98.9%	98.7%	98.6%	98.6%	98.8%	98.9%	99%	98.9%	98.7%	98.9%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	3%	2.7%	2.6%	2.9%	2.5%	2.9%	2.7%	3.1%	3.5%	3%	3.7%	3.1%	3%	2.4%	2.8%	3.1%	3.3%	2.7%
	B05	ED Left Without Being Seen Rate	5%	5%	2.4%	2.1%	2.9%	2.3%	2%	2.3%	2.4%	2.4%	2.2%	2.6%	2.7%	2.5%	2.1%	2%	2.2%	2.3%	2.6%	2.1%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	1102	134	29	38	36	92	96	86	104	236	153	140	62	72	166	286	529	134

EFFICIENT

Topic	ID	Title	Annual 15/16	Annual 16/17 YTD	Monthly Totals Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Quarterly Totals 15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1
Sickness	AF02	Sickness Rate	4.2%	3.8%	4.1%	4.2%	3.9%	4.1%	4.3%	4.2%	4.4%	4.6%	4.6%	4.5%	3.9%	3.8%	4.1%	4.4%	4.5%	
		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	8239	8088.3	8096.3	8110.8	8128.9	8168.6	8197.6	8199.8	8224.1	8229.4	8258.8	8241.7	8239	8128.9	8199.8	8258.8	
	AF09A	Actual Staff FTE (Including Bank & Agency)	8319.4	8277.5	8114.4	8069.3	8149.2	8253.7	8249.7	8198	8180	8233.9	8246.6	8319.4	8339.7	8277.5	8253.7	8180	8319.4	
	AF13	Percentage Over Funded Establishment	0.7%	0.5%	0.3%	-0.3%	0.5%	1.5%	1%	0%	-0.2%	0.1%	0.2%	0.7%	1.2%	0.5%	1.5%	-0.2%	0.7%	
		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	370	423.5	395	399.2	446.2	377.6	339.3	336.1	342.8	361.7	350.9	337.2	370	446.2	336.1	350.9	
	AF11A	Percentage Bank Usage	4.2%	4.5%	5.2%	4.9%	4.9%	5.4%	4.6%	4.1%	4.1%	4.2%	4.4%	4.2%	4%	4.5%	5.4%	4.1%	4.2%	
		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	131.9	157.3	163.5	185.2	193.1	180	156.1	134	152.1	144.9	153.4	156.4	131.9	193.1	134	153.4	
	AF11B	Percentage Agency Usage	1.8%	1.6%	1.9%	2%	2.3%	2.3%	2.2%	1.9%	1.6%	1.8%	1.8%	1.8%	1.9%	1.6%	2.3%	1.6%	1.8%	
		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	380	463.6	507.9	465.1	436	416.4	420.1	431.3	412	422.3	361	305.8	380	436	431.3	361	
	AF07	Vacancy Rate (Vacancy FTE as Percent of Funded FTE)	4.4%	4.7%	5.8%	6.3%	5.8%	5.4%	5.1%	5.2%	5.3%	5.1%	5.2%	4.4%	3.8%	4.7%	5.4%	5.3%	4.4%	
		For 2015/16, target is below 5% for Green, 5% or above for Red																		
Turnover	AF10A	Workforce - Number of Leavers (Permanent Staff)	148	189	156	147	398	227	146	148	120	137	154	148	229	189	227	120	148	
	AF10	Workforce Turnover Rate	13.4%	13.3%	14.1%	13.7%	13.7%	13.6%	13.7%	13.9%	13.8%	13.9%	13.6%	13.4%	13.6%	13.3%	13.6%	13.8%	13.4%	
		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%	-	89%	90%	90%	89%	91%	91%	91%	92%	92%	91%	-	-	89%	91%	91%	
		Green is above 90%, Red is below 85%, Amber is 85% to 90%																		
Essential Training 2016/17	AF21a	Three Yearly Training (14 Topics)														88%				
	AF21b	Annual Training (Fire & Info Governance)														56%				
	AF21c	Induction														96%				
	AF21d	Resuscitation Training														78%				
	AF21e	Safeguarding Training														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
NOF	Abbreviation used for Neck of Femur
NRLS	National Learning & Reporting System
RAG	Red, Amber Green – the different ratings applied to categorise performance for a Key Performance Indicator
RCA	Root Cause Analysis
RN	Registered Nurse
RTT	Referral to Treatment Time – which measures the number of weeks from referral through to start of treatment. This is a national measure of waiting times.
STM	St Michael's Hospital

Appendix 2

Breakdown of Essential Training Compliance for May 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%**	89%	86%	88%	89%	91%	86%	84%
Annual (Fire and IG)	**56%**	73%	53%	54%	60%	52%	59%	53%
Induction	**96%**	97%	98%	96%	97%	96%	97%	95%
Resuscitation	**78%**	76%	N/A	77%	80%	78%	83%	78%
Safeguarding	**88%**	92%	86%	92%	88%	90%	89%	80%

Safeguarding Adults and Children

	UH Bristol	Diagnostics & Therapies	Facilities & Estates	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Safeguarding Adults L1	**90%**	95%	88%	91%	86%	89%	91%	88%
Safeguarding Adults L2	**87%**	93%	79%	93%	92%	91%	86%	78%
Safeguarding Adults L3	**60%**	100%	-	68%	71%	64%	48%	30%
Safeguarding Children L1	**90%**	92%	89%	94%	87%	88%	91%	-
Safeguarding Children L2	**88%**	87%	77%	91%	85%	90%	87%	89%

Child Protection level 3

	UH Bristol	Diagnostic & Therapies	Medicine	Specialised Services	Surgery Head & Neck	Trust Services	Women's & Children's
Core	**75%**	73%	52%	92%	57%	50%	78%
Specialist	**73%**	-	-	-	-	100%	73%

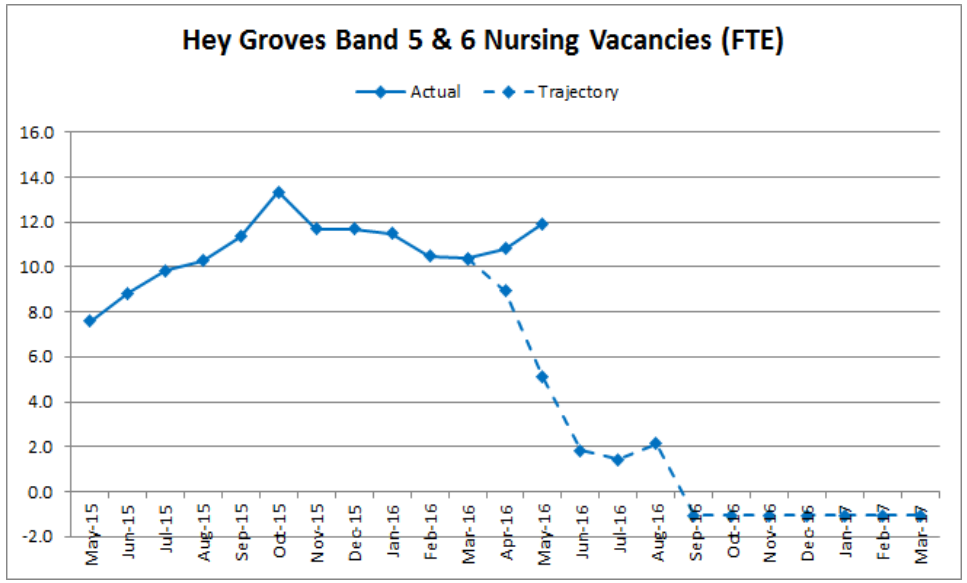
Appendix 2 (continued)

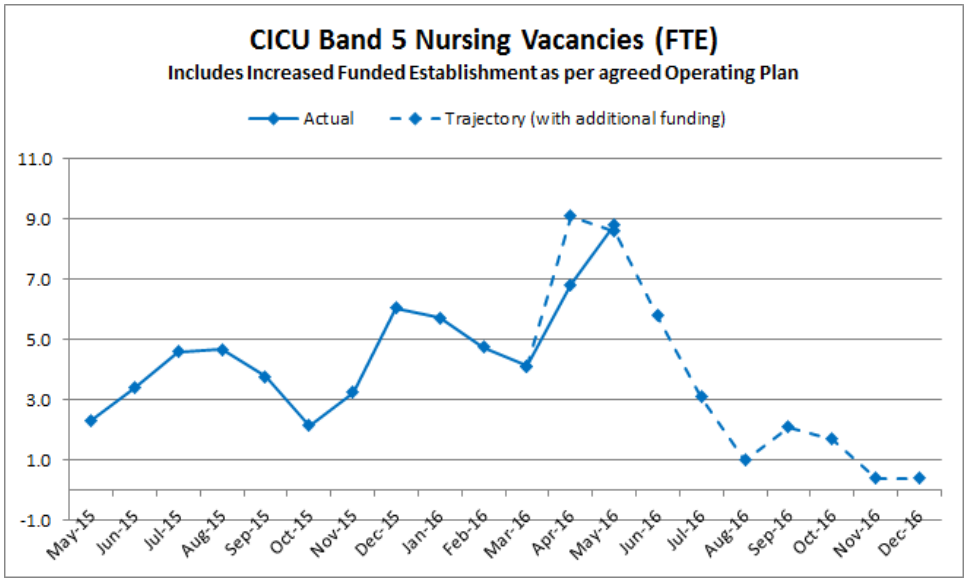
Agency shifts by staff group for May 2016

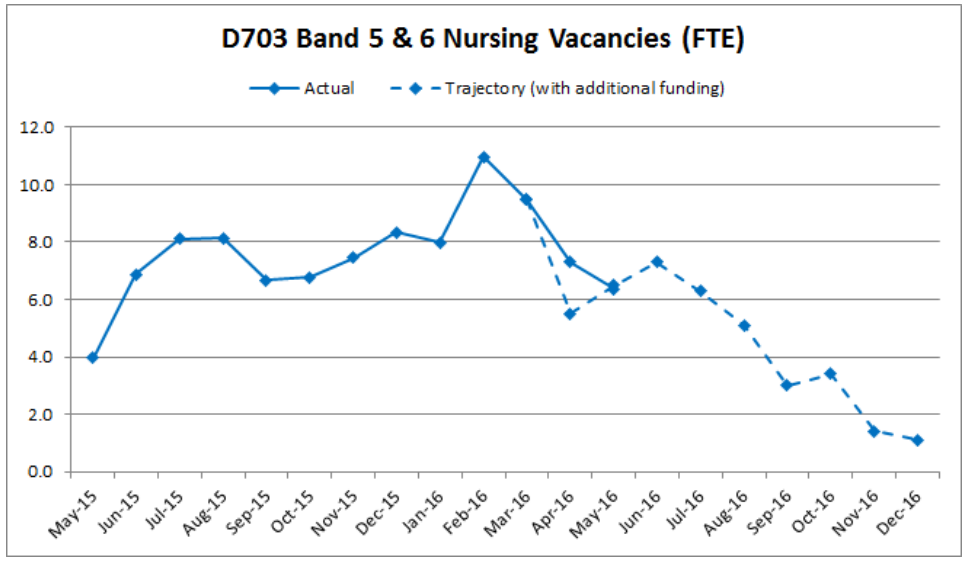
Staff Group	Non framework (but within price cap)	Above price cap (but within framework)	Non framework and above price cap	Within framework and price cap	Grand Total
Admin and Clerical				148	148
AHP and Healthcare Scientist				0	0
Facilities and Estates				270	270
Healthcare Assistant /Other		6	3	173	183
Medical and Dental		174		11	185
Nursing and Midwifery		889	315	5	1209
Grand Total		1069	318	607	1994

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

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







Appendix 3

Access standards – further breakdown of figures

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

Tumour Site	UH Bristol	Internal operational target	National
Breast*†	100%	-	94.8%
Gynaecology	91.7%	85%	77.5%
Haematology (excluding acute leukaemia)	80.0%	85%	79.7%
Head and Neck*	90.5%	79%	65.5%
Lower Gastrointestinal	65.4%	79%	71.2%
Lung	45.2%	79%	74.5%
Other*	100%	-	78.4%
Sarcoma*	-	-	-
Skin	97.3%	96%	96.4%
Upper Gastrointestinal	70.0%	79%	74.1%
Urological*†	0.0%	-	78.7%
Total (all tumour sites)	**76.4%**	**85.0%**	**82.7%**
Performance for internally managed pathways	**86.2%**		
Performance for shared care pathways	**53.1%**		
Monthly trajectory target	**72.7%**		

*3 or fewer patients treated in accountability terms

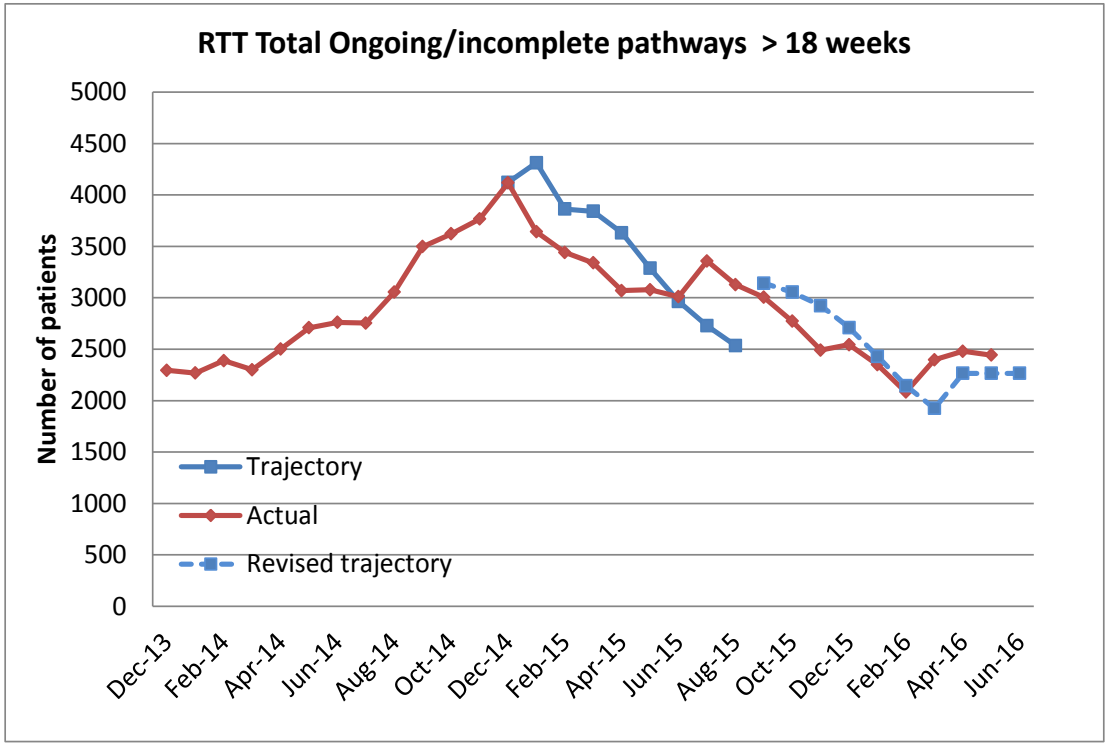
†Tertiary pathways only (i.e. no internally managed pathways), with management of waiting times to a great extent outside of the control of the Trust

Appendix 3 (continued)

Access standards – further breakdown of figures

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

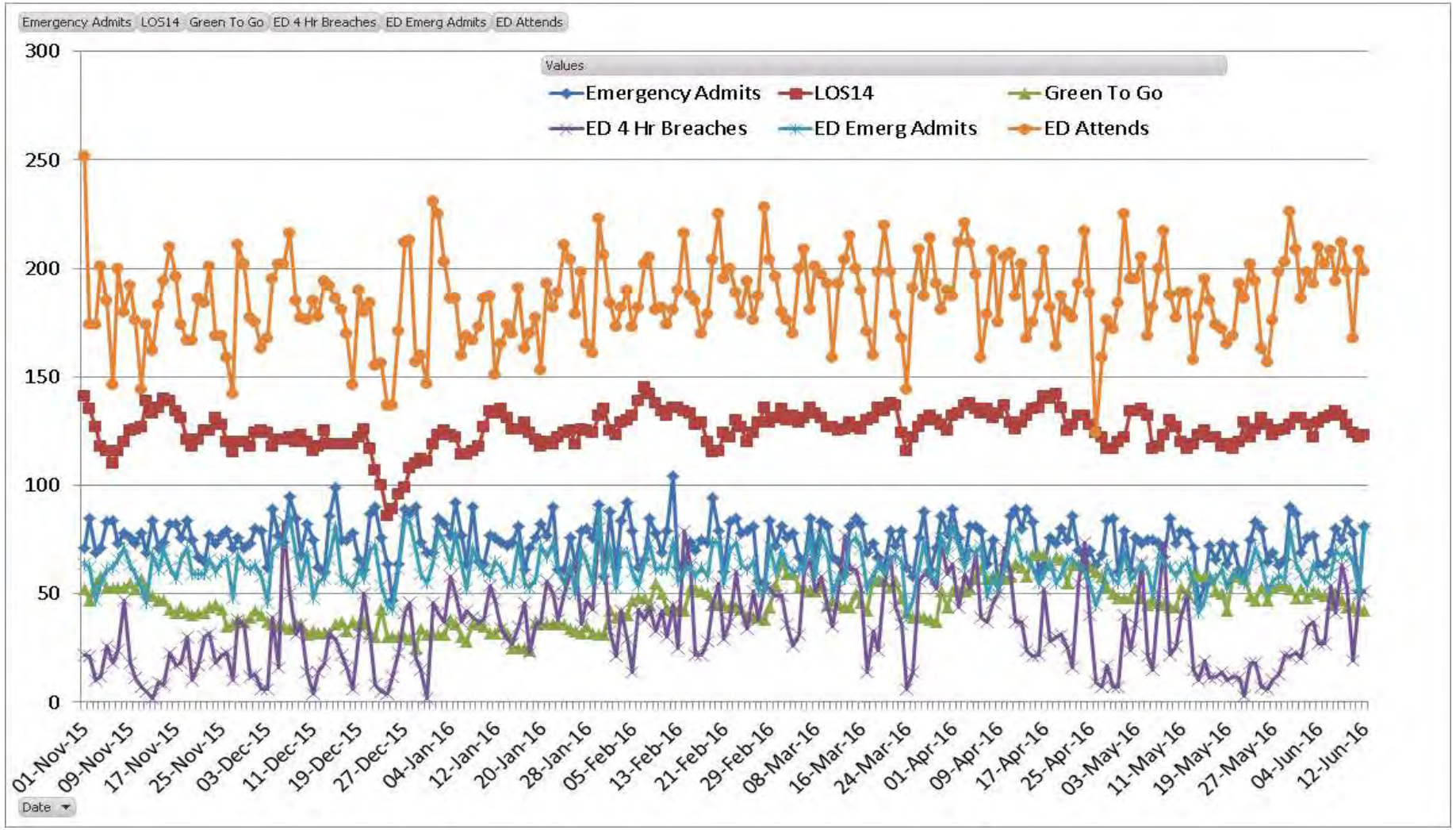
RTT Specialty	Ongoing Pathways Over 18 weeks	Ongoing Pathways	Ongoing Performance
Cardiology	285	2,021	85.9%
Cardiothoracic Surgery	10	233	95.7%
Dermatology	56	2,019	97.2%
E.N.T.	51	2,386	97.9%
Gastroenterology	56	467	88.0%
General Medicine	0	42	100.0%
Geriatric Medicine	1	162	99.4%
Gynaecology	84	1,294	93.5%
Neurology	58	372	84.4%
Ophthalmology	153	4,690	96.7%
Oral Surgery	199	2,645	92.5%
Other	1,397	14,523	90.4%
Rheumatology	5	383	98.7%
Thoracic Medicine	20	875	97.7%
Trauma & Orthopaedics	67	1,064	93.7%
Urology	0	1	100.0%
Grand Total	**2,442**	**33,177**	**92.6%**



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

Appendix 3 (continued)

BRI Flow metrics



Report to the Board of Directors meeting 28 June 2016

From QOC Chair – Alison Ryan, Non-Executive Director

This report describes the business conducted at the Quality and Outcomes Committee held 28 June 2016, indicating the challenges made and the assurances received.

Item	Report/Key Points	Challenges	Assurance
Children's Bereavement Support Team	Members received a presentation from the Division covering: • The complex of reports that follow an incident requiring careful navigation for families • Investment in family support and psychology services • Commitment to conducing more independent reviews • Addressing residual unhelpful cultures of defensiveness	The issue of how the faith teams were involved was raised.	Assurance was provided that this was an integral part of the pathway.
		The process of learning was questioned and whether this had been integrated into the Division.	Assurance was provided that significant progress has been made. An extended timescale of September 2016 has been agreed to ensure more focussed work.
		Challenges were made in relation to the recording of meetings especially whereby families have lost trust.	A framework to change the way in which meetings were recorded was in progress. There would be a formal transcript of the meeting. would be made of the meeting.
		The process of the RCA and the Divisional learning on the identification of serious and significant incidents.	Assurance was provided in terms of the process. This would be brought to the Committee as soon as available.

Item	Report/Key Points	Challenges	Assurance
Serious Incidents and Root Cause Analysis	7 Serious Incidents were reviewed including further information on a previous incident resulting from a Serious Incident Panel review.	The number of wrong tooth extractions in the Dental Hospital was questioned.	Assurance was provided that the supervision arrangements had been changed.
		Challenges whether pathways and procedures out of hours should be consistent with in hours procedures.	Assurance was provided that these are consistent.
		Criteria for setting up a SI Review panel was questioned	This is largely done when issues are Cross divisional
Quality Performance report	As provided to Governors	NEDs asked about RTT and Cancer waits.	Pressure on RTT mounting but currently being handled
		Impact of histopathology bottlenecks on waiting times	Cancer waits should show improvements, especially in lung, in the next two months as improvements come on stream
		Noted 100% EWS scores – well done!	University Hospitals Bristol Trust are working hard with NBT toi overcome what are thought to be temporary problems with timely production of histopathology results. To be further reviewed.
Infection Control Annual Report	Members received the Infection Control Annual Report.	Advanced Screening Programme for staff groups who may be a greater risk.	Confirmation was provided that this was current NHS Policy. Further assurance was provided and it was agreed to seek further clarification.
Monthly Nurse staffing	The report provided information contained in the NHS national staffing return submitted for May 2016.	Divisional hotspots were raised in relation to skill mix and numbers.	Considerable discussion was held in relation to the specific areas. There was an agreement to include skill mix as part of the Internal Audit Plan for 2016/17.
		Further challenges were made in	Members were satisfied that the

Item	Report/Key Points	Challenges	Assurance
		relation to the mix of agency, bank and substantive staff.	Finance Committee were assured with the robust plans in place, across divisions, for controls around agency spend.
Complaints and Patient Experience Quarterly Report	Members received the quarterly complaints report.	Clarification was raised in relation to the increase in communication related complaints. Enquiries about some hotspots in poorer patient feedback. Noted improvements in A900	Assurance was provided in terms of the work being progressed and an explanation provided in relation to the way in which the data was collated and recorded. Assurance that these were under scrutiny.
Patient Safety Improvement Panel	A presentation on metrics was given	NEDs had asked for assurance that there were crisp measures of the effectiveness of the excellent and innovative work on patient safety being planned and implemented.	A full raft of measurable factors were demonstrated.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
09. Quality and Outcomes Committee Terms of Reference									
Sponsor and Author(s)									
Sponsor & Author: Alison Ryan, Non-Executive Director and Chair of the Quality and Outcomes Committee									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
The purpose of this report is to approve the Terms of Reference for the Quality and Outcomes Committee following the annual review at the last meeting of the QoC.

Key Issues:
Significant amendments to the Terms of Reference were made in 2015 with regard to the duties of the Committee, in particularly, further clarity with regard to reporting and responsibilities relating to; complaints and patient experience; infection control; annual reporting and oversight; serious incidents and Never Events, and Trust-wide learning. A minor change has been suggested which includes the reference to NHS Improvement in section 2.1.1.

Recommendations

The Committee are asked to :

- Approve the Terms of Reference of the Quality and Outcomes Committee.

Impact Upon Board Assurance Framework

The Terms of Reference of the Quality and Outcomes Committee support the achievement of objective to deliver all quality objectives and exceed national standards.

Impact Upon Corporate Risk

Implications (Regulatory/Legal)

Equality & Patient Impact

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	✓	For Information	

Date the paper was presented to previous Committees

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

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Quality and Outcomes Committee

Document Data	
Corporate Entity	Quality and Outcomes Committee
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Carolyn Mills, Chief Nurse & Sean O'Kelly, Medical Director
Document Owner	Trust Secretary
Approval Authority	Board of Directors
Review Cycle	12 months
Next Review Date	01/06/2017

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision (Major/Minor)**	**Description of Revisions**
16/03/2011	1	Trust Secretary	Major	Initial draft for comment
26/04/2011	2	Trust Secretary	Major	Incorporated committee Chair's comments
27/04/2011	3	Trust Secretary	Minor	Revisions following initial meeting of committee members
25/05/2011	4	Trust Secretary	Minor	Final consideration by the Quality and Outcomes Committee
26/05/2011	5	Trust Secretary	Minor	For approval by the Trust Board of Directors
27/03/2012	6	Trust Secretary	Minor	Revisions recommended by Quality and Outcomes Committee for approval by the Trust Board of Directors
27/09/2012	7	Trust Secretary	Minor	Revision to meeting regularity from bi-monthly to monthly (in months where there is a meeting of the Board of Directors) in accordance with the purpose of scrutinising the Quality and Performance report prior to each meeting of the Board of Directors
21/04/2015	8	Trust Secretary	Major	Complete review
18/05/2015	9	Trust Secretary	Minor	Incorporation of comments from Quality and Outcomes Committee held 30/04/15
17/05/2016	10	Trust Secretary	Minor	Change from 'Monitor' to 'NHS Improvement'; Section 2.1.1.

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1. Constitution of the Committee

1.1 The Quality and Outcomes Committee is a non-statutory Committee established by the Trust Board of Directors to support the discharge of the Board's responsibilities ensuring the quality of care provided by the Trust.

2. Purpose and function

2.1 The purpose of the Quality and Outcomes Committee is to ensure:

2.1.1 That the Board establishes and maintains compliance with health care standards including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professionals (including NHS Improvement);

2.1.2 That the Board receives and takes into account accurate, comprehensive, timely and up to date information and insight on quality of care and workforce;

2.1.3 To support the Trust to actively engage on quality of care with patients, staff and other relevant stakeholders and take into account as appropriate views and information from these sources;

2.1.4 That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate;

2.1.5 To support the Trust's objective to strive for continuous quality improvement and outcomes; and

2.1.6 To support the objective that every member of staff that has contact with patients, or whose actions directly affect patient care, is motivated and enabled to deliver effective, safe, and person centred care in line with the NHS Constitution.

2.2 To achieve this, the Committee shall:

2.2.1 Extend the Board's monitoring and scrutiny of the standards of quality, compliance and performance of Trust services and the workforce strategy which supports this;

2.2.2 Make recommendations to the Board on opportunities for improvement in the quality of services;

2.2.3 Support and encourage quality improvement where opportunities are identified.

2.3 The Committee shall discharge this function on behalf of the Board of Directors by:

2.3.1 Considering the Board's Quality and Workforce Strategies and associated objectives, and scrutinising the quality, performance, workforce and compliance reports;

2.3.2 Seeking and considering such additional sources of evidence upon which to base its opinion on the robustness of Board Assurance with regards to 'quality governance'; and

2.3.3 Working in consultation with the Audit Committee and the Finance Committee, cross-referencing data and ensuring alignment of the Board assurances derived from the activities of each Committee.

3. Authority

3.1 The Quality and Outcomes Committee will:

3.1.1 Monitor, scrutinise and where appropriate, investigate any quality or outcome activity considered to be within its terms of reference;

3.1.2 Seek such information as it requires to facilitate this monitoring and scrutiny; and

3.1.3 Obtain whatever advice it requires, including external profession advice if deemed necessary (as advised by the Trust Secretary) and may require Directors or other officers to attend meetings to provide such advice

3.2 The Quality and Outcomes Committee is a Non-Executive Committee and has no executive powers.

3.4 Unless expressly provided for in Trust Standing Orders, Trust Scheme of Delegation or Standing Financial Instructions the Quality and Outcomes Committee shall have no further powers or authority to exercise on behalf of the Trust Board of Directors.

4. Membership and attendance

4.1 The Quality and Outcomes Committee is appointed by the Trust Board of Directors from amongst the Non-Executive Directors of the Board and shall consist of not less than four members.

4.2 The following officers shall be required to attend meetings of the Quality and Outcomes Committee on a standing invitation by the Chair:

4.2.1 Chief Nurse

4.2.2 Medical Director

4.2.3 Chief Operating Officer

4.2.4 Director of Workforce and OD

4.3 Duly nominated deputies may attend in their Director's stead.

4.4 The following officers are expected to attend meetings of the Committee at the invitation of the Chair:

4.4.1 Associate Director of Performance

4.4.2 Head of Quality (Patient Experience and Clinical Effectiveness)

4.4.3 Head of Quality (Patient Safety)

4.4 The Trust Secretary shall attend from time-to-time to provide advice to the Directors and to facilitate the formal evaluation of the Committee's performance

5. Quorum

5.1 The quorum necessary for the transaction of business shall be three members, all of whom must be independent Non-Executive Directors.

5.2 Committee members may be represented at meetings of the Committee by a duly nominated delegate on no more than two successive occasions. Nominated delegates must be independent Non-Executive Directors.

5.2 A duly convened meeting of the Quality and Outcomes Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable as set out in these Terms of Reference.

6. Duties

The Quality and Outcomes Committee shall discharge the following duties on behalf of the Trust Board of Directors:

6.1 Quality Strategy

6.1.1 Receive and assess the Board's Quality Strategy and provide an informed opinion to the Board on the suitability of the associated objectives; and

6.1.2 Monitor progress and achievement of the Board's Quality Strategy.

6.2 Annual Plan and Quality Report

6.2.1 Monitor the status of compliance with Care Quality Commission's Fundamental Standards of Care and Quality Objectives as set out in the Annual Plan; and

6.2.2 Review the Trust's Annual Quality Report prior to submission to the Trust's Board of Directors for approval.

6.3 Clinical and Service Quality, Compliance and Performance

6.3.1 Seek sources of evidence from existing Management Groups at divisional and sub-divisional level and Board Committees on which to base informed opinions regarding the standards of:

6.3.1.1 Clinical and service quality;

6.3.1.2 Organisational compliance with the CQC Fundamental Standards of Care and National targets and indicators as determined by the Monitor Risk Assessment Framework; and

6.3.1.3 Organisational performance measured against specified standards and targets.

6.3.2 Review the quarterly Trust declaration against Monitor's Risk Assessment Framework (excluding financial information) prior to submission to the Board of Directors for approval;

6.3.3 Review the Board Quality and Performance Report; and

6.3.4 Review the Quarterly Workforce and Organisational Development report.

6.4 Action Plan Monitoring

6.4.1 Monitor progress of the quality-related action plans (i.e., Francis recommendations)

6.5 Benchmarking, Learning and Quality Improvement

6.5.1 Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust;

6.5.2 Review the Annual Clinical Audit report;

6.5.3 Receive quarterly reports on complaints and patient experience;

6.5.4 Receive reports to monitor against action plans arising from Serious Untoward Incidents, complaints and never events to ensure: Trust-wide learning; actions have been completed; and ensure divisional intelligence and oversight;

6.5.5 To receive reports about patient experience and review the results and outcomes of local and national patient and staff surveys;

6.5.6 Receive and review quarterly reports on Infection Control;

6.5.7 Receive and review the annual report on Safeguarding;

6.5.8 Receive and review the annual report on Children's Services;

6.5.9 Receive and review the Equality and Diversity Annual Report;

6.5.10 Receive the monthly Nurse Staffing report on the information contained in the NHS national staffing return to ensure Trust-wide staffing levels remain safe;

6.5.11 Receive Quality Impact Assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience, patient safety and staff. The definition of significant will be determined by the Chief Nurse and Medical Director; and

6.5.12 Receive assurance regarding data quality assessment against the six national domains of data quality outlined in the Audit Commission's National Framework.

6.6 Risk

6.6.1 Receive the Corporate Risk Register and review the suitability and implementation of risk mitigation plans with regard to their potential impact on patient outcomes.

6.7 Quality Governance

6.7.1 Identify any gaps in evidence or measures of quality utilised by the Board of Directors

6.8 Procedural Documents and Corporate Record Keeping

6.8.1 Assess the suitability of Trust-wide relevant Procedural Documents in accordance with the Trust Procedural Document Framework (i.e., Board Quality Strategy);

6.8.2 Maintain and monitor a schedule of matters arising of agreed actions (for the Committee only) and performance-manage each action to completion; and

6.8.3 Maintain the corporate records and evidence required to support the Board Assurance Framework document.

7. Reporting and Accountability

7.1 The Chair of the Quality and Outcomes Committee shall report to the Board of Directors on the activities of the Committee.

7.2 The Chair of the Quality and Outcomes Committee shall make whatever recommendations to the Board deemed by the Committee to be appropriate (on any area within the Committee's remit where disclosure, action or improvement is needed).

7.3 Outside of the written reporting mechanism, the Committee Chair should attend the Council of Governors General meeting including the Annual Members Meeting, and be prepared to respond to any questions on the Committee's area of responsibility to provide an additional level of accountability to members.

7.4 Outside of the formal reporting procedures, the Governors' Quality Focus Group shall be informed by the Quality and Outcomes Committee via the Chair and Executive Leads, supported by the Trust Secretariat.

8. Administration

8.1 The Trust Secretariat shall provide administrative support to the Committee.

8.2 Meetings of the Quality and Outcomes Committee shall be called by the Secretary at the request of the Committee Chair.

8.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

8.4 Supporting papers shall be made available to Committee members no later than five working days before the date of the meeting.

8.5 The secretary shall minute the proceedings and resolutions of all Committee meetings,

including the names of those present and those in attendance.

8.6 Draft Minutes of meetings shall be made available promptly to all members of the Committee.

9. Frequency of Meetings

9.1 The Committee shall meet on a monthly basis, in advance of each meeting of the Board of Directors at which the Quality and Performance Report is to be considered, and at such other times as the Chair of the Committee shall require.

10. Review of Terms of Reference

10.1 The Committee shall, at least once a year, review its own performance and Terms of Reference to ensure it is operating at maximum effectiveness.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title
10. Approach to Strategy Refresh and Strategic Planning and Implementation Framework 2016/17
Sponsor and Author(s)
Sponsor: Paula Clarke, Director of Strategy and Transformation **Author:** Paula Clarke Director of Strategy and Transformation and Sarah Nadin, Head of Strategy and Business Planning

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The purpose of this paper is to provide an update to Trust Board and assurance on the development and delivery of a revised approach to the planning, development and implementation of strategy within the Trust.

Key issues to note

The paper provides a summary of approach and outlined timelines for the completion of the strategy refresh and strategic planning and implementation framework through 2016/2017. This covers the following areas of focus;

1. Our strategic governance structure

2. A stocktake of the content, alignment and consistency of our existing and future Trust Strategies.

3. Our Strategic Implementation Framework, including;
   a. Prioritisation of our Clinical Strategy
   b. A standardised framework and tools for development and route map for implementation
   c. Renewing our Hospitals – A revised strategic capital prioritisation process

4. A full refresh of our Trust Strategy – with consideration of the context of the developing local Sustainability and Transformation Plan (STP).

Recommendations
That the Board notes the proposed approach to ensure our strategy is dynamic and continues to respond and drive our strategic choices
Impact Upon Board Assurance Framework
Following the Well Led Governance Review, the Board agreed to review the Board Assurance Framework. This work is in progress and will be reported to the July Board. This report provides assurance on the development and delivery of the revised strategy, which will have a clear link to the revised Board Assurance Framework.

Impact Upon Corporate Risk							
None.							
Implications (Regulatory/Legal)							
None.							
Equality & Patient Impact							
Equality and patient impact implications and involvement will be integral to the processes for identifying strategic priorities and associated implementation plans							
Resource Implications							
Finance		Information Management & Technology					
Human Resources		Buildings					
Action/Decision Required							
For Decision		For Assurance	**X**	For Approval		For Information	X
Date the paper was presented to previous Committees							
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**		

Refreshing Our Strategy and Strategic Planning and Implementation Framework 2016/17

1. Introduction

The purpose of this paper is to provide an update to Trust Board on the development and delivery of a revised approach to the planning, development and implementation of strategy within the Trust.

An overview of the timeline for the delivery of this programme of work is outlined in appendix 1.

2. Background

A programme of work has been established to provide clarity on the approach to Trust strategic development and implementation. The overarching aim is to establish and oversee a strategic planning framework for the Trust which ensures:

- a coherent and co-ordinated programme of strategic review to inform decision-making by Divisions, the Senior Leadership Team and the Trust Board;
- the full alignment of goals and strategies, through Trust wide and divisional strategies to deliver the agreed objectives of the Board;
- a clear structure to oversee the design and implementation of strategic development programmes and projects, approved and designated by the Trust Board.
- assurance that strategic plans are internally aligned and respond appropriately to national policy, commissioning intentions, market developments and the plans of system partners.
- practical tools for divisional teams and a supportive framework in which strategic initiatives can be developed and successfully implemented.
- a prioritised view of the Trust's clinical strategy and establishment of a clear programme of work, with associated time scales for decision making and implementation.
- internal alignment to the emerging priorities of the system Sustainability and Transformation Plan (STP) and a structure for internal engagement

3. Strategic Governance

To deliver the objectives outlined about, a programme of work is in place to address two key elements of the Trust's strategic governance.

i) Our strategic governance structure

A new meetings structure has been established to manage and oversee the development and implementation of the Trust's strategic agenda. This new structure consists of (see appendix 2 for detail)

- Strategy Steering Group
- Clinical Strategy Group

- IDEA (Image, Design, Environment and Arts Reference Group)

Progress in the implementation of this revised structure has been made, with terms of reference and revised membership for these groups approved through Senior Leadership Team (SLT) in May 2016. The key purpose of this new structure is to ensure clear oversight and governance of the development and delivery of our strategic development programme, with alignment of goals and strategies, through Trust and divisional level plans. It also provides a clear structure for engagement within and between senior divisional teams in the development of the strategic agenda and supports wider stakeholder involvement in developing our environment to promote health & healing, improve quality of working life and reinforce our connections with local community.

ii) A stocktake of the content, alignment and consistency of our existing and future Trust Strategies.

This stocktake of the content of our existing broader strategy portfolio within the Trust will be undertaken over late summer, early Autumn 2016. This will be a desk based exercise, led by the Head of Strategy and Business Planning, drawing in other key stakeholders as required. The stocktake will establish the following;

- Do we have a strategy in all of the areas that we would expect and require?
- Are they fit for purpose against a standard criteria?
- Do they align and complement of the overarching Trust Strategy?
- Is there a process to ensure they are reviewed against an agreed timetable?

This will be delivered through;

- Establishing an agreed framework against which the quality and content of all internal strategies can be evaluated – produce gap analysis against each, with recommendations.
- Ensuring all internal strategies are consistent, with clear alignment to overall trust strategy and annual delivery objectives in BAF and divisional operating plans.
- Identifying any gaps in our strategy portfolio and agree a work plan to develop strategies where required, with owners and timescales.
- Establishing an on-going process for how and where all strategies will be kept and owned and refreshed on an agreed basis.

4. Strategic Implementation

A revised approach to strategic implementation has been developed, building on the output of the Strategic Implementation Process completed in 2015. The content of this revised approach is as follows;

4.1 Prioritisation of Clinical Strategy

Our current Trust Strategy (2014-2019/2020) states that as an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite available resources and our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services. We are also clear that we operate as part of a

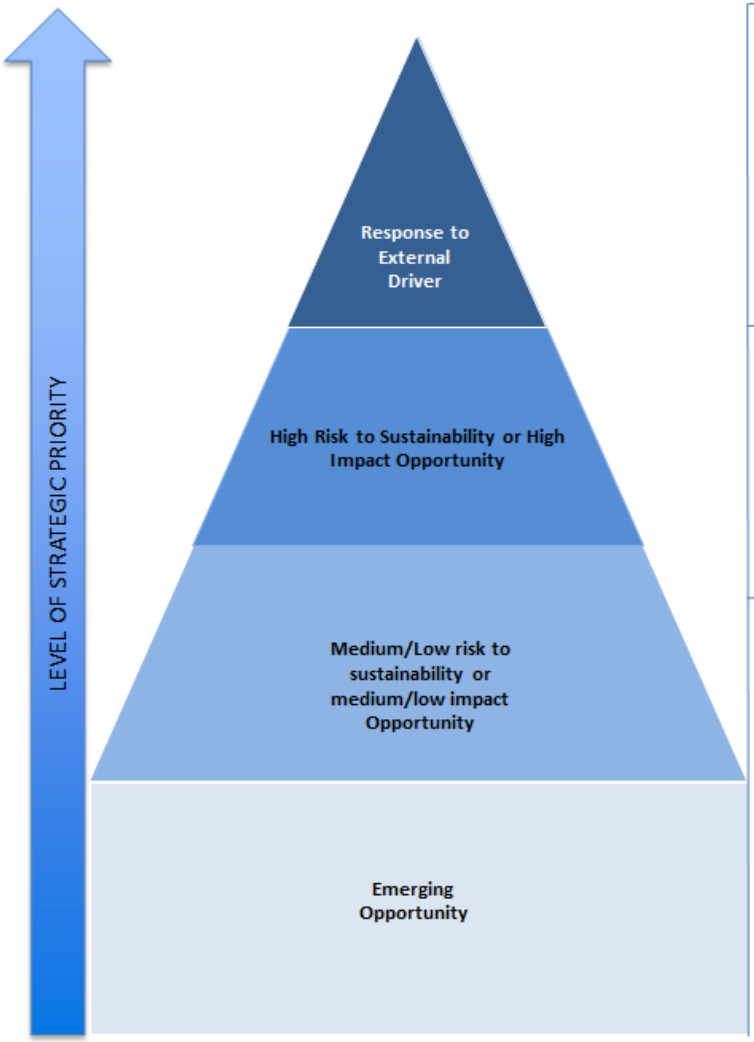
wider health and care community and our strategic intent sets out our position with regard to the key choices that we and others face.

Our strategy outlines nine key clinical service areas. These are:

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

The recent Strategic Implementation Process exercise and our 2016/2017 Operational Planning Process (OPP) have highlighted that within the high level priority areas outlined above, there a need for a more detailed level of prioritisation to assist with some of the specific strategic choices we may need to consider, either in response to internal issues of sustainability or driven by our evolving external local and national environment. To support this further prioritisation process, a revised high level methodology has been produced and is outlined below.

UH Bristol 16/17 Clinical Strategy – Strategic Priorities



Definitions
• Tenders • Designations • National Service Specifications.
• High risk of operational, financial or clinical un-sustainability • Assessed as significant opportunity to improve productivity /income /quality /performance. • Fully strategically aligned.
• Medium or risk of operational, financial or clinical un-sustainability • Medium or low impact opportunity to improve productivity /income /quality /performance. • Partially strategically aligned.
• No current risk to sustainability identified • Impact and strategic alignment to be determined.

The Strategy and Transformation team are currently working with divisional teams to use this methodology to identify specific specialty areas considered to be of priority for review in 2016/2017 and beyond. The Clinical Strategy Group will review the proposed prioritised clinical strategy at the end of July 2016. In parallel, Divisional teams will work to produce initial plans for the review of options within each of the areas identified and an indication of timelines for the implementation of plans.

These inputs will be used to produce a high level plan, outlining the programme of actions and activity which will drive the development of options associated with the priority areas, along with decision making, planning and implementation. Delivery of plans will primarily be focussed through the existing Operational Planning Process (OPP) and associated governance however, consideration and alignment to the developing local system Sustainability and Transformation Plan will also be key through the completion of this process.

The divisional teams will also be provided with support and structure from the Strategy and Transformation Team as required, oversight of the programme will be held by the revised Clinical Strategy Group, reporting to the Senior Leadership Team (SLT), through the new Strategy Steering Group. It is proposed that the prioritised clinical strategy alongside a development and implementation programme will come to SLT and Trust Board in October 2016 for approval.

4.2 **Standardised Framework and Tools for development and Route map for Implementation**

To support Divisional Boards with the process of prioritisation, development and implementation, a package of standardised tools has been developed including;

- Summary of delivery routes for the development and implementation of strategic choices, including the interface with STP.
- A standardised template and framework for evaluating service developments and producing an outline business case to support proposed options. This includes links to the existing tender and disinvestment processes.
- A framework outlining the process for decision and making and governance .

This package of standardised tools has been reviewed and approved through the Clinical Strategy Group and Senior Leadership teams and the Strategy and Transformation team are currently providing support and training through divisional boards and other engagement routes. Divisional teams are using the set of tools to evaluate and progress with strategic choices identified as a priority within their divisional operating plans which will inform the overall development and implementation programme, outlined above.

4.3 Renewing our Hospitals - Strategic Capital Prioritisation Process

As the Trust's major capital schemes (Phases 1-4) have come to fruition it is timely to consider our future priorities for capital investment. In support of this work, the Medium Term Capital Programme (MTCP) has been developed to set out the available capital to 2020/2021 and in parallel the Trust Board has approved the over-arching Estates Strategy which sets out the estate priorities for the period out to 2020/2021.

Within the Medium Term Capital Programme, there remains provision in each year for 'business as usual' investments in major medical equipment and operational capital. However further provision is also made for the purpose of supporting the development of further "strategic schemes".

There are two primary drivers to future capital priorities, capital investment to further the Trust's strategy and investments to improve areas of the estate that have not been impacted by the recent major programme of works and which, as a consequence, are now more apparently in need of modernisation and/or refurbishment.

Previously, strategic refurbishment funds have been targeted at individual investments exceeding £3 million however it is proposed that schemes in excess of £1.0 million are considered against the available funding with residual priorities being funded from operational capital.

For the purpose of scoping future priorities against the available funding, it is proposed that priorities are considered in two main ways:

i) **Investments to deliver the Trust's Strategy (Strategic Schemes).** These have been surfaced through the Strategic Implementation Planning (SIP) process and the 16/17 Operating Plan and will be further aligned to the programme of work to provide a refreshed view of the Trust's clinical strategy. This may be the Trust's clinical strategy, or other elements of the strategy, such as Research and Innovation or Teaching and Learning. Examples include where additional clinical capacity, or change in the use of space is required to support the development of a particular clinical specialty or pathway or where development of the UH Bristol estate in a specific area may support the delivery of one of the aims of the developing BNSSG STP.

ii) **Investments to upgrade and/or remodel existing trust estate (Infer structure Improvement Schemes)**. This relates to the improvement of estates infrastructure and may include the refurbishment clinical or staff environment. This also explicitly includes the refurbishment and updating of estate not included in Phase 1-4 of the BRI redevelopment. This may also include where change to environment could significantly improve productivity and/or address a significant and known risk.

The table below provides an overview of the timeline for the prioritisation of strategic capital and a full outline of the process can be found in appendix 3.

5. Refresh of Trust Strategy

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

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

Although we remain confident that our five year strategy is still relevant and sound in the evolving local and national environment, it is recognised that there are a number of notable internal and external developments that now need to be reflected our strategy document. These factors can be summarised as;

External

1. The NHS England *5 Year Forward View* and national policy direction.
2. The emerging Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Plan (STP).

3. The developing strategies of our local acute providers, notably North Bristol NHS Trust's new 2016/2017 Clinical Strategy.

Internal

4. Our internal Strategic Implementation Planning (SIP) process and prioritised clinical strategy.
5. The outputs of our internal strategy stocktake exercise.
6. Revised internal Quality and Teaching and learning strategies.
7. Our revised Estates Strategy and our Renewing our Hospitals programme, through the revised strategic capital process.

A full refresh of the content of our current Trust strategy will be completed in Autumn 2016, to report to Trust Board at the end of the year, to ensure that our approach to our key strategic choices positions us to be effective in progressing our aligned agenda over the next 3 years.

6. Communication and Engagement

A process of engagement is underway with divisional teams across the Trust. This has included the following;

- Establishing a regular fortnightly meeting with the divisional Clinical Chairs, with a focus on ensuring strong clinical input into the developing Sustainability and Transformation Plan.
- Attendance at Divisional Director meetings.
- Attendance at Divisional Board meetings, with Clinical Directors, Matron and General Manager attendance.
- Session for broader general manager teams at the General Manager development meeting.

Further work to ensure broader engagement within the organisation will be progressed as the full strategy refresh develops.

Appendix 1 – Summary Programme Timeline

Timescale	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	2017/18
Clinical Strategy Prioritisation and Strategic Implementation	Divisional validation of draft prioritisation of strategy and development of outline plans	Clinical Strategy Group review of divisional returns and development of Implementation Programme	Divisons develop options appraisals and outline business cases using standard approach - Divisional Board review in September.		**Early October (date tbc)** Strategy Steering Group review of divisional plans and Implementation Programme - recommendation to SLT	Development of detailed project and implemention plans per scheme , leading to implementation through 2016/17 and into 2017/18. Oversight of delivery through CSG						
				21st September - Clinical Strategy Group (CSG) consideration of divisional plans	**19th October** - SLT review of Implementation Plans.							
					31st October - Trust Board approval of Implementation Plans							
Strategic Capital Process	Approval of strategic capital process through SLT and Finance Committee	Process starts - Database opened for bids	Bids submitted on database	**5th September** - deadline for bids.	**12th October -** Capital Programme Steering Group (CPSG) ratify prioritised list of schemes.							
				16th September -Deadline for divisions to complete provisional scoring.	**19th October** - SLT ratify prioritised list of schemes.	Development of approved strategic capital projects and implementation.						
				21st September - Clinical Strategy Group (CSG) review of provisional prioritised list of bids and make recommendation, in context of provisional clinical strategy plans.	**24th October** - Finance Committee review prioritised strategic capital programme and make recommendation to Board.							
					31st October - Trust Board approval of Implementation Plans							
Strategy Stocktake and Refresh	Update to SLT and Trust Board on proposed plans	Completion of stocktake activity		**21st September** - Update on progress to Clinical Strategy Group for comment.	Report on outcome, recommendation and next steps to Strategy Steering Group SLT and Trust Board	Completion of full strategy Refresh	Revised Clinical Strategy approved through SSG, SLT and Board	Implementation of refreshed clinical strategy through standardised framework. Further refresh as required in evolving STP Context. Oversight of broader strategy				
Revised Strategic Governance Structure	Revised approached including new Terms of Reference and membership agreed through SLT		Ongoing use of revised governance structure to provide assurance on the alignment of planning, development and implementation of strategy within the Trust.									
	First Revised Clinical Strategy Group	First new Strategy Steering Group										
	Attendence at Divisional Board Meetings to discuss full approach with broader teams.											

Appendix 2 - Summary of Strategic Planning and Implementation Governance Structure

Trust Board

Governors Strategy Group

Senior Leadership Team

IDEA Group

Strategy Steering Group

Divisional Boards

Clinical Strategy Group

Implementation and Oversight

Strategy Steering Group

Establish and oversee a **strategic planning framework** for the Trust which ensures:

- a coherent and co-ordinated **programme** of strategic review to inform decision-making by Divisions, the Senior Leadership Team and the Trust Board;
- the full **alignment** of goals and strategies to deliver the agreed objectives of the Board;
- Oversee the design and implementation of **strategic development programmes and projects**, approved and designated by the Trust Board.

- Provide **assurance** to the Senior Leadership Team that strategic plans are internally aligned and respond appropriately to national policy, commissioning intentions, market developments and the plans of system partners.

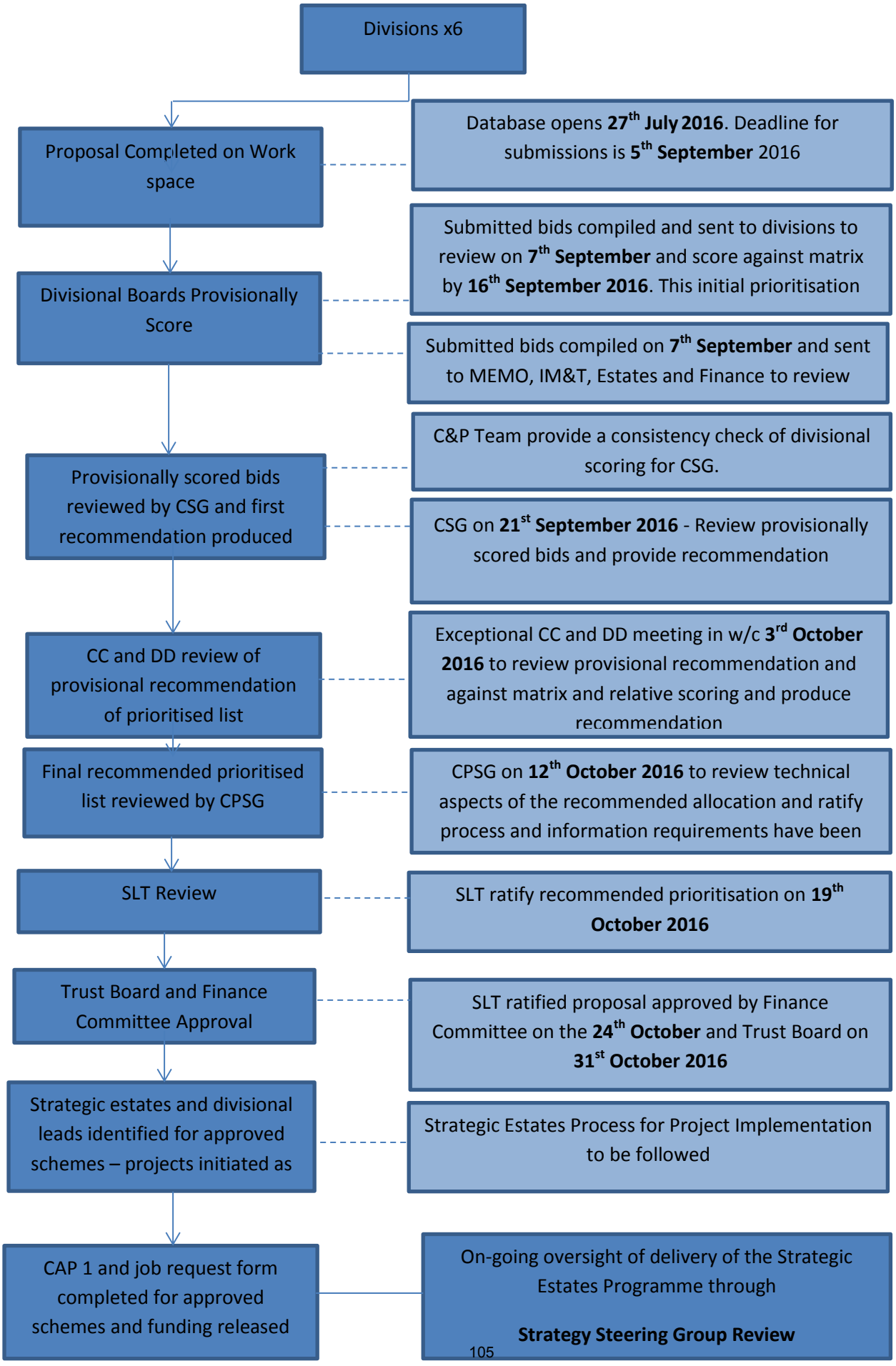
- Director of Strategy and Transformation (Chair)
- Divisional Director and/or Clinical Chair from each Division.
- Medical Director or rep
- COO or rep
- Director of Finance
- Chief Nurse or rep
- Director of Facilities and Estates
- Strategic Development Programme Director
- Head of Strategy and Business Planning
- Director of Transformation
- Head of Information Management and Technology
- Head of Workforce Strategy
- Director of Research

Clinical Strategy Group

- To oversee the development and implementation of a comprehensive, integrated clinical services strategy for the Trust based on national drivers and locally identified priorities.
- Provide a forum for cross divisional evaluation and challenge of choices and prioritisation of developments and disinvestments within and between clinical service areas and make recommendations to Strategy Steering Group.
- To use agreed decision making framework and scenario planning approach in evaluating strategic choices regarding clinical services against the overall Trust strategic priorities.
- To coordinate clinical/staff engagement, as required in the development and implementation of internal and system wide clinical strategy.
- Oversight of the service designation process across the Trust.
- Oversight of service compliance with national service specifications,
- To act as the point of focus for the coordination of internal clinical services choices/ developments/ pathways changes associated with the system wide Sustainability and Transformation Plan.

- Director Strategy and Transformation (Chair)
- Medical Director (Vice-Chair)
- Chief Nurse or rep
- Clinical Chair and/or Clinical Director (1 from each division)
- Heads of Nursing and/or Matron (1 from each division)
- Lead AHP
- Lead HCST
- One Deputy/ Divisional Director or General Manager from each division
- Head of Strategy and Business Planning
- Director of Facilities and Estates or nominated deputy
- Deputy Director of Research
- Representative for Teaching and Learning/workforce
- Deputy Head C&P

Appendix 3 – Capital Prioritisation Process



University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
11. Quarterly Complaints and Patient Experience Reports									
Sponsor and Author(s)									
Sponsor: Carolyn Mills, Chief Nurse **Authors**: Paul Lewis, Patient Experience Lead (surveys and evaluation); and Tanya Tofts, Patient Support & Complaints Manager									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

To provide the board with a summary of patient-reported feedback and complaints received during Quarter 4 of 2015/16.

Key issues to note

Complaints

- Surgery Head & Neck – zero complaints about nursing/midwifery staff or clinical care from nursing/midwifery staff; reduction in complaints received by the Upper GI service
- Medicine – increase in informal resolution of complaints
- Specialised Services – zero complaints in respect of access or facilities and environment issues or with regards to attitude of medical or nursing staff; reduction in complaints received by Bristol Heart Institute Outpatients and the Chemotherapy Day Unit/Outpatients
- Women's & Children's Services – reduction in the number of complaints received in respect of cancelled or delayed appointments/operations for the second successive quarter
- Training has been rolled out by the Patient Support & Complaints Team tailored to the theme of how to write a good response letter (sessions are currently arranged through to September 2016)
- Recovery in overall response rate performance towards the end of Q4
- Continue to focus on: improving quality of response letters, meeting agreed timescales, reducing extensions

Patient Experience

- All of the Trust's key survey metrics remained "green" in Quarter 4 – indicating a high quality patient experience at UH Bristol
- Survey scores showed improvement for ward A900, following service improvements in response to dissatisfaction amongst patients with Cystic Fibrosis
- Q4 report for the first time includes divisional responses to negative comments made by patients via the Friends and Family Test (FFT).
- Priority actions:
    - Action needed by Ward 38B (paediatric neurology) to address low patient experience ratings for 'kindness and understanding' and the inpatient tracker
    - Newly established Division of Medicine Patient Experience and Involvement Group to focus on improving communication with patients whilst they are in hospital
    - Improve outpatient FFT response rate

Develop tender specification for new Trust-wide patient feedback system
Recommendations
None.
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
28 June 2016				22 June 2016	

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 4, 2015/16

(1st January 2016 to 31st March 2016)

Author: Paul Lewis, Patient Experience Programme Manager

1. Patient-reported experience at UH Bristol: Quarter 4 overview

Successes	Priorities
• All of the Trust's key survey metrics remained "green" in Quarter 4 – indicating a high quality patient experience at UH Bristol • Survey scores showed improvement for ward A900, following service improvements in response to dissatisfaction amongst patients with Cystic Fibrosis • Implementation of a process to capture ward/department actions in response to negative ratings in the Friends and Family Test. • Positive praise for staff remains by far the most frequent form of written feedback received from patients	• Action by Ward 38B (paediatric neurology) to address low patient experience ratings for 'kindness and understanding' and the inpatient tracker • The newly established Division of Medicine Patient Experience and Involvement Group to focus on improving communication with patients whilst they are in hospital • Maintain a response rate of in excess of 30% in the combined inpatient and day case Friends and Family Test (FFT) • Achieve a minimum 6% response rate in the Trust's outpatient FFT survey • Convene a working group to develop a tender specification for a new electronic patient feedback system at the Trust
Opportunities	**Risks & Threats**
• To trial the use of text messaging (SMS) survey technology for the Friends and Family Test in the Bristol Royal Infirmary Emergency Department • To share the positive patient feedback in this Quarterly Report with staff delivering care and users of our services	• The introduction of a touchscreen survey system in the Trust's Emergency Departments has supported an increase in Friends and Family Test (FFT) response rates, but appears to have resulted in more negative scores. The ED teams continue to look for opportunities to improve care in response to feedback, whilst FFT data capture options will continue to be explored as the Trust develops and implements plans for more responsive patient feedback systems. • Although the vast majority of feedback about UH Bristol staff is positive, where a negative experience occurs, this is often related to the way a member of staff behaved. These "human factors" are usually the determinant of a positive or negative patient experience.

2. Trust-level patient-reported experience

In Quarter 4 (January to March 2016) the Trust maintained positive scores in the headline patient-reported experience measures (Charts 1-6 over)[1]. This data is derived from UH Bristol's two main survey programmes: the Friends and Family Test and the monthly postal surveys. These charts are designed to detect any deterioration in the quality of patient experience at UH Bristol. The Trust also has response rate targets in relation to the Friends and Family Test and performance against these is shown in Charts 7-9.

Response rate for the combined inpatient and day case Friends and Family Test

During 2015/16 the Trust did not meet the 30% target response rate for this survey (Chart 7) and in January 2016 was issued with a contract performance notice by the Bristol Clinical Commissioning Group. This was primarily due to low response rates in the day case element of the survey. With support from the Trust's Patient Experience and Involvement Team, the Divisions have been focussing on improving response rates and are exceeding the improvement trajectory targets (Table 1). (Note: in 2016/17 to date the 30% target has been exceeded).

Table 1: improvement trajectory for the inpatient and day case Friends and Family Test response rate

Survey month	February 2016	March 2016	April 2016	May 2016 (provisional)
Trajectory (target)	20%	25%	25%	30%
Actual	22.0%	26.3%	35.2%	42.4%

Emergency Department Friends and Family Test scores

The negative effect on the Trust's Friends and Family Test scores of adopting touchscreen technology to collect feedback in the waiting rooms (Chart 6) has been well documented in previous Quarterly Patient Experience Reports, and these low scores continued in Quarter 4[2]. In order to explore methods of generating a more rounded view of the care experience, starting in June 2016 the Trust's Patient Experience and Involvement Team will carry out a three month pilot of an SMS (text messaging) approach to the Friends and Family Test in the Bristol Royal Infirmary Emergency Department. In the meantime the Emergency Departments continue to receive and use Friends and Family Test feedback (see Table 3 of this report for a summary of how this feedback has been used across the Trust to improve patient experience).

Outpatient Friends and Family Test response rate

Although there are no nationally set response rates for this survey, the Bristol Clinical Commissioning Group have requested that a locally-agreed target is put in place for 2016/17. At present the Trust receives in the region of 500 responses per month via the Outpatient Friends and Family Test. This is a reasonable level of responses for a monthly sample survey, but due to the size of this service at UH Bristol equates to only around 1.5% of outpatient attendances. It has been agreed with the Commissioners that by the end of 2016/17 UH Bristol's monthly response rate will be 6% (the national average). UH Bristol has a large outpatient population relative to the national average, but a significant expansion of coverage is central to the Trust's plans for patient feedback during 2016/17.

[1] A description of the key Trust surveys is provided in Appendix B. The headline metrics that are used to track patient-reported experience are: being treated with kindness and understanding, the inpatient and outpatient trackers (which combine several scores across the surveys relating to cleanliness, respect and dignity, communication, and waiting times), and the Friends and Family Test score.

[2] A higher number of responses are being received during the wait in the department, relative to the feedback received at the end of the experience. This is a particular issue in the Bristol Royal Infirmary and Bristol Royal Hospital for Children Emergency Departments, as the screens are used more frequently in those settings (the Bristol Eye Hospital Emergency Department still primarily use cards to collect feedback).

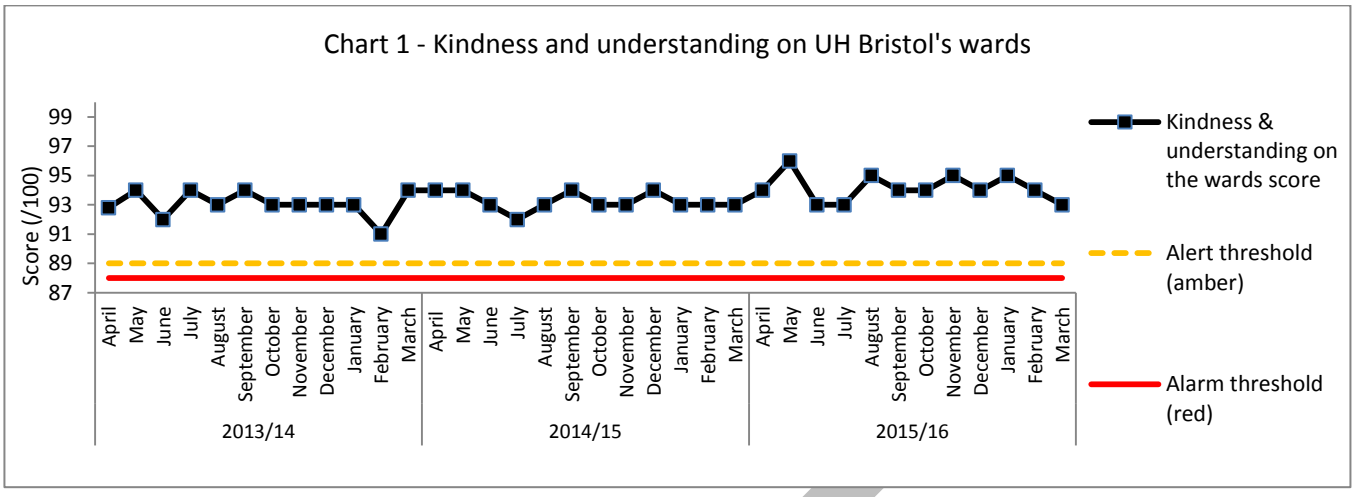


Chart 1 - Kindness and understanding on UH Bristol's wards
Score (/100)
99
97
95
93
91
89
87
April May June July August September October November December January February March
2013/14
2014/15
2015/16
Kindness & understanding on the wards score
Alert threshold (amber)
Alarm threshold (red)

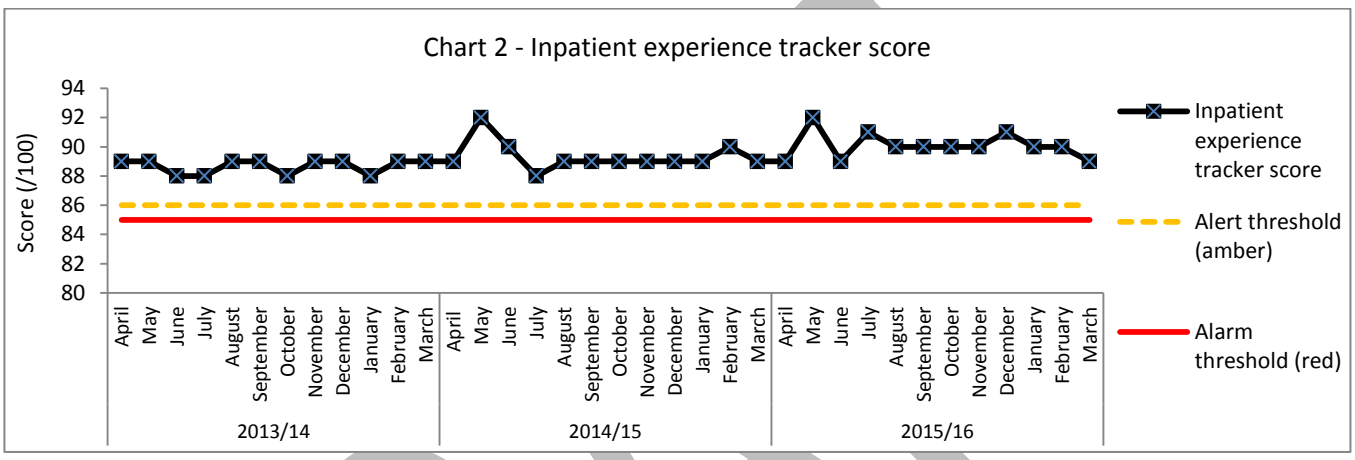


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2013/14
2014/15
2015/16
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

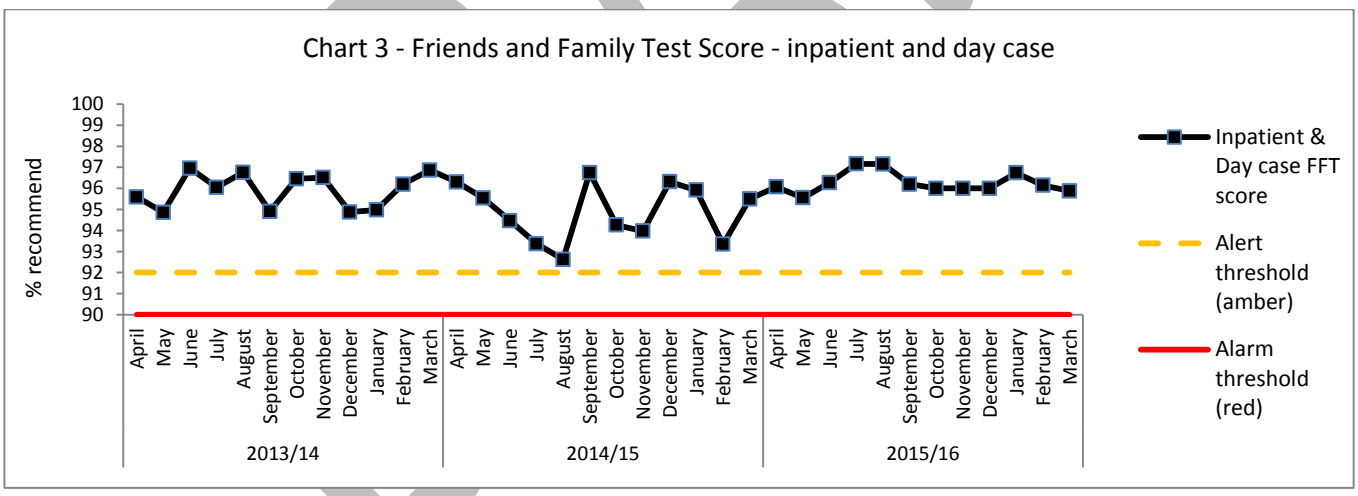


Chart 3 - Friends and Family Test Score - inpatient and day case
% recommend
100
99
98
97
96
95
94
93
92
91
90
April May June July August September October November December January February March
2013/14
2014/15
2015/16
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

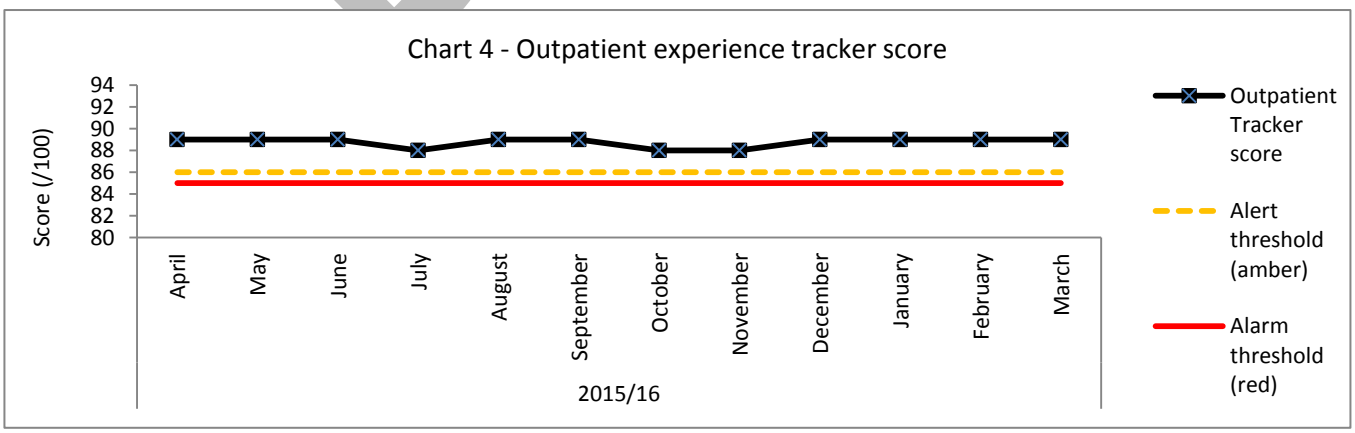
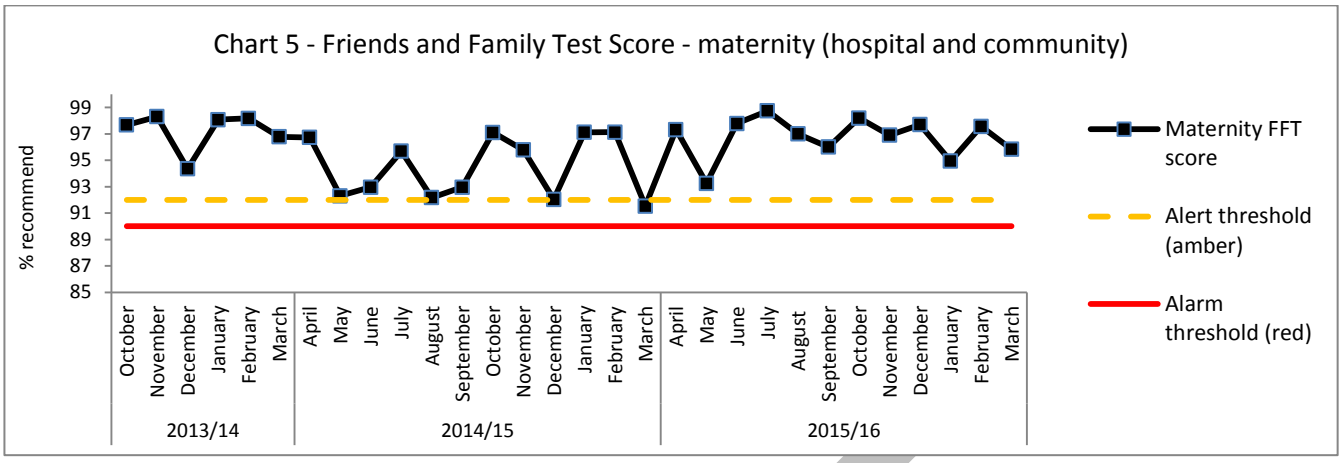
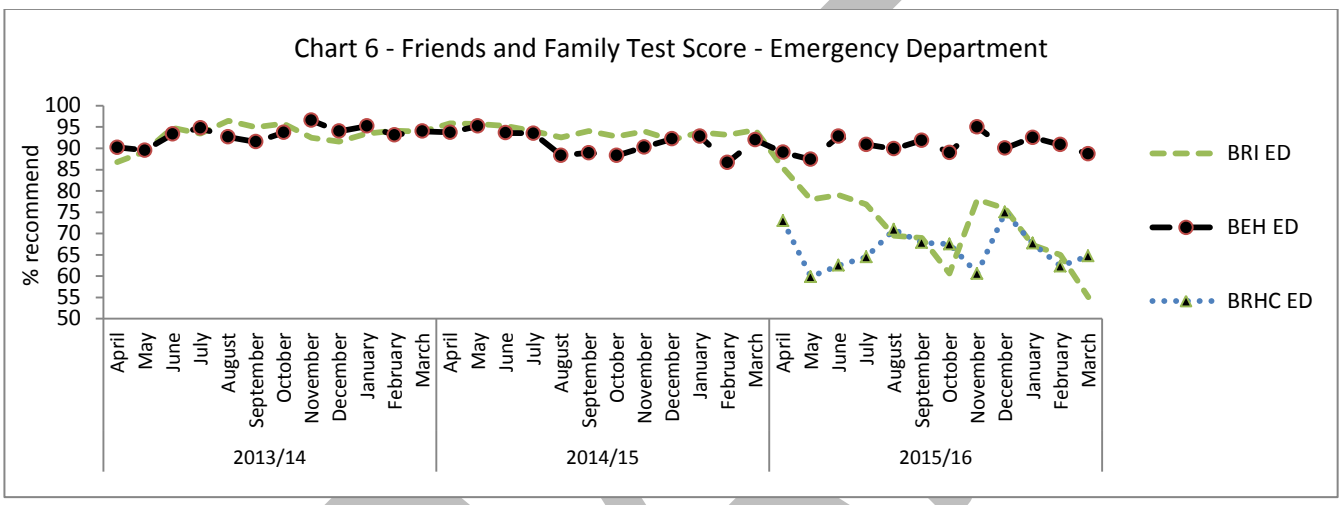
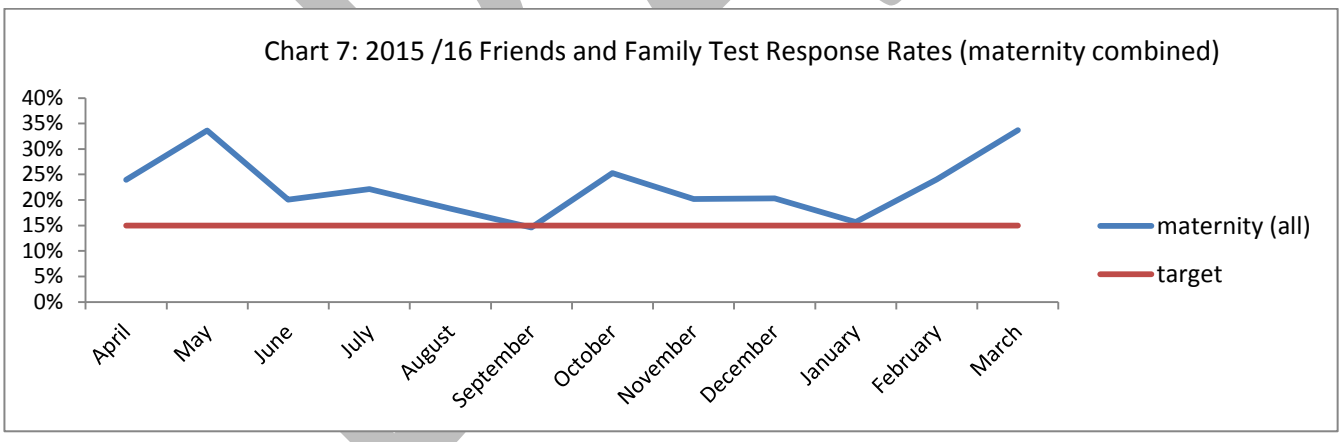


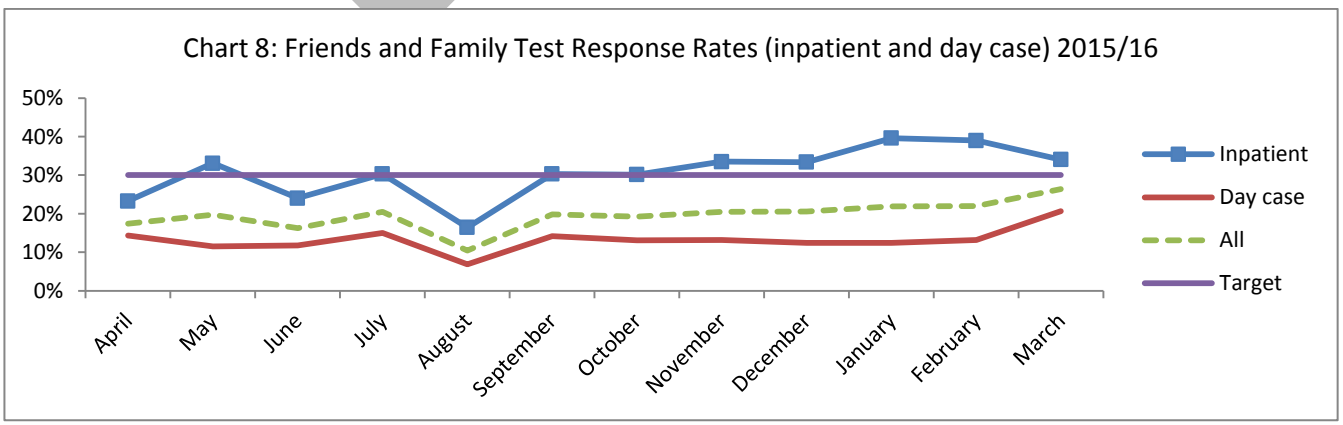
Chart 4 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March
2015/16
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

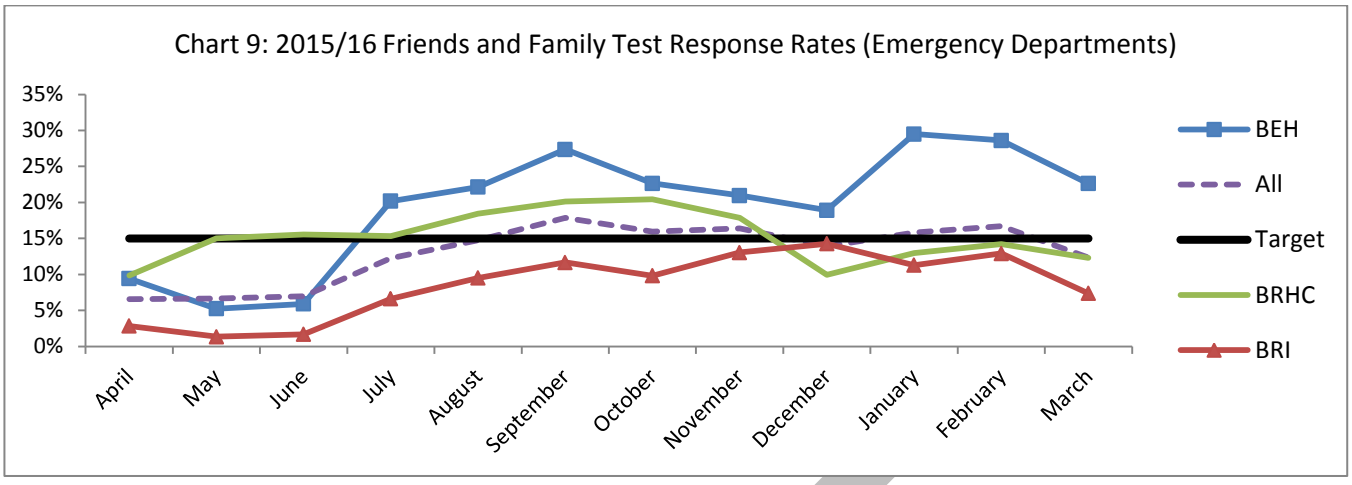




(Key: BRI = Bristol Royal Infirmary; BEH = Bristol Eye Hospital; BRHC = Bristol Royal Hospital for Children; ED = Emergency Department)







3. Divisional-level patient-reported experience

Charts 10-13 provide a view of UH Bristol's performance on the key patient survey metrics at a Divisional-level. A breakdown of the full Divisional data is provided in Table 2 (page 8).

A number of "negative outliers" are present for the Division of Medicine, principally for South Bristol Community Hospital (wards 100 and 200 - see Sections 4 and 5 of this report), care of the elderly wards (A528 / C808 – see Section 5), and more specifically for question scores around explaining medication and procedures (Table 2). As outlined in previous Quarterly reports, the key underlying theme that needs to be addressed in all of these cases is communication with patients whilst they are in hospital. A multi-disciplinary Division of Medicine Patient Experience Group has been set up and as part of their remit will develop specific actions relating to communication during Quarter 2 2016/17. In addition, a series of staff workshops is being arranged for Ward C808 and A528, modelled on the successful "Patient Experience at Heart" workshops in Maternity Services, so that the ward teams have the opportunity to reflect on the delivery of a positive patient experience. These wards were also "inspected" as part of the Trust's recent Delivering Best Care week - the findings were generally a positive and a number of actions have been taken forward by the Division.

The Trust's Pharmacy Department has two new service developments that directly relate to communication about medications (Table 2). A new on-line system ("MaPPs") produces bespoke patient information sheets for common medicines, and other helpful material including a summary chart of administration times[3]. A representative from the Pharmacy Department will attend the Division of Medicine Patient Experience Group to explore how this system can support the Division's work around communication. In collaboration with the West of England Academic Health Sciences Network, the Pharmacy Department has also implemented a new IT system ("PharmOutcomes") which allows community pharmacists to receive information about the medications that UH Bristol patients have been discharged with. The community pharmacist can then proactively engage / support patients using the most up to date and accurate medicines information. It is important to provide this additional support in the community, particularly as patients may not find it easy to take in information about medications during their hospital stay and / or at the point of being discharged.

[3] MaPPs stands for: Medicines – a Patient Profile Summary. The Pharmacy Department had developed an "in-house" system that was a similar concept to MaPPs, but this proved very difficult to maintain and did not progress beyond the pilot stage.

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

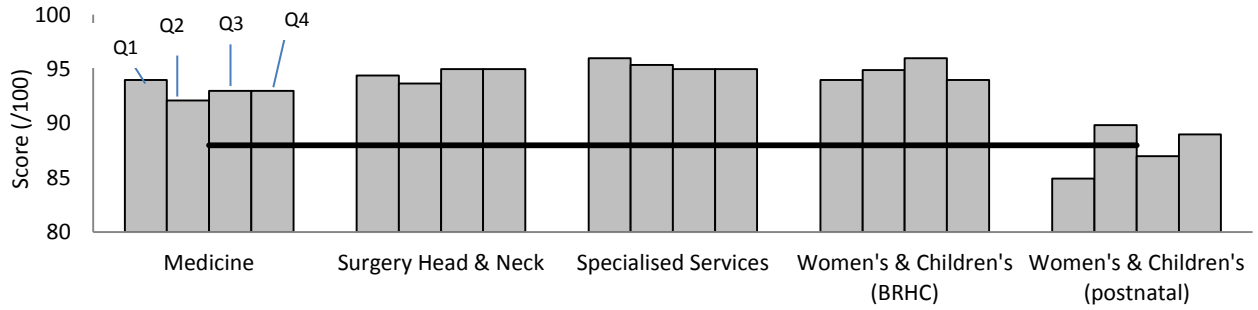


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

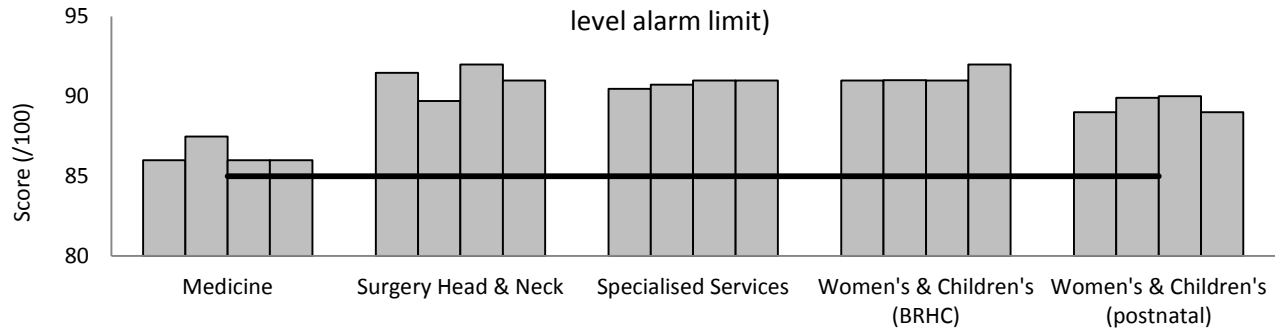


Chart 12 - Inpatient Friends and Family Test score - last four quarters by Division (with Trust-level alarm limit)

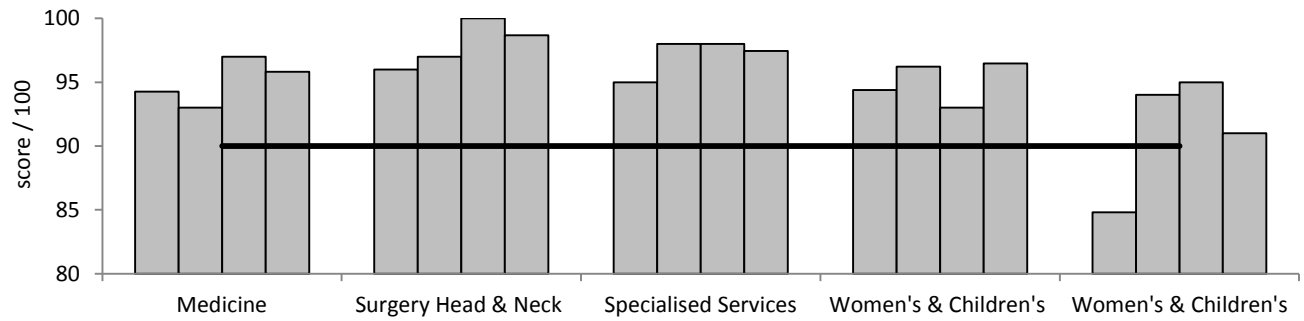


Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit

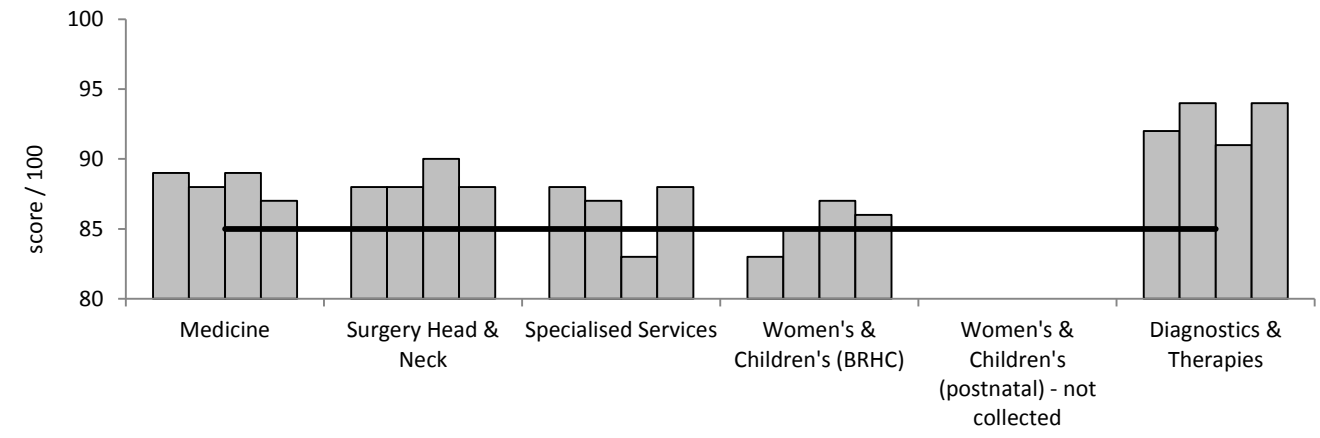


Table 2: full-set of Quarter 4 Divisional scores from UH Bristol's monthly postal survey (cells are highlighted if they are 10 points or more below the Trust score)

	Division					
	Medicine	Surgery, Head and Neck	Specialised Services	Women's & Children's	Maternity	Trust
Were you / your child given enough privacy when discussing your condition or treatment?	91	94	92	92	n/a	92
How would you rate the hospital food you / your child received?	64	62	63	64	57	63
Did you / your child get enough help from staff to eat meals?	83	83	84	82	n/a	83
In your opinion, how clean was the hospital room or ward you (or your child) were in?	94	95	95	92	90	94
How clean were the toilets and bathrooms that you / your child used on the ward?	92	92	90	93	84	92
Were you / your child ever bothered by noise at night from hospital staff?	78	85	78	82	n/a	81
Do you feel you / your child was treated with respect and dignity on the ward?	95	96	97	95	92	96
Were you / your child treated with kindness and understanding on the ward?	93	95	95	94	89	94
How would you rate the care you / your child received on the ward?	84	88	89	88	85	88
When you had important questions to ask a doctor, did you get answers you could understand?	83	89	88	90	87	88
When you had important questions to ask a nurse, did you get answers you could understand?	84	88	89	89	93	88
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	70	74	73	79	79	74
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	82	87	85	89	93	86
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	75	86	84	89	86	84
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	86	89	88	87	n/a	88
Did you / your child find someone to talk to about your worries and fears?	65	73	73	78	81	72

	Division					
	Medicine	Surgery, Head and Neck	Specialised Services	Women's & Children's	Maternity	Trust
Staff explained why you needed these test(s) in a way you could understand?	79	86	85	92	n/a	85
Staff tell you when you would find out the results of your test(s)?	65	70	72	76	n/a	70
Staff explain the results of the test(s) in a way you could understand?	72	76	76	88	n/a	77
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	72	94	91	94	n/a	91
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	62	79	75	82	n/a	77
Staff were respectful any decisions you made about your / your child's care and treatment	89	92	92	93	n/a	92
During your hospital stay, were you asked to give your views on the quality of your care?	27	26	26	25	34	26
Do you feel you were kept well informed about your / your child's expected date of discharge?	84	90	87	90	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason?	63	63	56	64	66	61
% of patients delayed for more than four hours at discharge	15	14	15	26	25	17
Did a member of staff tell you what medication side effects to watch for when you went home?	49	65	59	66	n/a	60
Total responses	*387*	*554*	*427*	*330*	*224*	*1922*

4. Hospital-level patient-reported experience

Charts 14-17 show the headline metrics by UH Bristol hospital site[4]. It has already been noted in Section 3 of this report that the South Bristol Community consistently scores below the alert threshold on the inpatient experience tracker score (Chart 15), and that this primarily relates to communication and involvement in care decisions. In Quarter 4, the Bristol Eye Hospital scored slightly below the alert threshold on the outpatient experience tracker (scoring 84/100, when the minimum target is 85 – see Chart 17). It was the "waiting times in clinic" element of this score that affected the Bristol Eye Hospital's performance, with 61% of patients saying that they were seen on time or within fifteen minutes of their appointment, compared to 73% for the Trust as a whole. At the Bristol Eye Hospital, appointments often involve patients moving through several stages of tests / investigations within the department, lasting several hours, rather than there being a single consultation with a clinician. Therefore, the notion of being seen within fifteen minutes of the appointment time is less applicable in this context. The more relevant wait here is between different stages of the appointment. In order to ensure that this process is as efficient as possible, the Bristol Eye Hospital management team is developing a method of tracking patients throughout their visit using the Medway system, which will help to ensure that people aren't waiting too long between the various stages. This is currently being launched in the Corneal and Glaucoma services, with a view to expanding this to all outpatient services at the hospital during 2016/17.

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

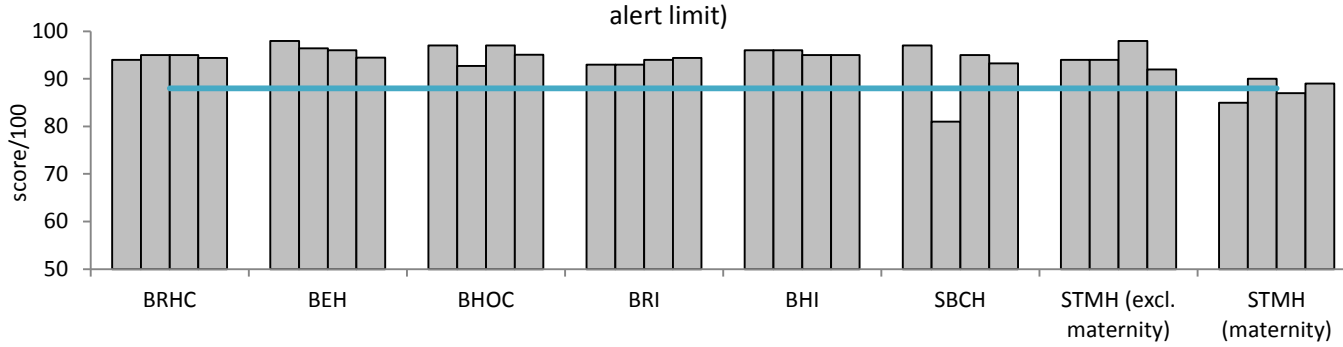
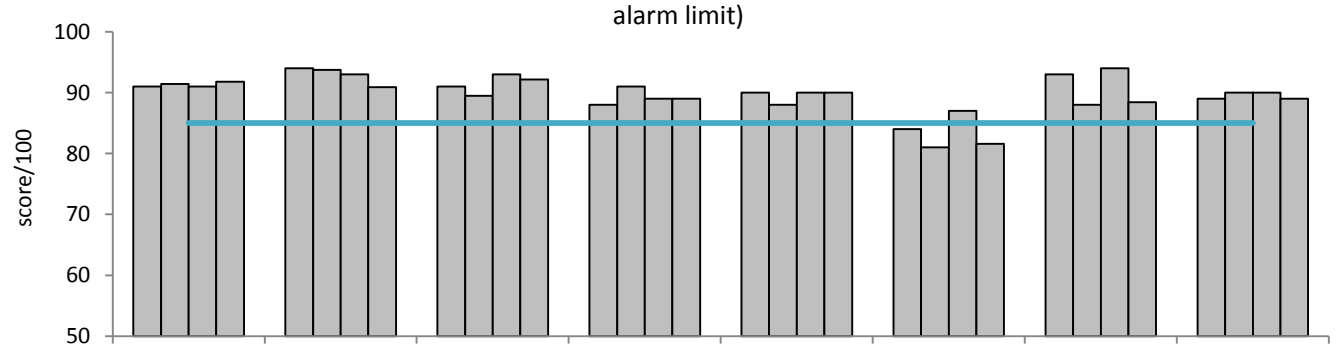
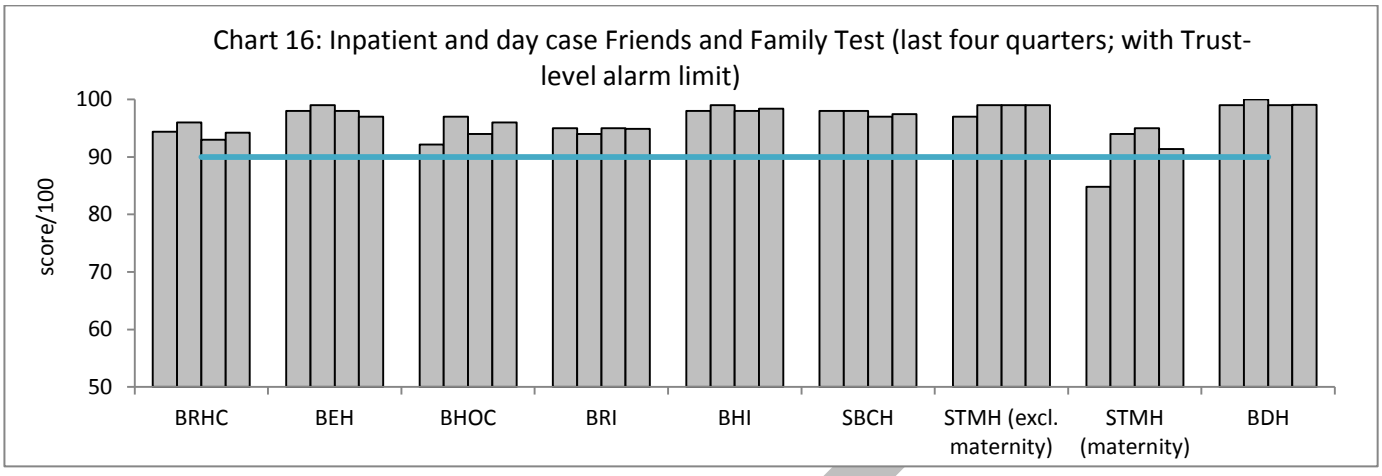
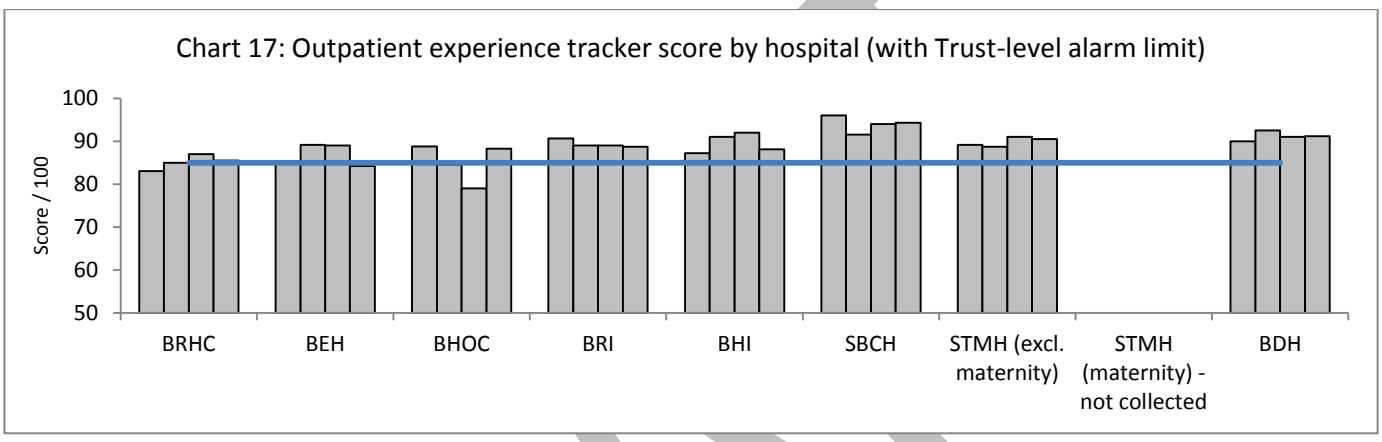


Chart 15: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)



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





5. Ward-level patient-reported experience

5.1 Quarter 4 ward scores

Charts 18-20 provide the headline patient-reported experience metrics at a ward-level. At this level, the data is less reliable (i.e. has a larger margin of error), and so it is important to look for consistent trends across the charts. In this way the following wards have two or more scores that are relatively low:

Ward 38B

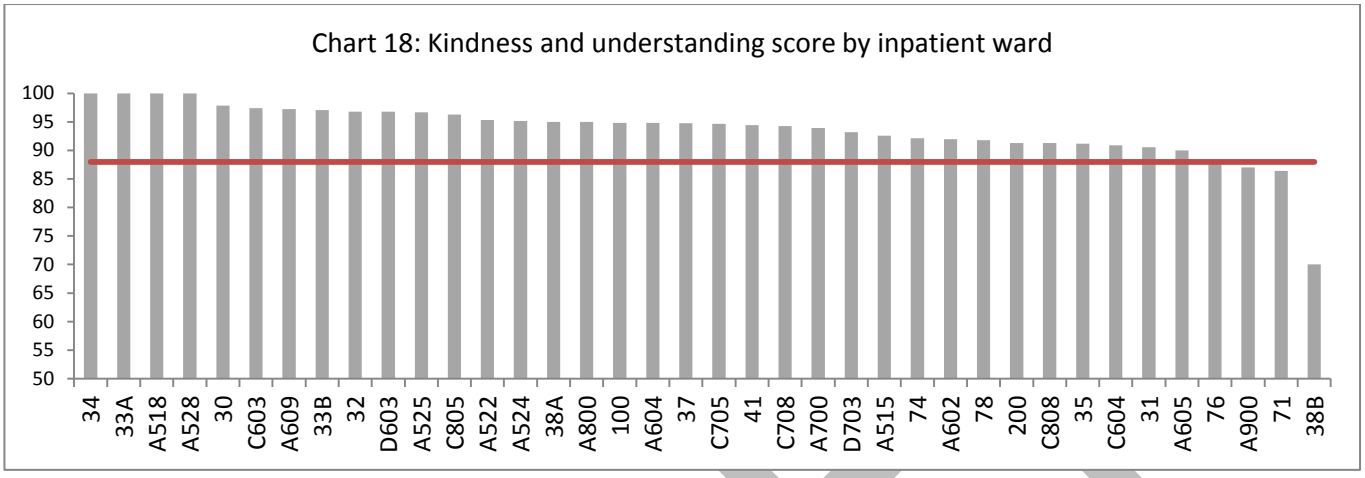
This ward was formed as part of the transfer of Children's neurological services from Frenchay Hospital in 2014. The number of responses for this ward is particularly low and so caution is needed in using this data[5]. This relatively large margin of error in the data may partly explain the disparity between the ward achieving a very positive Friends and Family Test score (Chart 20), but also the lowest scores of any ward in the two metrics derived from the postal survey (Charts 18 and 19). Rehabilitation beds on ward 38B have been closed and moved to the main Ward 38A. There are also significant reductions taking place in the number of parent-led beds, but some do remain and additional support from the nurses on 38A has been put in place to ensure that regular contact with the family is maintained during their stay. The Bristol Royal Hospital for Children Patient Experience Group will review this data and identify further specific actions if necessary. A representative from the LIAISE[6]

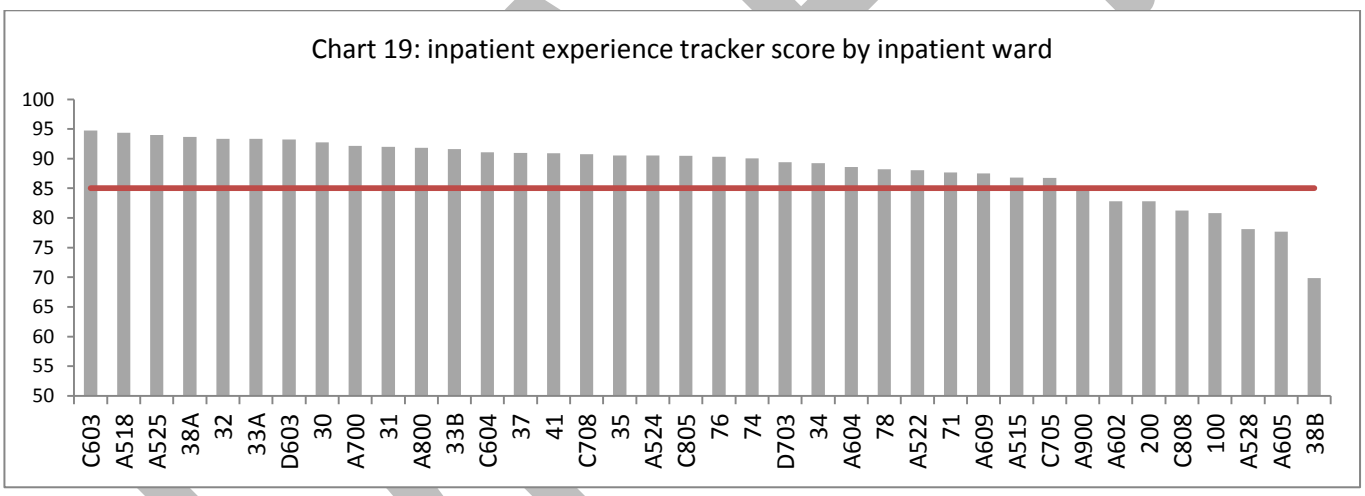
[5] Previous reports have often not been able to include Ward 38B because the number of responses is so low, but having now built up a "critical mass" it is possible to determine that the data is broadly reliable, if used with caution.
[6] The Listening Information Advice Involving Support and Experiences service.

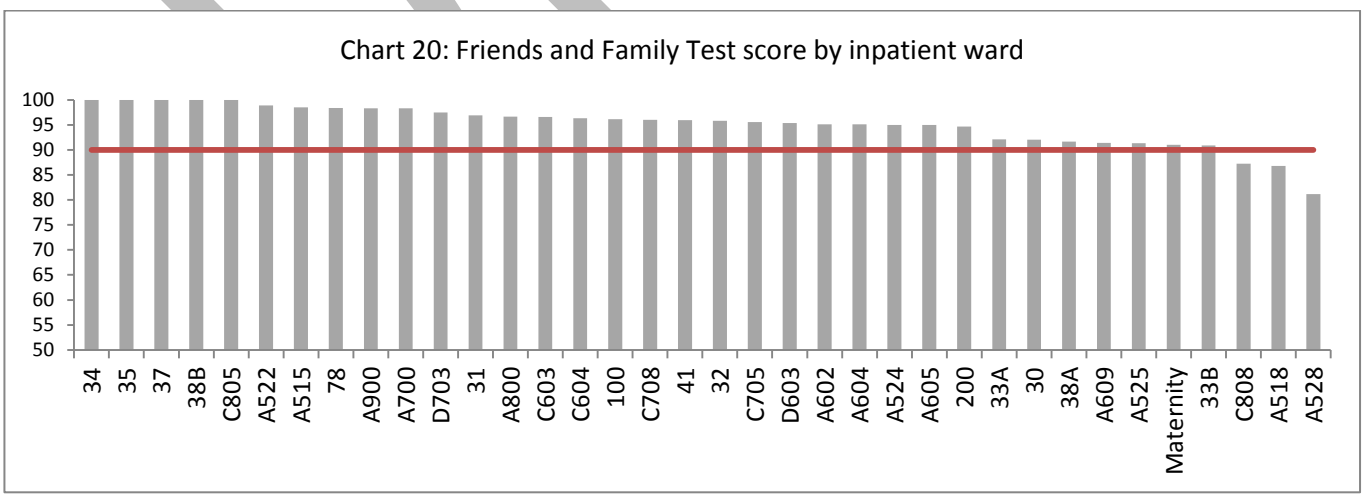
service at the Bristol Royal Hospital for Children will visit parents on the ward to discuss their experiences of care and identify improvements if necessary.

Wards C808 / A528

These Division of Medicine wards received relatively low scores on both the Friends and Family Test and inpatient experience tracker. Further information was provided in Section 3 (above) of this report.







5.2 Update on wards identified as outliers in Quarter 3

Table 3 provides an update on wards identified in the previous (Quarter 3) Patient Experience Report as having relatively low scores. All of the scores will continue to be monitored for sustained improvement.

Table 3: update on ward scores identified as outliers in Quarter 3

Area	Issue in Quarter 3	Quarter 4 Update
Ward A900	Low survey scores, primarily reflecting dissatisfaction among patients with Cystic Fibrosis.	The Trust's Face2Face interview team revisited the ward during Quarter 4 and found that patients were more positive about their care on A900. This has been corroborated by an improvement in the key survey scores in Quarter 4. The scores do still require further improvement and will continue to be monitored by the Division.
Ward A522	Low scores for this Hepatology ward on both the "kindness and understanding" and "inpatient tracker" survey measures, attributed to a number of ward moves during the period.	The moves involving this ward were completed in Quarter 3. As anticipated, this has resulted in more positive satisfaction scores for A522 during Quarter 4 (Charts 18-20).
Ward C604	The Cardiac Intensive Care Unit (ward C604) had the lowest Friends and Family Test score in Quarter 3, which we were unable to determine the reasons for at that time and did not reflect the usual scores (which were generally positive).	The score has reverted to normal during Quarter 4 and so Quarter 3 appears to have been a "statistical blip".

5.3 Specific issues raised via the Friends and Family Test

In a review of the Friends and Family Test[7], NHS England found that the most effective use of this survey was as a tool for identifying ward/department level "quick win" service improvements[8]. During Quarter 4, the UH Bristol Patient Experience and Involvement Team began trialling the central collation of actions that wards had undertaken in response to negative Friends and Family Test scores (i.e. where a respondent stated that they would not recommend the Trust to friends and family). It is important to note that the feedback received via the Friends and Family Test is overwhelmingly positive, and that when a negative rating is given it is often not accompanied by a comment that the ward can act upon (typically either because no usable comment is provided, or because the issue raised cannot be directly fixed by the staff on the ground[9]). Nevertheless, a number of Friends and Family Test responses received each month do provide this opportunity. Often this relates to a specific occurrence that can be shared as learning for the individual or team involved, but in some cases can also lead to interventions if the comment made by the respondent is sufficiently insightful and "actionable". For the first time in this Quarterly Report, a list of these actions is provided in Table 4. This work forms part of the wider developments that the Trust is undertaking around more effective use of patient feedback[10].

[7] https://www.england.nhs.uk/wp-content/uploads/2014/07/fft-rev1.pdf

[8] As opposed to surveys designed to be a robust measurement of patient experience over a longer time frame, such as UH Bristol's postal survey programme and the Care Quality Commission's national surveys.

[9] Such as waiting times in Emergency Departments - although all of this feedback is shared with the Divisions so that these wider themes can be seen.

[10] This will form a key theme of the Trust's new Quality Strategy.

Table 4: Divisional response to specific issues raised via the Friends and Family Test, where patients / parents stated that they would not recommend the care provided by UH Bristol

Division	Issue raised	Explanation from Division	Action
Division of Medicine	Ward A300 (Medical Assessment Unit) – two patients commented on the ward being cold	This has been an ongoing issue which has been raised with Facilities and Estates and Laing O'Rouke.	The heating has been altered and is currently being monitored by the Facilities and Estates Department. This has recently improved in both the bays and the cubicles.
	Receptionists in the Bristol Royal Infirmary Emergency Department could show more sympathy to patients.	The reception staff are aware of the Trust Values and the importance of being polite / welcoming to patients, but this comment provides an opportunity to reinforce this message.	The Team Lead for the reception area has shared this feedback to remind the team of this.
	A522 (Hepatology) negative comment about the food service.	Because of the high turnover new patients on this ward, new arrivals sometimes have to be given a choice from the meals that remain after the main service is completed. Unfortunately on this occasion the patient was unhappy with the food offered.	The ward staff do try to meet a patient's food requirements and often a member of staff will go to other wards if needed to obtain what the patient would like. This feedback has been shared with the ward.
	Communication about waiting times in the Emergency Department.	Although waiting times are a challenging issue to resolve, better communication with patients can go some way to alleviating the frustration of waiting.	New Design Council signage will be installed by August 2016, explaining the departmental processes and reasons for delays.
Division of Specialised Services	Ward D703 (Haematology) - room temperature (too cold) and lack of plugs in sinks.	Work has been underway to upgrade the glazing of the windows on D703. Sinks across the trust do not have plugs as they create an infection control risk.	To monitor progress on the glazing upgrade.
	C708 (Cardiology) – negative Friends and Family Test comment received about the food service staff.	These comments have been fed back directly to the hotel services team to discuss with their staff.	Continue to monitor feedback.
	Haematology Day Unit – negative comment about the clinical care received (including criticism of the name banding process).	The comment has been highlighted directly with the Ward Sister, and will be discussed at the Sisters' meeting. Further to this a name band audit has been undertaken across the Division which has shown excellent compliance.	Follow-up name band audit during Quarter 1 2016/17.
	D603 (Oncology) – negative comment about response times to the call button, and the body of a patient who had died not being removed quickly.	This comment has been fed back to the team directly. This concern was also dealt with directly at the time by the Matron.	No further actions.

Division	Issue raised	Explanation from Division	Action
Division of Surgery, Head and Neck	Ward A609 (Surgical Trauma and Assessment Unit) – patient waited 7 hours for transport home.	Acknowledging that this is an unacceptable wait, it is possibly more to do with the ambulance service and we do not know the additional workload of the service on this day.	Feedback shared with ward staff and staff reminded of the importance of ongoing communication with patients about waiting times.
	Bristol Eye Hospital Day Case – two comments about waiting times for surgery. One patient would have preferred to lie down during their wait.	Due to the layout of the area it would be impractical to have a cubicle with a trolley as suggested by one patient. Patients are assessed at pre-op regarding whether they can sit or whether they need a bed.	The matron will review the rationale for all patients to arrive at 7.30 a.m., as some patients do have a long wait after arrival.
	Ward A604 (Trauma and Orthopaedics) – negative comment received about Junior Doctors on the ward.	Feedback is generally very positive about staff and unfortunately this patient didn't specify what "incident" had occurred so that it could be investigated.	General feedback was provided to the clinical staff, but we were unable to identify specific individuals from the patient's feedback.
	A609 (Surgical Trauma and Assessment Unit) – negative Friends and Family comment about cleanliness of the ward and the responsiveness of staff.	A large number of shifts were covered by agency staff throughout March 2016, which unfortunately may have contributed to this poor experience.	Staff have been reminded to check bathrooms frequently. Patients are now asked to inform a nurse when they have finished using a bedpan in the bathroom, so that the specimen can be collected and measured immediately.
	Lack of signage in the Bristol Eye Hospital Emergency Department to ask patients to take a ticket on arrival.	There is signage for this but this patient has highlighted that improvements could be made.	Additional signs have been put in place.
Women's and Children's Division (Maternity)	Three negative Friends and Family Test comments were received for the Amelia Nutt community midwifery clinic – primarily relating to "communication".	The key underlying issue here is continuity of antenatal midwifery care. Many midwives are part time, which means that women often see a number of midwives during the antenatal period.	The feedback has been provided to the Amelia Nutt midwifery team to highlight the need for good communication. It has been agreed with the Bristol Clinical Commissioning Group that women will see a maximum of three midwives during their pregnancy.
	Ward 71 (postnatal ward) – "Our other child was crying so they asked us to leave."	It is unacceptable that this occurred. The Ward Sister has been informed and has discussed this with her team.	This experience has been shared with the ward team to ensure it does not occur again. No further action on this specific issue.
	Unknown postnatal ward – criticism of cleanliness ("left for an hour in blood and vomit") and attitude / behaviour of the Assistant who attended to this.	This is clearly an unacceptable experience. Unfortunately we do not have further specific information with which to follow this up with individual members of staff.	The Ward Sister has discussed this comment in the ward team meeting.

Division	Issue raised	Explanation from Division	Action
Women's and Children's Division (Bristol Royal Hospital for Children)	The feedback named a specific nurse in the Emergency Department whom the parent felt was insensitive.	This feedback has been discussed with the nurse directly.	No further action.
	Negative comment about the food service on Ward 38 (neurology).	We understand that this was caused by the kitchen fridge containing food and drink which had been brought in by parents. This conflicted with the Trust's policy of having clear "chill chain accountability" for items in its fridges.	This issue has now been resolved.
	Improve communication at handover on Ward 30 (paediatrics).	It is acknowledged by the hospital that communication at handover could be improved.	These comments have been fed back directly to the ward sister to ensure communication at handover is clear. Feedback will continue to be monitored to ensure that improvements are evident.
	Waiting time unacceptable for an ECG in hospital, particularly as the child had severe autism.	It is acknowledged that the needs of this patient and their family had not been properly met due to the hour-long delay they experienced.	This experience has been shared directly with the Sister on the Clinical Investigation Unit to ensure that patients with Learning Disabilities are known in advance of admission and plans put in place to meet their needs.
	Strong smell of smoke when Emergency Department exit doors are opened.	It is acknowledged that this is an issue.	This is an ongoing issue and we will work with the Estates Department to look at solutions. An update will be provided in the next Quarterly report.

6. Themes arising from inpatient free-text comments in the monthly inpatient survey

At the end of the Trust's postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. All comments are categorised, reviewed by the relevant Heads of Nursing, and shared with ward staff for wider learning. The over-arching themes from these comments are provided below. (Please note that "valence" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed)). The themes are by their nature very broad, but it can be seen that they are consistent across Divisions. By far the most frequent type of feedback is praise for staff, with the key improvement issues being around communication, staff behaviour and waiting times. Although these categories do not directly overlap with the way that the Trust classifies complaints, there are similarities between these issues (see accompanying Quarter 4 complaints report).

Table 5: inpatient survey comments by theme (Quarter 4 2016/17)

	Theme	*Valence*	*Percentage of comments containing this theme*
Trust (excluding maternity[11])	Staff	Positive	64%
	Communication	Negative	16%
	Staff	Negative	10%
Division of Medicine	Staff	Positive	59%
	Communication	Negative	14%
	Staff	Negative	12%
Division of Specialised Services	Staff	Positive	63%
	Communication	Negative	16%
	Staff	Negative	8%
Division of Surgery, Head and Neck	Staff	Positive	65%
	Communication	Negative	17%
	Waiting / delays	Negative	10%
Women's and Children's Division (excluding Maternity)	Staff	Positive	69%
	Communication	Negative	15%
	Staff	Negative	10%
Maternity	Staff	Positive	62%
	Communication	Negative	15%
	Staff	Negative	13%

7. National Patient Surveys

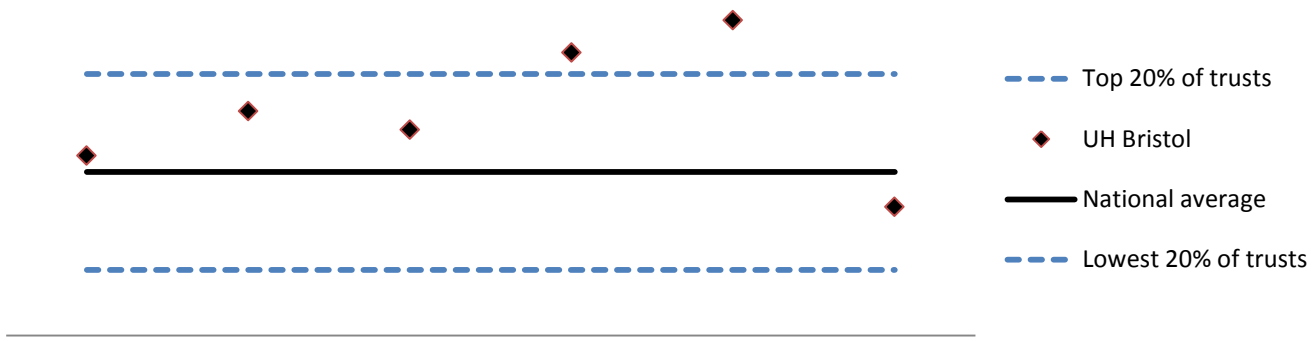
The Care Quality Commission's (CQC's) National Patient Survey programme is a mandatory survey programme for acute English trusts. It provides a robust national benchmark against which the patient experience at UH Bristol can be compared to other organisations. Chart 21 (over) provides an overview of UH Bristol's performance in these surveys, based on respondents' overall rating of their experience. It can be seen that the Trust had strong performances in the most recent national maternity and Accident and Emergency surveys, and that inpatient care tends to be slightly above the national average (although this is not to a statistically significant degree). UH

[11] The maternity comments have a slightly different coding scheme to the other areas in Table 5.

Bristol's performance in the National Cancer Survey is therefore a negative outlier in this respect. A significant programme of improvement work has been carried out in response to the National Cancer Survey and the next set of results is due in Quarter 2 2016/17.

The Trust Board receives a full report containing the results of each national survey and UH Bristol's action plan in response (see Appendix A). The next set of results that the Board receives will be for the 2015 National Inpatient Survey, which will be presented in July 2016.

Chart 21: Comparison of UH Bristol patient satisfaction to the national average



The Care Quality Commission recently released a report that considered whether the national-level scores in the national inpatient survey had improved over the course of ten years (2005-2014)[12]. The answer, for the great majority of questions in the survey, was that the scores were generally good but that they had essentially been static over this period. The exceptions were primarily around hospital cleanliness, single-sex wards, and patients being asked about the quality of their care, which showed relatively large improvements in the survey scores[13]. These findings mirror UH Bristol's own national inpatient survey results, although UH Bristol also saw significant improvements in food quality ratings. The Care Quality Commission is currently running a consultation about the national survey programme, and UH Bristol will participate in this process.

[12] https://www.cqc.org.uk/content/trends-adult-inpatient-survey-2005-2014

[13] Although the large majority of patients still reported that they did not get asked about the quality of their care. Some further scores did see a small improvement, which were statistically significant due to the very large sample sizes at that level, but would have had little impact for the average patient attending hospital.

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

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2014 National Inpatient Survey	57/60 scores were in line with the national average. One score was below (availability of hand gels) and two were above (explaining risks and benefits and discharge planning)	July 2015	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Explaining potential medication side effects to patients at discharge	May 2016
2015 National Maternity Survey	9 scores were in line with the national average; 10 were better than the national average	March 2016	Six-monthly	• Continuity of antenatal care • Partners staying on the ward • Care on postnatal wards	January 2018
2013 National Cancer Survey	30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average	November 2014	Six-monthly	• Providing patient-centred care • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	July 2016
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	March 2017
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	No longer part of the national programme

Appendix B – UH Bristol corporate patient experience programme

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

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before leaving hospital, all adult inpatients, day case, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view.
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

Appendix C: survey scoring methodologies

Postal surveys

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

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

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

Friends and Family Test Score

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 4, 2015/2016

(1st January 2016 to 31st March 2016)

Author: Tanya Tofts, Patient Support and Complaints Manager

Overview

Successes	Priorities
• Surgery Head & Neck – zero complaints about nursing/midwifery staff or clinical care from nursing/midwifery staff; reduction in complaints received by the Upper GI service • Medicine – increase in informal resolution of complaints • Specialised Services – zero complaints in respect of access or facilities and environment issues or with regards to attitude of medical or nursing staff; reduction in complaints received by Bristol Heart Institute Outpatients and the Chemotherapy Day Unit/Outpatients Women's & Children's Services – reduction in the number of complaints received in respect of cancelled or delayed appointments/operations for the second successive quarter • Training has been rolled out by the Patient Support & Complaints Team tailored to the theme of how to write a good response letter (sessions are currently arranged through to September 2016) • Recovery in overall response rate performance towards the end of Q4	• Continue to improve the quality of response letters and in doing so, reduce the amount of dissatisfied cases • Reduce the number of complaint responses that breach the agreed deadline • Reduce the number of cases where the deadline agreed with the complainant is extended • Scope out detail of corporate quality objective for 2016/17 to reduce the number of people who complain about aspects of how we communicate with them (focus on telephone communications) • Refresh Complaints and Concerns Policy, with focus on customer care
Opportunities	**Risks & Threats**
• Continue to provide training sessions on how to write a good response letter, across all Divisions • Review learning from national complaints symposium attended in June 2016 – in particular, explore potential to record severity of complaints to enable future benchmarking • For next report (Q1), include more information about local learning from upheld PHSO cases • Patient Support & Complaints Manager to continue working closely with Divisions in order to identify themes and trends in complaints and to share learning from complaints Trust-wide	• Complaints investigations and responses not being given appropriate priority due to other conflicting pressures • Managers not responding to informal complaints in a timely manner • Managers responsible for investigating complaints and drafting response letters not having received the most up to date training on this topic • Q4 increase in complaints about attitude and communication in Women's & Children's Services. No common themes identified – continue to monitor.

1. Complaints performance – Trust overview

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

- Total complaints received as a proportion of activity;
- Proportion of complaints responded to within timescale; and
- Numbers of complainants who are dissatisfied with our response.

1.1 Total complaints received

The Trust's preferred way of expressing the volume of complaints it receives is as a proportion of patient activity, i.e. total inpatient admissions and outpatient attendances in a given month.

We received 476 complaints in Q4, which equates to 0.24% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff. The number of complaints received in Q4 represents an increase of approximately 7% compared to Q3 and an 8% decrease on the corresponding period one year previously.

Figure 1 shows the increase in the number of complaints received in Q4 (2015/16) compared to Q3 and the decrease when compared to the corresponding period last year. Figure 2 shows the complaints received as a percentage of patient activity and Figure 3 shows the numbers of complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process.

1.2 Complaints responses within agreed timescale

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

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q4, 74.6% of responses were posted within the agreed timescale, compared to 56.5% in Q3 and 83.9% in Q2. This represents 31 breaches out of 122 formal complaints which were due to receive a response during Q4[2]. Figure 4 shows the Trust's performance in responding to complaints since January 2015. By March 2016, performance had recovered to 86.1%.

[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

Figure 1: Number of complaints received

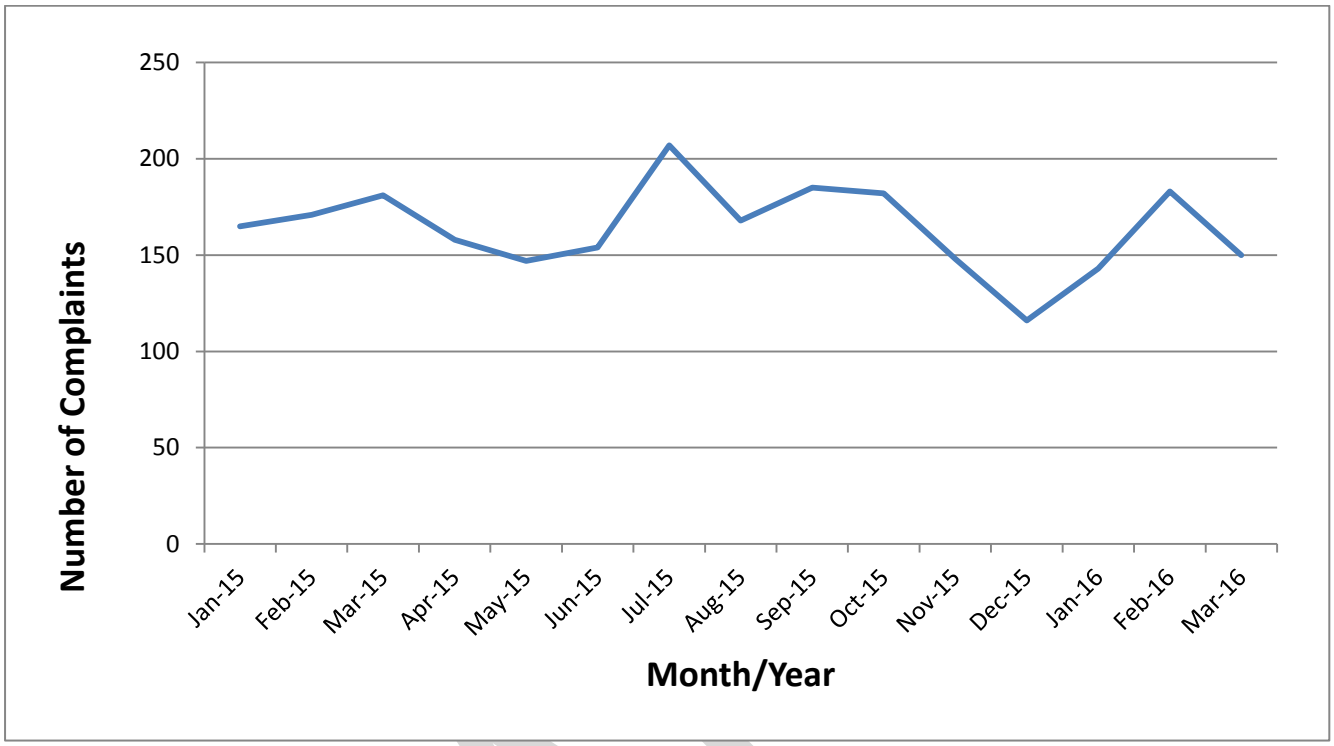


Figure 2: Complaints received, as a percentage of patient activity

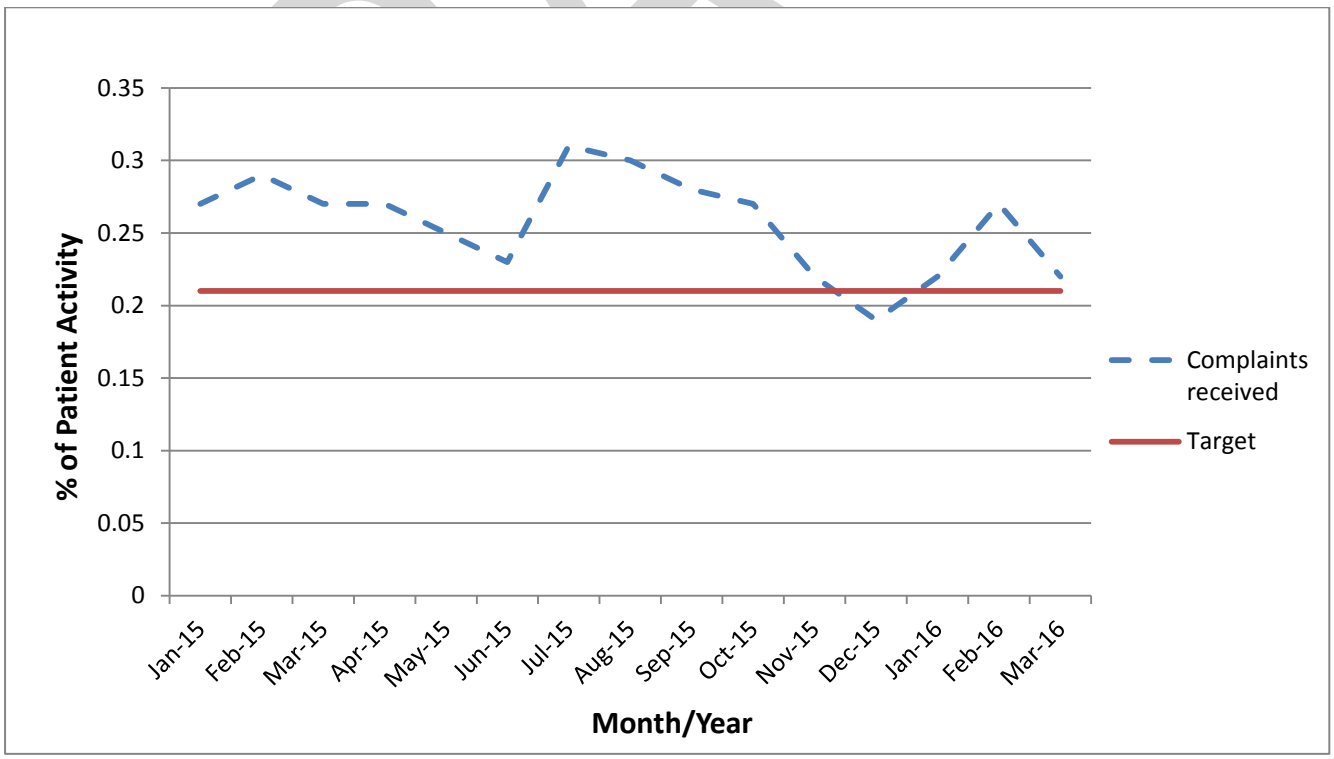


Figure 3: Numbers of formal v informal complaints

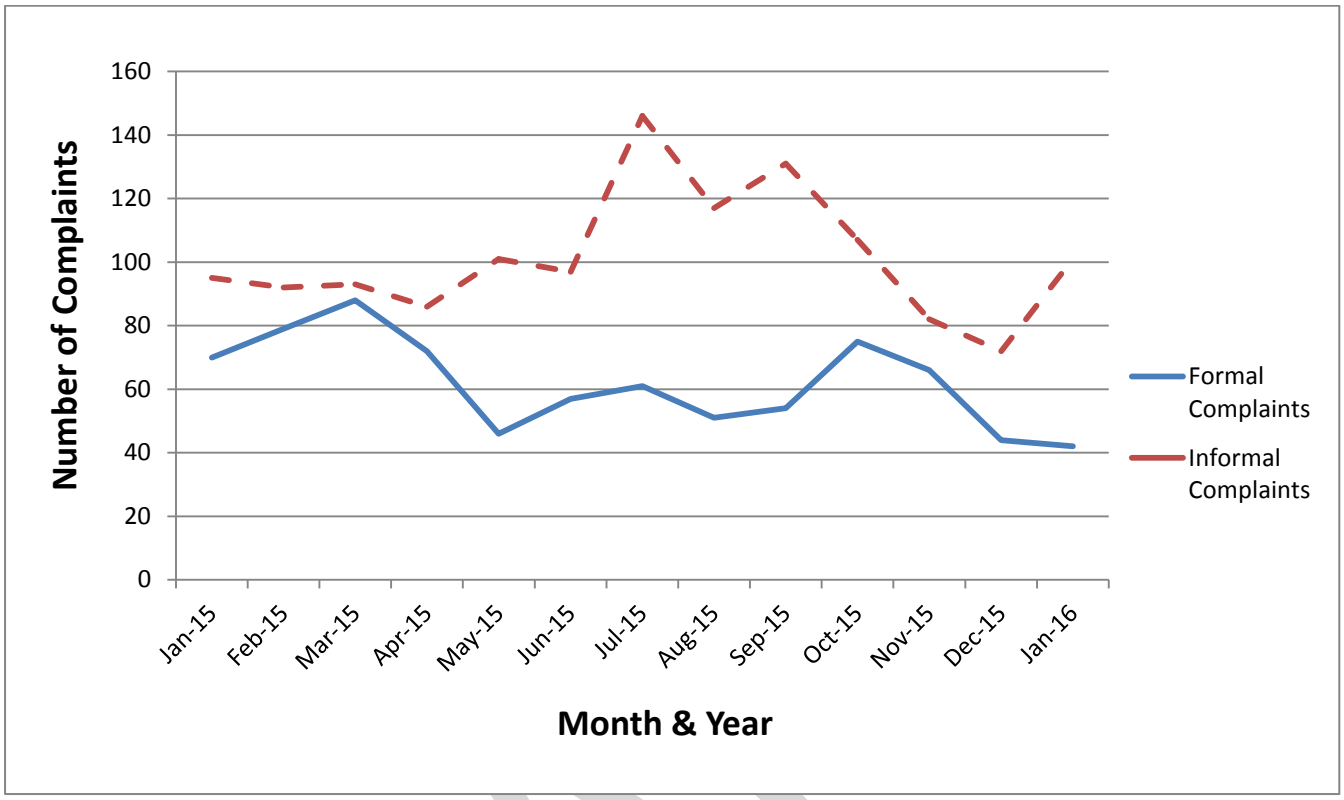


Figure 4: Percentage of complaints responded to within agreed timescale

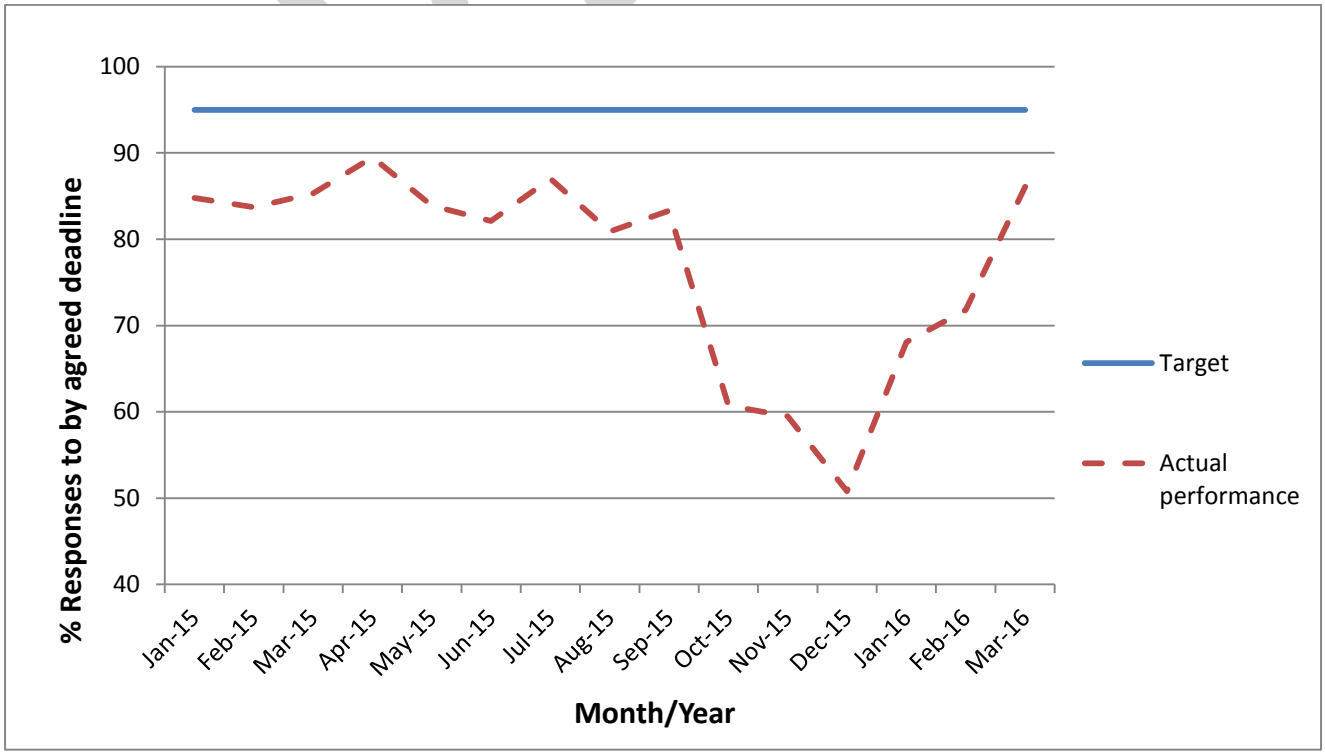


Table 1: Complaints performance

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

		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Total complaints received (inc. TS and F&E from April 2013)	TOTAL	181	158	147	154	207	168	185	182	148	116	143	183	150
	Formal	88	72	46	57	61	51	54	75	66	44	42	39	40
	Informal	93	86	101	97	146	117	131	107	82	72	101	144	110
Number and % of complaints per patient attendance in the month	%	0.27%	0.27%	0.25%	0.23%	0.31%	0.30%	0.28%	0.27%	0.22%	0.19%	0.22%	0.27%	0.22%
	Complaints	181	158	147	154	207	168	185	182	148	116	143	183	150
	Attendances	66,317	59,419	58,716	66,548	65,810	55,657	66,285	68,131	67,434	61,126	63,582	68,391	67,932
% responded to within the agreed timescale (i.e. response posted to complainant)	%	85.3%	89.5%	83.9%	82.1%	87.0%	80.9%	83.3%	60.7%	59.5%	50.8%	68.1%	71.8%	86.1%
	Within timescale	58	51	52	55	47	38	40	34	25	32	32	28	31
	Total	68	57	62	67	54	47	48	56	42	63	47	39	36
% responded to by Division within required timescale for executive review	%	92.6%	87.7%	91.9%	94.0%	98.1%	93.6%	95.8%	80.4%	81.0%	90.5%	91.5%	84.6%	100.0%
	Within timescale	63	50	57	63	53	44	46	45	34	57	43	33	36
	Total	68	57	62	67	54	47	48	56	42	63	47	39	36
Number of breached cases where the breached deadline is attributable to Division	Attributable to Division	8	3	9	6	6	3	2	7	7	20	12	10	5
	Total Breaches	10	6	10	12	7	9	8	22	17	31	15	11	5
Number of extensions to originally agreed timescale (formal investigation process only)		7	7	21	16	11	14	10	23	13	26	21	14	25
% of complainants dissatisfied with response and case re-opened	%	-	1.8%	1.6%	9.0%	13.0%	12.8%	16.7%	10.7%	4.8%	7.9%	6.4%	7.7%	-
	Reopened Dissatisfied	-	1	1	6	7	6	8	6	2	5	3	3	-
	Total Responses Due	-	57	62	67	54	47	48	56	42	63	47	39	-

1.3 Dissatisfied complaints

Reducing numbers of dissatisfied complainants was one of the Trust's corporate quality objectives for 2015/16 and remains a priority moving into 2016/17. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are then dissatisfied with the quality of our investigation into and response to their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation to that we do not make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint[3].

The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month. From Q3 2015/16 onwards, our target has been for less than 5% of complainants to be dissatisfied.

In Q4, a total of 122 responses were sent out. By the cut-off point of mid-May 2016 (the date on which the dissatisfied data for March 2016 was finalised), nine people had contacted us to say they were dissatisfied with our response. This represents 7.4% of the responses sent out and is an increase on the 6.2% (10 of 161) reported in Q3. Figure 5 shows the percentage of complainants who were dissatisfied with aspects of our complaints response.

Each case where a complainant advises they are dissatisfied, the case is reviewed by the Patient Support and Complaints Manager. This review leads to one of the following courses of action, according to the complainant's preference:

- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues;

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

- A letter is sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of asking the Ombudsman to independently review their complaint.

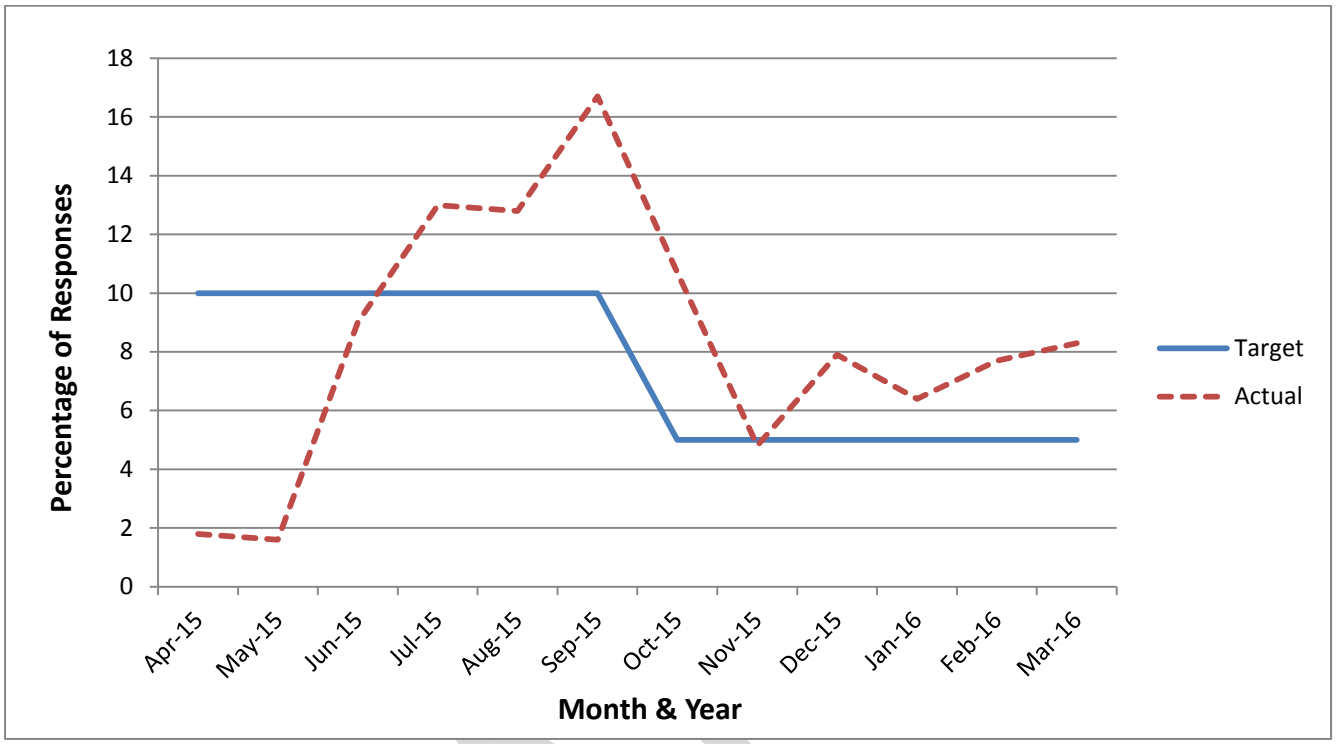
In the event that we do not have enough information to initiate the process outlined above, the allocated caseworker from the Patient Support and Complaints Team will contact the complainant to clarify which issues remain unresolved and, where possible, identify some specific questions that the complainant wishes to be answered. Following this, the process noted above would then be followed.

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

In the event that a complainant comes back to us again, having received two responses (whether in writing or by way of a meeting), the case will be escalated to the Chief Nurse for review.

[3] Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

Figure 5: Percentage of complainants dissatisfied with complaint response



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major categories, or themes. Table 2 provides a breakdown of complaints received in Q4 compared to Q3. Complaints in all categories, except 'clinical care' and 'access' increased in Q4 in real terms. Most notably, complaints about 'attitude and communication' increased by a third, following a previous reduction in Q3.

Table 2: Complaints by category/theme

Category/Theme	Number of complaints received in Q4 (2015/16)	Number of complaints received in Q3 (2015/16)
Access	7 (1% of total complaints) ↓	9 (2% of total complaints) ↓
Appointments & Admissions	150 (32%) ↑	139 (31%) ↓
Attitude & Communication	154 (33%) ↑	125 (28%) ↓
Clinical Care	112 (23%) ↓	127 (29%) ↑
Facilities & Environment	25 (5%) ↑	23 (5%) ↓
Information & Support	28 (6%) ↑	23 (5%) ↓
Total	**476**	**446**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 3 lists the eight[4] most consistently reported sub-categories. In total, these sub-categories account for approximately 65% of the complaints received in Q4 (307/476).

[4] Please note that an eighth sub-category of 'attitude of admin/clerical staff' has been included for the first time in Q4 as the number of complaints received in this sub-category is now greater than for 'attitude of nursing/midwifery staff'

Table 3: Complaints by sub-category

Sub-category	Number of complaints received in Q4 (2015/16)	Q3 2015/16	Q2 2015/16	Q1 2015/16
Cancelled/delayed appointments and operations	111 (8% increase compared to Q3)	103	151	124
Communication with patient/relative	62 (51% increase)	41	31	33
Clinical Care (Medical/Surgical)	41 (24% decrease)	54	48	49
Failure to answer telephones/failure to respond	29 (71% increase)	17	22	34
Clinical Care (Nursing/Midwifery)	25 (39% increase)	18	20	24
Attitude of Medical Staff	18 (13% increase)	16	24	11
Attitude of Admin/Clerical Staff	13 (44% increase)	9	10	6
Attitude of Nursing Staff	8 (38% decrease)	13	14	10

Complaints about cancelled or delayed appointments or operations/procedures have increased slightly from 103 in Q3 to 111 in Q4. This consists of 69 complaints about cancelled or delayed appointments and 42 complaints about cancelled or delayed operations/procedures.

Most notably, however, there was a 51% increase in the number of complaints received in Q4 about communication with patients or relatives, with 62 complaints received compared to 41 in Q3. Complaints in respect of failure to answer telephones or to respond to patients also saw a significant increase from 17 complaints in Q3 to 29 in Q4.

Figures 6, 7, and 8 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since January 2015. These graphs suggest an improving trend in respect of complaints about clinical care (medical/surgical), but a deteriorating trend for complaints about communication with patients/relatives. One of the Trust's corporate quality objectives for 2016 is to reduce complaints about failures in communication.

Figure 6: Cancelled or delayed appointments and operations

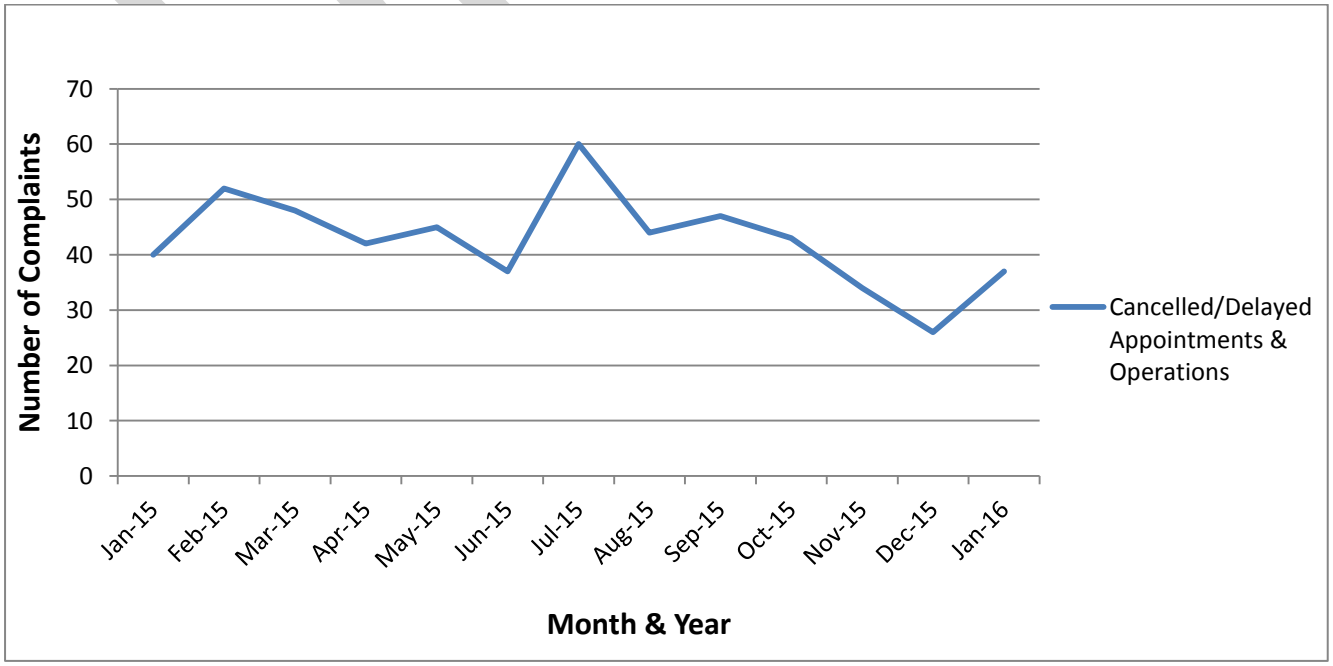


Figure 7: Clinical care – medical/surgical

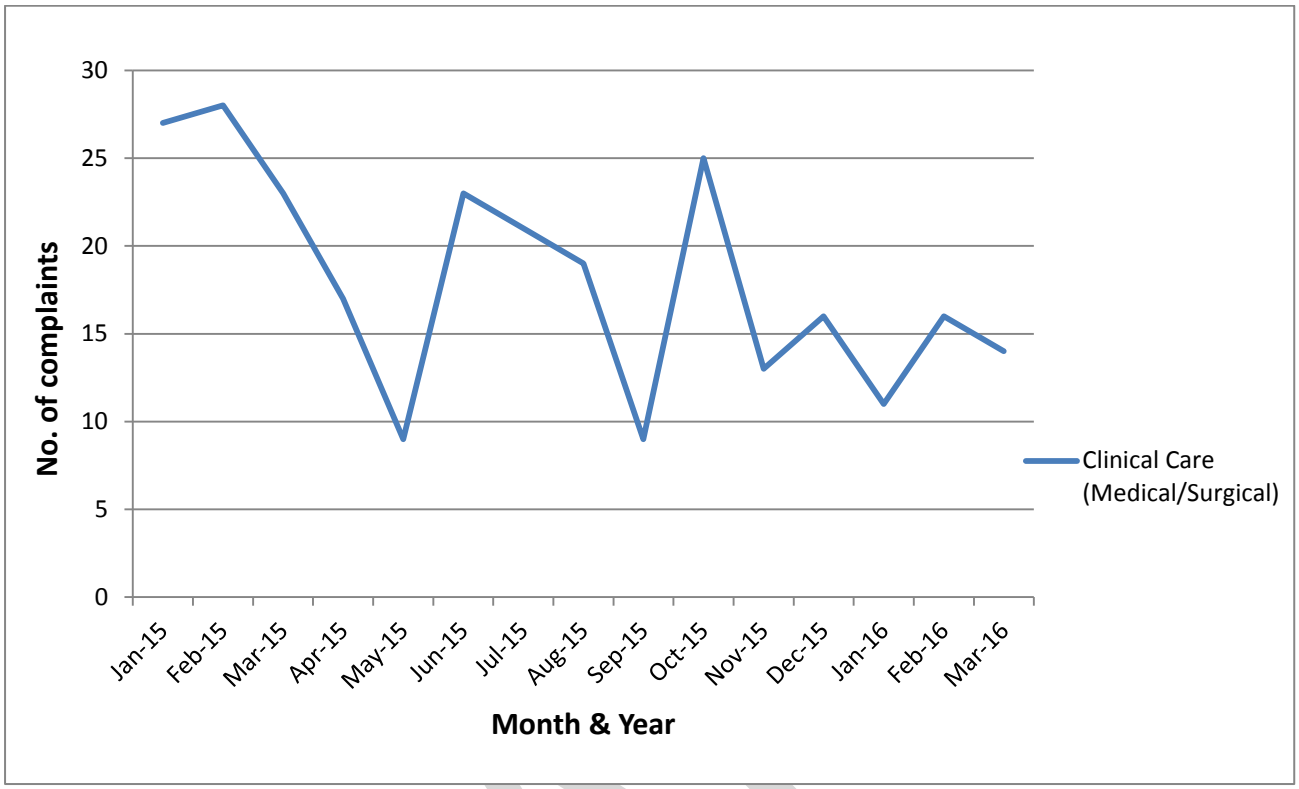
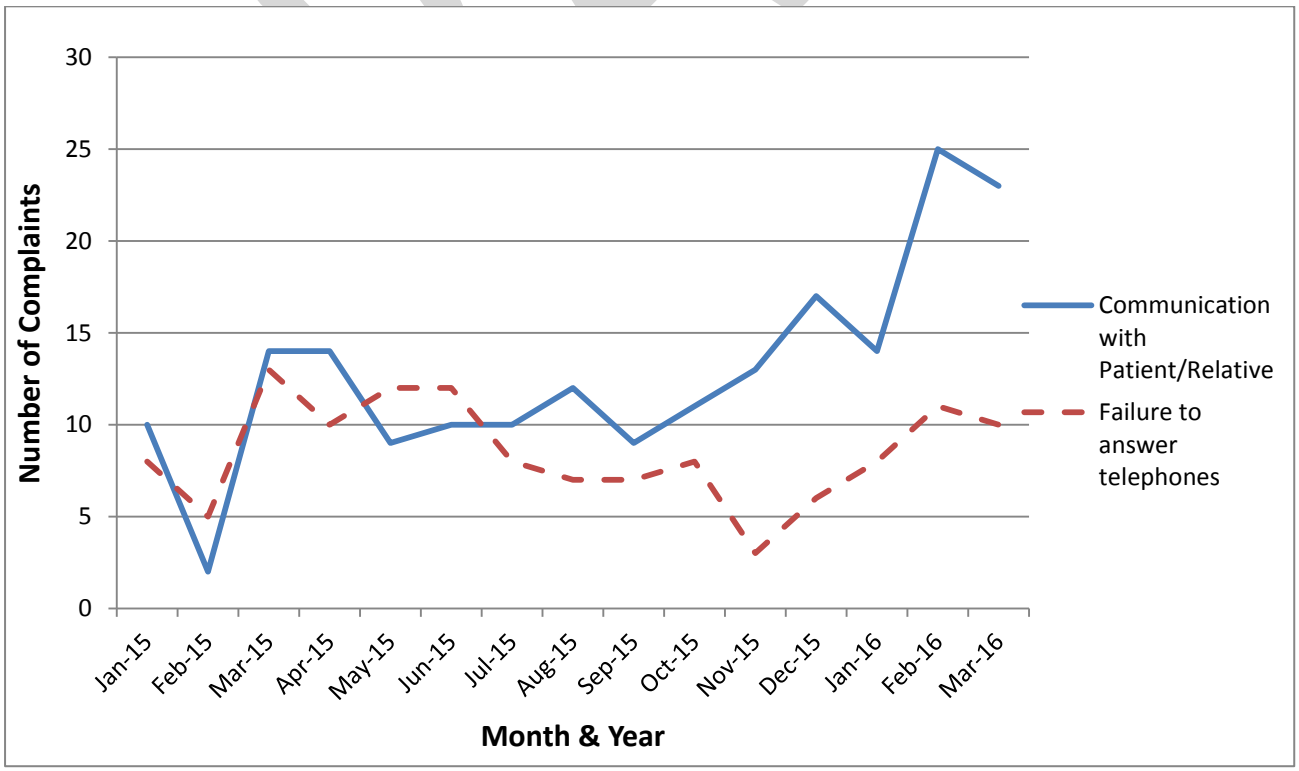


Figure 8: Communication with patient/relative and telephone answering

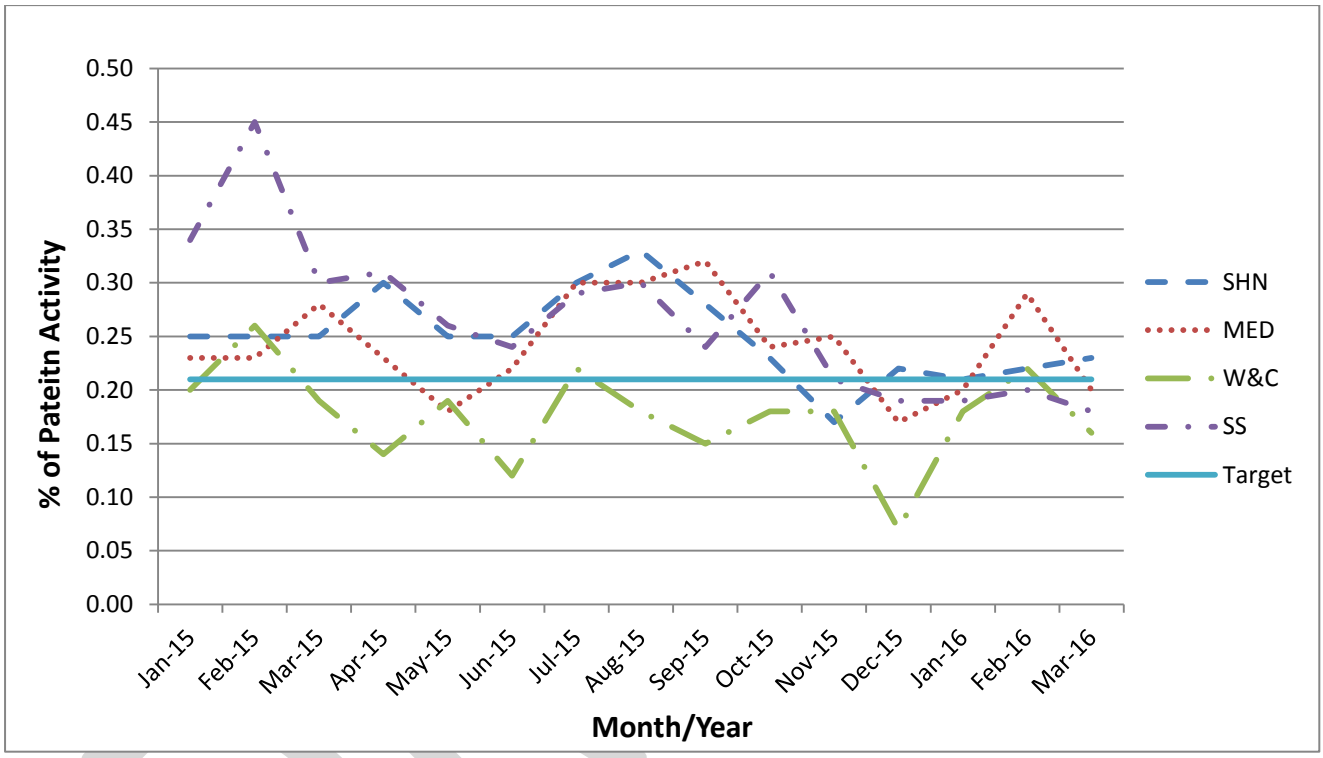


3. Divisional performance

3.1 Total complaints received

A divisional breakdown of the percentage of complaints per patient attendance is provided in Figure 9. This shows an overall increase in the volume of complaints received in the bed holding Divisions during Q4, with only Specialised Services showing a decrease in the number of complaints received.

Figure 9: Complaints by Division as a percentage of patient attendance



It should be noted that data for the Division of Diagnostics and Therapies is excluded from Figure 9 because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Overall, reported Trust-level data includes Diagnostics and Therapies complaints, but it is not appropriate to draw comparisons with other Divisions. For reference, numbers of reported complaints for the Division of Diagnostics and Therapies since January 2015 have been as follows:

Table 4: Complaints received by Division of Diagnostics and Therapies

	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
No. of complaints received	7	5	11	2	5	7	10	4	5	12	5	7	5	13	6

3.2 Divisional analysis of complaints received

Table 5 provides an analysis of Q4 complaints performance by Division[5]. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 5	**Surgery, Head & Neck**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**
Total number of complaints received	182 (169) ↑	102 (94) ↑	49 (59) ↓	87 (67) ↑	24 (24) =
Total complaints received as a proportion of patient activity	0.22% (0.20%) ↑	0.23% (0.22%) ↑	0.19% (0.24%) ↓	0.18% (0.14%) ↑	N/A
Number of complaints about appointments and admissions	80 (70) ↑	19 (17) ↑	21 (21) ↓	23 (25) ↓	6 (6) =
Number of complaints about staff attitude and communication	56 (48) ↑	40 (38) ↑	11 (15) ↓	30 (10) ↑	11 (7) ↑
Number of complaints about clinical care	35 (38) ↓	28 (35) ↓	14 (19) ↓	29 (27) ↑	6 (8) ↓
Area where the most complaints have been received in Q4	Bristol Eye Hospital - 52 (49) Bristol Dental Hospital – 44 (31) Trauma & Orthopaedics - 34 (31) ENT - 17 (13) Thoracic Surgery - 7 (4)	Emergency Department (BRI) – 25 (14) Gastroenterology & Hepatology - 11 (7) Ward A300 (AMU) - 7 (4) Ward A800 - 6 (4)	BHI Outpatients - 15 (16) GUCH Services - 9 (10)	Gynaecology Outpatients – 9 (2) Paediatric Neurology - 7 (9) Paediatric Orthopaedics - 7 (4) Ward 31 - 5 (1)	Radiology – 12 (10) Pharmacy – 7 (5)
Notable deteriorations compared to Q3	Bristol Dental Hospital - 44 (31)	Emergency Department (BRI) - 25 (14) Dermatology - 19 (8)	None	Gynaecology Outpatients - 9 (2) Antenatal Clinic - 6 (1)	None
Notable improvements compared to Q3	Upper GI - 6 (14)	Respiratory - 1 (5)	Chemo Day Unit / Outpatients - 2 (9)	Children's ED & Ward 39 - 4 (9)	None

[5] It should be noted that the overall percentage of complaints against patient activity as shown in Table 5 differs slightly from the overall Trust percentage of 0.24% as the latter includes complaints from non-bed-holding Divisions.

3.2.1 Division of Surgery, Head & Neck

Most notably in Q4, the number of complaints received by Bristol Eye Hospital and Bristol Dental Hospital remained high and there was an increase in the number of complaints received about communication with patients/relatives. However, no complaints at all received in respect of attitude of nursing/midwifery staff or clinical care from nursing/midwifery staff throughout the Division.

Table 6: Complaints by category type

Category Type	Number and % of complaints received – Q4 2015/16	Number and % of complaints received – Q3 2015/16
Access	2 (1.1% of total complaints) =	2 (1.2% of total complaints) ↓
Appointments & Admissions	80 (44%) ↑	71 (42%) ↓
Attitude & Communication	56 (30.8%) ↑	48 (28.4%) ↓
Clinical Care	35 (19.2%) ↓	38 (22.5%) ↓
Facilities & Environment	4 (2.2%) ↑	3 (1.8%) ↓
Information & Support	5 (2.7%) ↓	7 (4.1%) ↓
Total	**182**	**169**

Table 7: Top sub-categories

Category	Number of complaints received – Q4 2015/16	Number of complaints received – Q3 2015/16
Cancelled or delayed appointments and operations	69 (16.9% increase compared to Q3) ↑	59 (33% decrease compared to Q2) ↓
Clinical Care (Medical/Surgical)	14 =	14 =
Communication with patient/relative	24 (60% increase) ↑	15 (25% increase) ↑
Attitude of Medical Staff	9 (12.5% increase) ↑	8 (33.3% increase) ↑
Attitude of Nursing/Midwifery	0 (100% decrease) ↓	2 (75% decrease) ↓
Clinical Care (Nursing/Midwifery)	0 (100% decrease) ↓	2 (77.8% decrease) ↓
Failure to answer telephones	9 (50% increase) ↑	6 (60% decrease) ↓

Table 8: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
There has been an increase in the number of complaints received in respect of attitude and communication (56 complaints compared to 48 in Q3) and in particular, a 60% increase in complaints about communication with	Within the Eye Hospital, this has been identified as concerns/dissatisfaction from patients regarding their diagnosis and the treatment plan presented. Within Trauma &	Actions to be taken include: • In all cases, feedback has been provided to the clinical areas regarding the complaints received and the themes identified. Themes identified are already raised at Divisional and specialty

patients/relatives. Of the complaints in respect of attitude and communication, 23 were about the BEH; eight were received by Trauma and Orthopaedics; seven were for the BDH and three each were received for ward A800 and ENT outpatients.	Orthopaedics, the complaints all relate to delays in surgery, waiting for admissions and failure to respond to telephone calls promptly. Within A800, three complaints related to communication with family members and one was around the discharge process.	governance meetings and at the Surgery, Head & Neck Divisional Board. • A Division-wide secret shopper exercise is to be undertaken in August regarding the answering of telephones. • During July 2016, a review will be undertaken on A800 as to the way the communications between healthcare professionals and the patient/relative are recorded and documented.
Complaints received about the Bristol Dental Hospital increased from 31 in Q3 to 48 in Q4, with 20 of these being about Adult Restorative Dentistry and six in respect of Child Dental Health.	All complaints relate to diagnosis and the treatment plan presented to the patient.	The Divisional governance lead and matron will investigate this pattern of concerns.
Trauma & Orthopaedics complaints remained high at 34 (compared to 31 in Q3). The majority of these complaints (15) were in respect of cancelled or delayed appointments or procedures, with five about failure to answer telephones and three regarding clinical care (medical/surgical).	Five of these complaints were about telephone calls not being answered promptly. This has been identified and discussed in previous reports and was attributed to staff vacancies. In respect of cancelled/ delayed appointments, the Division continues to focus on ensuring timely discharges and review of pathways to ensure capacity for patient admissions is available.	Trauma & Orthopaedics has been identified as an area with increased complaints relating to telephone calls. Since May 2016, the area has been fully staffed and the number of complaints will be monitored.

Figure 10: Surgery, Head & Neck – formal and informal complaints received

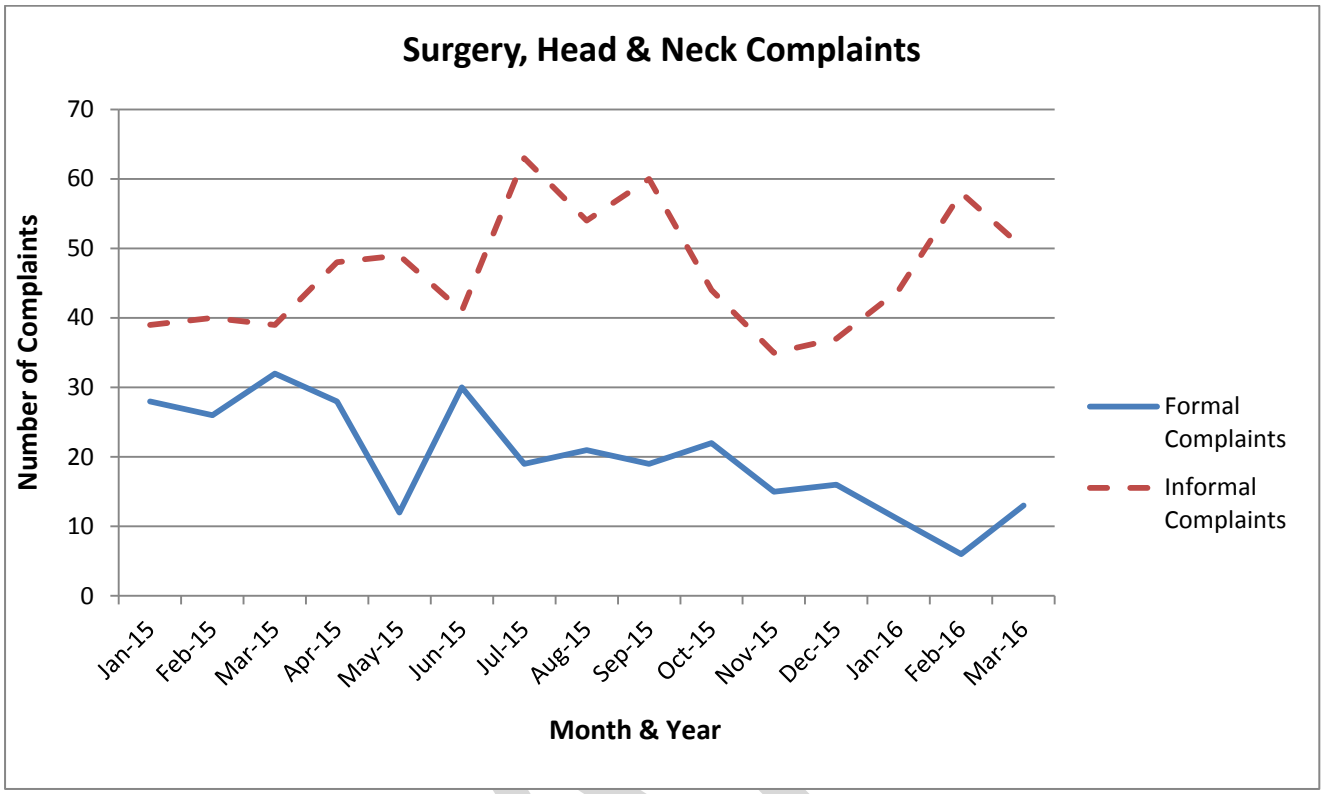
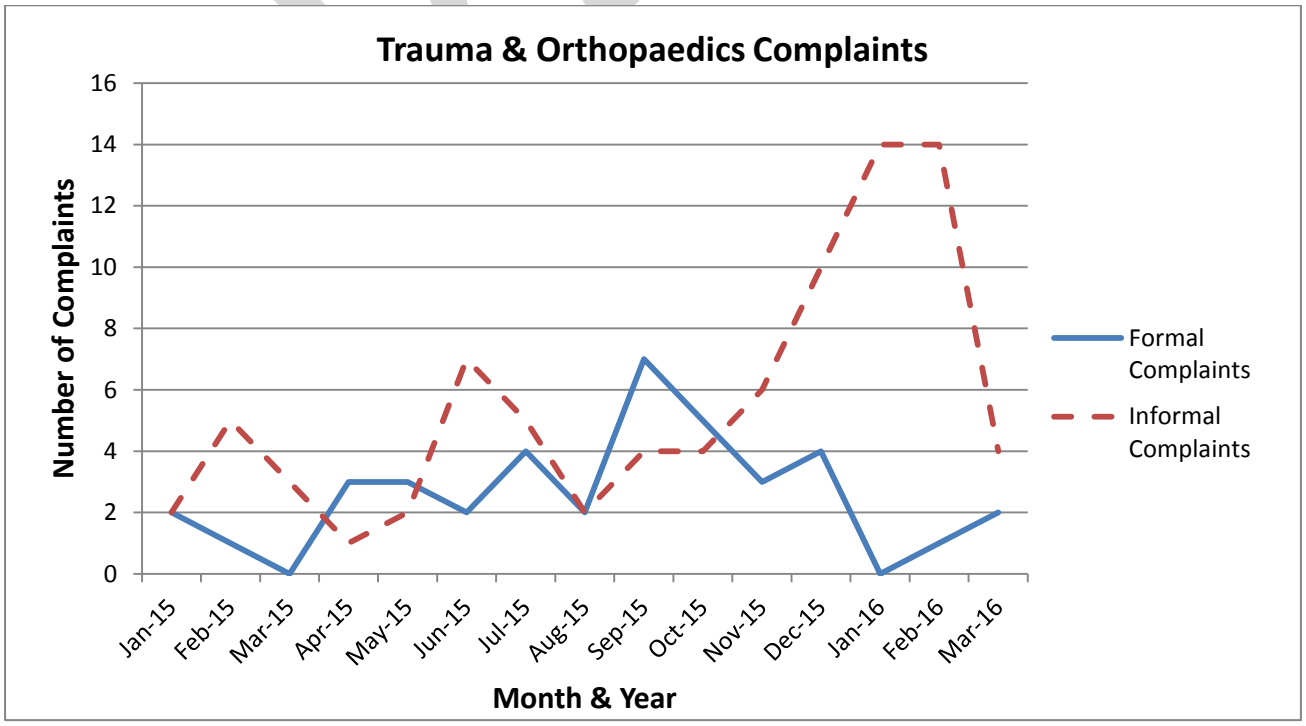


Figure 11: Complaints received by Trauma & Orthopaedics



3.2.2 Division of Medicine

Most notably in Q4, the number of complaints received by the BRI Emergency Department and the Dermatology service remained high and there was an increase in the number of complaints received under all category types, with the exception of clinical care. The majority of complaints continued to be resolved via the informal complaints (76 compared to 26 managed through the formal process).

Table 9: Complaints by category type

Category Type	Number and % of complaints received – Q4 2015/16	Number and % of complaints received – Q3 2015/16
Access	1 (1% of total complaints) ↑	0 (0% of total complaints) ↓
Appointments & Admissions	19 (18.6%) ↑	16 (17%) ↓
Attitude & Communication	40 (39.2%) ↑	36 (38.3%) ↑
Clinical Care	28 (27.5%) ↓	33 (35.1%) ↑
Facilities & Environment	8 (7.8%) ↑	4 (4.3%) ↓
Information & Support	6 (5.9%) ↑	5 (5.3%) ↓
Total	**102**	**94**

Table 10: Top sub-categories

Category	Number of complaints received – Q4 2015/16	Number of complaints received – Q3 2015/16
Cancelled or delayed appointments and operations	12 (71.4% increase compared to Q3) ↑	7 (68.2% decrease compared to Q2) ↓
Clinical Care (Medical/Surgical)	8 (55.6% decrease) ↓	18 (157.1% increase) ↑
Communication with patient/relative	12 (14.3% decrease) ↓	14 (55.6% increase) ↑
Attitude of Medical Staff	6 (100% increase) ↑	3 (40% decrease) ↓
Attitude of Nursing/Midwifery	4 (50% decrease) ↓	8 (100% increase) ↑
Clinical Care (Nursing/Midwifery)	12 (71.4% increase) ↑	7 (16.7% increase) ↑
Failure to answer telephones	9 (50% increase) ↑	6 (200% increase) ↑

Table 11: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The ED received 25 complaints in Q4, compared with 14 in Q3. Of these 25 complaints, 10 were in respect of attitude and communication; seven were about clinical care, four were about information and support and there were two each related to facilities and environment and appointments and admissions.	Q4 saw sustained pressure in the ED, often with patients queuing to get into the department. This will have had an impact on the positive patient experience we would wish for our patients, many of whom waited for longer than the target four hours.	The new communications board for the ED waiting room is being developed and funding has been agreed. This will help those waiting to understand the delays and improve the experience of those in the department.
Dermatology saw a significant increase in complaints received, from eight in Q3 to 19 in Q4. Most significantly, 13 of the 19 complaints were in respect of attitude and communication.	All are informal complaints and mostly relate to access to or changed appointments and finding it difficult to make contact with the department. This has been impacted on by changes to appointments due to the junior doctors' strikes and performance issues of one of the administrative team.	The performance issues are being addressed via formal HR routes and the impact of the junior doctors' strikes should now be resolved and will not have a further impact.
Ward A300 (AMU) received seven complaints in Q4, compared to four in Q3. Six of these complaints related to clinical care and one was in respect of facilities and environment.	There are no common themes within these six clinical complaints; they were diverse in nature and each one involved a different clinical team.	Local action plans have been agreed and delivered where necessary.

Figure 12: Medicine – formal and informal complaints received

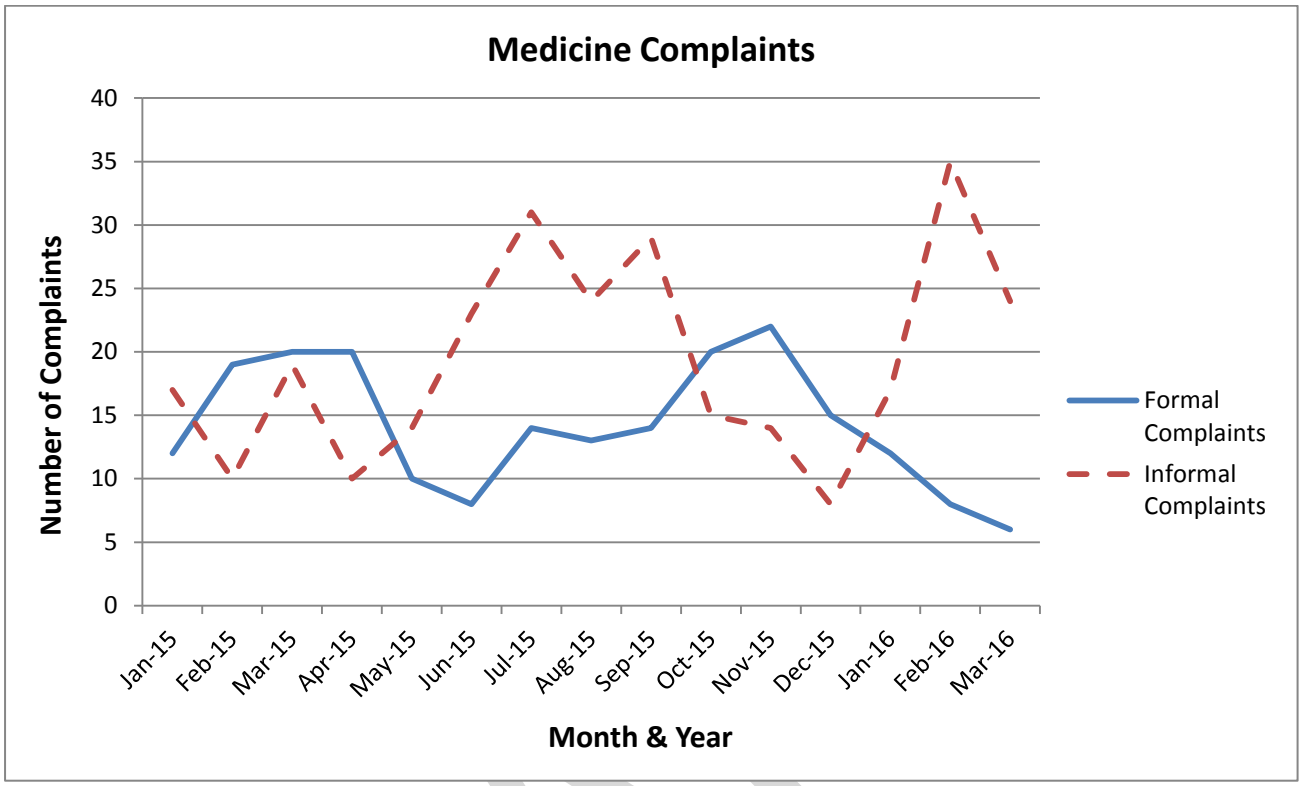
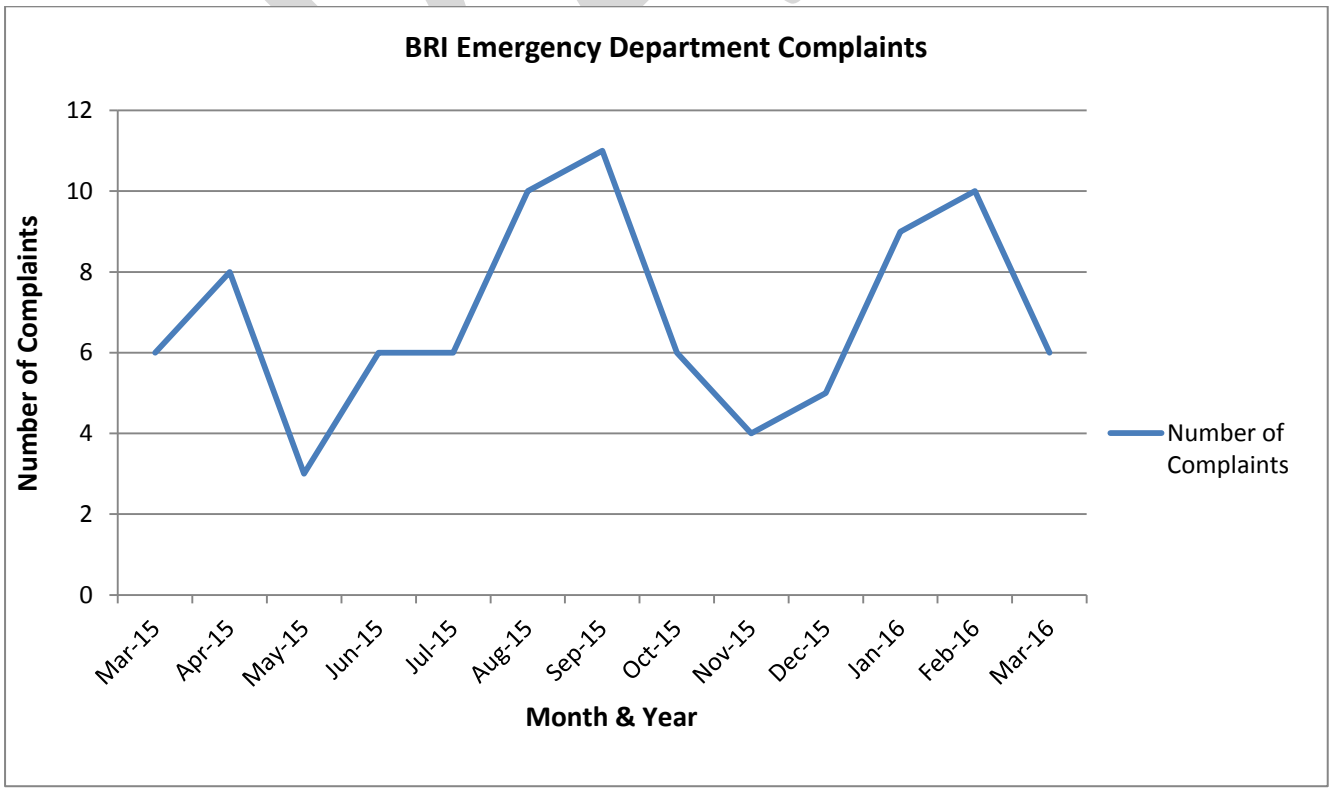


Figure 13: Complaints received by BRI Emergency Department



3.2.3 Division of Specialised Services

In Q4, the Division did not receive any complaints in respect of access or facilities and environment issues or with regards to attitude of medical or nursing staff. Additional positive points to note are the reduction in the number of complaints received by Bristol Heart Institute Outpatients and the Chemotherapy Day Unit/Outpatients.

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q4 2015/16	Number and % of complaints received – Q3 2015/16
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	21 (42.9%) =	21 (35.6%) ↓
Attitude & Communication	11 (22.4%) ↓	15 (25.4%) ↓
Clinical Care	14 (28.6%) ↓	18 (30.5%) ↑
Facilities & Environment	0 (0%) ↓	2 (3.4%) ↓
Information & Support	3 (6.1%) =	3 (5.1%) ↓
Total	**49**	**59**

Table 13: Top sub-categories

Category	Number of complaints received – Q4 2015/16	Number of complaints received – Q3 2015/16
Cancelled or delayed appointments and operations	16 (14.3% increase compared to Q3) ↑	14 (26.3% increase compared to Q2) ↑
Clinical Care (Medical/Surgical)	5 (44.4% decrease) ↓	9 (28.6% increase) ↑
Communication with patient/relative	3 (50% decrease) ↓	6 (500% increase) ↑
Attitude of Medical Staff	0 (100% decrease) ↓	1 (80% decrease) ↓
Attitude of Nursing/Midwifery	0 =	0 =
Clinical Care (Nursing/Midwifery)	3 =	3 (200% increase) ↑
Failure to answer telephones	3 =	3 (57.1% decrease) ↓

Table 14: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
21 complaints were received about appointments and admissions. Of the complaints recorded under this category, five were in respect of delayed appointments at the BHI; four were about delayed operations or procedures at BHI; two were related to admissions arrangements at the BHI and two were regarding delayed procedures at BHOC.	Of the five complaints about delayed appointments, one related to a patient awaiting a cardiac surgery outpatient appointment, two were related to cardiac device checks, one was about a delay with an MRI scan appointment and one was in respect of a cardiology outpatient appointment. The four delayed operations or procedures reported highlight an extended wait for ablations and patient foramen ovale (PFO) closures. NHS England allocates a set number of PFO closures it is able to undertake within a 12 month period. The Division has undertaken the allotted numbers of procedures and is awaiting the allocation for the new financial year.	The Division has reduced the waiting times for ablation procedures from 52 weeks to 40 weeks over the last few months. The Division is working closely with the Spire Hospital in addition to implementing weekend waiting list initiatives to further reduce the waiting time for this procedure. The Deputy Divisional Director has communicated to NHS England that there are further patients awaiting PFO closures.

Figure 14: Specialised Services – formal and informal complaints received

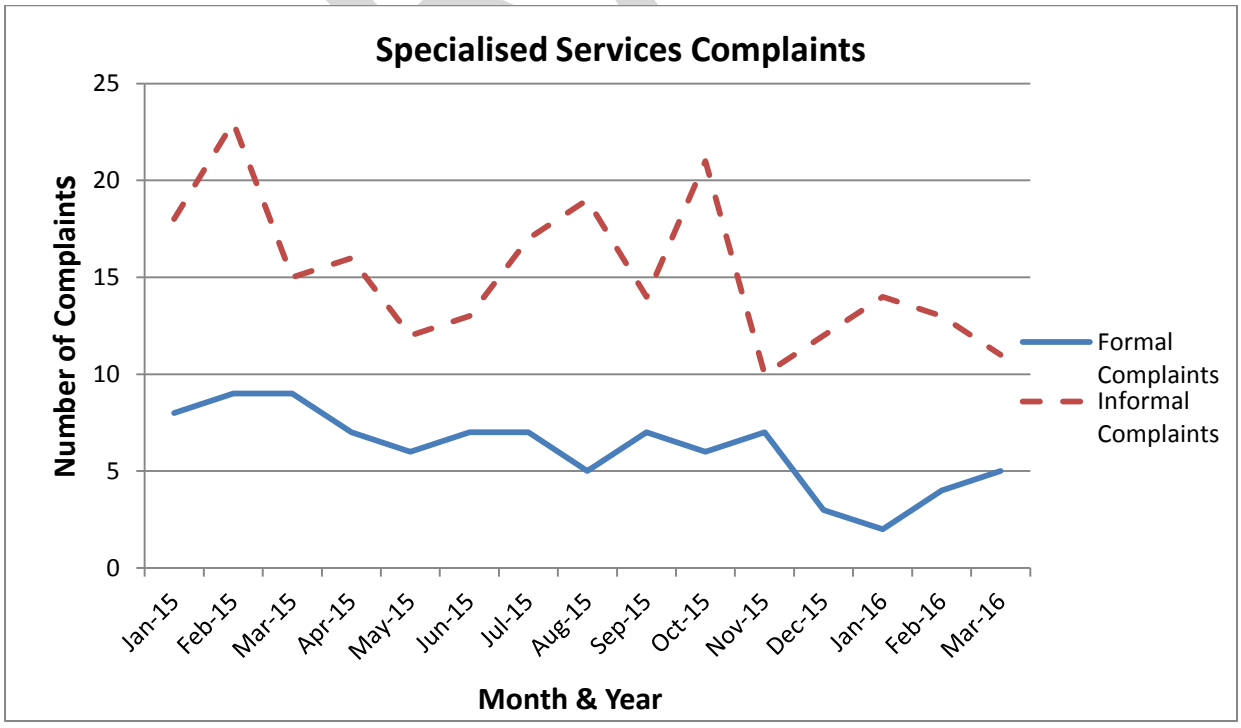
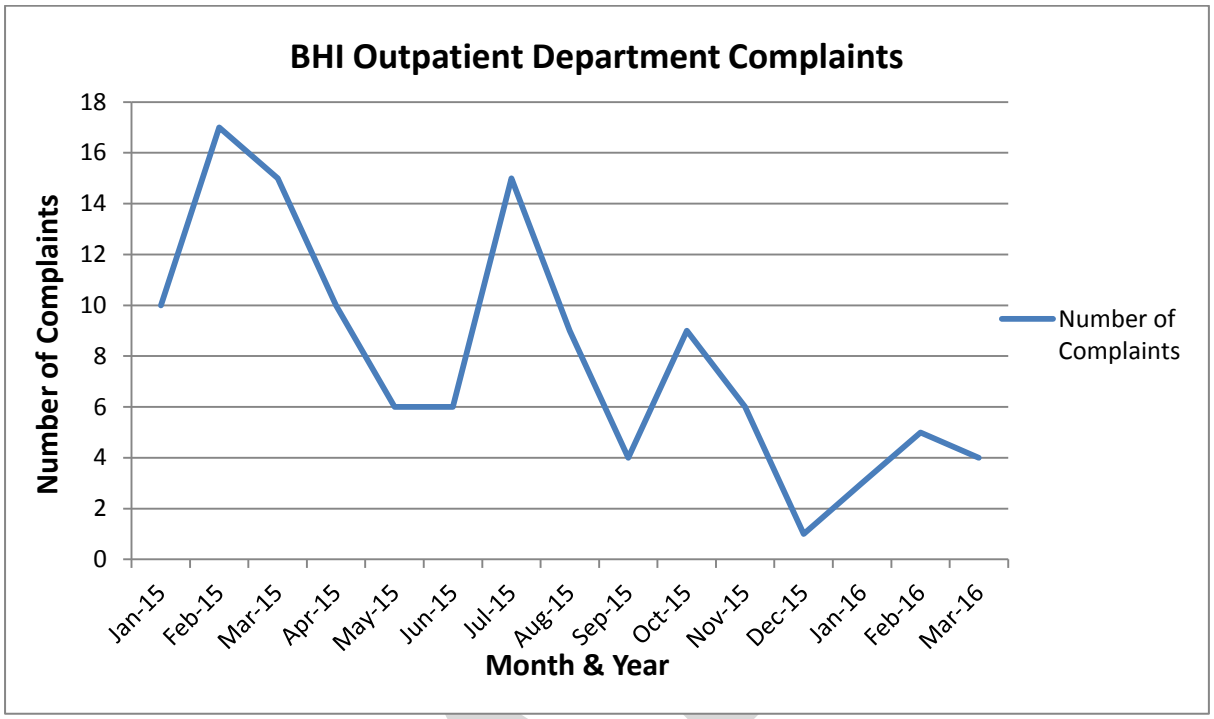


Figure 15: Complaints received by BHI Outpatients



3.2.4 Division of Women's and Children's Services

Most notably in Q4, the Division saw a significant increase in complaints about attitude and communication, however there was also a sizeable reduction in the number of complaints received in respect of cancelled or delayed appointments/operations for the second successive quarter.

Table 15: Complaints by category type

Category Type	Number and % of complaints received – Q4 2015/16	Number and % of complaints received – Q3 2015/16
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	23 (26.4%) ↓	26 (38.8%) ↓
Attitude & Communication	30 (34.5%) ↑	11 (16.4%) ↓
Clinical Care	29 (33.3%) ↑	27 (40.3%) ↑
Facilities & Environment	2 (2.3%) =	2 (3%) =
Information & Support	3 (3.4%) ↑	1 (1.5%) ↓
Total	**87**	**67**

Table 16: Top sub-categories

Category	Number of complaints received – Q4 2015/16	Number of complaints received – Q3 2015/16
Cancelled or delayed appointments and operations	12 (36.8% decrease compared to Q3) ↓	19 (24% decrease compared to Q2) ↓
Clinical Care (Medical/Surgical)	12 =	12 (9.1% increase) ↑
Communication with patient/relative[6]	18 (260% increase) ↑	5 (28.6% decrease) ↓
Attitude of Medical Staff	2 (33.3% decrease) ↓	3 (50% decrease) ↓
Attitude of Nursing/Midwifery	3 (50% increase) ↑	2 (33.3% decrease) ↓
Clinical Care (Nursing/Midwifery)	10 (66.7% increase) ↑	6 (20% increase) ↑
Failure to answer telephones	1 =	1 ↑

Table 17: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
In Q4, there was a significant increase in the number of complaints relating to attitude and communication, with 30 complaints compared to 11 in Q3. 17 of complaints in this category were received by BRHC and 13 by STMH. Communication with patient/relative accounted for 18 of these complaints; four were in respect of attitude of nursing/midwifery staff and three were regarding attitude of medical staff.	**St Michael's Hospital** Many of the complaints received were in respect of complex clinical care and women having a misunderstanding of what had happened to them or their baby. Some of the patients do not always understand what has been communicated to them or they have unrealistic expectations about what can be offered or what labour will be like. There were also some issues raised with regards to the role of the ambulance service attending a BBA (born before arrival) and the requirement for a midwife to attend. Q4 complaints were also	**St Michael's Hospital** Encouragement will continue to be given to midwives to debrief patients about their labour. A meeting is being organised with the ambulance service to discuss the issues identified about the role of the community midwives in cases where the baby is BBA. Attempts are currently underway to arrange this meeting for August 2016. Learning from complaints is part of the midwifery specific patient safety day, which midwives attend every other year.

[6] The other twelve complaints about attitude and communication were made up of four complaints about the attitude of nursing/midwifery staff, three about the attitude of medical staff, two about failure to answer telephones and one each about confidentiality, attitude of administrative staff and attitude of another patient.

	affected by dissatisfaction expressed by BRI 'outlier' patients who were accommodated at St Michael's Hospital during a period of acute winter pressures. **Bristol Royal Hospital for Children** In Q3, the Division received a total of 67 complaints, against patient attendance of 46,316 (0.14%). During Q4, it was an incredibly busy period and winter pressures were high. The Division received a total of 87 complaints against patient attendances of 47,546 (0.17%). The formal and informal complaints received that related to attitude and communication were spread across many specialties (over 15 individual areas) with no discernible trends identified.	**Bristol Royal Hospital for Children** Complaints received are shared with the teams or individuals involved, who investigate these and reflect and share learning. Themes are reviewed and will be actioned through the Bristol Royal Hospital for Children's Patient Experience Group which has multi-specialty staff membership.
The Division received 10 complaints about clinical care provided by nursing/midwifery staff.	These complaints were spread across various departments without a discernible trend, other than that one was received by BRHC and the remaining nine were received by STMH.	N/A

Figure 16: Women & Children – formal and informal complaints received

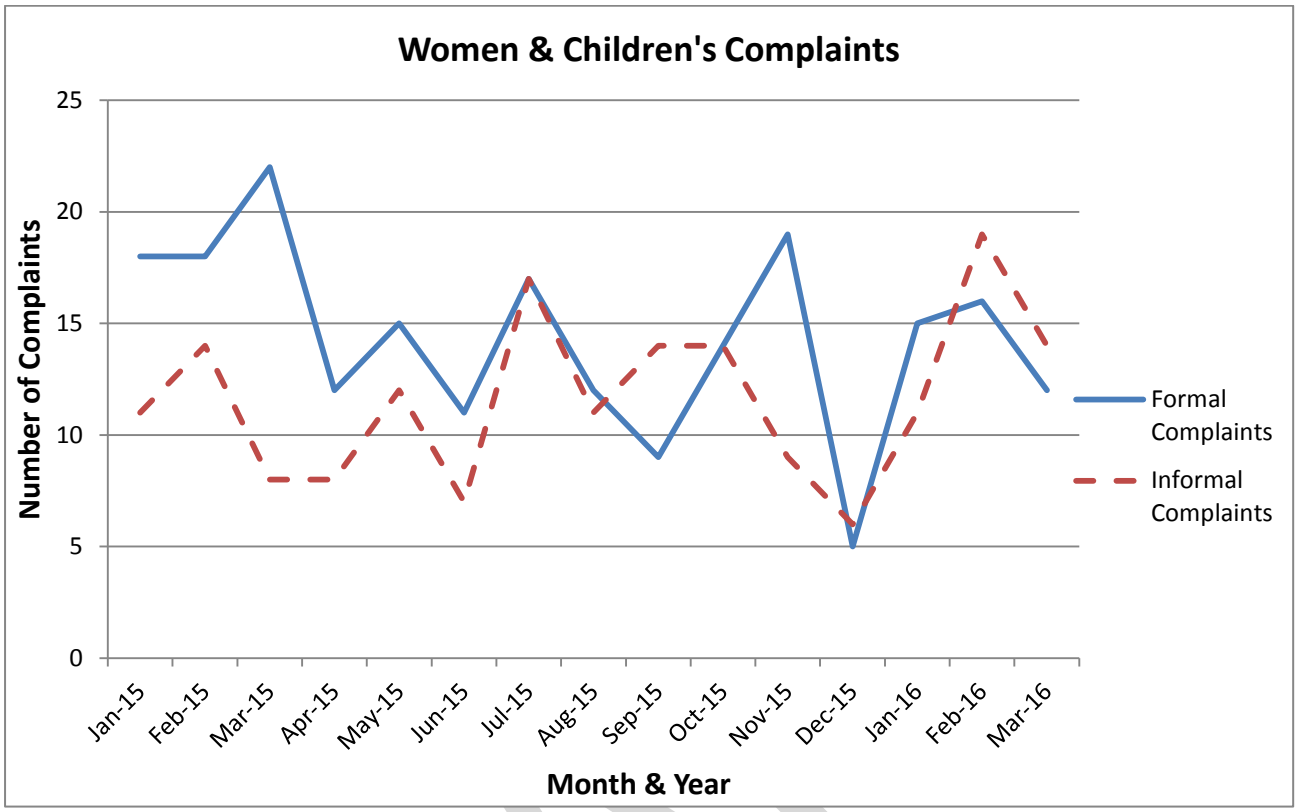
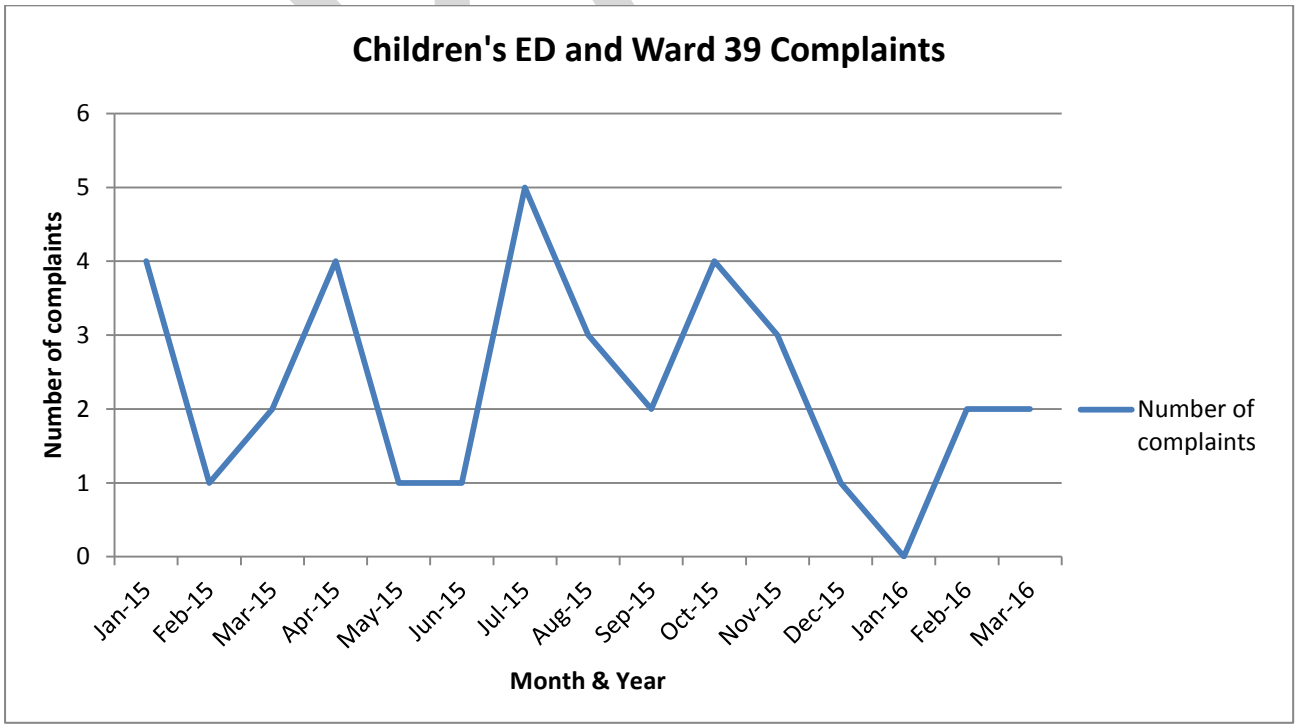


Figure 17: Complaints received by Children's Emergency Department and Ward 39[7]



[7] Ward 39 is included with the Emergency Department as it provides observational care to patients attending the Emergency Department.

3.2.5 Division of Diagnostics & Therapies

Most notably in Q4, the Division saw an increase in complaints about Radiology and Pharmacy services (Trust-wide). In common with all other Divisions (except Specialised Services), the Division received an increased number of complaints in relation to attitude and communication.

Table 18: Complaints by category type

Category Type	Number and % of complaints received – Q4 2015/16	Number and % of complaints received – Q3 2015/16
Access	0 (0% of total complaints)	0 (0% of total complaints =
Appointments & Admissions	6 (25%) =	6 (25%) =
Attitude & Communication	11 (45.8%) ↑	7 (29.2%) ↑
Clinical Care	6 (25%) ↓	8 (33.3%) ↑
Facilities & Environment	0 (0%) ↓	2 (8.3%) ↑
Information & Support	1 (4.2%) =	1 (4.2%) ↑
Total	**24**	**24**

Table 19: Top sub-categories

Category	Number of complaints received – Q4 2015/16	Number of complaints received – Q3 2015/16
Cancelled or delayed appointments and operations	6 (50% increase compared to Q3) ↑	4 (33.3% decrease compared to Q2) ↓
Clinical Care (Medical/Surgical)	2 (100% increase) ↑	1 (75% decrease) ↓
Communication with patient/relative	4 (300% increase) ↑	1 (50% decrease) ↓
Attitude of Medical Staff	0 (100% decrease) ↓	1 (50% decrease) ↓
Attitude of Nursing/Midwifery	0 (100% decrease) ↓	1
Clinical Care (Nursing/Midwifery)	0 =	0 =
Failure to answer telephones	2 (100% increase) ↑	1 ↑

Table 20: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Radiology services received 12 complaints in total for Q4, seven of which were formal and 5 informal. There were five complaints in respect of attitude and communication; four about appointments and admissions; two regarding clinical care and one in respect of information and support.	The complaints in respect of radiology services were spread across the Trust with five being in respect of BRI Radiology, four about radiology services at the Children's Hospital and one each about Bristol Haematology & Oncology Centre, the MRI scanner and the BRI ultrasound.	All complaints were thoroughly investigated through either the formal or informal complaints process and the following actions have been taken: • Staff are undertaking regular audits to ensure no duplicate requests for scans are made; • Patient leaflets have been redesigned to reiterate the possible side effects of taking bowel preparations prior to scans; • The radiology administration manager has reiterated the importance of complying with the Trust values to all administrative staff; • An action plan has been developed to improve referral processes and referring electronically through ICE where possible, rather than sending paper referrals; • Changes have been made to a patient information leaflet about scans, with the help of the patient involved in the complaint; • Capacity has been increased in order to speed up the turnaround of radiology reporting.

Adult Therapies received three complaints in Q4, all of which were dealt with via the informal process.	One of these complaints was in respect of attitude and communication; one was about clinical care and one was regarding appointments and admissions. The clinical care complaint related to a patient feeling they had not been fully assessed in physiotherapy.	All complaints have been thoroughly investigated and apologies issued where appropriate. In one case the patient advised that they had been waiting for 30 weeks when in fact they had been waiting for four weeks and one patient was contacted on the Monday and an apology issued after they had failed to get through to the department on the Friday. The patient had received a full assessment on three separate occasions. The patient did not attend they last appointment and did not respond to the department's attempts to resolve the complaint.
Audiology received three complaints in Q4, two of which were dealt with informally and one formally.	Two of the complaints were regarding attitude and communication and one was in respect of appointments and admissions. One complaint was in respect of a potential breach of patient confidentiality.	As a result of these complaints, the following actions have been taken: • Appointment letters have been updated to include clearer directions to the department; signage to the audiology department has been improved. A formal investigation found no evidence of information being provided to a third party. Information Governance and IM&T were involved in the investigation.

Pharmacy received 3 complaints in Q4, two of which were dealt with through the formal complaint process and one through the informal process.	Two complaints were received in respect of clinical care, both of which related to the BRHC pharmacy. One complaint was regarding attitude and communication and was about the Boots pharmacy at the BRI.	All complaints were thoroughly investigated and apologies issued where appropriate. As a result of the complaints, the following actions have been taken: • Additional safeguards have been agreed and put in place across all hospital dispensaries; • A new process has been agreed between the Trust and one of its external providers regarding dosage checking.
There was a significant increase in the number of complaints in Q4 relating to attitude and communication. Five of these complaints were received by radiology services, three by adult therapy services and two by the audiology service.	The individual complaints have been investigated.	The Division is establishing a Clinical Quality Committee which will review complaints/trends and patient experience to ensure themes and learning are being shared and actioned across the whole Division, as well as within individual services.

Figure 18: Diagnostics and Therapies – formal and informal complaints received

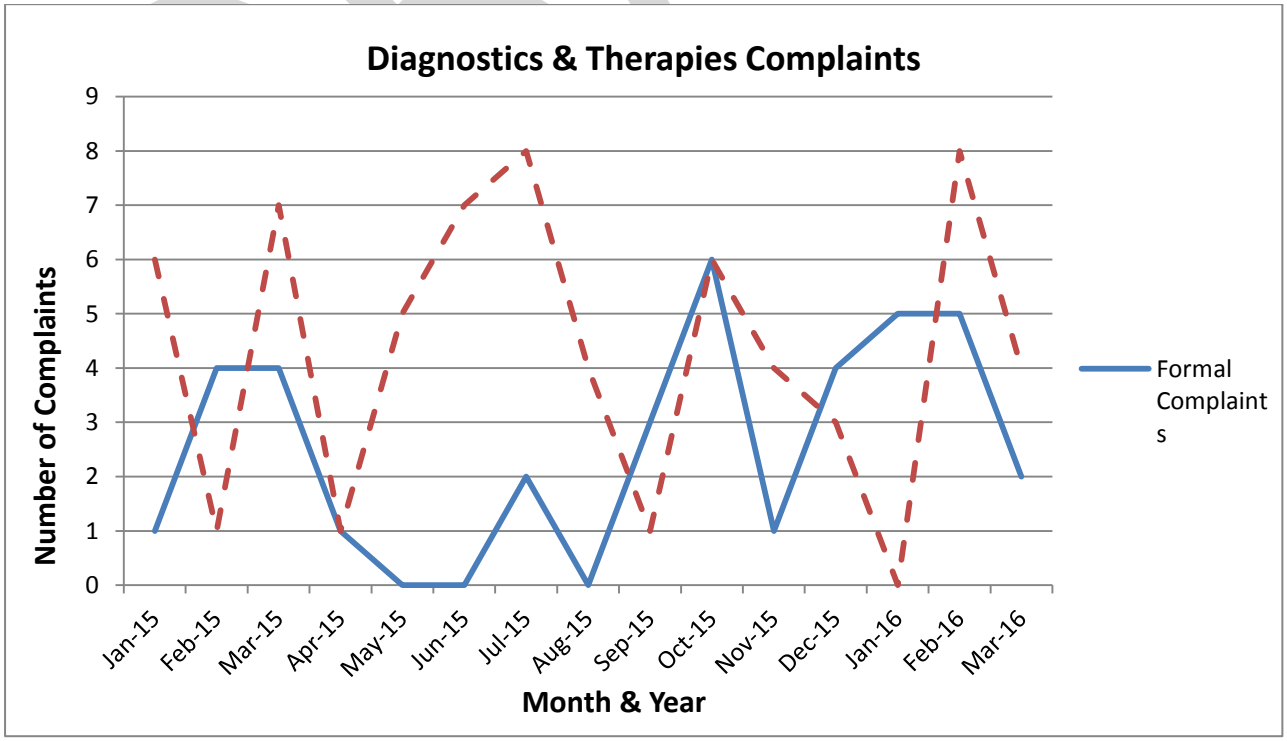
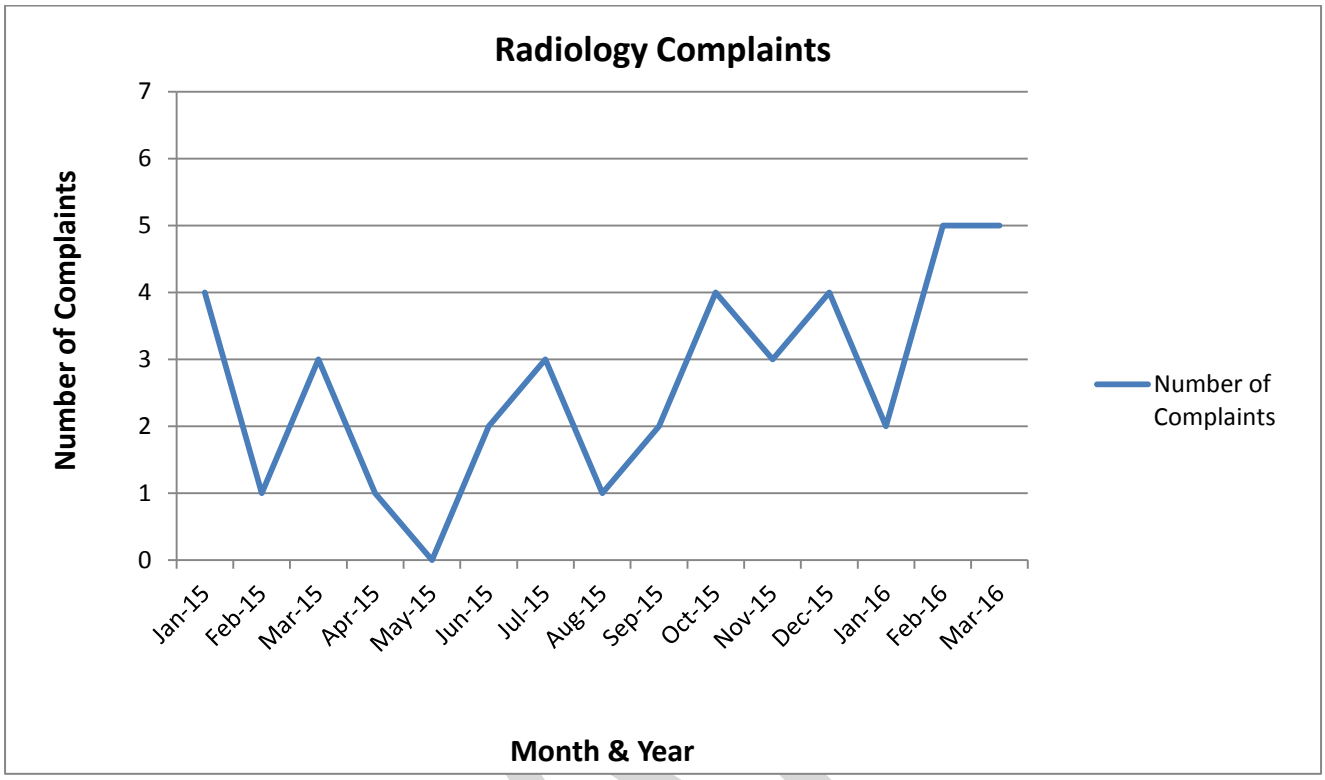


Figure 19: Complaints received by Radiology (Trustwide)



3.3 Complaints by hospital site

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

Table 21: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q4 2015/16	Number and % of complaints received in Q3 2015/16
Bristol Royal Infirmary (BRI)	209 (43.9% of total complaints)	196 (43.8% of total complaints)
Bristol Eye Hospital (BEH)	52 (10.9%)	49 (11%)
Bristol Dental Hospital (BDH)	44 (9.2%)	31 (7%)
St Michael's Hospital (StMH)	52 (10.9%)	31 (7%)
Bristol Heart Institute (BHI)	45 (9.5%)	52 (11.7%)
Bristol Haematology & Oncology Centre (BHOC)	10 (2.1%)	17 (3.8%)
Bristol Royal Hospital for Children (BRHC)	59 (12.4%)	55 (12.3%)
South Bristol Community Hospital (SBCH)	5 (1.1%)	15 (3.4%)
Total	**476**	**446**

The table below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints each hospital site receives is broadly in line with its proportion of attendances. For example, in Q4, BRHC accounted for 16.2% of all attendances and 12.4% of all complaints.

Table 22: Complaints rates by hospital site

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	209	61,311	0.34%	30.5%	43.9%
BEH	52	32,160	0.16%	16%	10.9%
BDH	44	21,425	0.21%	10.6%	9.2%
StMH	52	21,963	0.24%	10.9%	10.9%
BHI	45	5,216	0.86%	2.6%	9.5%
BHOC	10	19,227	0.05%	9.6%	2.1%
BRHC	59	32,643	0.18%	16.2%	12.4%
SBCH	5	7,147	0.07%	3.6%	1.1%
Total	**476**	201,092	0.24%		

This analysis shows that Bristol Royal Infirmary and Bristol Heart Institute continue to receive the highest rates of complaints and that they both receive a disproportionately high volume of complaints compared to their share of patient activity.

3.4 Complaints responded to within agreed timescale

All of the clinical Divisions, with the exception of Diagnostics & Therapies, reported breaches in Q4, totalling 31 breaches, which represents a significant improvement on the 65 breaches reported in Q3. The table below shows how these breaches were broken down by Division.

Table 23: Breakdown of breached deadlines

Division	Q4 2015/16	Q3 2015/16	Q2 2015/16	Q1 2015/16
Surgery, Head & Neck	10 (24.4%)	16 (31.4%)	12 (22.6%)	9 (12.9%)
Medicine	10 (28.6%)	18 (48.6%)	3 (8.8%)	9 (20%)
Specialised Services	3 (23.1%)	8 (36.4%)	6 (30%)	2 (11.1%)
Women & Children	8 (34.8%)	21 (65.6%)	2 (5.1%)	7 (17.1%)
Diagnostics & Therapies	0 (0%)	2 (22.2%)	0 (0%)	1 (10%)
All	**31 breaches**	**65 breaches**	**23 breaches**	**28 breaches**

(So, as an example, there were eight breaches of timescale in the Division of Women & Children in Q4, which constituted 34.8% of the complaints responses that had been due in that Division in Q4).

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

Table 24: Source of delays

	Source of delays in Q4 2015/16			Totals
	Division	**PSCT**	**Executive sign-off**	
Surgery, Head & Neck	7	2	1	**10**
Medicine	9	0	1	**10**
Specialised Services	3	0	0	**3**
Women & Children	5	1	2	**8**
Diagnostics & Therapies	0	0	0	**0**
All	**24**	**3**	**4**	**31 breaches**

Although the majority of responses were prepared by the Division within the time agreed (112 out of 122 responses or 91.8%), the need for changes/improvements following executive review led to 31 cases breaching the deadline by which they were sent to the complainant. Therefore only 74.6% of responses were actually sent out on time, against a target of 95%.

Actions being taken to improve the quality of responses and reduce the number of breaches include:

- All response letters received from Divisions are checked by the caseworker managing the complaint and then reviewed by the Patient Support & Complaints Manager prior to Executive sign-off.
- A random selection of complaint responses are also reviewed by the Head of Quality (Patient Experience & Clinical Effectiveness) prior to Executive sign-off.
- Training aimed at improving the quality of written complaint responses is being rolled out to all Divisions, with two sessions having already been delivered at the time of writing this report.
- Standard Operating Procedures (SOPs) have been produced in respect of the process for checking and signing off response letters and for the escalation of more serious or complex complaints for Executive review.
- During Q4, the process was changed to allow seven working days for the review and sign-off process. This has resulted in a reduction in the number of breaches from 65 in Q3 to 31 in Q4.

4. Information, advice and support

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

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

In Q4, the team dealt with 135 such enquiries, compared to 153 in Q3. These enquiries can be categorised as:

- 95 requests for advice and information (104 in Q3)
- 37 compliments (41 in Q3)
- 3 requests for support (8 in Q3)

The table below shows a breakdown of the 98 requests for advice, information and support dealt with by the team in Q4.

Table 25: Enquiries by category

Category	Number of enquiries
Information about patient	27
Hospital information request	23
Signposting	11
Accommodation enquiry	6
Clinical information request	6
Medical records requested	4
Travel arrangements	3
Patient choice information	2
Freedom of Information request	2
Clinical care (medical/surgical)	2
Waiting time in clinic	1
Transport request	1
Personal property	1
Benefits and social care	1
Bereavement support	1
Disability support	1
Communication with patient/relative	1
Complaints handling	1
Discharge arrangements	1
Emotional support	1
Follow-up treatment	1
Medication not received	1
Total	**98**

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

One of the Key Performance Indicators (KPIs) used by the Patient Support and Complaints Team is the length of time between receipt of a complaint and sending an acknowledgement.

The Trust's Complaints and Concerns Policy states that when the Patient Support and Complaints Team reviews a complaint following receipt:

- a risk assessment will be carried out;
- agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so;

- The appropriate paperwork will be produced and sent to the Divisional Complaints Coordinator for investigation; and
- an acknowledgement letter confirming how the complaint will be managed will be sent to the complainant.

In line with the NHS Complaints Procedure (2009), the Trust's policy states that this review will take place within three working days of receipt of written complaints (including emails), or within two working days of receipt of verbal complaints (including PSCT voicemail).

In Q4, 195 complaints were received verbally and 281 were received in writing. Of the 195 verbal complaints, 180 (92.3%) were acknowledged within two working days. The remaining 15 cases were all acknowledged within three working days.

Of the 281 written complaints, 280 (99.6%) were acknowledged within three working days. The remaining case was acknowledged within four working days.

6. PHSO cases

During Q4, the Trust has been advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in five new complaints (two of which are from the same complainant), compared to five in Q3 and three in Q2. Tables 26 to 28 list these new cases, cases with existing PHSO interest and cases now closed by the PHSO. Of the six cases that were closed in Q4, one was upheld, two were partly upheld and three were not upheld.

Table 26: New PHSO cases

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
18315	SOC		19/03/2015	BRI	Rheumatology	Medicine
Contacted by PHSO in January 2016. Copy of complaints file and medical records sent to PHSO; Division had no comments to make at this stage. PHSO contacted us 6 June 2016 to confirm that they would be investigating this complaint and the patient's other complaint (see below) together and requesting copies of patient's x-rays. Disc containing the requested images sent to the PHSO on 9 June 2016. PHSO have asked for Division to comment by 15 June 2016 as complainant has added further information to his complaint.						
18318	SOC		27/03/2015	BRI	Adult Therapy	Diagnostics & Therapies
See case 18315 above – complaints being dealt with together by PHSO.						
18856	SC	VP	22/05/2015	BRI	Ward B501	Medicine
Contacted by PHSO in February 2016. Copy of complaints file and medical records sent to PHSO; Division had no comments to make at this stage. Currently waiting to hear further from PHSO.						
19541	AA	LA	13/08/2015	BRI	Gastroenterology & Hepatology	Medicine
Contacted by PHSO in March 2016. Copy of complaints file and medical records sent to PHSO; Division had no comments to make at this stage. Currently waiting to hear further from PHSO.						

16841	JA	RA	17/09/2014	BHOC	Ward D603	Specialised Services
Contacted by PHSO in March 2016. Copy of complaints file and medical records sent to PHSO; Division had no comments to make at this stage other than to confirm that complainant had not come back to us to say they were dissatisfied following our original response. Received final report from PHSO on 6 June 2016, advising that they were not upholding the complaint.						
15534	AN		22/04/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Contacted by PHSO in March 2016. Copy of complaints file and medical records sent to PHSO; Division had no comments to make at this stage. Currently waiting to hear further from PHSO.						

Table 27: Existing PHSO cases

18420	MK		31/03/2015	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
PHSO draft report received 14 March 2016 stating that they did not uphold the complaint. However, the patient is appealing this and we are currently awaiting the PHSO's final report following this appeal.						
16474		CM	05/08/2014	BRI	Ward A604	Surgery, Head & Neck
PHSO contacted us in June 2016 requesting from further information. This has been provided to the PHSO, who state that we should receive their final report by the end of June 2016.						
16977	LG	KG	30/09/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
PHSO requested copies of some x-rays – these were sent to them in March 2016. Currently waiting to hear further from the PHSO with their findings.						
17173	DF	DJ	29/10/2014	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Currently awaiting further contact from the PHSO.						

Table 28: Closed PHSO cases

15213	WE	VE	10/03/2014	BHOC	Chemotherapy Outpatients	Specialised Services
PHSO final report received in January 2016 and complaint upheld. Recommendation made that Trust writes to the complainant acknowledging the failings identified and apologising for these and the impact they had. The Trust also had to produce an action plan detailing what actions would be taken to avoid a recurrence.						
15952	KH	JH	09/06/2014	BRI	Ward 11	Medicine
PHSO final report received March 2016 confirming that they would not be upholding the complaint.						
12124 & 11500		SM	21/11/2012 & 13/08/2012	BRI & BHI	Urology & Cardiology	Surgery, Head & Neck and Specialised Services
PHSO final report received on 29 January 2016, partially upholding the complaint. PHSO recommended that we write to the patient acknowledging the failings identified and apologising for these and to produce a joint action plan with North Bristol Trust (NBT) in order to address the points raised and prevent a recurrence.						

17584	LT	CT	19/12/2014	BRI	Trauma & Orthopaedics	Surgery, Head & Neck
PHSO's final report received in February 2016, partially upholding the complaint. PHSO recommended that the Trust should write an apology to the patient, completes an RCA to identify why the failing happened and pay the patient compensation of £150. The PHSO also asked the Trust to provide evidence of learning from this case and make changes to its procedures to ensure that flexibility would be applied to similar cases in future.						
17400	NM	KT	26/11/2014	BHOC	Ward D603	Specialised Services
PHSO's final report received in February 2016 and they did not uphold the complaint.						
15464	JR	LM-J	10/04/2014	BHI	Ward C708	Specialised Services
PHSO's final report received on 30 March 2016 confirming that they are not upholding the complaint.						

7. Protected Characteristics

We are unable to report on protected characteristics in Q4 2015/16 as the information held on the new Datix system, which is now used to record complaints, does not match the information held on Medway and is therefore not transferring across. This issue is currently being investigated by the Risk Management Team responsible for the Datix system.

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
12. Finance Report									
Sponsor and Author(s)									
Sponsor & Author: Paul Mapson, Director of Finance & Information									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To report to the Board on the Trust's financial position and related financial matters which require the Board's review. Key issues to note The summary income and expenditure statement shows a surplus of £1.861m (before technical items) for the first two months of the year. The 2016/17 financial plan, which includes receipt of £13.0m sustainability funding, is to deliver a surplus of £14.2m before technical items. At month two the Trust is £0.550m adverse to plan.									
Recommendations									
None.									
Impact Upon Board Assurance Framework									
Impact Upon Corporate Risk									
Implications (Regulatory/Legal)									
Equality & Patient Impact									
Resource Implications									
Finance	✓	Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			

Date the paper was presented to previous Committees					
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
	27/06/16				

REPORT OF THE FINANCE DIRECTOR

1. Overview

The summary income and expenditure statement shows a surplus of £1.861m (before technical items) for the first two months of the year. The 2016/17 financial plan, which includes receipt of £13.0m sustainability funding, is to deliver a surplus of £14.2m before technical items. At month two the Trust is £0.550m adverse to plan.

The run rate in Clinical Divisions and Corporate Services decreased in May. The adverse variance was £0.602m compared to £0.985m in April. The year to date overspend is now £1.587m compared to the operating plan trajectory to date of £0.499m.

The subjective analysis is shown below:

(Adverse)/Favourable	May £m	April £m	2015/16 outturn £m
Nursing & midwifery pay	(0.555)	(0.348)	(4.276)
Medical & dental staff pay	(0.321)	(0.123)	(1.805)
Other pay	0.346	0.175	1.587
Non-pay	(0.444)	(0.270)	(3.527)
Income	0.372	(0.419)	(1.208)
Totals	**(0.602)**	**(0.985)**	**(9.229)**

At month 2 it is possible to form some early judgements as to the 2016/17 financial outlook. Recognising that two months represents early days a few conclusions are possible:

1) The plans for reducing nursing spend are not delivering at Trust level. The May net Divisional overspend is accounted for entirely by nursing (although there are other issues which net off).
2) The Trust is well above the NHS Improvement agency and locum ceiling (by £0.624m) which will almost certainly result in financial sanctions (probably refund of a percentage of sustainability funding).
3) Activity is holding up reasonably well (after a dip in April) – maintenance of activity during the summer months is essential.
4) Workforce metrics appear to be adverse to plan – this contributes to the financial position within pay spend above.
5) The Divisional positions (£1.587m adverse to month 2) are not compatible with the submitted Operating Plan (0.499m adverse to date). Three Divisions are generating this adverse position broadly equally at c.£0.5m year to date each – Medicine, Women's and Children's and Surgery, Head and Neck.

Hence once again the Trust will need to find non-recurrent savings to cover an inevitable Divisional overspend in year. However this must be minimised and therefore non-recurring measures will need to be introduced in year.

It is not possible to make a proper assessment of the level of non-recurrent savings in 2016/17 as yet. This will depend on factors such as the conclusion of the SLAs, level of contingencies used,

pay increments, fines and penalties, CQUIN delivery and necessary provisions. Whilst the outcome is not yet know the May (month 2) position has already included £0.6m benefit shown against reserves i.e. projected £3.6m. A better estimate will be reported in month 3 (quarter 1) results.

There are four key financial drivers which are key to controlling the Trust's financial position to achieve the 2016/17 financial plan. These are described in the following sections.

Nursing & Midwifery Pay Spend:

Nursing and midwifery pay spend for the month is £10.768m. The table below shows the analysis between substantive, bank and agency with a comparison to last month and the 2015/16 position.

	May	April	2015/16 Outturn	Average Monthly 2015/16	Average Quarter 4 2015/16
	£m	£m	£m	£m	£m
Substantive	9.422	9.051	105.245	8.770	8.980
Bank	0.754	0.541	8.455	0.705	0.772
Agency	0.592	0.796	9.066	0.756	0.831
Totals	**10.768**	**10.387**	**122.766**	**10.231**	**10.584**

Whilst agency expenditure reduced in month by £0.204m, there were increases for substantive staff of £0.381m and bank staff of £0.213m. The increase in substantive staff costs was primarily due to additional enhancement costs resulting from an additional weekend, an additional bank holiday and a full month's effect of the 1% pay increase on enhancements in May. There was a small reduction in substantive staff numbers in post in month.

The table below shows the Nursing and ODP price and volume variance for May. It shows that Nursing and ODPs were £0.550m overspent in the month with £0.264m as a result of the premium price paid for staff and £0.286m from using above the funded establishment (wte). The table also shows that the wards in the clinical divisions are primarily responsible for the overspend (£0.475m) with £0.147m attributable to the premium price paid for staff and £0.328m for operating above establishment.

Division	Nursing Category	Price Variance fav/ (adv) £'000	Volume Variance fav/ (adv) £'000	Total Variance fav/ (adv) £'000	Lost Time %
Medicine	Ward	(6)	(141)	(147)	**133%**
	Other	(40)	60	20	
	ED	(27)	5	(21)	
Medicine Total		**(73)**	**(76)**	**(149)**	
Surgery, Head & Neck	Ward	44	(137)	(93)	**126%**
	Theatres	(10)	20	10	
	Other	(42)	6	(36)	
	ED	(1)	1	0	
Surgery, Head & Neck Total		**(9)**	**(111)**	**(120)**	
Specialised Services	Ward	(75)	(29)	(103)	**133%**
	Other	8	17	24	
Specialised Services Total		**(67)**	**(12)**	**(79)**	

Women's & Children's Services	Ward	(110)	(22)	(132)	**129%**
	Theatres	(13)	8	(5)	
	Other	(41)	(32)	(73)	
	ED	(12)	(13)	(25)	
Women's & Children's Services Total		**(176)**	**(59)**	**(235)**	
Clinical Division Total	Ward	(147)	(328)	(475)	**130%**
	Theatres	(23)	28	5	
	Other	(120)	55	(65)	
	ED	(39)	(8)	(47)	
CLINICAL DIVISIONS TOTAL		**(329)**	**(253)**	**(582)**	
NON CLINICAL DIVISIONS	Other	65	(33)	32	
TRUST TOTAL		**(264)**	**(286)**	**(550)**	

As requested at May's Finance Committee meeting this report now includes the HR Nursing Controls dashboard (Appendix 3) which shows the registered nursing position for each Division against 8 KPIs. Highlights from the KPIs are as follows,

- Sickness –Surgery, Head and Neck and Women's and Children's Divisions are above trajectory for their sickness levels, with no improvement from the previous month.
- Vacancies – all but the Women's and Children's Division are above the Trust target of 5% for vacancies with the Division of Medicine being the highest at 8.7%.
- Operating Plan for nursing agency wte – all Divisions are above their Operating Plan position with the Division of Surgery, Head and Neck being the most concerning with an actual position of 29.6wte against a target of 6.1wte. This is also reflected in their percentage of nursing agency against total nursing spend, 10.5% against a target of 1.8%.
- Nursing assistant, 1:1 and RMN usage – the Women's and Children's Division continues to be significantly above the funded level for NA 1:1s and RMNs as a result of a couple of long stay patients requiring specific care.

Medical and Dental Pay Spend:

Medical pay spend for the month is £9.711m, of which £9.204m is substantive staff, £0.312m locum and £0.195m agency. A comparison of this position to 2015/16 is shown below:

	May 2016/17	April 2016/17	2015/16 Outturn	Average Monthly 2015/16	Average Quarter 4 2015/16
	£m	£m	£m	£m	£m
Substantive	9.204	9.150	106.038	8.837	9.293
Locum	0.312	0.369	4.705	0.392	0.339
Agency	0.195	0.224	3.350	0.279	0.333
Totals	**9.711**	**9.743**	**114.093**	**9.508**	**9.966**

There has been little change in total pay costs for medical and dental staff from April to May, with the total expenditure falling slightly by £32k. However, there is a deterioration in the variance to budget on medical staffing reflecting some budget realignments and service changes such as the transfer of cellular pathology, where in April there was an underspend against budget.

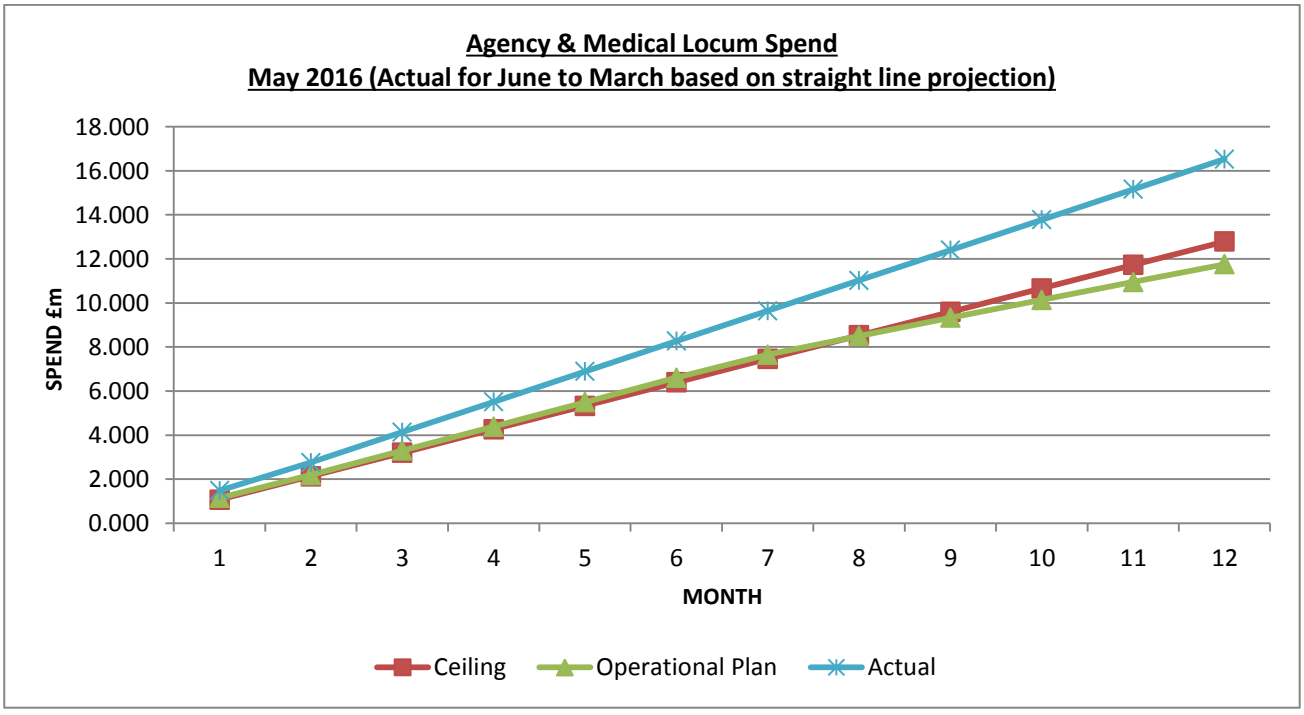
NHS Improvement Locum and Agency Ceiling

NHS Improvement has set an expenditure ceiling of £12.793m for all agency and medical locum spend for the Trust. The operational plan submitted by the Trust to NHS Improvement for 2016/17 had a forecast outturn of £11.755m. At the end of May the Trust is currently showing an adverse variance against the plan of £0.565m. This results from the nursing adverse variance of £0.788m against the plan.

The table below shows a summary of both the current month and year to date position against the NHS Improvement Operational Plan by staff group.

	Current month position (May)			Year to date position		
Staff category	Operational Plan £m	Actual £m	Variance fav/(adv) £m	Operational Plan £m	Actual £m	Variance fav/(adv) £m
Medical	0.579	0.507	0.072	1.229	1.100	0.129
Nursing (RNs and NAs)	0.297	0.592	(0.295)	0.600	1.388	(0.788)
Other clinical	0.036	0.040	(0.004)	0.097	0.078	0.020
Other	0.126	0.133	(0.007)	0.264	0.190	0.073
Totals	**1.038**	**1.272**	**(0.234)**	**2.190**	**2.756**	**(0.565)**

The graph shows the forecast outturn based on a straight-line projection against the ceiling and the NHS Improvement Operational Plan



Clinical Activity:

Activity based contract performance improved by £1.105m in May to give a cumulative over performance of £0.720m. The position improved in May for all divisions with the exception of Medicine as shown in the table below.

Divisional Variances	May Variance Fav/(Adv)	Year to Date Plan	Year to Date Actual	Year to Date Variance Fav/(Adv)
	£m	£m	£m	£m
Diagnostic & Therapies	0.126	6.546	6.644	0.098
Medicine	(0.119)	8.659	8.652	(0.007)
Specialised Services	0.197	9.860	10.203	0.343
Surgery, Head and Neck	0.324	13.411	13.602	0.191
Women's and Children's	0.259	17.206	17.028	(0.178)
Facilities and Estates	0.007	0.610	0.615	0.005
Corporate	0.311	17.674	17.942	0.268
Totals	**1.105**	**73.966**	**74.686**	**0.720**

Underperformance to date within Women's and Children's within critical care bed days and elective inpatients continues, although the performance has improved in month. The deterioration in Medicine was within emergency inpatients.

Savings Programme:

The savings requirement for 2016/17 is £17.420m. Savings of £2.174m have been realised to date, a shortfall of £0.617m against divisional plans. The shortfall is a combination of the adverse variance for unidentified schemes of £0.529m and a further £0.088m for scheme slippage. The 1/12th phasing adjustment increases the shortfall to date by £0.112m.

The year-end forecast outturn has increased this month to £14.545m, a shortfall of £2.875m, which represents delivery of 83.5%.

A summary of progress against the Savings Programme for 2016/17 is summarised below. A more detailed report is given under item 5.4 on this month's agenda.

	Savings Programme to 31st May 2016				
	Plan	Actual	Variance fav / (adv)	Phasing adjustment fav/(adv)	Total variance Fav/(adv)
	£m	£m	£m	£m	£m
Diagnostics and Therapies	0.242	0.274	0.032	(0.031)	0.001
Medicine	0.229	0.247	0.018	(0.052)	(0.034)
Specialised Services	0.237	0.184	(0.053)	(0.015)	(0.068)
Surgery, Head and Neck	0.745	0.494	(0.251)	(0.081)	(0.332)
Women's and Children's	0.814	0.444	(0.370)	0.041	(0.329)
Estates and Facilities	0.110	0.116	0.006	(0.021)	(0.015)
Trust HQ	0.165	0.154	(0.011)	0.047	0.036
Other Services	0.249	0.261	0.012	0.00	0.012
Totals	**2.791**	**2.174**	**(0.617)**	**(0.112)**	**(0.729)**

2. Divisional Financial Position

Clinical Divisions and Corporate Services overspend against budget increased by £0.602m in May to a cumulative position of £1.587m adverse to plan. The most significant in month deterioration was within Medicine (£0.403m). The table below summarises the financial performance in May for each of the Trust's management divisions against their budget and against their May Operating Plan

trajectory. Further analysis of the variances against budget by pay, non-pay and income categories is given at Appendix 2.

	Budget Variance favourable/(adverse)			Operating Plan Trajectory favourable/(adverse)	
	To 30 April £m	May £m	To 31 May £m	Trajectory To May £m	Variance £m
Diagnostic & Therapies	(0.045)	0.126	0.081	(0.028)	0.109
Medicine	(0.117)	(0.403)	(0.520)	(0.078)	(0.442)
Specialised Services	(0.026)	(0.101)	(0.127)	(0.105)	(0.022)
Surgery, Head & Neck	(0.324)	(0.170)	(0.494)	(0.162)	(0.332)
Women's & Children's	(0.488)	(0.058)	(0.546)	(0.124)	(0.422)
Estates & Facilities	(0.007)	(0.004)	(0.011)	(0.020)	0.009
Trust Services	0.007	0.008	0.015	0.009	0.006
Other corporate services	0.015	0.000	0.015	0.009	0.006
Totals	**(0.985)**	**(0.602)**	**(1.587)**	**(0.499)**	**(1.088)**

There is still a requirement to address the Division's adverse Operating Plans which are as follows:

	Savings programme shortfall £m	Support funding £m	Cost pressures/other £m	Total Operating Plan shortfall £m
Diagnostics & Therapies	(0.131)	0.478	(0.347)	0.00
Medicine	0.420	0.066	(1.429)	(0.943)
Specialised Services	(0.197)	0.339	(0.339)	(0.197)
Surgery, Head & Neck	(1.496)	0.491	(0.079)	(1.084)
Women's and Children's	(1.812)	1.041	(0.368)	(1.139)
Facilities & Estates	0.046	0.162	(0.209)	(0.001)
Trust Services	(0.068)	0.000	0.072	0.004
Other corporate services	0.058	0.000	0.000	0.058
Totals	**(3.180)**	**2.577**	**(2.699)**	**(3.302)**

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 April £m	May £m	To 31 May £m
Pay	(0.234)	(0.559)	(0.793)
Non Pay	0.024	(0.188)	(0.164)
Operating Income	0.050	(0.152)	(0.102)
Income from Activities	(0.408)	0.609	0.201
Sub Total	(0.568)	(0.290)	(0.858)
Savings programme	(0.417)	(0.312)	(0.729)
Total	**(0.985)**	**(0.602)**	**(1.587)**

Pay budgets have an adverse variance of £0.559m in the month increasing the cumulative adverse variance to £0.793m.
The significant adverse movement in the month was in Women's and Children's (£0.475m). Other adverse movements were in Surgery Head and Neck (£0.144m) and Medicine (£0.119m) which were offset by favourable movements in Diagnostic and Therapies (£0.100m) and Trust Services (£0.99m).
Cumulative adverse variances are within Women's and Children's (£0.706m), Surgery, Head and Neck (£0.256m), Medicine (£0.178m) and Specialised Services (£0.073m) offset by favourable variances in Diagnostic & Therapies (£0.205m) and Trust Services (£0.168m).
For the Trust as a whole, agency spend is £2.088m to date. The monthly average spend of £1.044m compares with a monthly average spend in 2015/16 of £1.260m. Agency spend to date is £0.572m in Medicine, £0.418m in Women's and Children's, £0.514m in Surgery, Head and Neck and £0.378m in Specialised Services. Waiting list initiatives costs to date are £0.542m of which £0.221m is within Surgery, Head and Neck, £0.103m in Women's and Children's and £0.097m in Specialised Services.

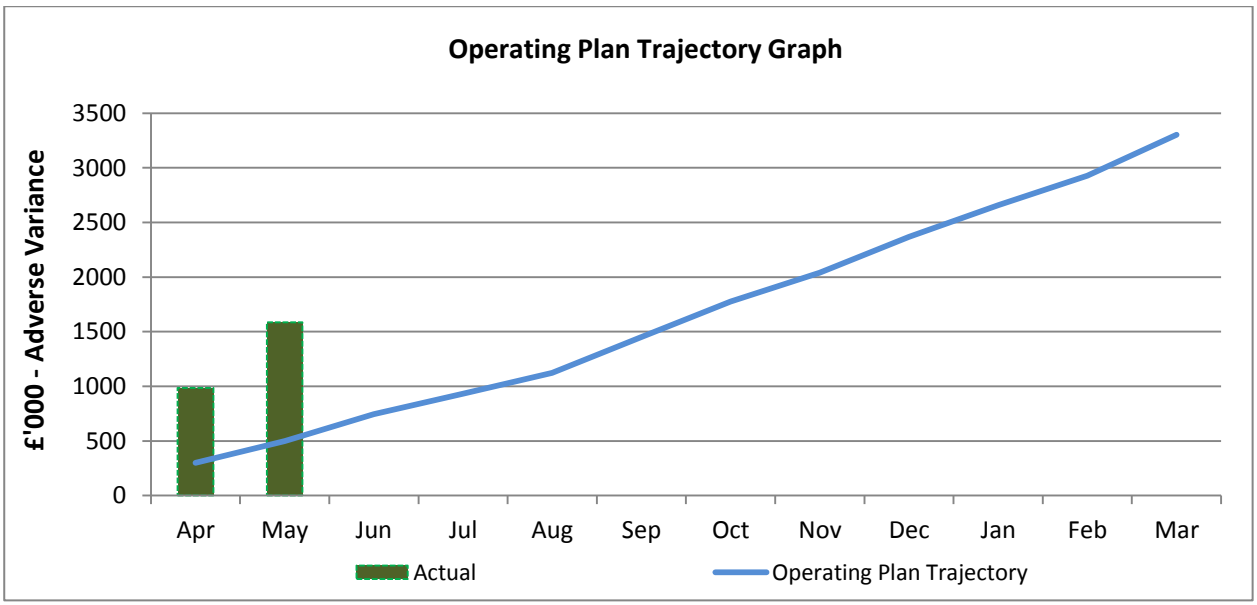
N**on-pay budgets** have an adverse variance of £0.188m in the month changing the cumulative variance to £0.164m adverse.
The significant adverse movements in the month were in Surgery, Head and Neck (£0.203m) and Diagnostic and Therapies (£0.138m). Women's and Children's had a favourable variance in month of £0.353m.
Cumulative adverse variances are within Medicine (£0.234m), Diagnostic & Therapies (£0.206m), Surgery, Head and Neck (£0.182m), and Specialised Services (£0.090m) offset by a favourable variance in Women's and Children's (£0.587m).

Operating Income budgets have an adverse variance in the month of £0.152m changing the cumulative variance to £0.102m adverse. Research and development income had an adverse variance in month of £0.077m which was reflected in a reduction in expenditure for the month.

Income from Activities budgets have a favourable variance in month of £0.609m changing the cumulative variance to £0.201m favourable.
Favourable movements in month were in Surgery, Head and Neck (£0.356m), Women's and Children's (£0.229m) and Diagnostic and therapies (£0.146m). Medicine had an adverse variance of £0.169m in month.
The principal areas of over achievement to date are within Surgery, Head and Neck (£0.248m) Diagnostic and Therapies (£0.107m), offset by under achievement to date by Women's and Children's (£0.106m) and Medicine (£0.089m).

Variance to Operating Plan:

Clinical Divisions and Corporate Services have an adverse variance of £1.587m against a combined operating plan trajectory of £0.499m. The May position is £1.088m above trajectory as shown in the graph below.



Further detail is given under agenda item 5.3 in the Finance Committee papers.

3. Divisional Reports

The following is intended to provide a brief update on the Divisional positions including reasons for variances and actions being taken to address adverse positions. As requested at the previous Finance Committee, the divisional reports at item 5.3 provide further detail on the impact of actions being taken and new actions that have been introduced since the last report.

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

Division of Medicine

The Division reports an adverse variance to month 02 of £0.546m; The Division is £0.442m adverse to its operating plan trajectory to date. The Division is reporting a savings programme year to date adverse variance of £0.034m and a savings programme forecast outturn favourable variance of £0.446m.

The key reasons for the variance are:

Adverse variances

- An adverse pay variance of £0.178m which represents an in month deterioration of £0.119m. Within this total nursing expenditure was £0.050m higher in May than April. Agency expenditure was lower than in April primarily because staffing of the escalation capacity used extensively throughout quarter 4 last year has been scaled back.
- An adverse variance on non-pay within drugs £0.044m and clinical supplies £0.131m.
- An adverse variance on SLA income of £0.089m which represents a deterioration in month of £0.169m, the main reason being lower than expected Emergency inpatient admissions.

Favourable variances

- A favourable variance on income from operations of £0.015m.

Actions being taken and mitigation to restore performance include:

- Reductions in nursing costs – this is being managed via a programme of close controls with respect to the booking of shifts out of hours, the continued close scrutiny of all agency use and the introduction of dementia initiatives aimed at reducing the number of 1:1 shifts required;
- The rolling out of 'Discharge to Assess' for 'Pathway 3' patients expected to improve both length of stay and ultimately occupancy rates;
- Development of Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs) within the Emergency Department (ED) to reduce medical staffing costs.
- Medical Staff Payments includes the review of all WLI and additional payments in accordance with new Trust guidance. A capacity planning exercise, in conjunction with refreshed job plans and the recruitment of acute physicians, is also underway;
- New - A full review of the acute medical model encompassing ability to recruit and contingency plans – it is proposed that will include a full review of recruitment practice across the City and an agreed way forward such that the Division and Trust is not compromised in its vision to deliver the agreed acute model of care;
- New- It is proposed that the ownership, accountability and responsibility for community bed placements are passed to commissioners with immediate effect. It is the Division's recommendation that commissioners seek to utilise Care Home Select's existing resources in the absence of an appropriate replacement programme of service. Indeed, the closure of ward A518 (unfunded post September 2016) is predicated on the re-provision of this service
- New- The Division intends to work with commissioners to ensure that the front door pilot, encompassing the urgent care centre, is progressed and rolled out in tandem with the 'high impact users' initiative – to progress one initiative without the other would be contradictory to the wider aims of managing pressures in the ED.

The 2016/17 financial plan forecasts a deficit of c. £0.94m but contains a number of risks and assumptions. These include:

- The consultation for and closure of ward A518, independent of ORLA Healthcare Ltd;
- The mobilisation and careful management of the ORLA Healthcare Ltd initiative;
- Recruitment to the Enhanced Supervision Team;
- Community and social care initiatives including the ownership of a bed placement scheme.

Division of Surgery, Head and Neck

The Division reports an adverse variance to month 02 of £0.494m; The Division is £0.332m 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 £0.332m. The majority relates to unidentified plans £0.250m.
- An adverse variance on pay of £0.256m primarily due to high nursing agency and bank usage.
- An adverse variance on non-pay of £0.182m this has been caused by spend on outsourcing clinical activity and adverse variances on drugs, there has been a significant deterioration in the variance on clinical supplies particularly in theatres £0.102m.

Favourable variances

- A favourable variance on income from activities of £0.248m after a significant improvement this month of £0.356m, improvements this month occurred in Upper GI £0.097m, Thoracic Surgery £0.051m, Ophthalmology £0.051m, ITU £0.069m and ENT £0.066m. There was, however, a significant deterioration within Oral/Dental with an in-month deterioration of £0.105m.
- A favourable variance on income from operations of £0.028m due to higher than planned research and development income.

The key reasons for the variance against the Operating Plan trajectory are:

- Overachievement on activity (including the share of cardiac surgery), £0.248m.
- Higher than planned nursing spend £0.297m.
- Higher than planned waiting list payments £0.042m.
- Higher than planned expenditure on outsourcing £0.085m.
- Higher than planned spend on drugs an clinical supplies £0.092m
- Slippage on CIP delivery.

Key risks to delivery of the Operating Plan and ongoing improvement include:

- Delivery planning is continuing with greater understanding of the issues in the more complex services in the division. Further workup and finalisation of resource planning is ongoing and there remains risk around delivery of service level agreement income which has the potential to be substantial, particularly around Oral and Dental services.
- The divisional team is aware of the risks around successful delivery of the recruitment plans – if this fails then the division could fail to provide increased capacity and hence risk failure of delivery of higher activity levels
- Bed pressures causing loss of activity to the division contributed to the adverse Month 01 position, (£280k of income was lost to bed pressures and strike action M01). The cancer recovery plans have supported recovery but this is driving further pressure into delivery of key performance targets and risks increased premium costs in the divisional position.
- The operating plan now includes £72k of additional costs to deliver cancer performance; these include – requirement to deliver through waiting lists, activity that has been lost in 2015/2016; Outsourcing plans for Thoracic Surgery and Liver Surgery (benign work) to enable the recovery of cancer performance in house; commitment to provide additional staffing in Hey Groves Recovery, including Intensivists, to enable cancer patients to be nursed in that environment. This has been successful in delivery of recovery but costs have not always been within the nursing agency cap.
- Failure to deliver the required improvements in both recruitment and retention of staff, in particular in the registered nursing and operating department practitioner workforce will drive additional costs in terms of agency spend into the position, (particularly an issue for the orthopaedic wards, across all theatres and intensive care).
- The Junior Medical and Dental workforce is vulnerable to changes in trainee levels and difficulty has been found in recruitment particularly in Trauma and Orthopaedics. The need to maintain cover on the wards is driving agency costs and posts remain unfilled.
- Failure to address the appropriate need for 1:1 nursing.
- Failure to work up additional Cost improvement plans to support financial shortfall, failure to take mitigating actions to control rising cost pressures.

Actions being taken and mitigation to restore performance include:

- The Division is holding fortnightly Finance and Performance Meetings where Service Line Managers are held to account for finance and service performance.
- The Division is holding fortnightly CIP meetings where service lines are clear on their individual savings targets and are presenting the development of plans and pipeline ideas to meet those targets.
- Review meetings are being held with Divisional Director, Divisional Finance Manager and General Manager, reviewing actual expenditure and challenging spend.
- A paper on improving financial controls is in progress, and levels of savings against these controls are being assessed. Additional controls on Estates works have already been implemented and have been shown to be effective.
- The Managed Inventory System Project has been approved and there have been 4 meetings in to date in order to progress the contract terms. The meetings to progress and close out contract terms have failed to close this action by the end of May due to many proposed changes to the contract terms (from the supplier Advanced Business Solutions). Work is ongoing and the new Director of Procurement is closely involved. The division as a whole is keen to realise the financial and quality benefits of this scheme and interviews for the project manager are 16 June.
- Recruitment plans are under way. The investment in a recruitment/training manager for theatres has been approved and this will drive improvements.
- Reduction of turnover is being approached with additional provision of training and staff development, and career progression opportunities.
- The new Head of Nursing is focussed on the monthly nursing performance and finance meetings. The terms of reference for these meetings will be reviewed to ensure the focus on recovery of the position is a key agenda item.
- The new Head of Nursing is working closely with Matron Colleagues to improve controls and reduce spend on agency and bank staffing.
- The Division continues to work with other divisions in understanding bed modelling and planning going forward.

The Division of Women's and Children's Services

The Division reports an adverse variance to month 02 of £0.546m. The Division is £0.422m adverse to the Operating Plan trajectory to date.

The key reasons for the variance are:

Adverse variances

- An adverse variance on pay of £0.706m including higher than planned nursing agency costs above NHS improvement cap rate £0.146m, mental health nurse specialling for 3 highly dependent children £0.095m and medical staff overspends £0.288m including costs associated with non compliant junior rotas and significant agency spend for consultants. It should be noted that there was a significant deterioration in the pay position this month of £0.463m which is of serious concern.
- An underperformance on the saving programme resulting in an adverse variance to date of £0.330m. The majority of which relates to the level of unidentified savings in the plan.
- An adverse performance on SLA income of £0.106m however there was a significant improvement in this area in month of £0.231m particularly in Paediatric Medicine £0.153m.

Favourable variances

- A significant favourable variance on non pay of £0.587m which includes a share of support funding and capacity growth reserves which offset the underachieved of income and slippage on developments.

Actions being taken and mitigation to restore performance:

- Nursing budget rebasing now complete and shared with Matrons.
- Cost improvement Plans now devolved to individual budget holders.
- Spinal Surgery investment plan and re-profiled activity plan developed by Spinal Pathway Transformation Group with first additional lists in June.
- Children's Hospital Flow Programme workshops held to ensure pressures are managed safely and efficiently
- Spend to Save funding for outpatients productivity no longer available but recruitment still pursued as Divisional Spend to Save.
- Meeting UK Specialist Children's Alliance colleagues in July to attempt a "mini Carter Review" process.
- Advertised for lead doctor and junior doctors, to provide strategic leadership and resolve long standing rota compliance issues.
- Further work needed on controlling medical pay budgets. This includes undertaking a detailed job plan review by relevant General Manager with Lead Clinicians.

The main challenges to the delivery of the Division's Operating Plan moving forward are:

- Identifying mitigations for the significant adverse pay variances caused by mental health nurse 'specialling', and agency cost premiums.
- Identifying a way of ensuring agency usage, where unavoidable, is within NHS Improvement capped rates.
- Ensuring that emergency demand does not disrupt elective throughput.
- Converting savings pipeline ideas into cash releasing savings and identifying new opportunities from the Carter Review and Model Hospital Programme.

The following two Divisions are rated Amber/ Red for their performance to date

Division of Specialised Services

The Division reports an adverse variance to month 02 of £0.127m. The Division is £0.022m 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 £0.007m. However, a very good in month performance has reduced the adverse variance from £0.059m last month. The division achieved 101% of contract in month.
- Medical pay budgets show an adverse variance of £0.032m mainly due to agency and waiting list costs.
- Non Pay budgets report an adverse variance of £0.090m spread across a number of areas.
- An adverse variance on Private Patients of £0.018m.

- Pay budgets are reporting an adverse variance of £0.073m with nursing reporting an adverse variance of £0.071m.
- A year to date shortfall on the savings programme of £0.068m.

Favourable variances

- Operating income reports a favourable variance of £0.033m.
- Cardiology now reports a favourable SLA variance of £0.032m after a very good in month performance.
- Clinical Genetics budgets are reporting a favourable variance of £0.079m.

Actions being taken and mitigation to restore performance:

- Ambitious plans have been identified for reductions in nursing overspends which will require significant work to achieve, the following actions have been identified:
    - Increased focus on recruitment, retention and training.
    - Reviewing sickness levels.
    - Reviewing one to one practices.

- Service Transfers are planned to be cost neutral, as such the following actions are required to ensure successful transfer and implementation:
    - Integration of new staff, grip and focus on new services and sufficient management time to understand new services.

- Agency expenditure:
    - Recruiting as quickly as possible once vacancies are known.
    - Replacing long term agency with substantive posts.
    - Developing and growing in house staff to fill hard to recruit to areas.
    - Increased controls on agency authorisation.

- Maintaining BMT Activity levels:
    - Proactive engagement with incoming head of service at Great Western Hospital Swindon, with the view to offering an outreach clinic with the aim of attracting referrals.

- National Commissioning changes to pass through items have been identified posing a significant risk to device income through increased bureaucracy. The Division will need to
    - Ensure medical colleagues are aware of changes.
    - Develop and implement new processes for prior approval.
    - Strengthen processes and support for purchasing and billing of high cost devices.
    - Ensure all billable income is claimed per instructions.

- Medical Staff Payments
    - Reviewing WLI payments.
    - Capacity Planning exercise.
    - Job planning additional PAs where possible.
    - Ensuring authorisation controls are followed.

The main challenges to the delivery of the Division's Operating Plan moving forward are:
- Delivery of Cardiac Surgery Activity.
- Meeting contracted levels of activity across other specialties.

- Controlling and reducing Nursing expenditure to deliver a breakeven year end out turn.
- Reducing agency staffing across all staff groups through; improved retention, reduced sickness, improving recruitment to posts that have been covered for longer than a short term period with temporary staff, improved training and development of staff.
- Delivering the savings programmes identified and continuing to develop new schemes.
- Maintaining controls on non pay expenditure.
- Ensuring successful service transfers for Echo, Clinical Genetics and Genomics.
- Developing procedures to ensure no adverse impacts will be incurred as a result of national commissioning arrangements e.g. prior approval for devices

Trust Services

The Division reports a favourable variance to month 02 of £0.015m. The Division is £0.006m favourable to the Operating Plan trajectory to date.

Two Divisions are rated Green for their performance to date

Diagnostic and Therapies Division

The Division reports favourable variance to month 02 of £0.081m. The Division is £0.109m 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 £0.206m which includes double running costs associated with LIMS £0.042m and clinical supplies of £0.172m.
- An adverse variance on operating income of £0.026m.

Favourable variances

- A favourable variance on pay of £0.205m, primarily the result of vacancies in clinical staff.
- The savings programme is £0.001m favourable year to date
- A favourable variance on SLA income of £0.107m of which services hosted by other divisions totals £0.061m.
- Adverse variances on non-pay above are offset by a balance of contract transfer funding.

Actions being taken and mitigation to restore performance:

- Developing the savings programme to address the shortfall.
- Realignment of non-pay budgets has taken place for 2016/17.
- Review of radiology contract income data underway with support from information analysts.
- Completed- Review of CT activity in Radiology now complete, CT scans now being correctly charged.
- Seasonal recruitment model for Radiology and Pharmacy in progress.
- New – Rolling programme of Service Line Reporting meetings to be established with Heads of Service.

Key risks to delivery of the operating plan and future performance include:

- Other Division's under-performance on contracted activity.

- Non-delivery or under-delivery of savings schemes currently forecast to achieve.
- Employing high cost agency and or locum staff into hard to recruit to posts to ensure delivery of key performance targets and resilience in services such as Radiology and Laboratory Medicine.

Facilities and Estates Division

The Division reports an adverse variance to month 02 of £0.011m. The Division is £0.009m favourable to the Operating Plan trajectory to date.

4. Income

Contract income was £0.22m higher than plan in May. Activity was above plan while pass through payments and contract penalties were below plan and contract rewards were in line with plan. The table below summarises the overall position which is described in more detail under agenda item 5.2.

Clinical Income by Worktype	In Month Variance Fav/(Adv)	Year to Date Plan	Year to Date Actual	Year to Date Variance Fav/(Adv)
Activity Based	£'m	£'m	£'m	£'m
Accident & Emergency	0.05	2.63	2.69	0.06
Emergency Inpatients	0.40	12.93	13.87	0.94
Day Cases	(0.05)	6.40	6.25	(0.15)
Elective Inpatients	0.58	8.25	8.40	0.15
Non-Elective Inpatients	(0.26)	4.56	4.05	(0.51)
Excess Bed days	(0.03)	1.15	1.19	0.04
Outpatients	0.31	13.38	13.37	(0.01)
Bone Marrow Transplants	0.23	1.34	1.83	0.50
Critical Care Bed days	(0.10)	7.36	7.14	(0.23)
Other	(0.02)	15.97	15.90	(0.07)
Sub Totals	**1.11**	**73.97**	**74.69**	**0.72**
Contract Penalties	(0.03)	(0.20)	(0.23)	(0.03)
Contract Rewards	0.00	1.56	1.56	0.00
Pass through payments	(0.86)	14.54	13.22	(1.32)
Totals	**0.22**	**89.87**	**89.24**	**(0.63)**

Elective inpatients were £0.58m ahead of plan. Cardiac surgery activity increased from last month and was £0.14m ahead of plan. Thoracic surgery was £0.09m ahead of plan and upper gastrointestinal surgery £0.07m ahead reflecting increased activity as the operations for cancer patients postponed due to the junior doctor industrial action were rescheduled. Activity in Women's and Children's was £0.1m ahead of plan.

Outpatient activity improved this month and was £0.31m ahead of plan of which £0.22m related to Women's and Children's.

Non Elective Inpatients were £0.26m behind plan, most notably the Women's and Children's Division. The Division is investigating the background to this.

Bone Marrow Transplants were £0.23m ahead of plan as the increased activity in April continued to give a year to date over performance of £0.50m. It is not currently anticipated that this level of over performance will continue through the year.

Emergency inpatients were £0.40m ahead of plan. Cardiac surgery and cardiology over performed in month by £0.22m. The admission method is being reviewed to ensure this is not reflected in the

underperformance in non-elective activity, which was £0.26m below plan for the Trust as a whole. Upper gastrointestinal surgery activity was £0.13m ahead of plan, reflecting continued high numbers of patients in May.

National core penalties and local penalties will not be applied in 2016/17 assuming receipt of the Sustainability and Transformation Funding (STF). All other national penalties will be applied. £1.3m has been set aside to cover these penalties. At the end of May, the penalty for cancelled operations readmissions within 28 days was £0.04m higher than planned. The year-end forecast for payable penalties is £1.45m. The implication of not meeting performance trajectories on the STF is not known and therefore any financial impact is not able to be assessed.

CQUINs have been agreed with CCGs but the NHSE Specialised CQUINs are still being negotiated. This delay and the quarterly monitoring for most indicators will most likely result in the monitoring of CQUINs from quarter 2. Therefore the actual is set to plan in the interim.

Pass through payments were £0.86m lower than plan in May with lower activity on drugs (£0.76m). The year to date adverse variance relates to drugs (£0.77m) and devices (£0.66m).

Performance at Clinical Divisional level is shown at appendix 4a.

5. Risk Rating

The table below shows performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For April and May, the Trust achieved an overall FSRR of 4 (actual 3.75) against a plan of 4.

The liquidity, capital servicing capacity and income and expenditure margin metrics are each in line with the plan to date with actual metric scores of 4. The income and expenditure margin variance from plan metric score is 3 for April and May against a plan of 4. This is due to the Trust's lower than planned net surplus before technical items of £1,861k against a planned surplus of £2,411k. A summary of the position is provided in the table below.

		31st May 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		14.77	14.08	14.29	14.29
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		3.97	3.60	2.66	2.66
Metric Rating	25%	4	4	4	4
Income & expenditure margin					
Metric Result		3.93%	3.45%	2.44%	2.44%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	(0.48)%	0.32%	0.00%
Metric Rating	25%	4	3	4	4
Overall FSRR		**4.0**	**3.75**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

6. Capital Programme

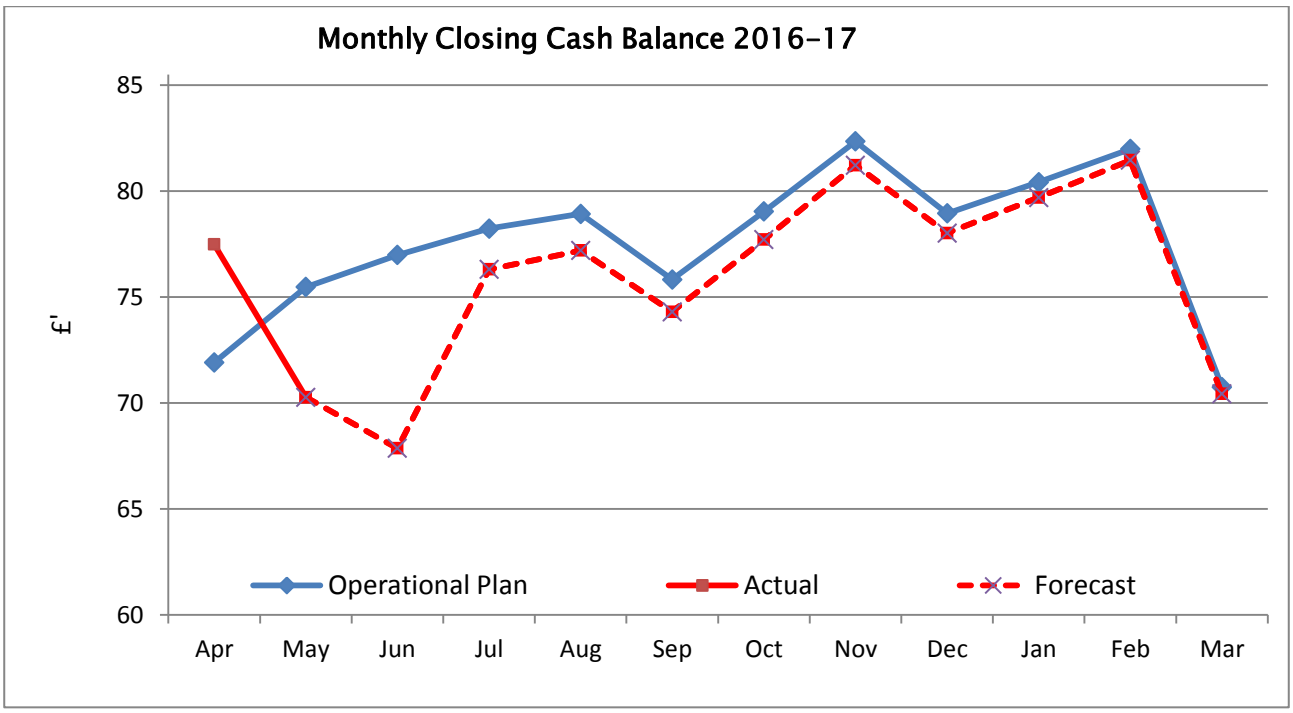
A summary of income and expenditure for the two months ending 31 May is provided in the table below. Expenditure for the period is £4.118m against a plan of £3.254m. The variance to date of £0.864m ahead of plan results from schemes being £0.193m behind their profiled operational plan and an unallocated planned slippage of £1.057m linked to the receipt of Sustainability and Transformation funding. Further information is provided under agenda item 6.1.

Operational Plan	Current Annual Plan		Month ended 31st May 2016		
			Operational Plan	Actual	Variance
£'m	£'m	**Sources of Funding**	£'m	£'m	£'m
0.273	0.273	PDC	-	-	-
2.732	2.923	Cash donations	2.000	2.060	0.060
21.634	21.634	Depreciation	3.472	3.551	0.081
4.461	5.582	Cash balances	(2.216)	(1.493)	0.723
29.100	**30.412**	**Total Funding**	**3.254**	**4.118**	**0.864**
		Expenditure			
(14.761)	(14.244)	Strategic Schemes	(3.793)	(3.233)	0.560
(9.741)	(11.142)	Medical Equipment	(0.084)	(0.182)	(0.098)
(3.971)	(4.659)	Information Technology	(0.221)	(0.292)	(0.071)
(2.545)	(2.815)	Estates Replacement	(0.042)	(0.145)	(0.103)
(11.721)	(13.191)	Operational Capital	(0.171)	(0.266)	(0.095)
(42.739)	**(46.051)**	**Gross Expenditure**	**(4.311)**	**(4.118)**	**0.193**
1.636	3.636	Planned Slippage	-	-	-
12.003	12.003	I&E Variation from Plan	1.057	-	(1.057)
(29.100)	**(30.412)**	**Net Expenditure**	**(3.254)**	**(4.118)**	**(0.864)**

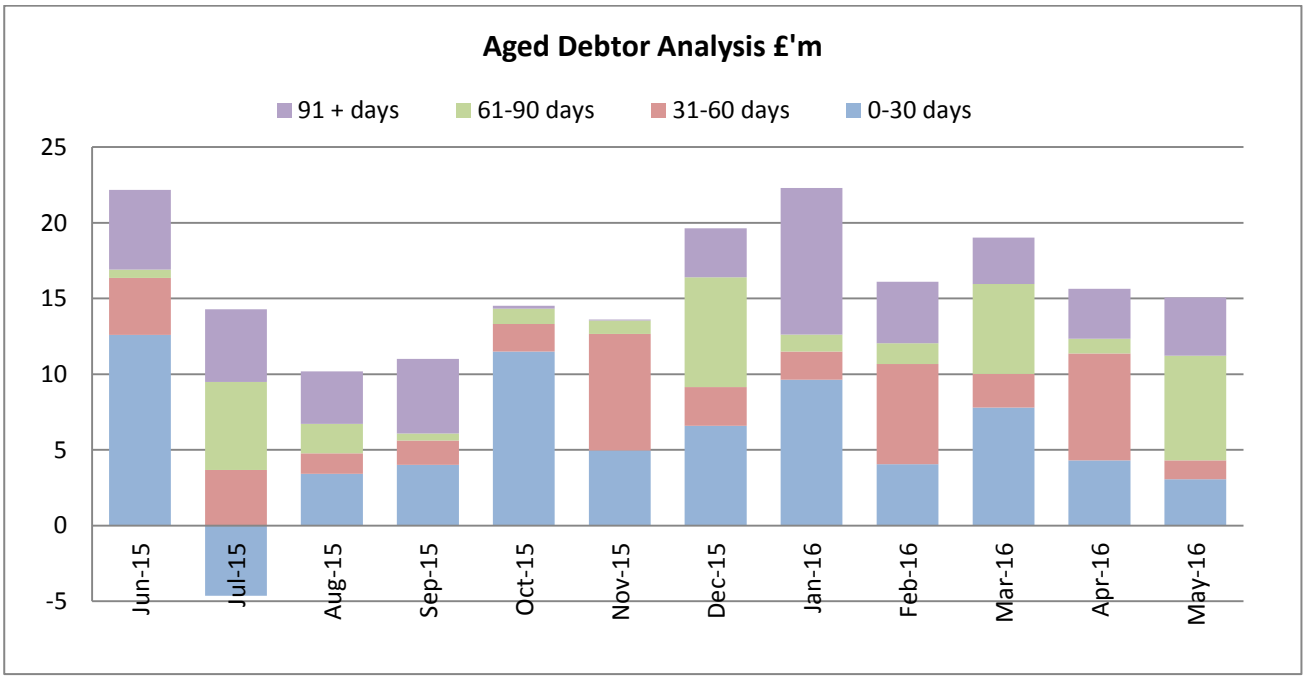
7. Statement of Financial Position and Cashflow

Overall, the Trust had a strong statement of financial position as at 31st May 2016 with net current assets of £33.797m, an increase of £3.394m from last month.

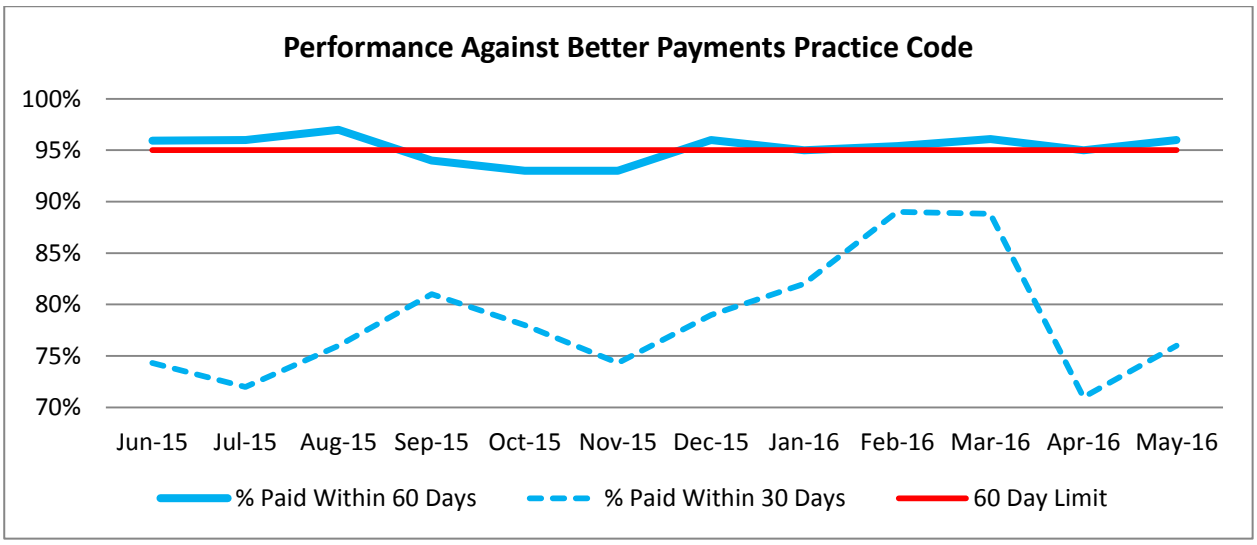
The Trust held cash of £70.274m at the end of May, £5.202m lower than the Operational Plan. Cash receipts were £7.371m lower than forecast reflecting Commissioners paying the monthly SLA contract at 2015/16 contract levels whilst the 2016/17 contract is finalised. Cash payments were £2.354m higher than planned following the settlement of a disputed invoice relating to South Bristol Community Hospital. This is offset by higher than planned opening cash balances. The forecast year end cash balance is £70.432m. The graph below shows the month end cash balance trajectory for the financial year.



The total value of debtors decreased by £0.568m in May to £15.068m. SLA debtors increased by £0.839m and non SLA debtors decreased by £1.407m. The total value of debtors over 60 days old increased by £6.490m to £10.759m. £5.084m of this increase related to SLA debtors and reflected the ageing of the estimated invoices for March activity which have been replaced by actual invoices in June. The increase in non SLA debtors of £1.406m is primarily due to NBT (£0.584m) and the delay in payment of clinical excellence funding by NHS England (£0.231m). Further details are provided in agenda item 7.1.



In May, performance for payment of invoices within 60 days was 96% compared with the Prompt Payments Code target of 95%. The number of invoices paid within 30 days increased to 76% reflecting the action taken to recover the backlog resulting from additional year end requirements and reduced staffing. A chart plotting performance is provided below.



Attachments

Appendix 1 – Summary Income and Expenditure Statement
Appendix 2 – Divisional Income and Expenditure Statement
Appendix 3 – Nursing KPIs
Appendix 4 – Financial Sustainability Risk Rating
Appendix 5a – Key Financial Metrics
Appendix 5b – Key Workforce Metrics
Appendix 6 – Financial Risk Matrix
Appendix 7 – Monthly Analysis of Pay Expenditure
Appendix 8 - Release of Reserves

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report May 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 April	Operating Plan Trajectory Year to Date	Variance from Operating Plan Trajectory Year to Date
				Pay	Non Pay	Operating Income	Income from Activities	CIP				
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income											
544,417	Contract Income	89,859	89,858	-	-	(19)	18	-	(1)	-		
-	Overheads, Fines & Rewards	-	359	-	-	-	359	-	359	(43)		
35,921	NHSE Income	6,048	6,048	-	-	-	-	-	-	-		
580,338	**Sub Total Corporate Income**	**95,907**	**96,265**	**-**	**-**	**(19)**	**377**	**-**	**358**	**(43)**		
	Clinical Divisions											
(51,393)	Diagnostic & Therapies	(8,540)	(8,459)	205	(206)	(26)	107	1	81	(45)	(28)	109
(75,484)	Medicine	(12,674)	(13,194)	(178)	(234)	15	(89)	(34)	(520)	(117)	(78)	(442)
(101,996)	Specialised Services	(16,675)	(16,802)	(73)	(90)	33	71	(68)	(127)	(26)	(105)	(22)
(105,314)	Surgery Head & Neck	(17,463)	(17,957)	(256)	(182)	28	248	(332)	(494)	(324)	(162)	(332)
(119,183)	Women's & Children's	(19,923)	(20,469)	(706)	587	9	(106)	(330)	(546)	(488)	(124)	(422)
(453,370)	**Sub Total - Clinical Divisions**	**(75,275)**	**(76,881)**	**(1,008)**	**(125)**	**59**	**231**	**(763)**	**(1,606)**	**(1,000)**	**(497)**	**(1,109)**
	Corporate Services											
(35,994)	Facilities And Estates	(5,915)	(5,926)	21	(25)	1	7	(15)	(11)	(7)	(20)	9
(24,843)	Trust Services	(4,186)	(4,171)	168	(130)	(59)	0	36	15	7	9	6
(3,678)	Other	(1,964)	(1,949)	26	116	(103)	(37)	13	15	15	9	6
(64,515)	**Sub Totals - Corporate Services**	**(12,065)**	**(12,046)**	**215**	**(39)**	**(161)**	**(30)**	**34**	**19**	**15**	**(2)**	**21**
(517,885)	**Sub Total (Clinical Divisions & Corporate Services)**	**(87,340)**	**(88,927)**	**(793)**	**(164)**	**(102)**	**201**	**(729)**	**(1,587)**	**(985)**	**(499)**	**(1,088)**
(14,102)	Reserves	(600)	-	-	600	-	-	-	600	-		
(14,102)	**Sub Total Reserves**	**(600)**	**-**	**-**	**600**	**-**	**-**	**-**	**600**	**-**		
48,351	**Trust Totals Unprofiled**	**7,967**	**7,338**	**(793)**	**436**	**(121)**	**578**	**(729)**	**(629)**	**(1,028)**		
	Financing											
(22,471)	Depreciation & Amortisation - Owned	(3,610)	(3,550)	-	60	-	-	-	60	28		
244	Interest Receivable	41	53	-	12	-	-	-	12	5		
(291)	Interest Payable on Leases	(48)	(49)	-	(1)	-	-	-	(1)	1		
(3,124)	Interest Payable on Loans	(521)	(500)	-	21	-	-	-	21	14		
(8,509)	PDC Dividend	(1,418)	(1,431)	-	(13)	-	-	-	(13)	(6)		
(34,151)	**Sub Total Financing**	**(5,556)**	**(5,477)**	**-**	**79**	**-**	**-**	**-**	**79**	**42**		
14,200	**NET SURPLUS / (DEFICIT) before Technical Items**	**2,411**	**1,861**	**(793)**	**515**	**(121)**	**578**	**(729)**	**(550)**	**(986)**		
	Technical Items											
-	Profit/(Loss) on Sale of Asset	-	-	-	-	-	-	-	-	-		
2,732	Donations & Grants (PPE/Intangible Assets)	2,000	2,060	-	-	60	-	-	60	-		
(7,477)	Impairments	-	-	-	-	-	-	-	-	-		
385	Reversal of Impairments	-	-	-	-	-	-	-	-	-		
(1,542)	Depreciation & Amortisation - Donated	(257)	(265)	-	(8)	-	-	-	(8)	(3)		
(5,902)	**Sub Total Technical Items**	**1,743**	**1,795**	**-**	**(8)**	**60**	**-**	**-**	**52**	**(3)**		
8,298	**SURPLUS / (DEFICIT) after Technical Items Unprofiled**	**4,154**	**3,656**	**(793)**	**507**	**(61)**	**578**	**(729)**	**(498)**	**(989)**		

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs **APPENDIX 3**

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%										
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	3.4%	3.8%										
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	4.2%	4.2%										
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	4.2%	4.2%										
Total	Target	3.7%	3.7%	3.7%	3.9%	3.9%	3.9%	4.2%	4.2%	4.2%	4.2%	4.2%	4.2%
Total	Actual	3.7%	3.7%										

Source: HR

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Target	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Medicine	Actual	7.5%	8.7%										
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%										
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%										
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%										
Total	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%
Total	Actual	4.1%	5.4%										

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Target	15.1%	*15.1%*	15.1%	15.1%	15.1%	15.1%	15.1%	15.1%	15.1%	15.1%	15.1%	15.1%
Medicine	Actual	16.6%	16.3%										
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%										
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%										
Women's & Children's	Target	10.6%	*10.6%*	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%	10.6%
Women's & Children's	Actual	9.3%	10.1%										
Total	Target	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%	12.3%
Total	Actual	13.0%	12.8%										

Source: HR

Graph 4 **Operating plan for nursing agency £000**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Target	145.0	115.0	131.0	140.0	150.0	150.0	80.0	90.0	90.0	75.0	80.0	75.0
Medicine	Actual	244.6	132.0										
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										
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										
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										
Total	Target	275.2	258.8	312.0	271.2	291.0	287.4	246.7	159.2	150.0	131.1	136.1	131.1
Total	Actual	713.5	576.1	-	-	-	-	-	-	-	-	-	-

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										
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										
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										
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										
Total	Target	50.3	43.5	52.5	46.2	53.5	43.6	45.3	25.1	30.3	19.2	20.2	19.2
Total	Actual	84.7	72.9	-	-	-	-	-	-	-	-	-	-

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%										
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%										
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%										
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%										
Total	Target	3.3%	3.1%	3.7%	3.2%	3.5%	3.4%	2.9%	1.9%	1.8%	1.5%	1.6%	1.5%
Total	Actual	8.5%	6.6%										

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										
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										
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										
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										
Total	Target	27,600	28,520	27,600	28,520	28,520	27,600	28,520	27,600	28,520	28,520	25,760	28,520
Total	Actual	25,486	25,953	-	-	-	-	-	-	-	-	-	-

Source: Info web: KPI Bed occupancy

Graph 8 **NA 1:1 and RMN £000 (total temporary spend)**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Target	44	44	44	44	44	44	44	44	44	44	44	44
Medicine	Actual	64	56										
Specialised Services	Target	20	20	20	20	20	20	20	20	20	20	20	20
Specialised Services	Actual	17	25										
Surgery, Head & Neck	Target	43	43	43	43	43	43	43	43	43	43	43	43
Surgery, Head & Neck	Actual	24	16										
Women's & Children's	Target	12	12	12	12	12	12	12	12	12	12	12	12
Women's & Children's	Actual	86	32										
Total	Target	119	119	119	119	119	119	119	119	119	119	119	119
Total	Actual	191	129	-	-	-	-	-	-	-	-	-	-

Source: Finance temp staffing graphs

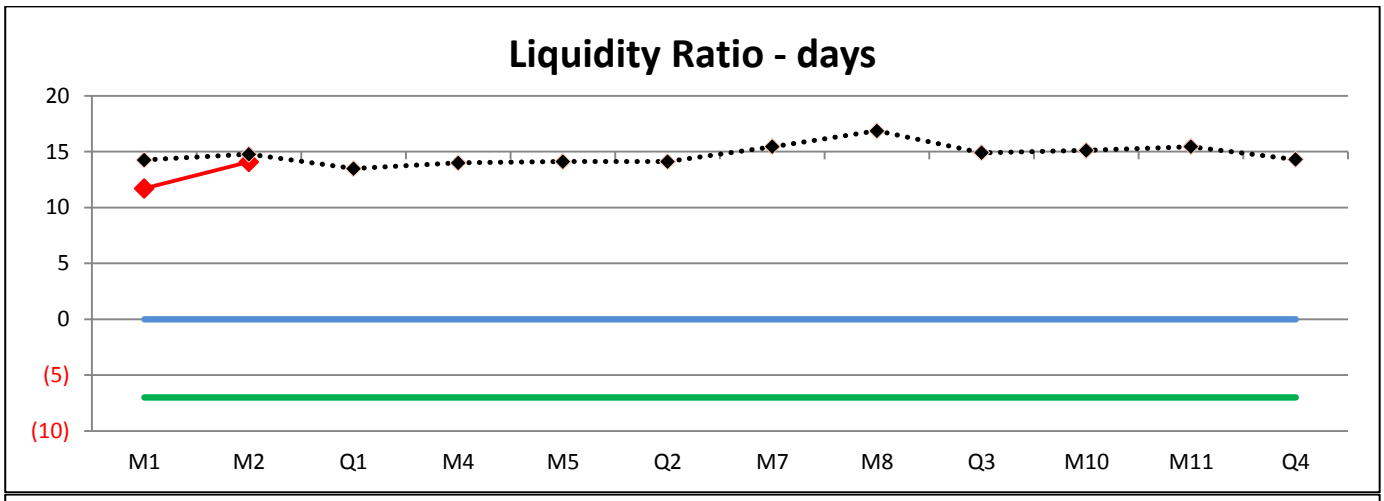
Financial Sustainability Risk Rating – May 2016 Performance

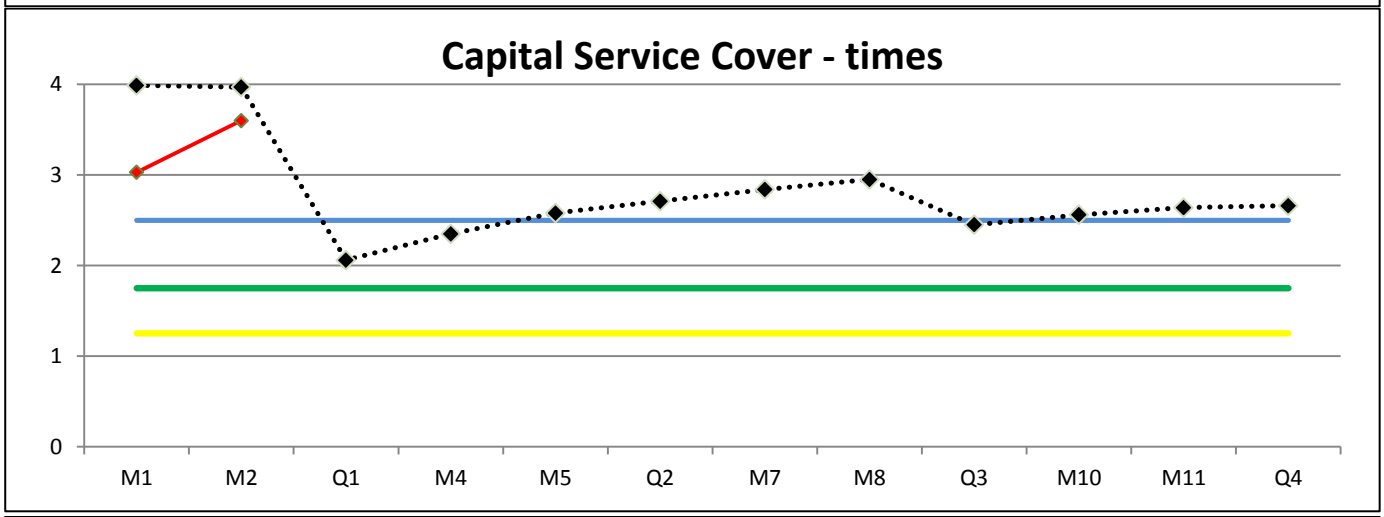
The graphs overleaf show performance against the four Financial Sustainability Risk Rating (FSRR) metrics. For the period to the end of May, the Trust achieved an overall FSRR of 4 (actual 3.75) against a plan of 4.

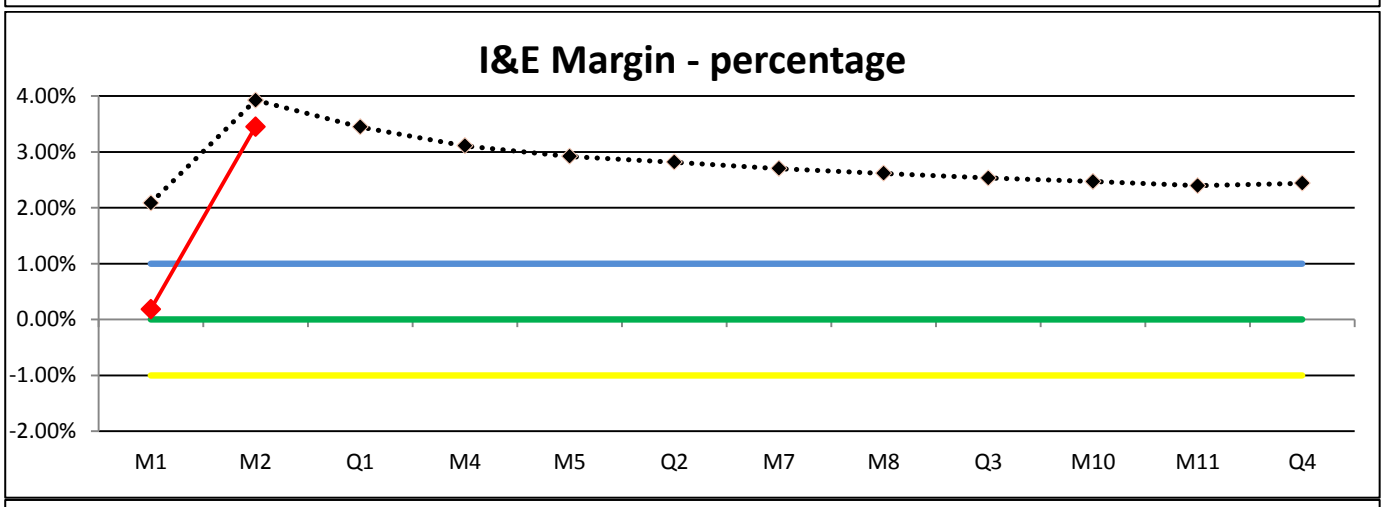
The liquidity, capital servicing capacity and income and expenditure margin metrics are each in line with the plan to date with actual metric scores of 4. The income and expenditure margin variance from plan metric score is 3 for April and May against a plan of 4. This is due to the Trust's lower than planned net surplus before technical items of £1,861k against a planned surplus of £2,411k. A summary of the position is provided in the table below.

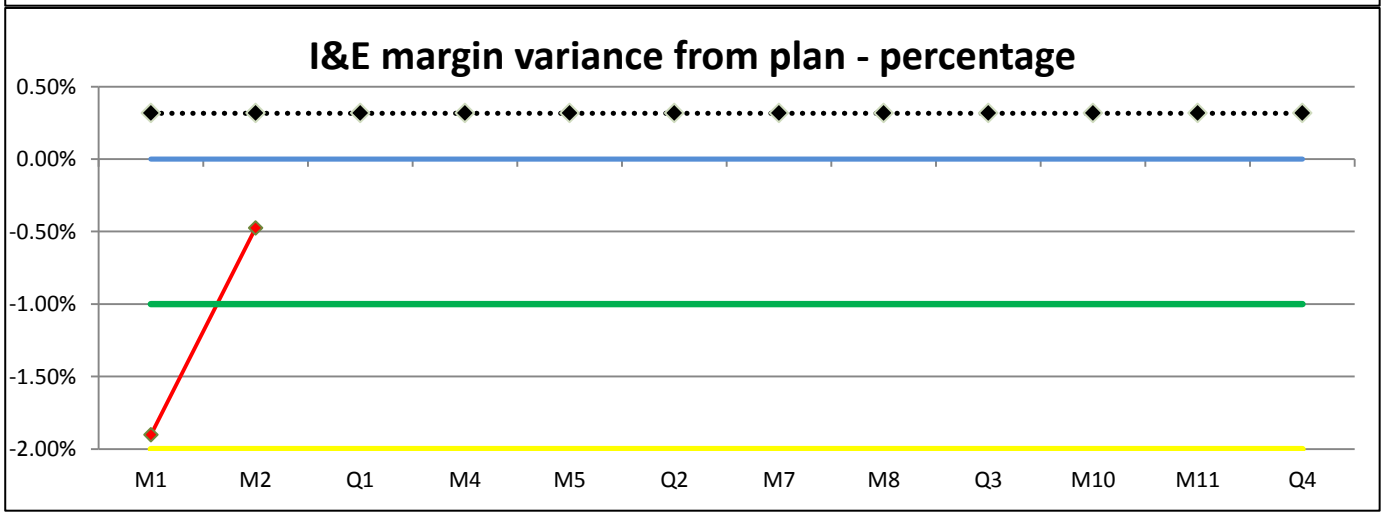
		31st May 2016		31st March 2017	
	Weighting	Plan	Actual	Plan	Forecast
Liquidity					
Metric Result – days		14.77	14.08	14.29	14.29
Metric Rating	25%	4	4	4	4
Capital Servicing Capacity					
Metric Result – times		3.97	3.60	2.66	2.66
Metric Rating	25%	4	4	4	4
Income & expenditure margin					
Metric Result		3.93%	3.45%	2.44%	2.44%
Metric Rating	25%	4	4	4	4
Variance in I&E margin					
Metric Result		0.32%	(0.48)%	0.32%	0.00%
Metric Rating	25%	4	3	4	4
Overall FSRR		**4.0**	**3.75**	**4.0**	**4.0**
Overall FSRR (rounded)		**4**	**4**	**4**	**4**

The charts presented overleaf show the trajectories for each of the four metrics. The 2016/17 Operational Plan submitted to Monitor on 18th April 2016 is shown as the black dotted line against which actual performance is plotted in red. The metric ratings are shown for **4 (blue line)**; **3 (green line)** and **2 (yellow line)**.


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


Capital Service Cover - times
4
3
2
1
0
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


I&E Margin - percentage
4.00%
3.00%
2.00%
1.00%
0.00%
-1.00%
-2.00%
M1
M2
Q1
M4
M5
Q2
M7
M8
Q3
M10
M11
Q4


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

Key Financial Metrics - May 2016

Appendix 5a

	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Facilities & Estates	Trust Services	Corporate	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Contract Income - Activity Based									
Current Month									
Budget	3,302	4,350	4,599	6,647	8,563	301		9,476	37,238
Actual	3,428	4,230	4,755	6,972	8,863	308		9,788	38,344
Variance Fav / (Adv)	126	(120)	156	325	300	7	-	312	1,106
Year to date									
Budget	6,546	8,659	9,860	13,411	17,206	610		17,674	73,966
Actual	6,644	8,652	10,203	13,602	17,028	615		17,942	74,686
Variance Fav / (Adv)	98	(7)	343	191	(178)	5	-	268	720

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

Contract Income - Penalties									
Current Month									
Plan		(65)	(10)	(21)	(5)			(49)	(150)
Actual		(70)	(11)	(58)	(78)			42	(175)
Variance Fav / (Adv)	-	(5)	(1)	(37)	(73)	-	-	91	(25)
Year to date									
Plan		(65)	(10)	(24)	(7)			(99)	(205)
Actual		(70)	(11)	(61)	(81)			(8)	(231)
Variance Fav / (Adv)	-	(5)	(1)	(37)	(74)	-	-	91	(26)

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

Contract Income - Rewards									
Current Month									
Plan								790	790
Actual								790	790
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-
Year to date									
Plan								1,560	1,560
Actual								1,560	1,560
Variance Fav / (Adv)	-	-	-	-	-	-	-	-	-

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

Cost Improvement Programme									
Current Month									
Plan	121	115	120	381	408	56	82	124	1,407
Actual	178	111	97	265	221	59	78	132	1,141
Variance Fav / (Adv)	57	(4)	(23)	(116)	(187)	3	(4)	8	(266)
Year to date									
Plan	242	229	237	745	814	111	165	248	2,791
Actual	274	247	184	494	444	116	155	261	2,175
Variance Fav / (Adv)	32	18	(53)	(251)	(370)	5	(10)	13	(616)

Key Workforce Metrics

Appendix 5b

Diagnostic & Therapies

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	355	111	36	(11)											25	86
Nursing agency expenditure (£'000)	7	1	12	(6)											6	(5)
Overall																
Sickness (%)	2.8%		2.4%	2.4%											2.4%	
Turnover (%)	12.5%		13.3%	13.4%											13.4%	
Establishment (wte)			1,000.69	958.00												
In post (wte)			961.64	927.00												
Under/(over) establishment (wte)			39.05	31.00	-	-	-	-	-	-	-	-	-	-		
Nursing:																
Sickness - registered (%)			1.7%	0.0%											0.8%	
Sickness - unregistered (%)			0.0%	0.0%											0.0%	
Turnover - registered (%)	4.1%		19.9%	19.2%											19.2%	
Turnover - unregistered (%)	0.0%		0.0%	0.0											0.0%	
Starters (wte)			1.00	1.00											2.00	
Leavers (wte)			-	-											-	
Net starters (wte)			1.00	1.00	0.00	0	0	0	0	0.00	0.00	0.00	0.00	0.00	2.00	
Establishment (wte)			17.66	17.66												
In post - Employed (wte)			16.57	18.75												
In post - Bank (wte)			0.16	1.41												
In post - Agency (wte)			3.46	0.10												
In post - total (wte)			20.19	20.26	-	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(2.53)	(2.60)	0.00	0.00	0.00	-	-	-	-	-	-	-		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Medicine

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,965	524	334	239											573	(49)
Nursing agency expenditure (£'000)	1,395	279	256	140											396	(117)
Overall																
Sickness (%)	4.6%		4.4%	3.7%											4.1%	
Turnover (%)	13.2%		14.8%	14.9%											14.9%	
Establishment (wte)			1,215.16	1,209.00												
In post (wte)			1,253.43	1,230.00												
Under/(over) establishment (wte)			(38.27)	(21.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	4.1%		3.1%	1.9%											2.5%	
Sickness - unregistered (%)	6.5%		7.8%	7.6%											7.7%	
Turnover - registered (%)	15.1%		16.7%	16.3%											16.3%	
Turnover - unregistered (%)	25.6%		18.1%	19.5%											19.5%	
Starters (wte)			11.19	14.85											26.04	
Leavers (wte)			12.26	9.16											21.42	
Net starters (wte)			(1.07)	5.69	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.62	
Establishment (wte)			769.87	767.62												
In post - Employed (wte)			695.64	686.14												
In post - Bank (wte)			82.62	88.69												
In post - Agency (wte)			36.20	21.30												
In post - total (wte)			814.46	796.13	-	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(44.59)	(28.51)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics **Appendix 5b**

Specialised Services

	Operating Plan Target		Actual												
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	1,332	298	182	196											378	(80)
Nursing agency expenditure (£'000)	410	111	100	110											210	(99)
Overall																
Sickness (%)	3.6%		3.5%	3.4%											3.5%	
Turnover (%)	12.4%		14.2%	13.4%											13.4%	
Establishment (wte)			908.17	937.00												
In post (wte)			901.55	933.00												
Under/(over) establishment (wte)			6.62	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	4.1%		3.4%	3.8%											3.6%	
Sickness - unregistered (%)	7.4%		7.0%	5.4%											6.2%	
Turnover - registered (%)	13.3%		15.6%	14.2%											14.2%	
Turnover - unregistered (%)	18.0%		12.1%	12.2%											12.2%	
Starters (wte)			7.80	4.60											12.40	
Leavers (wte)			6.37	3.00											9.37	
Net starters (wte)			1.43	1.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.03	
Establishment (wte)			480.47	486.02												
In post - Employed (wte)			441.23	438.90												
In post - Bank (wte)			27.30	37.55												
In post - Agency (wte)			12.07	14.14												
In post - total (wte)			480.60	490.59	-	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(0.13)	(4.57)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Surgery, Head and Neck

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	978	183	263	251											514	(331)
Nursing agency expenditure (£'000)	343	77	219	207											426	(349)
Overall																
Sickness (%)	3.7%		3.9%	3.8%											3.8%	
Turnover (%)	12.1%		14.1%	13.8%											13.8%	
Establishment (wte)			1,741.45	1,756.00												
In post (wte)			1,785.03	1,772.00												
Under/(over) establishment (wte)			(43.58)	(16.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	3.8%		4.0%	4.2%											4.1%	
Sickness - unregistered (%)	3.7%		7.7%	5.5%											6.6%	
Turnover - registered (%)	12.1%		14.6%	13.6%											13.6%	
Turnover - unregistered (%)	21.8%		17.0%	18.0%											18.0%	
Starters (wte)			4.00	6.37											10.37	
Leavers (wte)			8.00	4.50											12.50	
Net starters (wte)			(4.00)	1.87	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	- 2.13	
Establishment (wte)			695.49	699.86												
In post - Employed (wte)			662.80	658.55												
In post - Bank (wte)			49.28	44.54												
In post - Agency (wte)			28.85	30.80												
In post - total (wte)			740.93	733.89	-	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(45.44)	(34.03)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
The annual target for sickness is the average of the previous 12 months as at March 2017.
The annual target for turnover, because it is a rolling 12 month cumulative measure, is the position at March 2017.

Note: wte in post for nursing bank and agency staff is calculated based on data supplied by TSB for the hours verified as worked within Rosterpro. This data is dependent on the timing of shift verifications.
The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

Key Workforce Metrics

Appendix 5b

Women's and Children's

	Operating Plan Target		Actual													
	Annual	Year to date	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Year to date	Year to date variance
Overall agency expenditure (£'000)	775	113	255	162											417	(304)
Nursing agency expenditure (£'000)	662	101	217	141											358	(257)
Overall																
Sickness (%)	3.8%		3.9%	4.0%											4.0%	
Turnover (%)	10.8%		10.9%	11.0%											11.0%	
Establishment (wte)			1,899.46	1,878.00												
In post (wte)			1,932.95	1,898.00												
Under/(over) establishment (wte)			(33.49)	(20.00)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
Nursing:																
Sickness - registered (%)	4.0%		4.0%	4.2%											4.1%	
Sickness - unregistered (%)	5.0%		8.5%	9.8%											9.2%	
Turnover - registered (%)	10.6%		9.3%	10.1%											10.1%	
Turnover - unregistered (%)	15.3%		15.3%	12.7%											12.7%	
Starters (wte)			4.91	10.22											15.13	
Leavers (wte)			10.46	11.27											21.73	
Net starters (wte)			(5.55)	(1.05)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(6.60)	
Establishment (wte)			1,112.90	1,118.77												
In post - Employed (wte)			1,078.77	1,075.80												
In post - Bank (wte)			32.38	42.04												
In post - Agency (wte)			29.91	19.07												
In post - total (wte)			1,141.06	1,136.91	-	-	-	-	-	-	-	-	-	-		
Under/(over) establishment (wte)			(28.16)	(18.14)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		

Definitions:

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

Targets: There are no year to date targets for sickness and turnover. Targets are not set at staff group level for sickness absence.
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The calculation for wte in post for nurse bank continues to be reviewed in light of new data available from Rosterpro.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report May 2016 - Risk Matrix

Datix Risk Register Ref.	Description of Risk	Inherent Risk (if no action taken)		Action to be taken to mitigate risk	Lead	Current Risk		Target Risk	
		Risk Score & Level	Financial Value			Risk Score & Level	Financial Value	Risk Score & Level	Financial Value
959	Risk that Trust does not deliver future years financial plan due to under delivery of recurrent savings in year. Only 82% of the required savings have been identified at 30th April 2016, leaving a savings gap of £3.2m.	16 - Very High	£3.2m	Trust is working to develop savings plans to meet 2016/17 target of £17.4m and close the current savings gap of £2.9m. Divisions, Corporate and transformation team are actively working to promote the pipelines schemes into deliverable savings schemes.	OA	12 - High	£2.9m	4 - Low	£0.0m
416	Risk that the Trust's Financial Strategy may not be deliverable in changing national economic climate.	9 - High	-	Maintenance of long term financial model and in year monitoring on financial performance through monthly divisional operating reviews and Finance Committee and Trust Board.	PM	9 - High	-	9 - High	-
951	Risk of national contract mandates financial penalties on under-performance against key indicators.	9 - High	£4.0m	Ongoing negotiations with Commissioners but activity and finance largely agreed. Heads of Terms expected by the end of June 2016. If Sustainability & Transformation funding is agreed the risk reduces to c.£1m.	PM	9 - High	£2.0m	3 - Low	£1.0m
50	Risk of Commissioner Income challenges	6 - Moderate	£3.0m	The Trust has strong controls of the SLA management arrangements.	PM	6 - Moderate	£2.0m	3 - Low	£0.0m
408	Risk to UH Bristol of fraudulent activity.	3 - Low	-	Local Counter Fraud Service in place. Pro active counter fraud work. Reports to Audit Committee.	PM	3 - Low	-	3 - Low	-

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17					2013/14	2013/14	2014/15	2014/15
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Diagnostic & Therapies	Pay budget	10,357	10,483	10,432	10,413	41,686	3,474		3,580	3,350	6,929	3,465		3,294		3,373	
	Bank	82	109	93	88	371	31	0.9%	20	21	41	20	0.6%	26	0.8%	26	0.8%
	Agency	377	242	186	168	972	81	2.4%	36	(11)	25	12	0.4%	28	0.9%	87	2.6%
	Waiting List initiative	98	54	95	95	342	29	0.8%	21	42	63	32	0.9%	19	0.6%	22	0.7%
	Overtime	147	94	100	110	450	38	1.1%	47	37	84	42	1.3%	26	0.8%	34	1.0%
	Other pay	9,572	9,648	9,788	9,920	38,927	3,244	94.8%	3,351	3,112	6,463	3,232	96.8%	3,179	97.0%	3,198	95.0%
	Total Pay expenditure	10,276	10,146	10,261	10,382	41,063	3,422	100.0%	3,475	3,201	6,676	3,338	100.0%	3,278	100.0%	3,367	100.0%
	Variance Fav / (Adverse)	82	337	172	31	623	52		105	149	253	127		16		5	
Medicine	Pay budget	12,841	12,458	12,400	12,606	50,305	4,192		4,306	4,290	8,596	4,298		3,679		4,108	
	Bank	897	935	905	1,039	3,775	315	7.2%	243	319	562	281	6.3%	275	6.9%	297	7.1%
	Agency	826	875	814	1,119	3,634	303	7.0%	333	239	572	286	6.5%	196	4.9%	291	7.0%
	Waiting List initiative	51	45	56	42	194	16	0.4%	29	29	58	29	0.7%	13	0.3%	16	0.4%
	Overtime	16	21	35	32	105	9	0.2%	8	9	17	8	0.2%	16	0.4%	8	0.2%
	Other pay	11,212	10,941	10,982	11,308	44,443	3,704	85.2%	3,790	3,851	7,641	3,820	86.3%	3,479	87.4%	3,568	85.4%
	Total Pay expenditure	13,002	12,817	12,792	13,539	52,151	4,346	100.0%	4,403	4,447	8,850	4,425	100.0%	3,979	100.0%	4,180	100.0%
	Variance Fav / (Adverse)	(161)	(359)	(391)	(933)	(1,846)	(154)		(97)	(157)	(254)	(127)		(300)		(72)	
Specialised Services	Pay budget	10,135	10,245	10,342	10,557	41,279	3,440		3,657	3,968	7,624	3,812		3,060		3,266	
	Bank	402	404	352	423	1,581	132	3.7%	94	159	253	127	3.3%	99	3.1%	108	3.2%
	Agency	671	710	582	689	2,651	221	6.3%	182	196	378	189	4.9%	157	5.0%	228	6.7%
	Waiting List initiative	125	144	156	103	528	44	1.2%	41	56	97	49	1.3%	32	1.0%	42	1.3%
	Overtime	29	29	30	25	114	9	0.3%	8	11	18	9	0.2%	15	0.5%	12	0.4%
	Other pay	9,189	9,222	9,395	9,674	37,480	3,123	88.5%	3,330	3,646	6,976	3,488	90.3%	2,840	90.4%	2,995	88.5%
	Total Pay expenditure	10,415	10,510	10,516	10,913	42,354	3,529	100.0%	3,654	4,068	7,722	3,861	100.0%	3,142	100.0%	3,386	100.0%
	Variance Fav / (Adverse)	(280)	(265)	(174)	(356)	(1,075)	(90)		3	(100)	(97)	(49)		(82)		(120)	
Surgery Head and Neck	Pay budget	19,366	19,669	19,708	19,855	78,598	6,550		6,588	6,629	13,217	6,609		5,911		6,030	
	Bank	559	683	488	624	2,355	196	3.0%	172	176	348	174	2.6%	155	2.5%	169	2.7%
	Agency	603	908	738	752	3,000	250	3.8%	262	251	514	257	3.8%	67	1.1%	106	1.7%
	Waiting List initiative	407	387	371	249	1,414	118	1.8%	86	135	221	111	1.6%	116	1.9%	139	2.2%
	Overtime	38	47	45	41	171	14	0.2%	11	12	24	12	0.2%	40	0.7%	32	0.5%
	Other pay	17,853	17,860	18,200	18,209	72,122	6,010	91.2%	6,156	6,184	12,339	6,170	91.8%	5,766	93.8%	5,859	92.9%
	Total Pay expenditure	19,461	19,885	19,844	19,875	79,062	6,589	100.0%	6,687	6,758	13,446	6,723	100.0%	6,145	100.0%	6,305	100.0%
	Variance Fav / (Adverse)	(95)	(215)	(136)	(20)	(466)	(39)		(99)	(129)	(229)	(114)		(235)		(275)	

Analysis of pay spend 2015/16 and 2016/17

Division		2015/16							2016/17					2013/14	2013/14	2014/15	2014/15
		Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total £'000	Mthly Average £'000	Mthly Average %	Apr £'000	May £'000	Total £'000	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %	Mthly Average £'000	Mthly Average %
Women's and Children's	Pay budget	22,562	22,828	23,290	23,780	92,460	7,705		7,944	7,602	15,547	7,773		6,123		7,178	
	Bank	533	582	487	611	2,213	184	2.3%	141	185	325	163	2.0%	151	2.5%	181	2.5%
	Agency	703	840	866	719	3,128	261	3.3%	255	162	418	209	2.6%	117	1.9%	154	2.1%
	Waiting List initiative	205	169	203	206	783	65	0.8%	32	71	103	52	0.6%	30	0.5%	33	0.5%
	Overtime	23	19	26	35	102	9	0.1%	9	15	25	12	0.2%	19	0.3%	30	0.4%
	Other pay	21,492	21,695	22,409	22,958	88,554	7,379	93.4%	7,750	7,625	15,376	7,688	94.6%	5,843	94.9%	6,793	94.5%
	Total Pay expenditure	22,956	23,305	23,991	24,530	94,780	7,898	100.0%	8,188	8,058	16,247	8,123	100.0%	6,159	100.0%	7,190	100.0%
	Variance Fav / (Adverse)	(393)	(477)	(701)	(750)	(2,320)	(193)		(244)	(456)	(700)	(350)		(36)		(12)	
Facilities & Estates	Pay budget	5,057	5,113	5,142	5,070	20,382	1,699		1,708	1,788	3,495	1,748		1,536		1,618	
	Bank	296	320	278	246	1,140	95	5.6%	45	78	122	61	3.5%	46	3.0%	89	5.5%
	Agency	145	189	249	154	738	62	3.6%	32	27	59	29	1.7%	29	1.9%	42	2.6%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0.0%	0	0.0%
	Overtime	225	244	207	200	876	73	4.3%	68	68	136	68	3.9%	75	4.9%	80	5.0%
	Other pay	4,406	4,373	4,371	4,499	17,649	1,471	86.5%	1,572	1,609	3,181	1,591	90.9%	1,366	90.1%	1,394	86.9%
	Total Pay expenditure	5,072	5,126	5,106	5,100	20,403	1,700	100.0%	1,717	1,782	3,498	1,749	100.0%	1,516	100.0%	1,605	100.0%
	Variance Fav / (Adverse)	(16)	(12)	36	(30)	(21)	(2)		(9)	6	(3)	(2)		20		13	
Trust Services (Incl R&I and Support Services)	Pay budget	6,487	6,496	6,977	7,438	27,398	2,283		2,327	2,532	4,859	2,430		2,458		2,478	
	Bank	179	211	232	223	846	70	3.2%	60	61	121	61	2.6%	57	2.4%	57	2.4%
	Agency	69	177	390	367	1,002	83	3.7%	26	98	123	62	2.6%	31	1.3%	59	2.5%
	Waiting List initiative	0	0	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0.0%	0	0.0%
	Overtime	22	23	20	16	81	7	0.3%	4	5	9	5	0.2%	9	0.4%	9	0.4%
	Other pay	6,029	5,967	6,201	6,662	24,859	2,072	92.8%	2,190	2,213	4,403	2,202	94.6%	2,285	95.9%	2,223	94.7%
	Total Pay expenditure	6,299	6,378	6,843	7,268	26,788	2,232	100.0%	2,280	2,377	4,657	2,328	100.0%	2,383	100.0%	2,348	100.0%
	Variance Fav / (Adverse)	188	118	134	169	610	51		47	155	202	101		75		130	
Trust Total	Pay budget	86,805	87,293	88,292	89,718	352,109	29,342		30,109	30,158	60,267	30,134		26,060		28,050	
	Bank	2,949	3,244	2,834	3,254	12,281	1,023	3.4%	774	998	1,773	886	2.9%	809	3.0%	927	3.3%
	Agency	3,393	3,941	3,824	3,967	15,126	1,260	4.2%	1,127	961	2,088	1,044	3.4%	625	2.4%	967	3.4%
	Waiting List initiative	886	799	881	695	3,261	272	0.9%	209	333	542	271	0.9%	210	0.8%	252	0.9%
	Overtime	499	478	463	460	1,899	158	0.5%	156	157	313	156	0.5%	201	0.8%	204	0.7%
	Other pay	79,752	79,705	81,348	83,230	324,035	27,003	90.9%	28,139	28,240	56,379	28,190	92.3%	24,759	93.1%	26,031	91.7%
	Total Pay expenditure	87,480	88,166	89,352	91,607	356,602	29,717	100.0%	30,405	30,690	61,095	30,548	100.0%	26,603	100.0%	28,381	100.0%
	Variance Fav / (Adverse)	(674)	(873)	(1,058)	(1,889)	(4,493)	(374)		(296)	(532)	(828)	(414)		(543)		(331)	

NOTE: Other Pay includes all employer's oncosts.

Release of Reserves 2016/17 **Appendix 8**

	Significant Reserve Movements							Divisional Analysis								
	Contingency Reserve	Inflation Reserve	Operating Plan	Savings Programme	Other Reserves	Non Recurring	Totals	Diagnostic & Therapies	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Estates & Facilities	Trust Services	Other including income	Totals
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Resources Book	700	11,709	38,455	(690)	2,426	3,194	55,794									
April movements	(120)	(8,993)	(31,315)	-	166	(208)	(40,470)	3,694	9,102	8,756	7,388	9,590	1,238	1,749	(1,047)	40,470
May																
Contracts transfer			(1,116)				(1,116)	(25)	(15)	18	(628)	19	(1)		1,748	1,116
Service transfers			(2,413)				(2,413)	(39)			2,553		(101)			2,413
Strategic Schemes Costs					(32)	(95)	(127)						120	7		127
CSIP						(78)	(78)							78		78
RTT validators						(40)	(40)							40		40
MADEL					(365)		(365)	(64)	(39)	(41)	(37)	(26)			572	365
Bristol Health Partners					(47)		(47)							47		47
EWTD					(144)		(144)	9	32	20	26	54	2	1		144
Other	(28)	(6)		7		(4)	(31)			4			6	21		31
Month 2 balances	552	2,710	3,611	(683)	2,004	2,769	10,963	3,575	9,080	8,757	9,302	9,637	1,264	1,943	1,273	44,831

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
14. Monitor feedback on Quarter 4 Risk Assessment Framework Submission									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: Pam Wenger, Trust Secretary									
Intended Audience									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose

The purpose of this report is to inform the Trust Board of Directors of Monitor's analysis of the Trust's Quarter 4 submission.

Key issues to note

Monitor's analysis of the quarter 4 submission is based on the Trust's risk ratings relating to Continuity of Services and Governance, which the Trust submission as follows:

- Continuity of Services Risk Rating – 4
- Governance Risk Rating – Green

These ratings will be published on NHS Improvement's website later in June 2016.

Following the conclusion of NHS Improvement's review of whether the Trust's target failures indicate underlying governance concerns, Monitor have decided to return the Trust to a governance rating of Green.

Recommendations
The Board is recommended to receive the report to note
Impact Upon Board Assurance Framework
None.
Impact Upon Corporate Risk
None.
Implications (Regulatory/Legal)
None.
Equality & Patient Impact
There are no equality implications as a result of this report. Potential impact on patient experience as a result of the Trust's failure to meet targets.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

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

Report Title
15. Corporate Governance Statement – Board self-certification of Compliance
Sponsor and Author(s)
Sponsor: Robert Woolley, Chief Executive Officer Author: Pam Wenger, Trust Secretary

Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

This report provides the necessary assurance for the Board to enable approval of the proposed Corporate Governance Statement for submission to NHS Improvement on 30th June 2016.

Under the governance condition of the Provider Licence regime, the Board is required to submit the following self-certifications as part of its Annual Plan submission to NHS Improvement on 30 June 2016:

- Corporate Governance Statement
- Joint Ventures and Academic Health Science Centre; and
- Training of Governors

The governance statement specifically requires the Board to confirm:

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, identifying (i) any risks to compliance; and (ii) any actions proposed to manage those risks

Key issues to note

This paper outlines the proposed response for each question and the assurance in place to support the Board's self-certification process. The paper also clarifies achievement or non-achievement of the mitigating actions from the previous year submission (2015/16).

Those actions not achieved have been carried forward into the current year and/or explanations for non-achievement have been provided.

Recommendations

The Board is invited to:

a) Consider and, in light of the assurances described in the attached paper (Appendix A), certify each Statement and if unable to do so, agree what supporting commentary the Board wishes to submit; and

b) Approve (including any amendments agreed) the Corporate Governance Statement for submission to NHS Improvement on 30 June 2016.
Impact Upon Board Assurance Framework
7. We will ensure we are soundly governed and are compliant with the requirements of our regulators.
Impact Upon Corporate Risk
N/A
Implications (Regulatory/Legal)
Statutory requirement/submission as part of the Trust's compliance with its Provider Licence
Equality & Patient Impact
N/A

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Corporate Governance Statement - Board Self Certification
30 June 2016

1. Situation

The Risk Assessment Framework (RAF) requires Foundation Trusts to submit a one-year Operational Plan to NHS Improvement as part of the annual planning process. NHS Improvement uses the information provided in these documents primarily to assess the risk that an NHS Foundation Trust may breach its Licence in relation to finance and governance. NHS Improvement will also assess the quality of the underlying planning processes.

Part of this annual planning process is the Board Statements. These Statements to NHS Improvement are as follows:

30 June 2016 Submission

- Corporate Governance Statement – confirming compliance with condition FT (4) of the provider Licence;
- Certification for Academic Health Science Centres (AHSC) – as required by Appendix E of the Risk Assessment Framework (only required for Trusts that are part of a joint venture or AHSC, therefore, not applicable for University Hospitals Bristol NHS Foundation Trust); and
- Training of governor's statement – as required by section 151(5) of the 2012 Act (relating to the requirement for Foundation Trusts to ensure that Governors are equipped with the skills and knowledge they require to undertake their role).

2. Background

In accordance with NHS Improvement's Risk Assessment Framework, to comply with the governance conditions of their Licence, NHS Foundation Trusts are required to provide a statement (the **Corporate Governance Statement**) setting out:

- any risks to compliance with the governance condition; and
- actions taken or being taken to maintain future compliance.

Where facts come to light that could call into question information in the corporate governance statement, or indicate that a Foundation Trust may not have carried out planned actions, NHS Improvement is likely to seek additional information from the Foundation Trust to understand the underlying situation. Depending on the Trust's response, NHS Improvement may decide to investigate further to establish whether there is a material governance concern that merits further action. The Trust is expected to submit its declarations to NHS Improvement on 30 June 2016 immediately after the conclusion of the Board

meeting.

3. Self-certification process

The Board declarations are made through the Corporate Governance Statements which are provided in the Risk Assessment Framework. A table top exercise has been undertaken with the aim of providing evidence relating to each of the component parts of the Corporate Governance Statement to support the Board's assessment of its compliance with each of the key questions, the identification of any risks and mitigation and completion of the overall Statement. The proposed sources of evidence to substantiate thee statements in the Board's declaration is included as Appendix **A** to this paper.

In the event that the Trust is unable to fully self-certify, it must provide NHS Improvement with commentary explaining the reasons for the absence of a full self-certification and the action it proposed to take to address the issues. Where the corporate governance statement indicates risks to compliance with the governance condition, NHS Improvement will consider whether any actions or other assurance is required at the time of the statement or whether it is more appropriate to maintain a watching brief.

4. Recommendations

The Board is invited to:

c) Consider and, in light of the assurances described in the attached paper (Appendix A), certify each Statement and if unable to do so, agree what supporting commentary the Board wishes to submit; and

d) Approve (including any amendments agreed) the Corporate Governance Statement for submission to NHS Improvement on 30 June 2016;

Pam Wenger
Trust Secretary

University Hospitals Bristol NHS
NHS Foundation Trust

Appendix A : Corporate Governance Statement 2016/17

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
1.	The Board is satisfied that University Hospitals Bristol NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	CONFIRMED	• Annual Report outlining Code of Governance compliance • Annual constitutional review • Annual Governance Statement providing assurance on the strength of Internal Control regarding risk management processes, review and effectiveness • ISA 260/External Audit Opinion on Annual Report and Quality Accounts • Head of Internal Audit Opinion and audit of quality indicators • Approved Internal Audit Plan • Internal and external audits with recommendations approved by Executive Leads and follow up process • Trust Board Governance Structure • Board Effectiveness Review • Monitor Operational Plan 2015/16 • Quarterly progress reports against corporate and quality objectives • Quarterly self-declaration submissions to Monitor on financial and governance ratings • Monthly quality and performance reports to relevant committee and Board (including focus on workforce) • Programme of regular quality reports and reporting to committees and Board including: patient safety, workforce; patient experience; serious incidents; complaints; and trust wide learning • Monthly finance reports to the Board • Quarterly review of Board assurance framework and	<u>Risks to compliance going forward</u> None identified. <u>Mitigating Actions for 2016/17</u> • Review the Risk Management Strategy and Policy (WLGR 4) • Development of a risk management e-learning package (WLGR 5) • Review the appraisal process of the NEDs

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
			annual assessment of strategic objectives and associated risks • CQC reports and response to CQC inspection/actions • Risk Management Strategy and policy • Corporate and Divisional Risk Registers • IG Toolkit self-certification • Mandatory training compliance • Review of Code of Conduct for both Board and Council of Governors • SFIs, Scheme of Delegation and Standing Orders annual review • Board walk rounds • Staff appraisal performance and compliance	
2.	The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time	CONFIRMED	• Monitor guidance generally implemented on an ongoing basis, e.g. Risk Assessment Framework/ Code of Governance • Compliance with the guidance on Well Led Governance Reviews • Annual self-assessment on Monitor's guidance on strategic planning undertaken • Annual review of compliance with Monitor's Code of Governance as part of Annual Report submission • PwC technical updates to the Audit Committee advise on forthcoming changes to regulation	<u>Risks to compliance going forward</u> None identified.
3	The Board is satisfied that the Trust implements: (a) effective board and committee structures; (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	CONFIRMED	• Board committee and governance structure • Reports and minutes from Committees and the Board • Review of the effectiveness of the Board and its committees and Board development/seminar sessions • Terms of reference for Board, committees and working groups • Annual reports from committees and review of terms of	<u>Risks to compliance going forward</u> None identified. <u>Mitigating Actions for 2016/17</u> • Review the Board Development Programme to ensure it meets the

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
	(c) clear reporting lines and accountabilities throughout its organisation		reference/ annual forward planners • Internal Audit reports on corporate governance related issues • Annual Governance Statement • Annual self-assessment of compliance with Monitor Code of Governance • Review of the Trust Constitution, Standing Orders, SFIs and Scheme of Delegation • Cross Board Committee NED Membership and reporting lines • Individual board members annual objectives, appraisals and development plans • Board member training records • Performance Management Framework • Risk management strategy outlining flow of information through the organisation regarding risks and the management of corporate and local risks including escalation and de-escalation • Statutory disclosure of Director' responsibilities in Annual Report • Code of Conduct of Board Members and Governors • Organisational Structure	regulatory and statutory requirements • Ensure a work programme is in place to ensure continual improvement in corporate governance arrangements following the Well Led Governance Review
4.	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	CONFIRMED	• The Board has access on an ongoing basis to inform its assessment of the risks to compliance with its Licence: - Monthly performance data to the Board and reviewed in respect of targets and standards, in line with Risk Assessment Framework. - Programme of regular quality reports and monitoring information in respect of workforce, patient safety, patient experience, serious incidents, complaints and infection control - Monthly Board finance reporting the overall	<u>Risks to compliance</u> Financial sustainability/Delivery of Efficiency Programme. Potential gaps for compliance assurance reporting. Board does not have sufficient insight/awareness of risk to compliance.

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
	(c) to ensure compliance with healthcare standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern); (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) to ensure compliance with all applicable legal requirements		financial position/performance against efficiency savings and key financial risks - Quarterly consideration of Financial Risk Rating (FRR), Continuity of Service Risk Rating (CoSRR) through self-declaration to Monitor and supporting narrative • Monthly Chief Executive report to the Board • Annual Plan and business planning process/scrutiny/ challenge to KPI Board metrics • Monitoring complaints, survey results, incidents, claims and effective reporting mechanisms that provide intelligence triangulation • Board committee structure providing ongoing review, scrutiny and monitoring of required development actions throughout the year – ensuring the Board has appropriate mechanisms to respond should any concerns develop in year • Annual internal audit programme confirmed by annual accounts audit opinion and ISA 260 report to Audit Committee • Divisional performance review meetings /service line meetings • Quarterly Board report on progress with key elements of the organisation's strategy and corporate objectives • Regular reporting to relevant committees and Board on compliance with CQC Fundamental Standards • IG Toolkit annual submission • Cleanliness audits/PLACE inspections/Clinical Audit & Effectiveness programme /Infection Control standards • CCG Contract review meetings • Monthly Board finance reports to Finance Committee and Board, including progress on delivery of efficiency savings programme	<u>Mitigating Actions for 2016/17</u> • Update on the progress against the actions to be reported to Audit Committee; • Review of the use of the Document Management System (WLGR 9)

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
			• Internal audit reports on financial systems and controls • External audit report (ISA 260) on the Annual Report and Accounts • Approval of the operational plan and financial plan • Annual cycle of business (forward planner) for Board and committees ensuring appropriate scheduling of reports • Corporate Risk Register and Board Assurance Framework reports key risks for finance and performance • Board assessment of strategic risks • Risks and mitigations identified in Monitor's Operational Plan/ Annual Report and Long Term Financial Model • The Corporate Risk Register and mitigating actions monitored by Risk Management Group, Senior Leadership Team, committees and Board • Trust's going concern review • Cost Improvement plans and budget setting process • Governance arrangements (Constitution, Standing Orders, SFIs, Scheme of Delegation • Annual Clinical Audit Plans • Board walk rounds • Staff and Patient Surveys • Review of SIs, RCAs link to learning, adherence, improvement	
5	The Board is satisfied: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	CONFIRMED	• Quarterly and annual self-declarations to Monitor • Appraisal outcomes • Board approved Remuneration Committees Terms of Reference • Details of training undertaken by NEDs and EDs • Board Induction Programme, skills audit and succession planning • Register of interests and standards of business conduct • Pre-employment checks; contractual conditions regarding other employment	<u>Risks to compliance</u> None identified. <u>Mitigating Actions for 2016/17</u> • Development of a divisional board leadership programme to support professional development (WLGR 14) • Strategic risks affecting the

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
	(c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) that the Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) that there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate		• Constitution - Board composition and work of Remuneration Committee • Approved Quality Strategy and Quality Accounts • Patient Story to every Board meeting • Board line of sight – walk rounds • Confirm and challenge focussing specifically on complaints process – complaints trends and themes to Board • External assurance on Quality Account • CQC Intelligent Monitoring/ CQC Compliance assessment • Annual Plan • Head of Internal Audit Opinion • Quality Impact Assessments • Clinical Audit plan improvements – time required to understand progress and link to improvements in outcomes of care • IG toolkit compliance reporting • Clinical audit plan • CQUIN performance reports • Committee meeting minutes focusing on quality improvement • Complaints, claims and incidents reporting • SUI reporting to Board via relevant committee, robust RCA process with further work commencing to improve learning loop and dissemination of learning • Board monthly quality dashboard • Survey outcomes to Board with remedial actions • Data quality focus increasing – validation, internal audit focus, business analysts, coding, Buddying arrangements etc • Annual Plan Engagement • Friends and Family Test, patient and staff surveys • CoG Project Focus Groups – independent, influencing	delivery of the 5 year plan to be included in the BAF (WLGR 3)

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
			agenda CoG and committees • Governor feedback and activity – PLACE audits etc • Quality Strategy driving analysis of Trust's performance on key quality metrics • Direct link to quality improvement through quality accounts and quality strategy • National reporting mechanism to Board (Berwick) • Board approved Committee ToRs – clear responsibilities • Executive job descriptions • Transformation strategy • Risk registers supported by quality issues captured in Divisional registers • SLT escalation protocols re off plan performance/quality	
6.	The Board of University Hospitals Bristol NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence	CONFIRMED	• Formal, rigorous and transparent procedure for the appointment of new directors to the Board • Board approval of constitution review • Board is comprised of appropriately qualified Director of Finance, Medical Director and Chief Nurse • Employment checks • Annual skills and competencies audit and annual appraisal process • Minutes of Remuneration and Nomination Committee (EDs)/Council of Governors' Nomination and Appointments Committee (NEDs) • Nursing staffing review/monitoring of nursing numbers • Revalidation process for doctors • HR policies and procedures • Board development programme in place	<u>Risks to compliance</u> None identified. <u>Mitigating Actions 2016/17</u> • Revise the role description of the Senior Independent Director (WLGR10). • Succession plan for the Executive Directors to be considered by the Remuneration Committee (WLGR 11)

Ref	Declaration to be made	Board confirmation of compliance for 2015/16	Evidence of Self-Certification	Risks and mitigating actions
	TRAINING FOR GOVERNORS The Board is satisfied that during the financial year, most recently ended the Trust has provided the necessary training to its Governors as required by in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role		In consultation with the Council of Governors, a development programme for Governors has improved during the year. The programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively and to discharge their responsibilities with enhanced levels of insight. The programme reflects Monitor's guidance for governors and was co-created with governors using self-assessment and the Constitutional Focus Group. There is also range of other opportunities for training and development provided to governors in the course of their attendance at various project groups and other meetings and activities throughout the year. •	<u>Mitigating Actions 2016/17</u> • Review the induction process for new Governors; • Undertake a skills audit and review the development programme
	CERTIFICATIONS ON ACADEMIC HEALTH SCIENCE CENTRE (AHSCS) AND GOVERNANCE For NHS Foundation Trusts: • That are part of a major Joint Venture or AHSCS; or • Whose Boards are considering entering into either a major Joint Venture or an AHSC	**NOT APPLICABLE**		

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
16. Register of Seals									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: Pam Wenger, Trust Secretary									
Intended Audience									
Board members	✓	Regulators	✓	Governors	✓	Staff		Public	✓
Executive Summary									
Purpose: To report applications of the Trust Seal as required by the Foundation Trust Constitution. Key issues to note: Standing Orders for the Trust Board of Directors stipulates that an entry of every 'sealing' shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the person who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust Seal shall be made to the Board containing details of the seal number, a description of the document and the date of sealing. The attached report includes all new applications of the Trust Seal to June 2016 since the previous report on 30 March 2016.									
Recommendations									
The Board is asked to receive this report to note.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
Compliance with the Trust's Constitution and Standing Orders,									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance					Information Management & Technology				
Human Resources					Buildings				
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		

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

Register of Seals – April 2016 – June 2016

Reference Number	Date Signed	Document	Authorised Signatory 1	Authorised Signatory 2	Witness
778	29/04/16	Contract between Charitable Trusts for UHBristol alterations for 24a upper Maudlin Street	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance &	
779	29/04/16	Suite 4c Whitefriars, Lewins Mead, Bristol 2 x licences to alterations	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance &	
780	29/04/16	Suite 4c Whitefriars, Lewins Mead, Bristol 2 x lease	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance &	
781	13/05/16	Deed of extension amendments for Public Health Services (Sexual Health Services) between Bristol City Council, North Somerset Council and South Gloucestershire Council 4 x copies	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance &	
782	01/06/2016	Bristol General Hospital: Deed of Variation	Robert Woolley, Chief Executive	Paul Mapson, Director of Finance &	Pam Wenger, Trust Secretary

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
17. West of England Academic Health Science Network Board Report – June 2016									
Sponsor and Author(s)									
Sponsor: Robert Woolley, Chief Executive **Author**: N/A									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose To update the Boards of the member organisations of the West of England Academic Health Science Network of the decisions, discussion and activities of the Network Board. Key issues to note There are no key issues to note.									
Recommendations									
The Trust Board is recommended to note this report.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
N/A									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance		For Approval		For Information	✓		
Date the paper was presented to previous Committees									
Quality & Outcomes Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**				

Report from West of England Academic Health Science Network Board, 13 June 2016

1. Purpose

This is the twelfth quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website www.weahsn.net for information.

2. Highlights of our work in Quarter 1 2016/17

We have had the usual busy start to the year and highlights include:

- We have launched our Primary Care Patient Safety Collaborative – with 16 GP practices drawn from across the West of England. We will work together on patient safety culture, quality improvement, incident reporting and lessons learnt
- Our acute trusts joined by Taunton and Somerset NHS Trust are keen to work together with us to implement the forthcoming national programme on a structured approach to hospital mortality review and to share best practice. Dr Kevin Stewart of the Royal College of Physicians addressed our launch workshop.
- "Design Together, Live Better 2" – our innovation crowd sourcing programme is underway following a highly successful launch event in Swindon attended by 55 people.
- Our Diabetes Digital coach test bed is underway. Over the next two years we will recruit 12,000 people with diabetes in the West of England and encourage them to use a variety of digital self-management tools to support their self-care.
- We have 52 Improvement Coaches currently in training drawn from 20 of our member organisations. The aim is to develop staff who already have skills in improvement science so that they can coach colleagues and lead quality improvement at work. The Improvement Coach training is being supplemented by masterclasses. The first one "The Habits of an Improver" was given by Bill Lucas. Watch the film here http://www.weahsn.net/news/the-habits-of-an-improver/
- In partnership with Avon Primary Care Research Collaborative and the NIHR Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC west) we have developed online evidence and evaluation toolkits http://www.weahsn.net/what-we-do/using-evidence-based-healthcare/evidence-and-evaluation-toolkits/ We are offering training session on using the toolkits in every CCG.
- We have formed an Emergency Department Safety Collaborative to support rollout of the ED safety checklist across the West of England. We also held a master class on 25 April which was attended by 22 delegates from Emergency Departments across the country.

- Improving Medicines Safety on discharge from hospital - three of our acute trusts are using a system called PharmaOutcomes to notify community pharmacists when a patients medication has been changed in hospital so that waste can be avoided. We will go on to introduce medicines reviews which may reduce re-admissions to hospital.

3. Sustainability and transformation plans

The AHSN has allocated Anna Burhouse, Natasha Swinscoe and Deborah Evans to work with the Chief Executive leaders of the Sustainability and Transformation Plans for Gloucestershire, BNSSG and BaNES, Swindon and Wiltshire respectively. We are working with the STPs to define our support offer to each of them.

4. Annual Report 2015/16

Our Annual Report is out! Read it here. http://www.weahsn.net/who-we-are/reports/annual-report-2015-16/ The Year in Numbers is attached to this report.

5. Stakeholder survey

The second annual AHSN stakeholder survey is due to be released late June / early July. Last year we had over 120 responses; the highest amongst AHSNs and the most positive responses. This reflects the very strong engagement we have with all CCGs, NHS Trusts and social enterprises across the West of England and the strength of our partnerships.

This year's results will count towards our "re-licencing" for the five years so we will be looking forward to a very a strong response and will contact stakeholders once the timetable is confirmed

6. West of England Local Clinical Research Network

We are working ever more closely with the NIHR West of England Local Clinical Research Network whose job is to increase the numbers of patients enrolled in research trials.

We have a joint "Join Dementia Research" project through which we have recruited 1,500 West of England residents to take part in dementia studies.

Deborah Evans,
Managing Director
June 2016

The year in numbers

1,606

1,606 clinical and non-clinical staff took part in patient safety, informatics and quality improvement events on key themes, including sepsis, falls prevention, medicines optimisation, early warning score, and emergency laparotomy.

£2.1 million

Our new Diabetes Digital Coach Test Bed is receiving £1.65 million in funding from the Department of Health, with further funding from our partner companies taking the project value over £2 million.

6

Working with Royal United Hospitals Bath, the Health Foundation and Sheffield Microcoaching Academy, we have trained six local clinicians and managers in improving patient flow across three care pathways.

26

26 different organisations are actively involved in our Safer Care Through Early Warning Scores programme.

20

Up to 20 primary care practices are joining our new Primary Care Collaborative.

40,000

Since its launch, OpenPrescribing.net has attracted 40,000 visitors.

116

116 healthcare professionals have benefitted from advanced skills-based training to enhance leadership, patient safety and flow, innovation and evaluation.

85%

In our stakeholder survey, 85% of our members believe we are effective at building a culture of partnership and collaboration.

52

52 primary care practices in Gloucestershire are taking part in phase two of Don't Wait to Anticoagulate.

4

Four new websites were launched to support NHS commissioners and clinicians: OpenPrescribing, Don't Wait to Anticoagulate, Evaluation and Evidence Works.

291

We have given advice to 291 companies wanting to work with the health sector, providing 154 business assists.

£9.5 million

To date, we have helped secure £9.5 million in funding for SMEs for the development of innovative healthcare solutions.

133

133 atrial fibrillation (AF) patients are now being anticoagulated as a result of phase one of Don't Wait to Anticoagulate, which worked with 11 primary care practices over four months. Modelling shows this saved between five and seven strokes and up to £163,205.

100+

More than 100 people participated in the Design Together, Live Better project to share their ideas for new healthcare innovations.

1,400

Join Dementia Research recruited 1,400 people across the West of England in its launch year.

137,315

To date, 137,315 patients have benefited from having their Connecting Care record viewed by clinicians.

29

29 of our initiatives have influenced and informed national thinking and guidance.

West of England Academic Health Science Network

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

Report Title									
18. Audit Committee Chair's report									
Sponsor and Author(s)									
Sponsor & Author: John Moore, Non-Executive Director and Chair of Audit Committee									
Intended Audience									
Board members	✓	Regulators		Governors		Staff		Public	
Executive Summary									
Purpose This report provides a summary of the business discussed at the meeting of the Audit Committee held on 24 May 2016 and 7 June 2016. Key issues to note The report includes an overview of the key issues discussed, areas of challenge and scrutiny and assurance provided by the Executive, Trust representatives, Internal Audit and External Audit.									
Recommendations									
The Board of Directors are asked to receive the Audit Committee Chair's report of business conducted at the meeting held on 24 May 2016 and 7 June 2016.									
Impact Upon Board Assurance Framework									
N/A									
Impact Upon Corporate Risk									
N/A									
Implications (Regulatory/Legal)									
N/A									
Equality & Patient Impact									
None									
Resource Implications									
Finance		Information Management & Technology							
Human Resources		Buildings							
Action/Decision Required									
For Decision		For Assurance	✓	For Approval		For Information			
Date report submitted to other sub-committee									

Finance Committee	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Audit Committee**

Report to the Board of Directors meeting 28 June 2016

From Audit Committee Chair John Moore, Non-Executive Director

This report describes the business conducted at the Audit Committee held 24 May 2016, indicating the challenges made and the assurances received.

Item	Key Points	Challenges	Assurance
Annual Report	Members received the Annual Report which included the Annual Governance Statement	There were no specific issues.	Assurance was provided that the content was consistent with the guidance issued and had been subject to review by External Audit.
Annual Accounts	Members received the report and the annual accounts for consideration. Members noted the change in terms of the FTC and the summarisation certificate which is to be submitted to Monitor. Members noted the Accounting Policies and received an update on the estimates. It was noted that there		

Item	Key Points	Challenges	Assurance
	were no issues identified by the Audit.		
Quality Report	Members received the Annual Quality Report which would form part of the Annual Report.	Information in relation to complaints and specifically the quality of the complaints was raised. Specific question was raised in relation to data quality.	Members received assurance that this was not identified as a priority for this year. Work is still being progressed although it was not a specific objective for 2015/16. Internal Audit confirmed that this was an internal audit every year. Assurance was provided that overall data quality good and there were one or two areas to focus upon.
Head of Internal Audit Opinion	The Head of Internal Audit Opinion was received. Members noted the two red reports and that there had been improvement since the audits.	Members challenged the action plan and response in relation to the Discharge Planning and Infection Control Reports.	Management responses are being developed in relation to these specific issues.

Item	Key Points	Challenges	Assurance
	Members noted that significant assurance report.	Challenges in relation to the fire safety training and how this got to a position that it was non compliant.	Assurance was provided in relation to the processes and training for evacuation training and how the risks were currently being mitigated. Members were assured that the risks were significant and that this work was already in hand. Re-assurance was provided in relation to the quality of the fire safety training and that plans were in place to take forward further work to understand the cohort of training of staff required to undergo the training. Lessons learnt meeting has been arranged to understand what went wrong. Highlighted the fact to the distinction between essential training and essential to role training. Sue Donaldson is tasked with taking this work forward. Members received assurance of the work that previously was undertaken. Subsequent

Item	Key Points	Challenges	Assurance
External Audit	Members received the reports from the External Auditor including the ISA 260. There were no misstatements and a positive result from the audit process and the judgments were included in the report.	Challenges in relation to the significant transaction reported by the Auditors.	Assurance was provided that the team were working to resolve the issue with the Supplier. Further assurance was provided that additional software had been purchased which prevented duplicate payments being made.. Assurance was provided that overall process was being reviewed to bring the non-purchase order controls and the purchase order controls in line. The Committee was assured given the very small percentage of the overall spend that here was nothing further that could be taken to minimise the issue. Assurance was providing that t a review of the Annual Leave process would be picked up during the year.

Item	Key Points	Challenges	Assurance
Auditor's Report to the Council of Governors in relation to the Quality Report	The report was provided for content of the Quality Report and unqualified and the consistency of information which the EA are aware. RTT qualified opinion.	No specific challenges.	Members noted the further work that had taken place internally to review an additional 50 cases. Medway upgrade behind schedule but will support training and address the mandatory overrides data quality issues. The training has made some improvements which were undertaken in the latter part of the year. Simplify the way in which the data would be actioned. Data quality issues addressed going forward.
Review of External Auditor Performance	To confirm the extension of the External Auditors Contract	There were no areas where challenge was required.	Assurance from the Committee to extend for a further year.
AOB	Annual Declaration – General Condition 6	None	Agreed to raise at the Board as this was a specific return that was required to be submitted before the end of May 2016.

Report to the Board of Directors meeting 28 June 2016

From Audit Committee Chair John Moore, Non-Executive Director

This report describes the business conducted at the Audit Committee held 7 June 2016, indicating the challenges made and the assurances received.

Item	Key Points	Challenges	Assurance
09/06/16 Minutes of the meeting held on 9 March 2016 (Item 3)	With regard to the 4th paragraph of minute reference 64/03/16, Jenny McCall advised that she had met with Robert Woolley to review the outstanding recommendations for audits greater than 12 months with a review to reducing the number outstanding.	No challenges were made.	Robert Woolley advised that the Executive Directors were working with Russ Caton to review the long overdue recommendations, which would be closed if appropriate. The Committee noted that all recommendations to be actioned by the Chief Operating Officer had been closed and that generally, progress continued to be made.
	The Committee discussed the extension of Datix into Clinical Audit		Since the initial discussion Sarah Wright had received confirmation from Datix that a specific Clinical Audit module was in development and further information relating to the release would be available in November

Item	Key Points	Challenges	Assurance
	The minutes for the meeting held on 24 May 2016 were considered	Minor amendments were made for the purpose of accuracy.	It was resolved that the Committee approve the minutes of the meeting held on 9 March 2016 and 24 May 2016 as an accurate record of proceedings, subject to the amendments outlined in the minutes.
11/06/16 Matters Arising (Item 5)	Leigh Adams, Director of Estates and Facilities, advised the Committee that following the audit of the Estates and Facilities Department in September 2015 and March 2016	Robert Woolley enquired as to the assurances the Audit Committee could take until such time that a new system would be implemented.	Kate Parraman advised that a process mapping meeting had been scheduled for early July to understand the requirements for the new system, which must have the same level of controls currently in place.
		Emma Woolley queried the controls and assurances in the department as a whole.	Leigh Adams advised that the department had held a number of staff seminars to ensure the basic agreed principles were fed back to staff and had fully embraced the staff engagement agenda to positively bring about the required changes. The department had also likened systems already used within the Trust to work differently and this had been embraced throughout. The required culture change within the department was also noticeable.

Item	Key Points	Challenges	Assurance
		John Moore enquired on behalf of Deborah Lee the level of robustness around compliance with the Standing Financial Instructions (SFIs).	Kate Parraman advised that she felt much more assured than previously as staff in the Estates and Facilities department now sought clarity with the Finance department prior to making decisions and taking action. Targeted training around the SFIs had also been undertaken within the department.
		John Moore sought assurance that there was now a clear separation of duties i.e. with regard to the selection of providers, placing purchase orders, approving contracts and payment of invoices.	Leigh Adams confirmed this was the case.
12/06/16 Local Counter Fraud Status Report (Item 6)	Jenny McCall introduced the report, the purpose of which was to provide the Audit Committee with a summary of counter fraud work undertaken since the previous meeting, as well we the national developments and other areas of interest, in order to provide assurance on the Trust's anti-fraud arrangements.	In response to a query from John Moore, Robert Woolley was confident that the IM&T department had adequate systems and processes in place to maintain the security of the Trust's Wi-Fi.	Russ Caton confirmed that the Trust had a contract in place with a penetration and testing firm who routinely tested the Wi-Fi system. The Audit Committee noted that Internal Audit was also in the process of commencing an audit on the Wi-Fi system and IM&T representatives provided regular reports on cyber issues to the Information Risk Management Group.

Item	Key Points	Challenges	Assurance
	The report included details of alerts that had been received by the Local Counter Fraud Specialist and related to on-line extortion demands and the threats of public Wi-Fi.	Alison Ryan queried whether staff provided information to patients or families which detailed how to access the Trust's internal Wi-Fi, particularly in areas with poor internet access.	Jenny McCall assured the Audit Committee that counter-fraud team closely monitored any potential risks from such alerts. Russ Caton advised that codes were not required for patient access but the system did not provide free access to the Trust's intranet but did provide access to Wi-Fi.
	Jenny McCall advised that as part of the induction process, new employees were required to answer questions on counter fraud and the counter fraud team attended various meetings on a regular basis to obtain feedback from existing staff.	Alison Ryan commented that in a previous organisation, fraud training was included within the online mandatory training every 3 years and Committee members agreed it should be included within the Trust's mandatory training.	It was agreed that Jenny McCall would ask Sandra Bell to liaise with Kate Parraman to discuss how this could be linked with the SFI training. It was also agreed that Robert Woolley would take this to the Executive Directors to discuss whether it qualified.
		Lisa Gardner queried the process in place with regard to the submission of timesheets and where it had broken down.	Kate Parraman advised that the timesheet would be approved by the relevant line manage and submitted to the relevant agency. Jenny McCall advised that if an investigation identified that any controls were to be improved, an update report would be provided for the Director of Finance.

Item	Key Points	Challenges	Assurance
13/06/16 Local Counter Fraud Annual Report 2015/16 (item 7)	Jenny McCall introduced the Local Counter Fraud Annual Report for 2015/16. Page 3 of the report detailed the key areas of work undertaken by the counter fraud team and provided assurance of the Trust's compliance against all requirements from NHS Protect. The National Fraud Initiative exercise undertaken, in which the Trust participated, highlighted a number of potential fraud cases which had been referred to HR for disciplinary proceedings.	With regard to benchmarking against national referrals, it was noted that the latest quarterly report had not been received at the time of printing and an update would be included in next report.	Jenny McCall referred to a repayment of money which had been obtained fraudulently via sick pay and it was noted that system improvements are suggested where appropriate. The counter fraud team continued to provide advice to staff and raise awareness of counter fraud. The report also provided details of the ongoing counter fraud cases within the Trust.
14/06/16 Internal Audit Annual Report 2015/16 (item 8)	Jenny McCall introduced the Internal Audit Annual Report for 2015/16 which detailed progress against the rolling audit plan. The report highlighted the key areas of review through the year, which included fire safety and Estates. Detailed on page 4 of the report were the outcomes from the Operational Review of the Division of Medicine. Two pieces of work were scheduled to commence in June and updates would be provided in September.	Alison Ryan queried whether Internal Audit would undertake a comparative review of Root Cause Analysis (RCA) investigations, due to the different standards of the reports. Discussions continued with regard to the level of training required by staff who were to undertake RCA investigations; this had been raised previously by QOC as a matter of concern. John Moore commented that it would be helpful for the table on page 8 of the report to annotate in	The positive Divisional audit and subsequent report was noted. With regard to the Quality and Performance Management, the Committee noted the valuable and positive link with the Quality and Outcomes Committee. The report acknowledged the ongoing work with the Information Governance (IG) toolkit and it was noted that work was underway to provide training to new staff on induction rather than the current awareness session.

Item	Key Points	Challenges	Assurance
	Russ Caton advised that meetings had been arranged with the relevant Executive Director lead and managers to agree the project Terms of Reference. Once the Terms of Reference had been agreed, they would be circulated to all Executive Directors.	white where the report had not been received. The Trust's compliance against the Public Sector Internal Audit standards was noted.	Firm dates for every piece of work in the plan would be in place by the next meeting of the Audit Committee in September.
		E-Rostering: Alison Ryan referred to the recommendation related to the lack in the business plan of any smart plans to achieve the benefit savings and queried who approved the aspirations contained within business plans and who ensured a post-implementation review was undertaken.	Jenny McCall advised that an external review of the process would also be undertaken. Kate Parraman advised that it was dependent on the purpose of the business plan and the arena in which the scoping work was undertaken. Kate confirmed that a review process should be incorporated within all business plans, particularly those with financial implications. Robert Woolley confirmed the business planning process was well-developed and advised that Paula Clarke, Director of Strategy and Transformation, could review and adapt the process if a different emphasis was required.
	Management of Resuscitation Equipment: The Committee discussed the management responses to the recommendations	Emma Woollett queried the process to resolve disagreements around the management responses. Russ Caton acknowledged there would be	Robert Woolley confirmed there was Executive Director oversight over each report and the supporting action plans, which

Item	Key Points	Challenges	Assurance
	on pages 29 and 30 of the report. The Non-Executive Directors raised concerns over the level of assurance provided by the management responses provided. Infection Control – Rare and Imported Pathogens. Management of Waiting List Initiatives: Emma Woollett had been pleased to note the controls in place for Waiting List Initiatives. Finance Reporting: The Audit Committee noted the green rating for Financial Reporting.	occasions when Internal Audit had identified issues but Divisional management believed mitigating actions put in place were appropriate and sufficient. In response to a query from John Moore, Russ Caton advised that whilst the risk was extremely rare, the staff turnover of staff in the Emergency Department presented difficulties in updating the staff training records for the management of rare diseases.	were then signed off following further scrutiny, if required, by the Senior Leadership Team. Internal Audit had sought assurance that there was a training register in place within the department to record the specific training undertaken by every member of staff.
15/06/16 Losses and Compensation Report (item 9)	The totals for the quarter were significantly higher than typically reported but reflected the approach taken towards the year-end. The report identified a number of aged debts that had been deemed to be unrecoverable and provided context to the Committee with regard to the outstanding debts. A number of outstanding debts remained with a debt collection agency.	No challenges were made.	The Committee recognised that the framework for overseas visitors to the Trust had changed, and included new ways agreed to identify overseas visitors and changes to the legal requirements for providing treatment. As a result of the new framework, a significant piece of work had identified a number of recommendations to be implemented in order to improve the controls and processes in place.

Item	Key Points	Challenges	Assurance
16/06/16 Single Tender Action Report (item 10)	The summary report showed the number and value of STAs for each division, within each of the three approval categories for the period 1 March 2016 to 30 April 2016.	Jenny McCall advised that it would be useful to identify whether certain areas within the Trust used STAs more frequently than others. It was suggested that it may also be useful to undertake a benchmarking exercise with the Procurement Consortium to ascertain local activity.	Kate Parraman advised that she regularly met with her counterpart in North Bristol Trust to undertake local benchmarking and learning around overpayment of salaries and overseas visitors.
17/06/16 Risk Management Group Summary Report (item 11)	Robert Woolley introduced the report, prepared following the Risk Management Group meeting in April. The report demonstrated the comprehensiveness of the agenda and the Group's ability to review and discuss risk issues and to scrutinise the Divisional Risk Registers.	The Committee discussed the Document Management System (DMS) and the issue around obsolete items. John Moore queried whether the Risk Management Group would be the appropriate forum in which consideration would be given to the risk of non-monitored areas which should be routinely monitored. Alison Ryan would like to receive evidence that the Executive Team received information from the NHS community around those areas where other organisations had encountered issues.	Robert Woolley confirmed that work was ongoing to ensure duplicate or obsolete procedures / policies were not still available either on DMS or other platforms and that a re-audit was underway. It was noted that both the Internal and External Auditors provided information on external activities. Jenny McCall advised that the Internal Audit could provide, as part of every audit report, information about departmental KPIs and the reporting mechanisms. Robert Woolley advised this would be taken to the Risk Management Group for discussion.

Item	Key Points	Challenges	Assurance
18/06/16 Board Assurance Framework (item 12)	Robert Woolley introduced the Board Assurance Framework (BAF) update report. The report's cover sheet described how, following discussions at the Board Seminar and in response to the recommendations from the Well-Led Governance Review, the format of the BAF had been revised. Further alterations were still required and the final revised BAF would be presented to the Board in July. The BAF would be released to the Non-Executive Directors in advance should further discussion be required around the format.	The Committee discussed the Audit Committee meeting schedule and it was acknowledged that the meetings were possibly 4 – 6 weeks early in terms of the quarterly reporting.	John Moore advised that it was the responsibility of the Audit Committee to ensure appropriate processes were in place and that timely review of the BAF would enable this to happen. Robert Woolley would look at the wider context of a more dynamic use of the BAF, as with the CRR, and consider the revised timings of the Audit Committee meetings.
19/06/16 Corporate Risk Register (item 13)	It was noted that if a risk had been rated more highly on a Divisional Risk Register following a dynamic review and achieved the threshold of 12, the risk would be presented to the Senior Leadership Team via an Executive Director. The Executive Director would re-rate the risk with the Division but with a corporate perspective. It would therefore be possible that when reviewed from a corporate perspective, the rating be may revised and scored lower. The Senior Leadership Team would look to validate the judgement about	In response to a query from Emma Woollett, Sarah Wright advised that the level of risk around the pneumatic chute had been reduced and had reverted back to the Divisional Risk Register until resolved. In response to a query from Emma Woollett around the perinatal mental health service (risk no 949), Robert Woolley advised that confirmation was awaited from the Commissioners with regard to funding required to support a	John Moore was assured at the level of consideration and oversight given to the risks. In response to a query from Alison Ryan, Robert Woolley confirmed the Senior Leadership Team reviewed risks on a monthly basis.

Item	Key Points	Challenges	Assurance
	whether the risk remained on the Divisional Risk Register or transferred to the CRR for Board visibility.	service the Trust wished to provide. John Moore enquired as to the risk around the maintenance of fire safety equipment and Sarah Wright advised the risk remained on the Estates Risk Register and scored 10.	
20/06/16 Clinical Audit Quarterly Report (item 14)	The quarterly update on progress against the plan of clinical audit activity facilitated by the Clinical Audit & Effectiveness Team during the 2015/16 financial year was reviewed. A similar position to previous years had been sustained and the Committee noted that 158 out of 220 (72%) projects had commenced according to the planned timelines during the year. An improvement had been noted in meeting the timescales for Priority 1 and 2 projects, with a slight slippage reported for Priority 3 and 4 projects. This movement reflected appropriate prioritisation due to the continued clinical pressures.	No challenges were made.	In terms of Priority 1 projects, the Committee noted that 53 out of 55 (96%) had commenced or been completed. The report provided an explanation on the two Priority 1 projects (2 out of 55) that had not commenced in 2015/16.

Item	Key Points	Challenges	Assurance
21/06/16 Clinical Audit Forward Plan 2016/17 (item 15)	The Clinical Audit Forward Plan for 2016/17 presented an overall increase in the planned activity compared to the previous year. There had been an increase in re-audit levels, which had been driven by the Clinical Audit team, and also an increase in the number of planned audits linked to Divisional Operating plans. The Clinical Audit team had undertaken significant work to identify the categorisation of projects, in terms of improved documentation around projects, and how projects linked to Trust and Divisional priorities and risks.	In response to a query from Emma Woollett around the bereavement audit, Karin Bradley advised that it related to questionnaires the Committee had been pleased to note that the audit had been driven by the local clinicians.	The Committee noted that all of the major specialities and 69 out of 75 sub-specialties were represented in the Forward Plan. Emma Woollett acknowledged the clarity of the detail within the Forward Plan, particularly with regard to the breakdown by specialty and sub-specialty. Alison Ryan highlighted the patient safety issues, particularly around Serious Incident reporting and risks that had been discussed by the Quality and Outcomes Committee and was assured by the inclusion of these issues.
22/06/16 Report of the Chair of the Quality and Outcomes Committee (item 16)	Alison Ryan, Chair of the Quality and Outcomes Committee, presented the report on the key issues and risks arising from the meetings held on 29 March, 28 April and 24 May. Key areas of focus for the Committee included: • ITU bed capacity, which impacted patient flow • The RCA and Serious Incident process	The reported upturn in patients waiting over 18 weeks National Early Warning Scores (NEWS) and the Trust's ability to respond appropriately on the ward, particularly as NEWS had been cited in a number of Serious Incidents.	The Committee noted the report.

Item	Key Points	Challenges	Assurance
23/06/16 Report of the Chair of the Finance Committee (item 17)	Lisa Gardner, Chair of the Finance Committee, presented the report on the business transacted at the meetings held on 23 March, 25 April and 23 May 2016. Workforce issues, including agency, retention and the controls and demand management around rostering, continued to be significant areas of focus for the Committee. Following on from the productivity project in Surgery Head and Neck, the process had been rolled out to the other Divisions and would be followed through to support cost improvement plans. It had been positive to note that the clinical teams and the Divisions had fully embraced the process.	The Committee reviewed and approved the Financial Plan and the Resources Book for 2016/17, noting that the sustainability funding had not yet been confirmed. In response to a query from John Moore, Kate Parraman advised that confirmation of the Trust's budget for the coming year was anticipated. It was noted that confirmation was still awaited with regard to the sustainability funding.	The Divisional management team from Surgery Head and Neck were scheduled to attend the Finance Committee in June, followed by Women's and Children's in July, in order to maintain Divisional Board engagement. The Committee noted the report.
24/06/16 Register of Interests, Gifts and Hospitality Policy Review (item 18)	Robert Woolley introduced the report which described the approach taken around the policy review undertaken in April 2016 and Committee members could be assured that the review had been undertaken and reviewed appropriately.	No challenges were made.	The Committee could expect to receive the annual report of staff interests, gifts and hospitality at the next meeting in September. It was noted that the policy had been reviewed and approved by the Senior Leadership Team in April 2016.

Item	Key Points	Challenges	Assurance
25/06/16 Board of Directors Register of Interests, Gifts and Hospitality (item 19)	Robert Woolley introduced the Board of Directors Register of Interests, Gifts and Hospitality for the Committee to note.	No challenges were made.	The Committee noted the report.
Any Other Business	There was no other business.		N/A

University Hospitals Bristol NHS
NHS Foundation Trust

Cover report to the Board of Directors meeting held in Public
To be held on Tuesday 28 June 2016 at 3.00pm in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Report Title									
19. Governors' Log of Communications									
Sponsor and Author(s)									
Sponsor: John Savage, Chairman **Author:** Kate Hanlon, Head of Membership & Governance									
Intended Audience									
Board members	✓	Regulators		Governors	✓	Staff	✓	Public	✓

Executive Summary

Purpose:
The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board. The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-executive Directors when new items are received and when new responses have been provided.

Key issues to note:
Two new queries have been added to the log since May report: Item 151 and 152, for which responses have been provided. Item 150 was reopened for further clarification and an updated response has been provided. No other items are outstanding.

Recommendations
None.
Impact Upon Board Assurance Framework
Impact Upon Corporate Risk
Implications (Regulatory/Legal)
Equality & Patient Impact

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

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

ID	Governor Name		
152	Anne Skinner	***Theme*** Clinical nurse specialists	***Source:*** Governor Direct

Query **06/06/2016**

I know that there are "pockets" of good practice within the Trust where patients can contact specialist nurses regarding any queries they may have relating to their condition. I am also aware that patients, having been discharged from some wards, can contact the ward if they have any worries or queries. However, I would like to know if this practice is consistent across all specialities and wards within the Trust and whether any similar arrangements are in place for outpatients who have concerns and worries after being seen by a consultant?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **14/06/2016**

In the first few days following discharge all patients are advised to contact the ward/emergency department if they have any concerns, this is reiterated in the Trust's various discharge information leaflets.

All patients that are being treated in a service that is supported by Clinical Nurse Specialists (CNSs) will have the contact details of the CNS team for them to make contact with if they have concerns/worries. The majority of CNSs work is outpatient/clinic based, supporting medical colleagues, not inpatient based. A small number of specialities are not supported by a CNS team - for these patients the point of contact following outpatient appointments would vary depending on their issues, it could be direct with the relevant outpatient clinic team members, through the Trust's booking services, the relevant consultant's admin support team or directly with their consultant.

Status: *Awaiting Governor Response*

ID	Governor Name				
151	Mo Schiller	***Theme*** Cataract surgery		***Source:*** Chairman's Counsel	

Query **31/05/2016**

The Consultant Eye Surgeons Partnership has recently been involved in cataract surgery lists at weekends. The normal BEH consultant post surgery follow-up appointments are 6 weeks post surgery to look at the health of the eye. Patients are advised of this on discharge and it is suggested that they visit their usual optician for a vision review and possible new lens prescription at around 5 weeks post-surgery.

The present wait for a post-surgery follow up appointment is approx. 16 weeks and the Trust is suggesting to patients that this can be done by UH Bristol approved opticians. Is the Board aware of this and should the Trust itself not carry out this appointment rather than a third party so that it can ensure the information is recorded in the patient's notes for future reference? The appointment can be managed by a nurse practitioner at BEH.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **06/06/2016**

The Trust has been working with its commissioners to look at ways in which care can be transferred to the community where it is safe and appropriate to do so. The rationale for this approach is to provide care closer to patients and to deliver care at lower cost where that is possible. One such area, is the transfer of cataract follow up to community optometrists - the optometrists are accredited and remunerated by the Clinical Commissioning Group, not UH Bristol, but worked in partnership with the Bristol Eye Hospital team. This scheme is relatively new.

At present there is insufficient capacity available to ensure patients are followed up at 6-8 weeks when both a vision and “eye health” check should be done and as a result patients are waiting up to 16 weeks – this is being addressed both through additional clinics running at BEH and through use of the new scheme for seeing patients in the community, and we have seen wait times starting to fall. It is likely that a proportion of follow up care will need to continue to be provided by BEH.

It is clear from the example, that communication with patients about these changes has not been good enough and the service has been asked to address this urgently and is doing so. This will not only provide information about the changes and what patients can expect, but will also advise patients how to seek more urgent help if they experience problems whilst awaiting a follow up review.

Status: *Closed*

ID	Governor Name				
150	Anne Skinner	***Theme*** Cleanliness monitoring		***Source:*** Trust Board Meeting	

Query **13/05/2016**

During the 2016 PLACE inspections, ICU beds were found to be cleaned to a very high standard but the ceiling pendants supporting the monitoring equipment in Cardiac ICU and Neonatal ICU were found to have accumulated a significant volume of dirt and dust. The Estates & Facilities Department was aware of this problem in Cardiac ICU prior to the PLACE inspection. Nevertheless, the same problem was found a few weeks later in Neonatal ICU.

Why were checks not made to establish whether this issue was occurring elsewhere when it was first identified and why was prompt rectification not instituted? I would like assurance that the two teams responsible for cleaning bed areas are able to work together to give attention to all the equipment in a vacated bay in the limited time available before the next patient arrives. Further, I would like to understand why this issue was not identified during the audits undertaken by the Estates & Facilities Department and whether there is a procedure to escalate serious issues arising from PLACE inspections promptly to the Trust Executive.

Division: Trust Services ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 16/05/2016

Response **25/05/2016**

The facilities team have reviewed the cleaning schedule in CICU and other designated “very high risk” areas as a result of the PLACE inspection feedback to ensure that all elements of the high level cleaning standards are met.

A revised cleaning process has been agreed where the HSAs will clean the pendants on a daily basis as per a standard operating procedure, the lower part of the pendant remains a clinical staff members responsibility. The revised process has been formally incorporated into the cleaning schedule for the relevant areas and supported with a sign off checklist which is reviewed on a weekly basis by the domestic supervisor.

The facilities and clinical teams work closely together to maintain cleaning standards. There is regular audit of compliance with cleaning standards which is reported via the Trust's infection control group, any variance from the standards requires an exception report on actions taken to ensure compliance and there is an increase in the frequency of auditing as required.

Further clarification requested by governor and received 14/06/16:

1. "When the problem was identified in CICU , why were checks not made on similar equipment elsewhere?" There is no comment on this.

A formal communication across all other sites did not take place following identification of this failure in CICU, the focus was on discussion with department manager and matron for the area to rectify the issue. There is now a process in place where by cleanliness related failures will be circulated internally to all Hotel Services Managers as an immediate prompt for review in other relevant areas.

ID **Governor Name**

2. "Why was prompt rectification not instituted?" There is no comment on this.

The issue was first raised at this year's PLACE Assessment, 2016, whereupon immediate action has been taken to rectify. As a result Hotel Services Managers have reviewed each site and a scheduled programme is now in place to clean the high level pendants within their areas of responsibility. This will be supported by ongoing checks by the Supervisors for the areas. A review of the PLACE Assessment results for BRI in 2015 show that this issue was not reported prior to 2016.

3. "Assurance that the two cleaning teams are able to work together." This has been answered satisfactorily. No comment required.

4. "Why the issue was not identified by cleaning audits." There is no comment on this.

The issue was not identified by our regular Cleanliness Audits, as ceiling pendants specifically do not fall under one of the 52 Elements of the NHS Cleaning Specification. The wording around ceiling lighting in the National Specification indicates that ceiling lights should be visibly clean. From the auditors perspective, when walking the ward areas, the pendant lights were visibly clean as auditors audit from ground level, and what they were able to observe was clean to the naked eye. It is now acknowledged that dust is gathering on the top of the pendants (high level) and a regular 'check and resolve' has been put in place in all relevant areas, as described above.

5. "What is the procedure to escalate serious issues arising from PLACE inspections to the Trust Executive?" There is comment on reporting issues arising from the regular audits to the Infection Control Group (but no indication that this occurred in the cases I highlighted) and no comment on the process to raise serious issues arising from PLACE visits to executive level.

There is a process for escalating serious issues arising from PLACE or any other cleanliness inspections. This is to speak immediately with the department manager and matron responsible for the area to agree actions to rectify the issues identified. The process is to take action as required and then re-audit to ensure that satisfactory standards (at a National Level) have been reached. A final report detailing areas of good practice and areas for improvement following the PLACE process is submitted to Service Delivery Group (SDG) and Infection Control Group (ICG). The PLACE outcome report of 2015 went to SDG in November 2015.

There is a a process in place for monthly Cleanliness audit of against the 52 NHS cleaning specification and outcome reports (both by site and by Division) are circulated to Department Managers, Heads of Nursing, Key Stakeholders including Executives. The Monthly Audit Reports are also presented at the Trusts Infection Control Group and a summary quarterly report submitted to SDG.

Status: *Awaiting Governor Response*

ID	Governor Name		
149	Mo Schiller	***Theme:*** Bristol Eye Hospital	***Source:*** Governor Direct

Query **07/04/2016**

What priority will be given to improving the tired waiting areas in pre-op assessment and OPD department at BEH. Any improvement will enhance the patient experience. Some chairs that are easier for the elderly/disabled are needed. Patients have to wait 4+ hours in these areas and hard chairs are not good for the elderly. White boards and communicating long waits would be helpful.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 07/04/2016

Response **12/04/2016**

The management team at the BEH has recently met with the Trust Governors to hear first-hand about their experience of the eye outpatient department. An action plan, which has been shared with the Governor, has been developed which describes the steps that will be taken to improve the patient experience. This includes bidding to the Friend of BEH to secure funds to make physical enhancements to the seating in the waiting area. The action plan will be ciruclated by email as an attachment to this response.

Status: *Closed*